FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 493/07

Inquest into the Death of DEBORAH MARGARET RICKLEFS

Place of death: St Frances Xavier Cabrini Hospital

Hearing Dates: 15th and 16th December, 2009, Melbourne County Court

Representation: Senior Constable King Taylor - SCAU, assisting the Coroner

Ms Marietta Bylhouwer of Counsel (Holding Redlich) - on behalf of Professor and Mrs Margaret Ricklefs

Ms Dawne Galbally of Counsel (Monahan & Rowell Lawyers) - on behalf of Associate Professor Michele Levison

Mr Richard H. Stanley of Counsel (Monahan & Rowell Lawyers) - on behalf of Cabrini Hospital

Ms Aine Magee of Counsel (Avant Law P/L) - on behalf of Dr Ravinder Singh

Mr Sean Cash of Counsel (John W. Ball & Sons) - on behalf of Dr John Gunzburg

Findings of: AUDREY JAMIESON, Coroner
Delivered On: 15th March 2010
Delivered At: Melbourne Magistrate's Court

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST[1]

Section 67 of the ***Coroners Act 2008***

Court reference: 493/07

In the Coroners Court of Victoria at Melbourne

I, AUDREY JAMIESON, Coroner

having investigated the death of:

Details of deceased:

Surname: RICKLEFS
First name: DEBORAH
Address: 1/21 Macgowan Avenue, Glenhuntly 3163

AND having held an inquest in relation to this death on 15 and 16 December, 2009

at the County Court of Victoria at Melbourne

find that the identity of the deceased was **DEBORAH MARGARET RICKLEFS**

and death occurred on **6 February 2007**

at St Frances Xavier Cabrini Hospital

from:

1a. INVASIVE ASPERGILLOSIS

[1] The Finding Into Death With Inquest does not purport to refer to all aspects of the evidence received in the course of the Investigation/Inquest. The material relied upon includes statements and documents tendered in evidence together with the Transcript of Proceedings. The absence of reference to any particular piece of evidence either through a witness or a tendered document does not infer that it has not been considered.

SUMMARY OF THE INVESTIGATION:

1. The death of Deborah Ricklefs was reported to the Coroner by St Frances Xavier Cabrini Hospital. The cause of death was not clear but was considered *unnatural* and therefore, *a reportable death.* [2]

2. The investigation into the death of Deborah Ricklefs was originally concluded without Inquest. A "Chamber Finding" was completed on 9 October 2007.

3. Ms Ricklefs' parents, Professor and Mrs Margaret Ricklefs subsequently questioned the adequacy of the completed investigation, raising a number of concerns about the medical management of their daughter by Dr John Gunzburg and Cabrini Hospital. Of particular concern was the prescribing method of the medication Lamotrigine adopted by Dr Gunzburg and the possible relationship this medication may have had to their daughter's death.

4. I accepted that some of the matters raised by Professor and Mrs Ricklefs had not been addressed in the completed Record of Investigation. The investigation was re-opened.

5. In the initial investigation, the **Clinical Liaison Service** (CLS)[3] only reviewed Ms Ricklefs' medical management at Cabrini Hospital. The prescribing of Lamotrigine was not investigated. Subsequent to re-opening the investigation, CLS assisted in a more extensive investigation of the background and surrounding circumstances including Ms Ricklefs' commencement of Lamotrigine prior to her admission to Cabrini Hospital on 29 January 2007.

6. A Directions Hearing was held on 30 October 2009. The relevant issues identified by me as requiring further enquiry at an Inquest included the prescribing methods of Dr Gunzburg and the relationship, if any, of the prescribing of Lamotrigine, to Ms Ricklefs' death. Another issue identified by Ms Ricklefs' parents was the hospital's management of patients at greater risk to

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[2] Section 3 *Coroners Act 1985* defines "reportable death" means a death -

(a) where the body is in Victoria; or
(b) that occurred in Victoria; or
(c) the cause of which occurred in Victoria; or
(d) of a person who ordinarily resided in Victoria at the time of death-

being a death-

(e) **that appears to have been** unexpected, **unnatural** or violent or to have resulted, directly or indirectly, from accident or injury; or

[3] The Clinical Liaison Service (CLS) assists the Coroners Court of Victoria in ensuring that the true nature and extent of deaths caused during specialised clinical provision are fully elucidated and that any remedial factors are identified to prevent any future occurrences.

The Clinical Liaison Service draws on the distinct experiences and expertise of medical, nursing and research personnel to evaluate clinical evidence for the investigation of healthcare deaths reported to the Coroners Court.

exposure of infections (including aspergillious) - particularly those being treated with corticosteriods. Witnesses required for the Inquest were also identified. Dr Gunzburg was present but unrepresented.

7, A further Directions Hearing was held on 30 November 2009. An Inquest was held on 15 and 16 December 2009. The *Coroners Act 1985* applies.

THE ROLE OF THE CORONER - SECTION 19(1) *CORONERS ACT 1985*:

8. Section 19(1) *Coroners Act 1985* requires a Coroner to find, if possible, the identity of the deceased, how the death occurred, the cause of death and the date and place of death. In order to distinguish 'how death occurred' from the 'cause of death', the practice is to refer to the former within the context of the *background and surrounding circumstances* and the latter as the *medical cause* of death.

9. A coroner may, if appropriate, also comment on any matter connected with the death being investigated including public health and safety,[4] report to the Attorney General on the death and make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health and safety or the administration of justice.[5]

10. The identity, date and place of death of Deborah Margaret Ricklefs were without contention and required no formal coronial investigation.

APPLICABLE LAW:

11. The *Coroners Act 1985* does not specify the standard of proof which is required to be applied however the case law has determined that the standard of proof is on the balance of probabilities with the applicable test in accordance with *Briginshaw v Briginshaw*[6]. The Supreme Court of Victoria has confirmed on many occasions that this test should apply to findings of causation and contribution where the questions relate to individuals or other entities acting in their professional capacity. In *Briginshaw,* Dixon J stated:

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4 Section 19(2) *Coroners Act 1985*

5 Section 21(1) and (2) *Coroners Act 1985*

6 *(1938) 60 CLR 336*

The seriousness of the allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect references .[7]

12. The test is applicable where the performance of a medical practitioner or other health care provider is under scrutiny. Any finding in relation to causation is a matter of great seriousness. In *Clark v Stingel*[8] the Victorian Court of Appeal confirmed that this seriousness must be considered when applying the appropriate standard of proof. Their Honours Chief Justice Warren and Chernov and Kellam JJA stated:

.....the matters to be considered by the tribunal of fact may be of such seriousness that strong evidence - clear and cogent - may be required before reasonable satisfaction that the allegations have been made out can be attained on the balance of probabilities.[9]

13. In *March v Stramare*[10] the High Court of Australia considered the fundamentals of causation in the negligence context. Chief Justice Mason observed:

What was the cause of an occurrence is a question of fact which must be determined by applying common sense to the facts of each particular case.

14. In the matter of *Gurvich*, Justice Southwell stated:

That to say to professional people that they have contributed to the cause of death of another person in the course of their professional duties is to make a very serious allegation, an allegation of negligence that by breach of professional duty owed to the deceased they contributed to death.

The effect of a finding would be so devastating that no such adverse finding should be made unless there exists a comfortable satisfaction that negligence has been established which contributed to the death.[11]

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7 @ 361 - 362

8 [2007] VSCA 292

9 @ para 37

10 (1991) 171 CLR 506

11 Secretary to the Department of Health and Community Services v Gurvich (1995) 2 VR 69 @ 79

15. Such a finding - an adverse finding - is not to be made lightly. Amendments to the Act[12] removed the requirement to make a specific reference to contribution but at times, it is unavoidable. Similarly, although it is not the role of the coroner to make specific findings of negligence it can unavoidably be implied particularly when the professional person's duty to the deceased has been breached in some way.

BACKGROUND CIRCUMSTANCES

16. Ms Deborah Ricklefs[13] was born on 29 September 1977. She was 29 years old at the time of her death. She lived at 1/21 Macgowan Avenue, Glenhuntly. Deborah was a Registered Division 1 Nurse having completed her degree at RMIT University on 17 December 2004.

17. Deborah had a medical history of systemic lupus erythematosus (SLE) with renal involvement and possible cerebral involvement in the past. She suffered from a pulmonary embolism in 2003, peptic ulcer in 2004, irritable bowel syndrome, Raynaud's disease, avascular necrosis of the knees and alcohol abuse. Her SLE had been treated with steroids and chemotherapy in the past. The development of avascular necrosis of the knees had been attributed to her SLE treatment. This condition necessitated pain killer/relief medication for which she was prescribed Oxynorm and Neurontin. Deborah also reported adverse reactions to a number of medications including anti-depressants and antibiotics.

18. Deborah also had a history of mental health problems. In September 2006, she attempted suicide. She received treatment at The Alfred Hospital and the Albert Road Clinic. The diagnosis at the time was of bipolar affective disorder and borderline personality traits associated with chronic pain.

19. Other prescription medications included Epilem, Pariet, Plendil ER, Valpam, Panamax and Symbicourt Turbuhaler.

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[12] In July 1999 s19(1)(e) requiring a finding as to the identity of any person who contributed to the cause of death was repealed.

[13] Ms Ricklefs' parents requested that their daughter be referred to as Deborah during the course of the Inquest. For consistency, I have, for the most part, used only her first name in the Finding.

SURROUNDING CIRCUMSTANCES

20. On 10 January 2007, Deborah's treating medical practitioner, Dr Samuel Jaworowski, wrote a letter of referral to Dr John Gunzburg at the First Step Program. The reasons for the referral were to obtain help with reducing and managing Deborah's use of Oxynorm and to provide her with counselling.[14] Dr Jaworowski was concerned about Deborah's addiction to the opiate. His letter of referral to Dr Gunzburg also listed Deborah's current medications which included Epilem (Sodium Valporate) 500 mg 2 mane & 2 @ night.

21. On 16 January 2007, Deborah attended her first appointment with Dr Gunzburg. The Doctor reported that Deborah requested a prescription for the anticonvulsant medication, Lamotrigine for help with anger and mood swings. Dr Gunzburg prescribed 100mg to be taken daily. The initial dose prescribed by Dr Gunzburg exceeded the recommended initial dose of 50mg daily contained in the MIMS guidelines.[15]

22. On 23 January 2007, Deborah attended Dr Gunzburg for a second time. On this occasion, Dr Gunzburg reported that Deborah had advised him that she had ceased taking the Lamotrigine after a couple of days. He prescribed her Tramadol 50mgs, 1-2 capsules, 6 hourly for the pain she was experiencing in her knees.

23. On 24 January 2007, Deborah attended on Dr Jaworowski and advised him that she had been prescribed Lamotrigine by Dr Gunzburg. In a letter dated 29 January 2007[16] to Dr Ho, Dr Jaworowski reported that Deborah had been prescribed Lamotrigine by Dr Gunzburg, approximately 10 days earlier and the dose was 100mgs b.d. (i.e. a total of 200mgs per day).

24. On 26 January 2007, Deborah was admitted to Cabrini Hospital, Malvern, with a 3-4 day history of fever, migraine, chest tightness, shortness of breath and hypotension. A provisional diagnosis of sepsis was made. She was treated with intravenous fluid replacement and a number of blood tests were undertaken. She developed a red blotchy itchy rash from unknown causes which was treated with drug therapy. Deborah refused antibiotics on the grounds that she believed they interfered with her SLE. It was recorded that she was taking Lamotrigine 100mg nocte and she was prescribed and administered the medication that evening. She had a dispute with nursing staff over the administration of a narcotic analgesic for pain relief. Deborah believed that she had been administered Oxycontin (instead of Oxynorm) to which she professed to having an allergy to.

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14 See Exhibit 9

15 See Exhibits 7 & 8

16 See Exhibit 10

25. On the morning of 27 January 2007, Deborah discharged herself from hospital.

26. On 29 January 2007, Deborah was readmitted to Cabrini Hospital with rash, fever, raised liver function tests, a pulmonary infiltrate noted on chest X-ray and coagulopathy. It was noted that she had commenced on the anticonvulsant medication, Lamictal (Lamotrogine), 2 weeks earlier. A drug reaction was queried. She was treated with intravenous steroids.

27. On 30 January 2007, Deborah was admitted to the Intensive Care Unit due to increasing oxygen requirements. A chest X-ray confirmed the presence of infiltrates throughout both lungs suggestive of Acute Respiratory Distress Syndrome (ARDS) or atypical infection. She required intubation. An ultrasound confirmed the presence of small calculi within the gallbladder with increased vascularity suggestive of cholecystitis.

28. Deborah's condition continued to deteriorate. On 4 February 2007, she developed acute renal failure requiring dialysis.

29. On 6 February 2007, Deborah's pupils were noted to be fixed and dilated. Cerebral angiogram revealed no cerebral perfusion. She was pronounced deceased at 1:00pm.

30. The Medical Practitioner's Deposition queried whether the cause of death was related to a drug reaction to Lamictal leading to multi-organ failure and brain death. The Deposition also noted a query about whether Deborah had been on a higher dose of Lamictal than recommended.

INVESTIGATIONS: [17]

The medical investigation into cause of death:

31. An **autopsy** was performed by Dr Katherine White, Forensic Pathologist, at the Victorian Institute of Forensic Medicine. Dr White identified widespread invasive aspergillus, a fungal organism, in major organs including the lungs, kidneys, thyroid, trachea and heart. She also found evidence of acute septic infarcts of the brain associated with angioinvasive fungi. Dr White commented:

> *Aspergillus is a fungal organism. It has a tendency to invade and destroy blood vessel walls. This causes necrosis of the tissues supplied by that blood vessel. Fungal organisms can also extend beyond the blood vessel walls and form abscesses.*
> *Furthermore by invading blood vessels, the fungal organisms can easily spread to separate organs within the body.*

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[17] "Investigation" includes an inquest - see section 3 *Coroners Act 1985*

Steroid treatment can cause a degree of immunosuppression, predisposing a patient to fungal infection.

32. Toxicological analysis from samples obtained at the hospital on 26 January 2007 and 29 January 2007, identified an anti-epileptic drug, Gabapentin - also known as Neurontin. Diazepam and its metabolite, nordiazepam, were identified at non-toxic levels. The psychoactive ingredient of cannabis, delta 9-tetrahydrocannabinol, was also identified as was the anticonvulsant, Lamictal, at a level within the therapeutic range.

33. There was no controversy about the medical cause of Deborah's death.

34. I accept and adopt the medical cause of death as identified by Dr Katherine White and **find** that **Deborah Margaret Ricklefs** died as a consequence of widespread invasive aspergillosis.

Dr Gunzburg's medical management of Deborah:

35. Deborah attended on Dr Gunzburg on only two occasions, 16 and 23 January 2007. The proximity of the commencement of his involvement in her medical management and the rapid decline in her health is apparent. His involvement in her medical management specifically led to the prescribing of Lamotrigine. The proximity of the commencement of this medication and Deborah's rapid decline in health was questioned at the outset by doctors at Cabrini Hospital. The possible causal link between her death and the commencement of Lamotrigine has drawn attention to the standard of care adopted by Dr Gunzburg in his medical management of Deborah.

36. Dr Gunzburg prescribed Lamotrigine 100 mg daily as the starting or initial dose.

37. **I find** that this dose was excessive and in contravention of the MIMS prescribing guidelines. The Prescribing Information devotes 16 pages of information to the prescriber including information on known adverse reactions associated with its use and the known drug interactions associated with its use. The recommended treatment regime is contained within a Table within the Prescribing Information.

38. In his *viva voce* evidence Dr Gunzburg admitted that he made *an error* and *a mistake* in prescribing Lamotrigine 100 mg daily as a starting or initial dose to Deborah. He nevertheless maintained that he had consulted the Prescribing Information and informed Dr Jaworowski of his intentions. He also maintained that Deborah was not taking Epilem at the time of her attendance on him.

39. Dr Gunzburg's public admission of his error in exceeding the recommended prescribing guidelines for initial dose is acknowledged and commended however, this acknowledgement does not necessarily exculpate him. There were other aspects of Dr Gunzburg's evidence that I found difficult to reconcile with his lack of contemporaneous record keeping and the evidence of others. Dr Gunzburg's reference to the Prescribing Guidelines while Deborah was in attendance could not have involved the level of care that the prescribing of this medication deserves. Dr Gunzburg had no familiarity with this medication yet he proceeded to prescribe it to a patient with a complex medical history that he was seeing for the first time. Instead of these "firsts" creating a heightened level of caution in reading the extensive Prescribing Information, he acted upon the barest of gleamed information when he provided Deborah with the prescription. I am not satisfied that he properly informed himself by reading the warnings contained within the Prescribing Information before he provided Deborah with the prescription.

40. I do not accept Dr Gunzburg's evidence that he intended to prescribe 50 mg daily as the initial or starting dose. His explanation as to how the error may have occurred during the typing of the prescription merely depicted and reinforced the picture of a medical practitioner who failed to take proper care in his method of prescribing this medication. Whether he was distracted by a telephone call or some other event does not excuse his lack of attention to the final prescription he created.

41. In the initial prescribing of Lamotrigine another identified issue of concern relates to Deborah's **concomitant use of Epilem**. The Prescribing Information Recommended Treatment Regime Table, clearly distinguishes recommended treatment regime as a monotherapy and as an add-on therapy for patient's also receiving valporate. Within the Prescribing Information there are warnings to the prescriber that the concomitant use of valporate increases the mean half-life of Lamotrigine nearly two-fold.

42. Dr Jaworowski's letter of referral records Epilem as a *current medication.* Dr Gunzburg gave evidence that he had ascertained Deborah's current medications at the appointment on 16 January 2007. Epilem was not amongst them. Although I cannot exclude the possibility that Deborah may have been selective in the information she provided to Dr Gunzburg about either her medical history or the medication she was taking, the extent of the warnings within the Prescribing Information about the concomitant use of valporate should have alerted Dr Gunzburg to enquire further about the discrepancy between the contents of the referral letter and that information being provided by Deborah. There are no contemporaneous notes to support that any such enquiry for clarification was made. Accepting that doctors do not transcribe the totality of their conversation with a patient I cannot entirely dismiss that Dr Gunzburg did rely on information given to him by Deborah however, it would have been at the expense of the information provided by Dr Jaworowski.

43. I accept the evidence of Dr Jaworowski that Deborah was prescribed Epilem at the time of her attendance on Dr Gunzburg. His letter of referral confirms this. Dr Jaworowski had been treating Deborah since June 2004. He knew her well and was very concerned about her health and mental state. He could only state however that he was *moderately* confident that Deborah complied with his advice and or that of other members of the medical profession, and moderately confident that she took her prescription medication[18] from one appointment to the next.

44. I am unable to find to the requisite standard, that Deborah was taking Epilem at the time she attended Dr Gunzburg on the first occasion. I am therefore unable to conclude to a reasonable satisfaction that when she commenced Lamotrigine, she was receiving Epilem concomitantly.

45. At Deborah's **second attendance on Dr Gunzburg** on 23 January 2007, he reports that she had told him that she had ceased taking Lamotrigine after a couple of days. There are no contemporaneous notes to support or refute Dr Gunzburg's evidence. He denies increasing the dose to 200 mg daily and states that it is the lack of Progress Notes that supports his memory as he would have entered an alteration/increase to a medication. The are also a lack of contemporaneous notes about conversations he purports to have had with Dr Jaworowski about Deborah around the same time. I do not accept that Dr Gunzburg can always rely on his *good recall* nor do I accept that he has a right to as a medical practitioner, in the absence of any meaningful contemporaneous notes, regardless of how good he purports to be at remembering events.

46. There is evidence to support the proposition that after Deborah's second attendance on Dr Gunzburg on 23 January 2007, the dose of Lamotrigine was increased to 200 mg daily. Dr Jaworowski's contemporaneous notes of Deborah's attendance on him on 24 January 2007, and his letter to Dr Ho on 29 January 2007 support that Deborah had told him of a 200 mg per day dose. The statements of Kelly Gillet[19], Charles Ricklefs[20] and James Lehane[21] also provide support to the proposition that the dose of Lamotrogine had been increased. The box of Lamotrogine[22] prescribed by Dr Gunzburg on 16 January 2007, was provided to Mrs Ricklefs by the hospital after Deborah's admission on 29 January 2007. Fifteen (15) of the fifty-six (56) tablets are missing. One explanation for 15 missing tablets, is that Deborah's dose of Lamotrogine had increased to 200 mg daily on or about 24 January 2008, which would account for her taking 200 mg daily on a least 2 days and provides further support that she had not stopped taking the medication after a couple of days as reported by Dr Gunzburg.

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18 See Transcript of Proceedings pp 63-65
19 See Exhibit 1
20 See Exhibit 2
21 See Exhibit 3
22 Exhibit 4

47. There are however, other possible scenarios which may equally explain why there are 15 missing tablets from the box.

48. The evidence of Deborah's particular characteristics, behaviour at Cabrini Hospital on her first admission, her vulnerabilities including her extensive medical history, her own medical knowledge and interest, all contribute in raising sufficient doubt about her compliance with medical advice.

49. The totality of the evidence relating to the possible increased dose of Lamotrogine does not amount to providing me with a *reasonable satisfaction* to permit me to make a positive finding that Dr Gunzburg advised Deborah to increase the dose of Lamotrogine to 200 mg daily on 23 January 2007. The evidence of this occurrence is in effect contaminated by *inexact proofs, indefinite testimony* and/*or indirect references.*

The medical management of Deborah by St Frances Xavier Cabrini Hospital:

50. Deborah's presentation on 26 January 2007, warranted admission. She reported being unwell for 3-4 days with symptoms including fever and dry cough[23]. Investigations in response to the history she provided were initiated. Deborah discharged herself on 27 January 2007, against advice despite the development of a rash which was being treated but its cause, had not been definitively identified. Deborah reported that she had been given a medication she was allergic to (Oxycontin) and, as a consequence, felt unsafe in the hospital.

51. I am not satisfied that there was a rationale basis for her beliefs. I find that she was not administered Oxycontin. I find that the hospital's treatment of Deborah on 26 January 2007, was reasonable and appropriate in the circumstances.

52. On 29 January 2007, Deborah was readmitted to Cabrini Hospital. She was acutely unwell. Overwhelming sepsis was considered as a differential diagnosis as was Stevens-Johnson Syndrome[24] but a diagnosis of Hypersensitivity or overwhelming drug reaction evolved with the probable link to the recent commencement of Lamotrigine. Treatment included the cessation of Lamotrigine and the administration of steroids. There was a brief period of improvement in Deborah's condition on 31 January 2007, however her condition again deteriorated with clinical

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23 Deborah had only reported severe pains in her knees to Dr Gunzburg on 23 January and Dr Jaworowski on 24 January 2007.

24 *Erythema and Stevens-Johnson syndrome are basically manifestations of a similar disease process. It is considered a reactive process in which the raction can occur to multiple factors including infections or medications. ....Severe Stevens-Johnson syndrome generally occurs in reaction to medications.* (See Exhibit 14 - statement/report of Dr Christopher McCormack dated 1 December 2008)

indices of multi-system failure. Steroid administration was tapered/reduced on 5 February 2007, due to concerns of immuno-suppression which carries with it, the increased risk of infection.

53. Dr Christopher McCormack gave compelling evidence that Stevens-Johnson Syndrome was never present. He was confident that Hypersensitivity syndrome was the correct diagnosis and that the Lamotrigine remained the most likely cause. I accept Dr McCormack's evidence that Deborah did not have Stevens-Johnson Syndrome.

54. I accept that the treatment of Deborah with steroids was appropriate in the circumstances. There is no evidence to support that the dosage or the period of administration of steroids was excessive. I accept the evidence of Dr McCormack and Associate Professor Levison that the amount of steroid administered was "standard" and/or in the "middle range".

55. I also accept A/Professor Levison's evidence that one of the risks associated with the administration of steroids is immuno-suppression which leads to an increased risk of infection including the increased risk of fungal infections such as Aspergillosis, that is, the *unbiquitous environmental mold*[25] attributed to Deborah's cause of death.

56. Deborah's health was at its most compromised during her admission to Cabrini after 29 January 2007, but it was also clearly compromised on admission. She had a history of SLE and numerous other medical conditions. She may have already been exposed to aspergillosis spores prior to her admission but given the nature of the fungus, equally likely to have been exposed in hospital. The source of the aspergillosis spores cannot be identified. Deborah's precarious and compromised immune system made her more susceptible to the fungus. Her compromised immune system has been causally linked to the administration of steroids. However, Deborah's compromised immune system cannot exclusively be linked to the administration of steroids.

57. Professor Ricklefs raised the hospital's ventilation system as a possible source of the aspergillosis spores. He informed me that his own research suggested that where hospitals had enhanced the filtration of their ventilation systems, they had *successfully reduced the incidents of fungal infections in their patients.*[26] Professor Ricklefs agreed that Cabrini Hospital's protocols are *perfectly sensible* but felt there was sufficient information to prompt *all intensive care units to usefully look again and ask whether they can improve the filtration of their ventilation systems*[27].

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[25] See article: *Aspergillosis: Spectrum of Disease, Diagnosis, and Treatment* - Barnes & Marr, Infect Dis Clin N Am 20 (2006) 545 -561

[26] See p.221 Transcript of Proceedings.

[27] *ibid*

58. Professor Ricklefs' comments are worthy of note and indeed were given deserving weight by Mr Stanley, representing Cabrini Hospital, when he indicated that he would report back to the hospital about this, and other issues articulated by Professor Ricklefs[28]. However, I am constrained by the evidence[29]. As there is no evidence to suggest that there was anything deficient in the hospital's air ventilation system at the time of Deborah's admission, there is no basis on which I could reasonably make any comment or recommendation about the need for improvement of ventilation systems at Cabrini or in hospitals *per se.* Similarly, there is no evidence to suggest that there was anything deficient in the hospital's Infection Control policies or specifically connected to the management of Deborah that exposed her to a greater risk of infection of any kind.

59. I am satisfied that the medical management of Deborah during her second admission from 29 January 2007, was reasonable and appropriate in the circumstances. Of note, Professor and Mrs Ricklefs acknowledged that they *think they* (Cabrini Hospital) *did everything that could be done to save Deborah's life.*[30]

CONCLUDING COMMENTS AND FINDINGS:

1. Dr John Gunzburg prescribed Lamotrigine 100 mg daily as the starting or initial dose to Deborah. This was an excessive starting dose and in contravention of the MIMS prescribing guidelines. He failed to take proper care as a medical practitioner in his method of prescribing this medication in that he failed to pay close attention to the Treatment Regime Table, the warnings contained in the Prescribing Information and to take adequate precautions to check that Deborah was not also taking Epilem (valporate). In every aspect of the initial prescribing of Lamotrigine to Deborah, Dr Gunzburg failed to take the care that a reasonable practitioner should have taken in prescribing a medication he had never prescribed before and one that carried with its use, significant known risks.

2. I am unable to find conclusively that when Deborah commenced Lamotrigine she was receiving Epilem concomitantly. Similarly, I am unable make a finding that Dr Gunzburg advised Deborah to increase the dose of Lamotrigine to 200 mg daily at her second attendance on 23 January 2007.

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[28] See p.224 Transcript of Proccedings.

[29] See *Harmsworth v The State Coroner* (1989) VR 89

[30] See p.220 Transcript of Proceedings

3. I am satisfied that she did take 15 x 100 mg tablets of Lamotrigine from 16 January 2007 until her second admission to Cabrini Hospital on 29 January 2007.

4. I am satisfied on the evidence of A/Professor Levison and Dr McCormack of a causal connection between the prescribing and taking of 15 x 100mg tablets of Lamotrigine in this period, and Deborah's need for admission to Cabrini Hospital on 29 January 2007. The diagnosis of Hypersensitivity syndrome linked to the recent commencement of Lamotrigine was made at the time and I have not identified any reason to depart from that diagnosis.

5. The causal link between Deborah's commencement of Lamotrigine at an excessive dose and her admission to Cabrini Hospital is made out. The treatment for Hypersensitivity syndrome was steroids and I have accepted the relationship their administration can have on the immune system and the increased risk to infection. However, having accepted the cause of Deborah's death as Invasive Aspergillosis, I am unable to definitively find that the cause of her death was causally linked to the prescribing of Lamotrigine by Dr Gunzburg as there are other possible intervening reasons/contributing factors which effectively break the causal link between the commencement of Lamotrigine and her death.

RECOMMENDATION:

1. That the Medical Practitioner's Board of Victoria considers the circumstances surrounding Deborah's death but specifically the prescribing methods of Dr John Gunzburg and take whatever action it deems appropriate.

Signature:

AUDREY JAMIESON
CORONER
Date: 15 March 2010

WITNESSES:

viva voce evidence was obtained from the following witnesses:

- Dr Samuel Jaworowski
- Dr Ravinder Singh
- Associate Professor Michele Levison
- Dr Christopher McCormack
- Dr John Gunzburg

DISTRIBUTION OF FINDING:

- Professor & Mrs Margaret Ricklefs
- All witnesses
- All Legal practitioners representing the interested parties.
- Medical Practitioners Board of Victoria
- Minister for Health