FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

(Amended pursuant to s76 of the Coroners Act 2008 on the 26th August 2010 at 10.30am)

Court reference: 1561/07

Inquest into the Death of KATHERINE FIONA WALTON

Delivered On:	28th May, 2010
Delivered At:	Coroners Court of Victoria at Melbourne Hearing Room, Level 1, 436 Lonsdale Street, MELBOURNE 3000
Hearing Dates:	1, 2 & 3 March, 2010
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr Michael James WALTON, in person Ms Lucy HUNTER represented Latrobe Valley Health Senior Constable Kelly RAMSEY, S.C.A.U., to assist the Coroner

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Court reference: 1561/07

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname: WALTON
First name: KATHERINE
Address: 34 Bonwick Avenue, San Remo, Victoria 3925,

AND having held an inquest in relation to this death on 1-3 March, 2010, at Melbourne,

find that the identity of the deceased was KATHERINE FIONA WALTON born on the 2nd August, 1959,

and that death occurred between 24th and 26th April, 2007,

at the Novotel Hotel, 276 Collins St, Melbourne, Victoria 3000

from: 1(a) INSULIN OVERDOSE

in the following circumstances:

BACKGROUND & PERSONAL CIRCUMSTANCES

1. Ms Walton was a forty-seven year old married woman who resided with her husband Mr Michael James Walton and their only daughter, fifteen year old Brooke Walton. Ms Walton was a Registered Nurse working in a number of specialised areas such as coronary care and intensive care and as a theatre nurse. According to her husband, they had a happy life until 1995 when Ms Walton's life began to unravel.

2. In 1995 Ms Walton was diagnosed with Hepatitis C, first detected in the course of routine blood donation. At the time she was working as a Theatre Nurse at Wonthaggi Hospital and had suffered numerous "stick " injuries. The consequences were devastating for her. Treatment with interferon resulted in hair loss and significant weight loss, and she was unable to continue working in theatre which was work that she enjoyed and commenced working in a medical ward.

MEDICAL & WORK HISTORY

3. According to Ms Walton's general practitioner Dr Howard McCormick, she had a long history of back pain from 1984. At times this would flare up and impact on her ability to work. Her medical history also included epilepsy and some self-harming from 2002, alcohol abuse and further problems with her back in 2003, and depression from 2004 in part arising from her husband's regular absences from home due to his work commitments. Ms Walton appears to have been taking excessive analgesia at this time, particularly "Panadeine Forte" (paracetamol and codeine phosphate) and "Tramal" (tramadol hydrochloride). To treat her depression, Ms Walton was commenced on "Zoloft" (sertraline hydrochloride, an antidepressant) in October 2004 with good effect initially, but stopped taking this medication unilaterally in March 2005.

4. According to her husband, Ms Walton was using alcohol in addition to these pain killers and this would have a bad effect on her. He also expressed the view that Ms Walton had significant mood swings and something of an addictive personality but never used illicit drugs.

OTHER STRESSORS

5. In July 2005 Ms Walton resigned from her position at Wonthaggi Hospital to preserve her long service leave and other entitlements. The reason why she chose to do so is not clear but Mr Walton believed that his wife's hand was forced and she was "pushed out by management". These allegations were not investigated as being outside the scope of a coronial investigation of Ms Walton's death almost two years later, but it is tolerably clear that Ms Walton felt aggrieved that she had to leave the hospital, and that this affected her declining health and mood. She commenced employment at Warley Nursing Home in Cowes.

6. Additional stressors in Ms Walton's life were the death of her father in December 2006, after a long illness, and the sudden death of her mother-in-law from suspected cancer on 17th April 2007. Ms Walton nursed her mother-in-law through the final stages of her illness as she became a resident at Warley Nursing Home.

7. In early 2007, Dr McCormick was treating Ms Walton for depression with "Avanza" (mirtazepine, an antidepressant). He was also prescribing "Norspan" patches to help reduce her dependence on analgesics and the potential for their abuse. In March 2007, Ms Walton stated that she had not been having any alcohol, complained of a miscellany of symptoms and was worried that she may have cancer. Some investigations were undertaken but no diagnosis made.

EVENTS ON 23rd APRIL 2007

8. On 23rd April 2007, matters came to a head in the Walton household and an argument erupted between Ms Walton, her husband and her daughter. Ms Walton's mother was called to the house to try to help. Eventually, police and ambulance officers were called to the house as

Ms Walton was totally out of control, loud and aggressive. At one stage she was on the balcony and there were fears for her safety.

9. Shortly after 9:00pm, Ms Walton was taken to Wonthaggi Hospital Emergency Department for treatment for a suspected drug overdose. The attending doctor, Dr Erin Heatherall formed the view that Ms Walton was obviously under the influence of some substance - she was slurring her speech and was very emotionally labile. She was told that Ms Walton had taken eight phenobarbitone tablets as well as some unknown pills.

10. Dr Heatherall called Latrobe Regional Hospital Mental Health Service for a psychiatric assessment of Ms Walton. Shortly before 10:00pm, Mr Ian Edgar the Registered Psychiatric Nurse providing the after hours triage service on this occasion, assessed Ms Walton as requiring a "deferred response", that is an assessment within 24 hours. This was on the understanding that Ms Walton denied that the overdose was a suicide attempt, was not voicing any ongoing thoughts of self harm and had agreed to remain at Wonthaggi Hospital overnight.

EVENTS ON 24th APRIL 2007

11. Ms Walton discharged herself from hospital at about 4:05am the following morning. She caught a taxi home and stayed at home with her daughter Brooke until she left for school.

12. At about 8:30am Ms Walton went to Warley Nursing Home where she told her colleague Ms Nola Jeffrey that she needed a needle to remove a splinter from her finger. She was not seen taking anything on this occasion. As to the possibility that she took any insulin from the nursing home, Ms Jeffrey testified that it was stored in the fridge which was "usually" locked, but she could not be sure that it was locked on this particular morning. Certainly, she did not see Ms Walton take anything from the fridge or leave holding anything, but she could not exclude the possibility that insulin may have been taken. No register of stores of insulin was kept so it was not possible to ascertain by a reconciliation, if any insulin was missing, having been taken on that day or any prior occasion.

13. At about 11:00am Ms Walton attended her solicitor's office to make a will. She had no prior appointment. Mr Longstaff saw her but could not finalise her will as he required some details of her inheritance from her father's estate. It appears that her main concern was to make a specific bequest to her daughter. Mr Longstaff described Ms Walton as "full of beans" during the consultation but otherwise saw nothing unusual or concerning in her demeanour, although he didn't know her very well.

14. Ms Walton travelled to Melbourne in the family car. At 1:35pm she checked into the Novotel Hotel, Collins Street for two nights.. Some time between 7:30-8:00pm that evening Ms Walton spoke to her husband by phone. He did not know where she was but was not concerned as he understood that she was getting help. The phone call ended abruptly when the battery on

his portable home phone died. There was no further contact between Ms Walton and her family. All that is known about her movements is what can be inferred from evidence located by the police during their investigation of her death.

15. At about 11:30am hotel staff became concerned when Ms Walton had not checked out as required. The Manager and Shift Leader entered Ms Walton's room at about 11:52am and found her deceased, lying on her back on the floor wearing a wedding dress. When police arrived at about 12:35pm they ascertained that there were no signs of forced entry, that the bathroom appeared not to have been used and the bed appeared not to have been slept in.

16. Police searched the room and found handwritten suicide notes addressed to "Michael" and "Brooke", several framed family photos including a wedding photo, a Vitamin C bottle containing a miscellany of tablets, other packets of prescription and non-prescription medication and a near empty bottle of wine. Significantly, they found an empty 25ml syringe with needle attached, an empty ampoule of "Mixtard 30/70 insulin" and a box of "Norspan" transdermal patches, all in the rubbish bin. Police also found a card from housekeeping staff who had apparently tried to gain access to Ms Walton's room on the afternoon of 25th April 2007. As the room was displaying a "Do Not Disturb" sign they did not enter but left a card timed 2:35pm when she did not respond.

CAUSE OF DEATH

17. An autopsy was performed by Senior Forensic Pathologist Dr Malcolm Dodd from the Victorian Institute of Forensic Medicine (VIFM) who provided a detailed report of his findings. On external examination Dr Dodd found two transdermal patches on Ms Walton's body, superficial lacerations and scars over the forearms consistent with self-harm and lividity confined to the posterior aspect of the body consistent with death occurring while Ms Walton was lying on her back. Internal examination revealed chronic persistent hepatitis and hepatitis C and nondescript subscapular and intraparenchumal hepatic cysts but was essentially normal. Dr Dodd identified any natural disease or significant injury of a type which might have caused or contributed to death. Noting the results of toxicological analysis, Dr Dodd attributed death to an insulin overdose.

18. The results of toxicological analysis undertaken at VIFM revealed no ethanol (alcohol), traces of paracetamol (an analgesic) and zolpidem (a sedative), mirtazapine at a sub-therapeutic level of ~0.1mg/L, and sertraline at ~1.6mg/L in blood, a level exceeding normal therapeutic levels, as well as 6mg in stomach contents.

19. Analysis of a sample of serum at another accredited laboratory, revealed Insulin at 85.3mIU/L and C-peptide at 0.17nmol/L, consistent with exogenous insulin, that is insulin administered or ingested into and not produced by the body. At inquest Dr Dimitri Gerostamoulos, Manager of Toxicology at VIFM explained post-mortem redistribution and other

phenomena which need to be considered when interpreting such results. He noted that the insulin level which was significantly elevated was also from a haemolysed sample which may result in falsely low insulin levels, and advised that the actual level immediately before death may have been many times higher.

20. I am satisfied that the cause of death was insulin overdose.

CONCLUSION

21. I find that Ms Walton intentionally took her own life by ingesting an excessive quantity of insulin or overdose, knowing or believing that it would cause her death. The possibility that one or more of the other drugs revealed by post-mortem toxicological analysis contributed to her death cannot be entirely excluded.

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: Delivered - 28th May, 2010
Revised/typing errors - 11th June, 2010

Coroners Court of Victoria