FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 4352/10

In the Coroners Court of Victoria at Melbourne

I, IAIN TRELOAR WEST, Deputy State Coroner

having investigated the death of:

Details of deceased:

Surname: MOUSLEY
First name: DONNA
Address: Unit 1, 7 Swallow Street, Werribee, Victoria 3030

AND having held an inquest in relation to this death on 21st October, 2011 and 1st June, 2012 at Melbourne

find that the identity of the deceased was DONNA MARIA MOUSLEY
and death occurred on 12 November 2010

at Western General Hospital, Gordon Street, Footscray, Victoria 3011

from
1a. HYPOXIC BRAIN INJURY
1b. COMBINED DRUG TOXICITY

In the following circumstances:

1. Donna Mousley, aged 46 years, was a pet sitter by occupation and resided with her partner, Chris Mockridge and 10 year old daughter, at Unit 1, 7 Swallow Street, Werribee. She was on a Disability Support Pension at the time of her death and had three other children from two previous relationships. Her medical history included hypertension, severe migraine, anxiety, chronic obstructive airways disease, binge drinking and depression. Ms Mousley had been a heavy smoker over many years and her past history included alcohol dependency and being a victim of child sexual abuse. In addition, there had been a degree of instability in her relationship with her partner, with there being cycles of leaving him and subsequently returning.

2. In late 2005, Ms Mousley began to experience severe headaches, resulting in her attending a number of medical practitioners for pain relief and being prescribed codeine based medications. At the Primary Health Care Medical Centre, Werribee, she was treated by Dr Anthony Farnbach who was unable to determine what caused the headaches and arranged a brain CT scan, however, this failed to determine the cause. He prescribed panadeine forte to take as required, with a maximum of eight a day. Dr Farnbach remained Ms Mousley's medical practitioner and over the five years preceding her death he treated her for a number of problems, which included intermittent migraines, a shoulder tendon tear, some intermittent depression, chronic obstructive pulmonary disease and social stress. On a number of occasions, she was given morphine sulphide injections, or intravenous morphine for pain management. Ms Mousley openly admitted to Dr Farnbach that she had a weakness for mersyndol forte and panadeine forte and also admitted a weakness for ducene (diazepam). In the period leading up to her death, Dr Farnbach prescribed lexapro 20mg (28 with 5 repeats) on the 4th June, maxalon 5mg (25) on the 8th September, ducene 5mg (50) on the 25th September and panadeine forte (180) on the 9th September.

3. Ms Mousley came to realize that she had an addiction problem with panadeine forte and sought help to try and get off the medication. Accordingly, on the 26th October 2010 she consulted Dr Charles Cyngler at the Hennessy Clinic, St Kilda. Her mother, Rose Carkett, accompanied her to the clinic, however, she was not present during the consultation. The issues for which Ms Mousley presented for management were migraine, the overuse of panadeine forte (12-16 tablets per day) and valium 5mg (6-12 tablets per day) and in addition, she also sought assistance with severe anxiety. A mental health assessment was undertaken and a plan of management was discussed, with Dr Cyngler recommending that she be weaned off her panadeine and valium medication, and if she found that too difficult, then consideration would be given to transferring to the methadone program. Dr Cyngler held a methadone permit issued by the Department of Health, for prescribing methadone in the maintenance treatment of opioid dependence. During the course of the 50 minute consultation the issues relevant to going on to methadone or buprenorhine were discussed, as were the effects and potential risks associated with taking methadone. Dr Cyngler stated in his evidence that it was his usual practise to provide a patient information booklet, produced by DHS Drug and Dependency Unit detailing what the treatment involved, in order to assist her to make a fully informed decision regarding entry to the program. It was his belief that this document was given to her. I am satisfied that Ms Mousley accepted the advice to reduce her panadeine and valium and attempted to wean herself off these medications.

4. On the 9th November 2010, Ms Mousley reattended Dr Cyngler, with her mother also present, and during the 80 minute consultation, she indicated that with great difficulty she had reduced her medication to 8 panadeine forte tablets a day and six valium 5mg tablets per day, a reduction she found hard to sustain. She requested being started on the methadone program, with this being agreed to by Dr Cyngler, as he believed she was honest in her account and motivated

to change her habits. He stated in evidence that he emphasized to her to take no more panadeine forte, to limit her valium to a maximum of 5 tablets per day and to commence methadone the following day, the 10th November, due to her having taken codeine tablets earlier in the morning. Dr Cyngler calculated that Ms Mousley should commence on a dosage of 40mg as that was below her bio-equivalent opiate daily use, but sufficient so that she would cease using extra codeine and reduce diazepam until the methadone level reached its peak. Methadone was prescribed in preference to Buprenorphine as it was more suited to Miss Mousley's personality due to her history of manic episodes and bipolar mood swings. After what was described as a long and tiring consultation a break was taken, during which time Dr Cyngler obtained approval for Ms Mousley's entry to the methadone maintenance treatment program. A further 15 minute consultation later took place with him reiterating that overdose could cause respiratory depression, or cardiac arrest. Dr Cyngler wrote on the prescription, for the dispensing chemist, that if she suffered withdrawal symptoms to increase 5mg as required, to a maximum of 60mg. He further stated in evidence that he advised Ms Mousley to telephone him if she suffered any ill effects, or to go to hospital and that she should only increase her dose if she suffered severe withdrawal symptoms, as the methadone would increase and accumulate an effect over several days.

5. At 5.15pm on the 9th November 2010, Ms Mousley attended Direct Chemist Outlet, Werribee, which was her local dispensing pharmacist where she had been accepted onto the methadone program. Her dispensing pharmacist, Ms Maro Guirguis, dosed 40mg of methadone and on returning home, Ms Mousley became very tired and fell asleep on the couch, before being put to bed by her partner. On the 10th November, she again attended the pharmacy and was dosed 40mg methadone at midday by Ms Guirguis and after returning home and during the course of the evening, she was extremely lethargic and lacked co-ordination. Evidence was given that when trying to put a coffee cup to her mouth, or replacing the cup on the table, or holding and lighting a cigarette, Ms Mousley was unable to do such things as she misjudged different heights on the table and missed her mouth. At approximately 11.00pm she became more alert, with family telling her to make sure that she explained to the chemist the next day how the methadone was making her feel. She went to bed and slept well during the night.

6. The following day, the 11th November, Ms Mousley reattended the chemist in company with her daughter-in-law, Jessica Robinson, and was dispensed her dose at 11.50am, with the dose being 45mg. Ms Mousley returned home at about 2.00pm and due to feeling tired and lethargic, she went to bed at 2.30pm. Jessica Robinson routinely checked on her until she left the premises at 6.15pm. After returning home her partner checked on her at around 6.30pm and found her sleeping deeply, however approximately 40 minutes later when walking past her door, he did not hear her snoring. On entering the bedroom and checking her, he found that she was not breathing and her lips were cyanosed. As he was unable to find a pulse, Mr Mockridge called emergency services for assistance and commenced cardio pulmonary resuscitation, pending ambulance attendance. Following paramedic arrival, Ms Mousley was assessed with her pupils

being fixed and dilated and having a Glasgow Coma Score of 3. She was intubated and cardio pulmonary resuscitation was continued as she was transferred to the Western Hospital Emergency Department. The estimated downtime was 45-60 minutes and a CT brain scan that was subsequently performed, revealed global hypoxic injury. On the 12th November, formal neurological testing, together with the results of a cerebral perfusion study, confirmed that Ms Mousley was brain dead. At 3.25pm on the 12th November, life support was withdrawn after extensive discussion with the family regarding her poor neurological status.

7. No autopsy was performed in this case as the coroner, on advice from Dr Michael Burke, Senior Pathologist with the Victorian Institute of Forensic Medicine, directed that no autopsy was required. Dr Burke performed an external examination of Ms Mousley at the mortuary, reviewed the circumstances of her death, the medical deposition and clinical notes, the post mortem CT scan and provided a written report of his findings. Toxicological analysis of anti mortem body fluid was positive for methadone, diazepam, midazolam, citalopram, and verapamil. Dr Burke reported that in all the circumstances a reasonable cause of death appeared to be; 1a. Hypoxic brain injury due to; 1b. Toxicity to methadone.

8. In regard to the cause of death, I am not satisfied on the evidence before me that the brain injury was caused by methadone overdose. Toxicological analysis detected the presence of Citalopram, Diaxepam, Frusemide, Methadone, Midazolam, Promethazine and Verapamil. Midazalam is not relevant as it was introduced during intensive care management. The remaining drugs, including Methadone, are all found at low levels. I am not satisfied that methadone alone can be singled out as the implicated drug giving rise to the brain injury and accordingly, find that it was due to combined drug toxicity.

DR FARNBACH

9. Ms Mousley's family raised various concerns regarding Dr Farnbach's management, despite the fact that his treatment of her was temporally remote to her death. Ms Mousley's fiance, Mr Mockridge, told the hearing that he believed she was "hooked" on panadeine forte for the two years leading up to her death, through attempts to control her migraines. This resulted in her at times exceeding her monthly prescription quota and necessitating her accessing the next month's quota, earlier than scheduled. The clinical records, however, show that between March 2008 and January 2010, Ms Mousley was not prescribed panadeine forte, but was prescribed mersyndol and other forms of medication. Nevertheless, the family believe that Dr Farnbach over prescribed in his management of Ms Mousley.

10. Dr Farnbach told the hearing that he had 20 years experience in general practice and disputed the allegation of clinical mismanagement. He stated that Ms Mousley was not 'hooked' on any drug and that she did not exhibit drug seeking behavior. He was clear in his evidence that she never sought large quantities of drugs; that she never reported losing scripts, nor did she

present with 'bogus' excuses, nor did her representations for scripts suggest overuse. In addition and contrary to the family's belief, the clinical records indicate that Dr Farnbach did not administer Morphine to Ms Mousley every time she attended an appointment. When it was administered, there is no evidence to suggest it was inappropriate or contraindicated.

DR CYNGLER

11. Dr Cyngler has had extensive experience in treating addicted and mental health patients since 1976 and has held a methadone permit since 1995. I am satisfied that a starting dose of 40mg is within the initial methadone dose range recommended by the Australian Government's National Drug Strategy. It is the upper level of the range and is found in the "Clinical guidelines and procedures for the use of methadone in the maintenance treatment of opioid dependence," published by the Department of Health and Aging. Accordingly, Dr Cyngler should not be criticized for commencing the induction dose at this level. The evidence further satisfies me that he was endeavouring to achieve a balance between adequate relief of withdrawal symptoms, whilst ever mindful of the need to avoid toxicity. The difficulty for the prescriber is that inadequate commencement doses may cause patients experiencing withdrawal symptoms to "top up" the prescribed dose of methadone with other opiates, which can also have potential lethal consequences. In addition to the dose being within the recommended range it appears that it is not unusual to commence the induction at this level, with the dispensing pharmacist telling the hearing that it was "standard".

12. The evidence of Mrs Carkett and Dr Cyngler differ in a number of respects with regard to what took place at each consultation. Mrs Carkett stated:

a) That her daughter was prescribed medication on the 26th by Dr Cyngler, to help her to withdraw from codeine. This was disputed by Dr Cyngler who relied on his notes showing no entry for medication.

b) That she did not receive any booklet on the 26th from Dr Cyngler with him questioning this, as it was his normal practise to do so.

c) On the 9th there was no discussion about stopping panadeine forte/codeine for 36 hours before commencing the methadone, with Dr Cyngler stating to Ms Mousley that she could start straight away. This was denied by Dr Cyngler, with his evidence being that the time lapse was necessary and that he did not tell she could start straight away.

13. In regard to the first two matters, I accept the evidence of Dr Cyngler. Mrs Carkett was not present in the consulting room on the 26th and in her evidence, she conceded some uncertainty as to what occurred. Support for Dr Cyngler's evidence with respect to giving the information booklet comes from the dispensing chemist, who stated that Ms Mousley had told her that she had received it. With respect to the third matter, I prefer the evidence of Mrs Carkett. She was present throughout the first and second consultations on the 9th November. Whilst she had difficulty in recalling all aspects of what was discussed, she remained adamant that her

daughter was told she could start the methadone treatment straight away. Dr Cyngler had found Ms Mousley to be "honest and motivated to change her habits," and to have followed his advice to reduce her medication between the first consultation on the 26th and the second, on the 9th. I do not believe she would have ignored his instruction to delay commencement, had it been given. Further, I do not believe a loving mother would be complicit in her daughter and "best friend," ignoring her doctor's advice. Accordingly, I find that Dr Cyngler failed to advise her to delay commencement, knowing that she had recently taken codeine tablets.

MS GUIRUIS

14. The dispensing pharmacist Maro Guirguis, in her statement to investigating police indicates that Ms Mousley 'didn't feel good' and that is why she wanted her to increase her dosage. This evidence conflicts with Jessica Robinson's statement to police, in which she says that having given the history of the previous night (slurring speech, tiredness, uncoordinated, swollen tongue), the dispensing chemist indicated that she was suffering withdrawal symptoms of the codeine and therefore she needed to increase the dose to 45mg. At the same time it was asked of the pharmacist if it was alright to take ventolin for her asthma and vernergan for her hayfever, with the pharmacist indicating that it was 'OK' to do so.

15. Ms Guiruis told the hearing that when Ms Mousley presented at the pharmacy on the 11th, she stated that she was not feeling well and that she had "had the shakes" to the extent that she could not hold a cup. Ms Guiruis stated that there was no mention of a swollen tongue, or that she had been"out of it" the previous night and if it had been said, she would not have increased the dose. In addition, she stated that had reference been made to a swollen tongue she would have requested ambulance attendance, as she knew the patient's airway could potentially be compromised by obstruction. When interacting with Ms Mousley she was "overly anxious" , but there was no indication of slurred speech, shaking or respiratory problems. In support of her evidence, Ms Guiruis produced the pharmacy dispensing record book, which shows a clearly defined signature, precisely positioned on the line provided for it. This signature written on the 11th, is identical to the signatures written opposite the two previous dispensing entries. In addition, she told the hearing there was no mention of using ventolin, or vernergan. Had these medications been questioned, she would have substituted alternatives that were safer and readily available.

16. Ms Guiruis obtained her pharmacy degree in 2004 and has wide experience in dealing with methadone patients, with patient contacts being in the order of 3,000 per year. She told the hearing that she is experienced in observing symptoms of withdrawal and toxicity and is capable of differentiating between the two. I accept her capacity to do so. I am further satisfied that Ms Guiruis would act appropriately in contacting a doctor or calling for ambulance attendance, if a patient presented with difficulties that were indicative of methadone toxicity. I found Ms Guiruis to be an accurate historian and I accept her evidence of the conversation and presentation on the

11th. On the evidence before me, I am satisfied that when Ms Mousley presented her symptoms were consistent with withdrawal. In the circumstances, with Ms Mousley stating the methadone was not working and displaying symptoms of withdrawal, the increase to 45 mg cannot be criticized.

COMMENTS:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

a. The evidence does not support making an adverse finding against any of the health professionals involved in Ms Mousley's management. To do so, there would need to be clear cogent evidence of an act or omission that caused or contributed to the death. There is no such evidence in this case. Further, I am not satisfied that the hypoxic brain injury sustained by Ms Mousley was due to methadone toxicity.

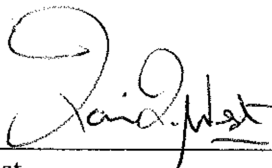
DISTRIBUTION

Family of Donna Mousley

Dr Farnbach

Dr Cyngler

Ms Guiruis



Iain T West

Deputy State Coroner

8 June 2012