CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Lauren Maree Johnstone**
Citation:	**[2019] ACTCD 5**
Hearing Dates:	25-27 March 2019
Decision Date:	4 June 2019
Before:	**Chief Coroner Walker**
Decision:	See [2], [54].
Catchwords:	**CORONIAL LAW** – cause and manner of death – use of medication – medical treatment – over-the-counter medication
Legislation Cited:	*Coroners Act 1997* (ACT) *Poisons Standard June 2019* (Cth)
Cases Cited:	*Harmsworth v The State Coroner* [1989] VR 989 *Inquest into the death of Suellen Edith Davis* [2018] ACTCD 10
Parties:	Counsel Assisting the Coroner Dr Alistair Taylor Dr Arne Schimmelfelder Dr Antonio Di Dio
Representation:	**Counsel** Sarah Baker-Goldsmith (Counsel Assisting) Thomas Lynch (Dr Taylor & Dr Schimmelfelder) Kristy Katavic (Dr Di Dio) **Solicitors** HWL Ebsworth (Dr Taylor & Dr Schimmelfelder) Moray & Agnew (Dr Di Dio)
File Number:	CD/10/2015

CHIEF CORONER WALKER:

1. Ms Lauren Maree Johnstone, born 1 September 1967, died on 7 January 2015 aged 48. An inquest was held to determine the manner and cause of her death, that death having been referred to the coroner pursuant to section 13(1)(c) of the *Coroners Act 1997* which provided relevantly, at that time,[1] that a coroner must hold an inquest into the manner and cause of death of a person who dies a sudden death the cause of which is unknown.

[1] Republication R33 is the applicable version.

2. Having held a hearing over three days, I now make the following formal findings:

   (a) The deceased, Lauren Maree Johnstone, died at 18 Jondol Place, Isabella Plains, in the Australian Capital Territory on 7 January 2015.

   (b) The manner and cause of her death was the combined toxic effect of prescription and non-prescription medications including doxylamine, tramadol, codeine, oxycodone, zopiclone and fluoxetine, lawfully prescribed or obtained.

General background

3. At the time of her death, Ms Johnstone was living with one of her two daughters, Ms Ariarne Bunyan. Ariarne heard her mother snoring at about 5:00am on 7 January 2015 before she left for work. When she returned at about 2:40pm, she found her mother lying in bed and unresponsive. Ariarne called the 000 helpline. ACT Ambulance Service staff attended but determined on arrival that Ms Johnstone was deceased. Police also attended.

4. Ms Johnstone was a former police officer who retired as a result of experiencing post-traumatic stress disorder around 2010. This was associated with anxiety and depression and was aggravated by severe lower back pain. She was alcohol dependent and suffered sleep apnoea requiring the use of a CPAP mask. As a result of her psychological distress, she had previously attempted suicide by an overdose of unknown prescription medication in 2011. She was admitted to hospital on occasion in respect to her psychological condition.

5. Her general practitioner was Dr Antonio Di Dio. About six months before her death, Ms Johnstone entered into a medication contract with Dr Di Dio in light of her inappropriate doctor and chemist shopping for access to prescription medication. This contract required, amongst other things, that she only obtain medications from a particular pharmacy. Ms Johnstone was also under the care of Dr Lean, a psychiatrist.

6. Ms Johnstone had a significant history of recent surgical intervention including a breast reduction on 27 November 2014, bladder reconstruction on 20 December 2014 and, most proximate to her death, cosmetic facial surgery on 5 January 2015.

7. The breast reduction and facial surgeries were conducted at the Canberra Plastic and Cosmetic Surgery ('CAPS') clinic in Deakin. For each, the surgeon was Dr Alastair Taylor and her anaesthetist was Dr Arne Schimmelfeder.

8. Before her death, Ms Johnstone was looking forward to the wedding of her daughter Ms Tamara Johnstone to Mr Thomas Farrell, planned for April 2015. She had lost approximately 50kg in weight in preparation for the event. Ms Johnson had commenced a new relationship with a Sydney-based man. As far as her family was concerned, Ms Johnstone was in a positive frame of mind at the time of her death.

Proximate medical treatment

9. Dr Di Dio referred Ms Johnstone to Dr Taylor at the CAPS clinic in July 2014 to be assessed in relation to breast reduction surgery. At the time of this referral, she was subject to a fairly extensive medication regime including: tramadol (trade name 'Zydol'); diazepam (tradename 'Valium'); zopiclone (tradename 'Imovane');

fluoxetine (tradename 'Prozac'); alprazolam (tradename 'Xanax'); and agomelatine (tradename 'Valdoxan').

10. She saw Dr Taylor in September 2014. Dr Taylor advised that she needed to reduce her weight to under 100kg, from her then 114kg, in order to be eligible for the surgery.

11. On 9 October 2014, Ms Johnson saw Dr Omar Gailani at the Capital Women's Health clinic for consultation in relation to surgery to assist with incontinence. Both Dr Taylor and Dr Gailani wrote to Dr Di Dio after their consultations with Ms Johnstone.

12. Ms Johnstone last attended Dr Lean, her psychiatrist, on 20 October 2014, when he increased her existing medication, Prozac, with a recommendation to commence another, Minipress.

13. Ms Johnstone saw Dr Di Dio on 7 November 2014. She was exercising and eating well. She told him that she was not drinking alcohol. At that time she had reduced from a maximum weight of 154kg to 105kg with a goal weight of 80kg.

14. Ms Johnstone attended the CAPS clinic again on 11 November 2014. It was noted that she was anxious and should be first on the theatre list for surgery.

15. She saw Dr Di Dio on 20 November 2014. He was aware of the intended breast reduction surgery and the bladder surgery. He went on leave in December and did not see Ms Johnstone again after this consultation, a cause of some distress to him.

16. On 24 November 2014, Ms Johnstone had a further consultation with Dr Taylor at the CAPS clinic in relation to facial surgery which was booked for 5 January 2015. Dr Di Dio was not made aware of this surgery until after Ms Johnstone's death.

17. On 27 November 2014, Ms Johnstone underwent the breast reduction surgery at the Sole Vita Clinic. Some tissue was taken for histopathology.

18. She re-attended the CAPS clinic on 2 December 2014 for stitch removal. Dr Taylor was happy with her progress and she was given a prescription for oxycodone (tradename 'Endone').

19. On 4 December 2014, Ms Johnson contacted the CAPS clinic complaining of pain and swelling. She was told this was a normal post-operative reaction which would settle with time. She was encouraged to take oral pain relief as required.

20. On 5 December 2014, Ms Johnstone was advised of an incidental finding of lobular carcinoma without invasive malignancy. She spoke with Dr Louise Stone, a general practitioner at her usual clinic, in Dr Di Dio's absence on 8 December 2014. She was anxious about the diagnosis. She consulted Dr Mike He, surgeon, about it on 9 December 2014. He indicated that she did not require any further surgery but should be reviewed regularly. A similar approach was recommended when she saw the Capital Region Cancer Service on 22 December 2014 although an MRI was also recommended. There is no evidence that this finding caused her significant ongoing concern.

21. On 15 December 2014, Ms Johnson saw Dr Gailani for a follow-up consultation regarding urinary incontinence. She was booked for surgery which was performed on 19 December 2014. She was discharged the next day.

22. On 5 January 2015, Ms Johnson was readmitted to the Sole Vita clinic where she underwent the planned facial surgery. In recovery, she complained of anxiety and a panic attack as well as the pain she was experiencing. She was discharged the next day by Dr Taylor with a prescription of oxycodone and metoclopormide hydrochloride (tradename 'Maxalon'). She was also prescribed Imovane, Valdoxan, Tramadol and Valium by Dr Schimmelfeder at her request. She said she had run out of the medications she was ordinarily prescribed by her general practitioner two days previously and that he was on leave and would be unable to prescribe them for her. Dr Schimmelfelder called the general practitioner's rooms in order to speak with Dr Di Dio but he was on vacation. He did warn Ms Johnstone of the risk of increased drowsiness as a result of combining those medications with Endone.

23. Those scripts were filled that day at the pharmacy in accordance with her medication contract with Dr Di Dio.

24. At a time, and for reasons unknown, Ms Johnstone also obtained Restavit and codeine.

25. This medication history is important because of post-mortem findings in respect Ms Johnstone.

Cause of death

26. Toxicological analysis of post-mortem blood samples disclosed the presence of doxylamine (tradename 'Restavit'), tramadol, codeine, oxycodone and fluoxetine at high levels.

27. Associate Professor Sanjiv Jain who conducted a post-mortem examination of Ms Johnson concluded with the benefit of this toxicology report that her death was caused by the toxic effects of a cocktail of prescription medication. I note that the medications listed as part of that cocktail included Restavit, which remains, and codeine which was at that time, non-prescription medication.

28. As a result of these findings, a report was sought from Associate Professor Vanita Parekh, a clinical forensic medicine specialist with qualifications in toxicology. Associate Professor Parekh concluded that co-administration of multiple sedative drugs was highly significant in that it was likely to cause more profound sedation, decreased heart rate and respiratory depression compared to these drugs taken individually. She noted that the toxicity of any one of these drugs, which may be below the lethal level, differed from their combined toxicity which may result in death even where there are lower levels of the individual substances. In short, the interaction of these drugs likely potentiated the sedating effect of the others. She opined that this could affect the user's ability to think rationally and therefore to recognise, for example, that they were having breathing problems or that their position was impacting upon their ability to access oxygen. She also noted that this reduction in rational thinking might impact upon a person's ability to recognise that they needed to act, such as move or seek help, if their breathing was affected. Further the high degree of muscle relaxation could impact on intentional coordinated muscle movement and thus reduce a person's physical ability to act in their own best interests. In Ms Johnstone's situation, the likelihood of positional asphyxia could be increased by obesity and sleep apnoea.

29. Ultimately, the medical evidence failed to disclose the precise mechanism of Ms Johnstone's death but the preponderance of the evidence allows a conclusion, consistent with that arrived at by Associate Professor Jain, that the cause of Ms Johnstone's death was the combined toxic effect of prescription and non-prescription medications including doxylamine, tramadol, codeine, oxycodone, zopiclone and fluoxetine. It is not possible to find with any degree of confidence which, if any, of the drugs was a more significant contributor to Ms Johnstone's death.

Manner of death

30. The inquest explored whether Ms Johnstone's death was:

    (a) suicide, that is an act of intentionally causing her own death;

    (b) an accidental overdose in the sense of ingesting higher than prescribed quantities of a drug or drugs; or

    (c) the unexpected result of self-administration of lawfully prescribed and obtained medication.

31. Whilst Ms Johnstone had previously disclosed suicidal thoughts, that was not evident in the period proximate to her death. Indeed, to the contrary, she was actively pursuing the improvement of her own health and well-being and was known to be looking forward to her daughter's wedding. While she was still experiencing mental health issues, including anxiety, these appeared to be reasonably well controlled. She certainly left no indication of an intent to cause self-harm which would allow a finding of suicide.

32. In respect to the possibility of an accidental overdose, insofar as it was possible to measure her prescribed medication with that which was missing from prescription she had filled, there is nothing to suggest an intake beyond what was prescribed to her. In so far as there is any evidence on this issue, the work undertaken by coronial investigator First Constable Fiegert, although inconclusive, in relation to current prescriptions and the medication found at her home supports a conclusion that she was taking those medications in accordance with advice. Dr Di Dio was also satisfied that Ms Johnson was largely complying with her medication contract and obtaining scripts at appropriate intervals, indeed, he described her compliance as impeccable. Prior to the spate of surgery she underwent, Ms Johnson appeared to be tolerating this medication regime without apparent ill effect for a reasonable period of time.

33. Of course that medication regime was augmented with Endone prescribed post-surgery for pain relief. In addition, Ms Johnstone was clearly using non-prescription medication which neither Dr Taylor nor Dr Schimmelfeder were aware of. I am satisfied that the use of all of these substances likely contributed to her death.

34. I conclude that Ms Johnstone's death came about as a result of compliance with her prescribed medication regime aggravated by the addition of non-prescription medication without the prescriber's knowledge, that is her death was the unexpected result of self-administration of lawfully prescribed and obtained non-prescription medication.

Matters of public safety

35. At the relevant time, sub-section 52(4) of the Act provided as follows:

> The coroner, in the coroner's findings—
>
> (a) must—
>
> (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and
>
> (ii) if a matter of public safety is found to arise—comment on the matter; and
>
> (b) may comment on any matter about the administration of justice connected with the inquest or inquiry.

36. In *Harmsworth v The State Coroner* [1989] VR 989 at 997, Nathan J discussed the ambit of the Coroner's power to comment as follows:

> The power to comment arises as a consequence of the obligation to make findings … It is not free ranging. It must be comment 'on any matter connected with the death.' The powers to comment and also to make recommendations … are inextricably connected with, but not independent of the power to enquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of the exercise of a coroner's prime function that is to make 'findings.'

37. The inquest examined the propriety of prescribing practices which allowed Ms Johnstone to legally have access to the medications which ultimately killed her. Of particular concern was the prescription of oxycodone post-surgery on the background of the pre-existing regime of medication with sedative properties. This picture of course was complicated by the use of over-the-counter medication which itself had sedating properties, indeed in respect to the Restavit, that was its very purpose.

38. Dr Di Dio, Dr Taylor and Dr Schimmelfeder all gave evidence as to their understanding of the medication regime applicable to Ms Johnstone and the rationale for their contributions to it. These are well summarised by Counsel Assisting, Ms Baker-Goldsmith, whose submissions were accepted without demur by Dr Taylor, Dr Schimmelfeder and Dr Di Dio. I largely adopt them in the following summary.

39. In the six months prior to her spate of surgery in December 2014 and January 2015, Ms Johnstone was generally compliant with the instructions given to her by doctors as to the frequency of consumption of prescription medication. The medication regime developed for her was the result of consultation between multiple specialist physicians and was in keeping with accepted medical practice. It was well tolerated by Ms Johnstone prior to December 2014 in that there does not appear to have been issues with sedation reported or observed prior to her death.

40. In the months prior to her death, Ms Johnstone was not completely open and forthright with her treating professionals as to the medications she was taking or treatment she was receiving. Dr Taylor said that at no time did Ms Johnstone disclose to him that she had been prescribed Tramadol by Dr Di Dio nor that she used over-the-counter products containing doxylamine.

41. Dr Schimmelfeder said that Ms a Johnstone did not disclose her use of Tramadol prior to his prescribing of it on 6 January 2015 nor her use of the over-the-counter drugs Restavit or Phenergen.

42. Neither Dr Taylor nor Dr Schimmelfeder were told by Ms Johnstone about her urinary tract procedure by Dr Gailani on 19 December 2014.

43. Neither Dr Taylor nor Dr Schimmelfeder were aware of the medication contract between Dr Di Dio and Ms Johnstone.

44. Dr Di Dio said that at no time did Ms Johnstone disclose to him that she intended to undergo a facelift in addition to a breast operation, despite there being a clear opportunity for her to have done so at the last consultation on 20 November 2014. Nor did she disclose to him that she used over-the-counter products containing doxylamine or codeine.

45. Ms Johnstone was not entirely forthcoming with her doctors whether by omission or design. In fairness to Ms Johnstone, it is not clear when she commenced use of the Restavit and codeine. Nor was she specifically asked about the use of non-prescription medications of this type. She may not have been aware of the potential significance of them to her health.

46. Whilst Dr Di Dio had provided Dr Taylor with a summary of Ms Johnstone's medication regime at the time of his referral, Dr Taylor and Dr Schimmelfeder relied on the history of medication Ms Johnstone gave them at their relevant consultations. This was in each instance incomplete. They were also unaware of her previous medication seeking behaviour and her medication contract with Dr Di Dio. It was they were aware of those facts, consistent with the approach of Dr Di Dio, they would nonetheless have prescribed strong pain relief medication post-surgery given the acute pain management issue this created. As observed previously, it is not evident that Ms Johnstone was taking Restavit and codeine when she consulted with Dr Taylor and Dr Schimeldfeder.

47. Dr Taylor stated that knowing of Ms Johnstone's ongoing use of Tramadol would not have altered his surgery plan but would have affected his willingness to prescribe two different opioids at the same time. He was unaware of Dr Schimmelfeder's prescription on 6 January 2014 of Tramadol when he had prescribed Ms Johnstone Endone. Had he known this he would have warned Ms Johnstone against using both together. Whilst it is unfortunate that he did not know of the second opioid prescription, his advice would have been to caution her as to their use together, advice which she in fact received from Dr Schimmelfeder.

48. Dr Schimmelfeder said that knowing of Ms Johnstone's ongoing Tramadol use would not have altered his overall anaesthetic plan but had he known, he may have refused to prescribe Tramadol to her post-surgery on 6 January 2015. He said that he was "unhappy" and "not entirely comfortable" about writing the prescription for Tramadol and Ms Johnstone's other regular scripts on 6 January 2015 and he discussed with her "that she had to be cautious and careful with all the medications", however, he judged that abrupt cessation of these medications was not advisable. I am satisfied that he did attempt to contact Dr Di Dio at the Yarralumla Surgery on 5 January 2015 to confirm Ms Johnstone' medication history but was told Dr Di Dio was away and he did not press further. Whilst this is unfortunate, it was not unreasonable to rely on the information Ms Johnstone gave him.

49. I make no criticism of Dr Taylor or Dr Schimmelfeder for failing to have regard to the referral letter nor of their prescription of opioids for Ms Johnstone in the circumstances. Nor do I criticise Dr Di Dio for failing to raise the issue of Ms Johnstone's past medication seeking behaviour in light of her compliance with the existing medication contract and the fact that he was unaware of further surgery planned for January 2015.

50. There is no doubt that closer communication between the treating doctors may have resulted in a different outcome, for example, by denying or delaying surgery, requiring lesser pain control with non-opiod substances or prompting closer enquiry as to the use of non-prescription medications. This is speculative and ultimately a counsel of perfection. It also fails to recognise the role played by Ms Johnstone in failing to fully inform her treating doctors as to medications she was using.

Consideration of recommendations

51. Following recommendations by Coroner Hunter in an *Inquest into the death of Suellen Edith Davis* [2018] ACTCD 10, the Drugs and Poisons Information System Online Remote Access system ('DORA') was introduced in the Australian Capital Territory. In that case, Coroner Hunter found that Ms Davis died from positional asphyxia caused by the combined effects of prescription opioid and non-prescription medications. Of relevance to this case, toxicology disclosed promethazine and doxylamine in Ms Davis's blood; two of the over-the-counter substances which were also present in Ms Johnstone's blood.

52. DORA provides real-time information to prescribing doctors and pharmacists in relation to patient use of Schedule 8 medications. Whilst this is a positive development, considering the application of the DORA system to the facts of Ms Johnstone's case demonstrates some deficiencies in the system as it has presently been implemented:

    (a) It does not include information as to other prescription drugs of potential dependence or harm contained in other Schedules to the *Poisons Standard*, such as diazepam ('Valium') or tramadol ('Tramal');

    (b) It does not include information as to non-prescription drugs which are still controlled by way of Schedules to the *Poisons Standard*, such as Doxylamine which is a Schedule 3 pharmacist only medication;

    (c) Access to, and use of, the DORA system is not mandatory for prescribing doctors or pharmacists in the ACT.

53. Each of the doctors who gave evidence at the hearing identified these deficiencies and supported change.

54. I have considered a number of recommendations proposed by counsel assisting which were either supported or not opposed by Dr Di Dio, Dr Taylor and Dr Schimmelfeder. I have adopted the majority of them as follows:

    (a) that the Therapeutic Drugs Authority consider whether promethazine and doxylamine are appropriately scheduled in the *Poisons Standard*, or whether some further form of restriction to these medications having regard to the risk of misuse (including when taken in combination with other sedating medications) is warranted;

(b) that irrespective of the response of the Therapeutic Drugs Authority, the ACT Health Minister by instrument declare the following substances to be monitored medicines for the purposes of the DORA system: tramadol, doxylamine and diazepam;

(c) that the ACT Health Minister consider widening the scope of monitored medicines under the DORA system to include the entirety of medicines listed in Schedules 3 and 4 of the *Poisons Standard*;

(d) in the alternative, that the ACT Health Minister consider widening the scope of monitored medicines under the DORA system to include certain prescription and over-the-counter medications that may have significant sedating or other adverse effects when taken in combination with opioids or benzodiazepines;

(e) that the ACT Health Minister consider adding functionality to the DORA system to highlight where a patient has demonstrated drug-seeking behaviour, including but not limited to, when a patient has signed a medication contract;

(f) that the ACT Health Minister consider making access to and use of the DORA system mandatory for all ACT prescribing physicians and pharmacists prior to writing and/or dispensing prescriptions;

(g) that the CAPS Clinic and Sole Vita Day Surgery alter its pre-admission forms to expressly prompt patients to list all over-the-counter medications they are either presently taking or take frequently, perhaps with examples of some common brand names;

(h) that the Royal Australian College of General Practitioners, the Australian and New Zealand College of Anaesthetists, and the Royal Australasian College of Surgeons all consider conducting information campaigns with their members to encourage specific prompting (verbally and on applicable forms) of patients on consumption of over-the-counter medications when taking a patient's history.

55. These recommendations will be forwarded to the relevant authorities for their consideration.

56. I am grateful to the parties for the collaborative way in which this inquest was approached.

57. I again express my condolences to Ms Johnstone's family for their loss.

I certify that the preceding 57 numbered paragraphs are a true copy of the findings of her Honour Chief Coroner Walker.

Associate: Riley Boughton

Date: 4 June 2019