IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 4359

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008 (Vic)

I, AUDREY JAMIESON, Coroner having investigated the death of ELIZA GILL

without holding an inquest:
find that the identity of the deceased was ELIZA GILL
born 24 March 1998
and the death occurred on 13 September 2016
at the Alfred Hospital 55 Commercial Rd, Melbourne, Victoria 3004
from:

1 (a) COLCHICINE TOXICITY

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Eliza Gill was 18 years of age at the time of her death. She resided in Whittlesea with her parents Karen Gill and Trevor Burton. Eliza was studying for her Victorian Certificate of Education (VCE) and worked one day each week at a retail store in Preston. She was academic and studious. Eliza had a history of mental ill-health which included previous self-harm and suicidality.

2. During the evening of 9 September 2016, Eliza was at home with her mother. At approximately 10.00pm, Eliza came into her mother's bedroom declaring that she needed an ambulance. It was evident that she was unwell and very upset. Ambulance Victoria paramedics arrived, she informed them she had taken many tablets of various medication and she was immediately transported to the Northern Hospital.

3. At approximately 5.30pm on 11 September 2016, Eliza was transferred from the Intensive Care Unit (ICU) of the Northern Hospital to the Alfred Hospital ICU for Extra-corporeal Membrane Oxygenation (ECMO)[1] but her health continued to deteriorate. At 3.52am on 13 September 2016, Eliza Gill died in the Alfred Hospital.

INVESTIGATIONS

Forensic pathology investigation

4. Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed an external examination upon the body of Eliza Gill, reviewed a post mortem computed tomography (**CT**) scan and referred to the Victoria Police Report of Death, Form 83. CT scanning identified occipital area of hypodensity, blood in the pelvis area, probably tablet residue in the stomach, bilateral pleural effusions and increased lung markings. Toxicological analysis of post mortem blood and urine detected ibuprofen,[2] desmethylvenlafaxine,[3] lignocaine,[4] midazolam,[5] morphine,[6] verapamil[7] and colchicine.[8]

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[1] An ECMO is like a cardiopulmonary bypass, it provides cardiac and respiratory support to the critically ill.

[2] Ibuprofen was detected in post mortem blood (~ 52 mg/L). It is a non-steroidal anti-inflammatory agent and analgesic.

[3] Desmethylvenlafaxine was detected in post mortem blood (~ 0.1 mg/L). It is a drug indicated to treat depression.

[4] Lignocaine was detected in post mortem blood. It is a local anaesthetic often administered to patients prior to surgery or during resuscitation attempts.

[5] Midazolam was detected in post mortem blood (~ 0.1 mg/L). It is a short acting benzodiazepine used intravenously in intensive care patient.

[6] Morphine was detected in post mortem blood (~ 0.1 mg/L). It is a narcotic analgesic used to treat moderate to severe pain and is a metabolite of codeine.

[7] Verapamil was detected in post mortem blood (~ 0.1 mg/L). It is a drug used to treat high blood pressure, angina and irregular heart beat (arrhythmias).

[8] Colchicine was detected in post mortem blood (~ 0.05 mg/L). It is a naturally occurring alkaloid. It is widely used for acute gouty arthritis.

5. Dr Parsons formulated the medical cause of Eliza Gill's death as consistent with colchicine toxicity.

Police investigation

6. Upon attending the Alfred Hospital after Eliza's death, Victoria Police prepared a report for the Coroner.

7. Senior Constable (SC) Andrew Wilkins was the nominated Coroner's investigator.[9] At my direction, SC Wilkins investigated the circumstances surrounding Eliza's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by: Karen Gill, Eliza's cousin Broadie Mellford, her General Practitioner (GP) Dr Emmanuel Florendo of Whittlesea Family Medical Centre and Eliza's treating psychologist Helen Cisternino of New Chapter Psychology.

8. During the investigation, police learned that Eliza had not disclosed mental ill-health to her GP Dr Emmanuel Florendo. However, on 30 June 2016, Eliza disclosed that she was feeling stressed due to her upcoming VCE examinations. The consultation was for investigations of headaches and tiredness and she denied feeling depressed.

9. In her statement, psychologist Helen Cisternino said that Eliza had been referred to her under a GP Mental Health Plan by Dr Soma Herath of Heidelberg West Medical. Ms Cisternino said that Eliza had been identified by her school's wellbeing coordinator, Adrienne Harris, as highly stressed by a difficult family dynamic and completing her final VCE examinations. Ms Cisternino said that she saw Eliza five times between 20 May 2016 and 2 September 2016.

10. During her sessions with Ms Cisternino, Eliza stated that she had a very strained relationship with her father and that she tried to stay out of Mr Burton's way but that they had daily arguments. Eliza also stated that she felt she needed to diffuse arguments between her parents. She also reported feeling frustrated that her mother would not *'put her daughter first'*.[10] Due to these stressors, and an array of others that Eliza nominated in relation to her relationship with her father, she was finding it difficult to sleep and to

[9] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

[10] Coronial Brief, Statement of Helen Cisternino dated 2 March 2017, page 23.

be motivated to study. Ms Cisternino suggested that Eliza consider anti-depressant medication and suggested that she consult a GP at the Mill Park Family Practice, where Ms Cisternino worked. Eliza agreed and asked Ms Cisternino to attend the appointment.

11. At 4.45pm on 8 September 2016, Eliza consulted Dr Alireza Moghbel at the Mill Park Family Practice with Ms Cisternino in attendance. While waiting for the doctor, Ms Cisternino said that she noticed Eliza had a black eye. Ms Cisternino had been informed by Ms Harris that Eliza had said Mr Burton had injured her eye during an altercation. Ms Cisternino said that Eliza directly told her *'it confirms to me Helen that I have to leave home'*[11] but did not elaborate.

12. In his statement, Dr Moghbel said he conducted a full mental health assessment of Eliza and concluded that she was suffering from depression with an anxious mood due to domestic violence. He advised that she continue counselling, make some life style modifications and prescribed her Pristiq[12] (5mg). He discussed potential side effects of the medication meticulously, as Eliza had expressed concern that medication could make her "crazy". Dr Moghbel provided Eliza with only one script for Pristiq and said that he wanted to review her again in one month.

13. Ms Cisternino stated that she was very surprised that Eliza had taken her own life. She said that, whilst Eliza deeply struggled with her family situation and wished it would change, she had never expressed suicidal ideation. Ms Cisternino stated that Eliza wanted to go to university and hoped to start a new life by living on campus.

14. Ms Gill said that her daughter had never attempted to end her own life before but that she had taken a small amount of Panadol when she was 14 years old. Mr Mellford said that he was very close with his cousin Eliza and that he felt she would have told him if she had any personal issues. However, he commented that Eliza kept her problems close to her chest. Mr Mellford indicated that she was a happy girl who did not abuse alcohol nor illicit substances and she had a great group of friends. Mr Mellford commented that Eliza studied hard and had high expectations and he opined that she was possibly stressed about her upcoming VCE examinations.

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[11] Above n 10, page 24.

[12] Desvenlafaxine.

15. At approximately 10.00pm on 9 September 2016, Mr Mellford received a call from Ms Gill asking him to come over because Eliza was very sick and needed an ambulance. When he arrived, Mr Mellford established that Eliza had taken some pills in an intentional overdose and he found that there were many pills in her bedroom, including what appeared to be half-digested tablets that Eliza had vomited. Mr Mellford said he was not sure whether Eliza tried to vomit to un-ingest the medication, or whether that had been an involuntary reaction. He said that Eliza was very upset and saying that she did not want to die and that she was sorry.

16. At the Northern Hospital Emergency Department, Eliza disclosed to a nurse and psychologist that she had taken Colgout[13] and antidepressants, all of which were prescribed to her father. Mr Mellford returned to Eliza's home and retrieved the medication and other medication packaging and brought them to the hospital. Ms Gill said that she was frustrated when the nurse put the medication away and said that she would inform the doctor when he returned. In his statement, Mr Mellford also said that he had found it frustrating that the medication he had located in Eliza's room was put to one side. He said that it appeared the nurse did not consider the situation urgent at that time.

17. During the evening, Eliza became increasingly weak and could no longer get to the bathroom on her own. Ms Gill said she found it distressing that Eliza did not see a doctor for several hours after the initial consultation with a psychologist and nurse. Ms Gill said that she and Mr Mellford went home where she tried to contact Mr Burton until approximately 10.30am the following morning.

18. At approximately 11.00am on 10 September 2016, Ms Gill and Mr Burton came to the Northern Hospital together and found that Eliza had been moved to another room. Ms Gill felt that her daughter looked weaker and more unwell; Eliza needed to use a wheelchair and have the assistance of a nurse to go to the bathroom. Eliza told her mother that she felt very sick. Some of Eliza's friends came in to see her and she told Ms Gill to go home and get some rest.

19. At approximately 4.45pm, one of Eliza's friends contacted Ms Gill telling her to return to the Hospital quickly, as Eliza was being transferred to the ICU due to trouble

[13] The active ingredient in this medication is colchicine.

breathing. Ms Gill said that, when she arrived, Eliza was very distressed about being intubated. Eliza said, *'I love you mum, I love you. You promise I'll wake up?'* Ms Gill replied, *'of course you will'*.[14] After Eliza was intubated and unconscious, Ms Gill said she spoke with a doctor who informed her that Eliza was very unwell, and that the doctor said he did not understand why she had not been transferred to the ICU earlier.

20. At approximately 8.00am on 11 September 2016, Ms Gill and Mr Burton returned to the hospital where they were informed that Eliza's condition had not improved. At approximately 3.00pm, Ms Gill said that a doctor spoke to them and said that he wanted to transfer Eliza to the Alfred Hospital for specialist care. She arrived at the Alfred Hospital ICU at approximately 5.30pm.

21. At approximately 10.30am on 12 September 2016, Ms Gill and Mr Burton spoke to Eliza's treating nurse and doctor at the Alfred Hospital. Ms Gill said that they were told Eliza's condition was critical and that the medical staff hoped that she would respond to treatment and improve. Ms Gill was informed some patients survived the severity of Eliza's type of illness, but that they would usually sustain liver damage. During the afternoon and early evening, it was apparent that Eliza's condition was worsening, and Ms Gill said that there was blood in her drool and the skin on her legs had become mottled, as if bruised.

22. In the evening, the ICU nurse and doctor discussed Eliza's condition with her parents once more. They informed them that Eliza's organs were shutting down and that she was dying. Ms Gill said that the Alfred Hospital staff seemed to try everything they could. Ms Gill and Mr Burton were told to remain at the Hospital, as Eliza would die during the night.

Further Investigation

23. In light of the statements made concerning family violence, I requested a Police LEAP search for reports concerning either Eliza or her mother. The reports identified, *inter alia*, that Ms Gill had contacted police when Eliza had run away from home on two occasions in 2012. On one of these occasions she had threatened to end her own life. On both occasions, Eliza was found quickly and was safely returned home. In 2012, Eliza

[14] Coronial Brief, statement of Karen Gill dated 24 January 2017, page 12.

also made a complaint against her father following an argument. Victoria Police attended and established that the incident was non-violent and non-abusive but consisted of conflict and involved controlling behaviours and alcohol. None of the incidents resulted in further action from Victoria Police.

Coroners Prevention Unit

24. During a meeting with the Coroners Prevention Unit (CPU)[15] on 16 August 2017, I requested a review of the Northern Hospital Emergency Department's management of Eliza.

Summary of Admission

25. The medical record indicated that Ms Gill ingested the following medications on 9 September 2016 at approximately 9.15pm:

- 20 to 30, 500 microgram colchicine tablets
- 200 milligrams of verapamil[16]
- 5 grams of cephalexin[17]
- less than 5 tablets of ibuprofen[18]
- less than 5 tablets of desvenlafaxine[19]
- less than 5 tablets of St John's Wort[20]

26. Medical staff ascertained, with the assistance of Eliza and her family, that the tablets belonged to her father and were taken over a period of approximately five minutes. No

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[15] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

[16] Verapamil is a calcium channel blocker used mainly to treat high blood pressure. Toxicity causes low heart rate and low blood pressure.

[17] Cephalexin is an antibiotic which is relatively safe in overdose

[18] Ibuprofen (Nurofen) is a non-steroidal anti-inflammatory medication which can cause serious toxicity but this is well below a potentially toxic dose.

[19] Desvenlafaxine (Pristiq) is an antidepressant of the serotonin-norepinephrine reuptake class. It can cause serotonin toxicity but this is well below the potentially toxic dose.

[20] St John's Wort is a herbal remedy used in the treatment of depression. This is well below a potentially toxic dose.

other drugs or alcohol were taken. Medical staff recorded that Eliza's overdose was in the setting of stress associated with year twelve examinations at school and her family circumstances.

27. Ambulance Victoria records indicate the emergency services call was received at 9.35pm on 9 September 2016 and an ambulance arrived at the scene at 9.41pm. Eliza was transported to the Emergency Department at the Northern Hospital at 10.12pm.

28. At 10.31pm on 9 September 2016, Eliza was triaged as a "category two".[21] She complained of chest pain, abdominal pain and thigh pain and was hyperventilating. Eliza was seen by the Emergency Physician and Hospital Medical Officer (HMO) at 10.59pm. The history of the ingestion was as above. The Emergency Physician and HMO were informed that Eliza had no significant medical history; she was not on regular medication at that time, but she was noted to be allergic to the antibiotic amoxicillin. Eliza's vital signs were all within normal limits apart from an increased heart rate of 120 beats per minute. The remainder of her examination was essentially unremarkable except for some peripheral vasodilation.[22]

29. The medical staff recognised the potential for serious toxicity related to Eliza's ingestion of colchicine and verapamil. Accordingly, medical staff consulted the Victorian Poisons Information Centre (VPIC). After hours calls to VPIC are diverted on a rotating basis to other State Poisons Centres so this call was handled by NSW Poisons Information Centre (NSW PIC). The NSW PIC advised that severe toxicity in colchicine overdose was seen in doses of greater than 0.5 mg/kg, but gastrointestinal symptoms were likely regardless. The CPU calculated the dose Eliza consumed was less than 0.2mg/kg based on her taking 30 x 500 microgram tablets and weighing 80 kilograms. The NSW PIC also advised that, due to the verapamil overdose, Eliza needed cardiac monitoring for at least six hours due to the potential for an arrhythmia.

30. After Eliza's initial assessment, the management plan was for admission under the Medical Unit, intravenous fluids, anti-emetics, and cardiac monitoring until 3am on

[21] There are five triage categories that have been established by the Australasian College of Emergency Medicine. These categories indicate the desirable time within which patients should be assessed. A category two patient treatment acuity time is 10 minutes with an 80% performance indicator set.

[22] Peripheral vasodilation refers to the widening of blood vessels located in peripheries, especially the veins. It happens due to the relaxation of muscles in the walls of the vessels.

10 September 2016. The admission notes to the Medical Observation Unit at 12.29am on the 10 September 2016 confirm the above assessment and management plan.

31. On 10 September 2016, Eliza was nauseous and vomiting. At 5.00pm, she became short of breath and a Medical Emergency Team (MET) was called. Medical staff thought she may have had aspiration pneumonia as she had a tachypnoea, hypoxia and crackles throughout her lung fields.[23] Ms Gill was transferred to the ICU where she was sedated, intubated and ventilated.

32. VPIC was consulted and they recommended repeating the paracetamol and salicylate levels and informed medical staff that Eliza's clinical presentation was inconsistent with the amount of medication she was thought to have ingested. Eliza continued to deteriorate further with multi-organ failure despite maximal medical management. VPIC were consulted again who thought the clinical picture was consistent with colchicine overdose and suggested continued supportive management. Eliza was subsequently transferred to the Alfred Hospital.

Review and Assessment of Contributing Factors

Statement of Dr Peter Jordan, Director of Emergency Medicine, Northern Health

33. Dr Peter Jordan stated he did not personally provide medical care to Ms Gill and prepared his statement from the medical records. The history and details of the ingestion was confirmed; Eliza was seen and assessed by the senior Emergency Physician, Dr Dean Pritchard and Emergency HMO Dr Matthew Davies at 10.59pm on 9 September 2016.

34. Dr Pritchard advised Dr Davies to contact the VPIC for further management advice and the HMO's after-hours-call was automatically diverted to NSW PIC. The medical record indicates the NSW PIC clinician advised that severe toxicity was seen in doses of greater than 0.5mg/kg and that gastrointestinal symptoms were likely. Dr Davies was advised to ensure Eliza was monitored by continuous ECG for at least six hours, due to the potential for arrhythmia secondary to verapamil ingestion. Based on the NSW PIC advice, a management plan was documented which included: intravenous fluids, antiemetic medication, blood tests, cardiac monitoring and admission to the medical unit.

[23] Infection and inflammation of the lungs due to inhalation of food or vomit into the lungs causing increased respiratory rate and reduced oxygenation.

35. Dr Jordan stated that decontamination with activated charcoal was considered after her assessment in the Emergency Department by Dr Pritchard, but discounted due to the advice given by NSW PIC. The remainder of the clinical course was confirmed as documented previously.

36. On 10 September 2016, VPIC was contacted for further advice as Eliza had deteriorated. VPIC Fellow Dr Leung reassessed the colchicine dosage and confirmed the calculated dose was approximately 0.25mg/kg. It was noted that 'bad toxicity' was expected at >0.5mg/kg. However, Dr Leung advised that Eliza's clinical picture gave rise to concerns for delayed colchicine toxicity. Dr Leung advised that full supportive care continue.

37. On 15 September 2016, an executive level review[24] considered Eliza's case. Questions were raised regarding the possible benefit of activated charcoal in this case. It was noted that administration of activated charcoal carries significant risk of severe life-threatening pneumonitis if aspiration occurs and that the evidence for benefit of charcoal administration in this case was extremely limited. The review determined that there were no serious issues with the care provided, such that the case did not require further internal investigation.

38. Eliza's presentation and care at the Northern Hospital was also reviewed at the Intensive Care Monthly Mortality Meeting. The Emergency Department and ICU's formal medical teaching program presents Eliza's case to highlight the risks associated with the ingestion of colchicine and review important management considerations.

Statement form Dr Andrew Dawson, Clinical Director of the NSW Poisons Centre

39. Dr Dawson gave a lengthy and considered statement regarding this case. In summary:

40. Dr Dawson confirmed the initial advice given from the call record. This advice was based on information in the Toxicology Handbook 3rd Edition 2015 which recommends activated charcoal for colchicine ingestion >0.5mg/kg. This handbook is the recommended text for Emergency Medicine Training and the same threshold for charcoal is published in the Australian Therapeutic Guidelines 2012.

41. Following Eliza's death, the NSW PIC funded and initiated a review as well as production of a new colchicine guideline. This process was conducted by clinical

[24] The Executive Level Review included senior specialists from the ICU, Emergency Department and Medicine Unit at the Northern Hospital.

toxicologists from different states.[25] The review recognised the specific advice in the Toxicology Handbook was not correct in using a threshold of >0.5 mg/kg of colchicine as the indication for administering activated charcoal. It also prompted a pop-up box to appear on the Poisons Information Centre (PIC) database recommending all cases of intentional colchicine toxicity be referred to the clinical toxicologist and that severe toxicity and death has occurred with doses <0.5mg/kg. Following on from this the NSW PIC has funded a position and created a process for systematically reviewing and updating all the PIC guidelines.

42. Dr Dawson commented that colchicine is a relatively rare but important poisoning and as such there is only a small body of evidence in the medical literature which may not be well interpreted. This evidence is then included in guidelines that are infrequently reviewed.

43. He also commented that the four Australian PICs are all state based and funded and although they recognise and try to resolve variations in clinical practice there is no national system and no service level agreements. Attempts have been made to resolve the fragmentation of Australian PICs by constructing an efficient national poisons information system, but this has failed to progress at intergovernmental level.

Colchicine Toxicity

44. The following information was given by Professor Olaf Drummer in an expert opinion on a previous case.[26]

> *Colchicine overdose is potentially lethal, causing severe gastroenteritis followed by multi-organ failure. Colchicine (amongst other properties) prevents proper cell division and proliferation leading to a range of systemic effects (cardiovascular abnormalities, impaired breathing and kidney function for instance) eventually causing multi-organ failure.*
>
> *The number of tablets required to cause fatal poisoning is variable but is at least several, probably greater than ten, however there is little relation between a*

[25] The Colchicine Guidelines were redrafted by three clinical toxicologists from New South Wales, Western Australia and Victoria. The review was chaired by Dr Andrew Hamilton Dawson.

[26] See 'Expert Toxicological Opinion in the Death of Stephanie Melia', prepared by Professor Olaf Drummer, dated 7 June 2011.

blood or tissue level and outcome. Death invariably occurs many hours and often a couple of days after the ingestion.

Colchicine is rapidly absorbed from the gastrointestinal tract hence gastric lavage to remove drug in the stomach and use of activated charcoal to capture unabsorbed drug needs to occur very soon after overdose to achieve any useful outcome. Once absorption has occurred there is no effective measure to remove excess drug and prevent multi-organ damage. Even if the drug is not removed by these processes supportive measures are often successful but survival is never guaranteed.

45. The VPIC adheres to the *Austin Health Toxicological Guidelines* (AHG).[27] The guidelines available at the time Eliza poisoned herself only recommended administration of activated charcoal to patients who have potentially ingested >0.5mg/kg of colchicine and consultation with a clinical toxicologist was not mentioned.

46. The AHG concerning colchicine overdoses was amended to advise:

- Discuss all cases with a clinical toxicologist;
- >0.1mg/kg: potential for toxicity including death, >0.5mg/kg: 10% mortality;
- Clinical Features: 0-24 hours: Gastrointestinal symptoms, 24-72 hours: multi-organ failure;
- Management: early decontamination and aggressive supportive care are the mainstay of treatment;
- Activated charcoal should be given to all patients as soon as possible following deliberate self-poisoning, consider intubation and ventilation to facilitate this;
- Aggressive fluid resuscitation and monitoring, and
- Following resuscitation administer multi-dose activated charcoal in ingestions >0.1mg/kg.

[27] Austin Health Clinical Toxicology Guidelines, Colchicine Clinical Guidelines published March 2018, please find at: http://www.austin.org.au (for review March 2020).

Summary of Contributing Factors

47. At 10.31pm on 9 September 2016, Eliza received a triage category two and was reviewed by the treating clinicians at 10.59pm. The Australasian Triage Scale recommend category two patients are assessed within ten minutes. Therefore, there was a potential delay in her assessment and treatment. This only becomes important due to the consideration whether activated charcoal should have been administered.

48. The initial assessment and management of Eliza was appropriate and NSW PIC was consulted for advice. According to the guidelines available at the time, charcoal was not recommended for ingestions of <0.5mg/kg of colchicine. Cardiac monitoring and supportive care was advised.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. It appears that the optimal clinical treatment upon Eliza's presentation would have been to provide her with activated charcoal and to refer her medical management to a clinical toxicologist. However, I make no adverse comment in relation to her treatment by staff at Northern Hospital and no adverse comment in relation to the advice given by the NSW PIC, as the same was informed by the guidelines for colchicine toxicity that were available at the time.

2. I commend the NSW PIC review of the colchicine toxicity guidelines and endorse the subsequent recommendation that all cases of colchicine toxicity be referred to the clinical toxicologist. I also commend and endorse the actions undertaken to review all the guidelines used by the PIC in an attempt to ensure they reflect the most up-to-date literature and available evidence.

3. I make no adverse comment in relation to the automatic diversion of after-hours VPIC calls to the NSW PIC; it is commendable and supportive to the community at large. However, if such a system is to continue, it is even more imperative that national guidelines are established.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendations:

1. In the interests of public health and safety and preventing like deaths, **I recommend** the Australian Commission on Safety and Quality in Healthcare assist clinical experts in developing National Poisons Information Guidelines.

FINDINGS

The investigation has identified that Eliza Gill consumed various medications prescribed to her father, in an attempt to end her own life. However, it is evident that she had changed her mind and expressed that to her mother and her cousin.

The medical care and treatment provided by the Northern Hospital and the Alfred Hospital appears to have been reasonable in the circumstances. The advice provided in relation to colchicine toxicity by the NSW Poisons Information Centre was not based on the most up-to-date literature. However, it was based on current guidelines and appropriate action has been taken to ensure the guidelines are updated.

I accept and adopt the cause of death formulated by Dr Sarah Parsons and I find that Eliza Gill tragically died from colchicine toxicity subsequent to an intentional overdose of a number of drugs. However, I find that, ultimately, Eliza Gill did not intend to end her own life.

Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

I direct that a copy of this finding be provided to the following:

Karen Gill & Trevor Burton, by Samuel Pearce of Maurice Blackburn
Legal Coordinator at the Northern Hospital Ms Jackie Petrov
Director of Clinical & Enterprise Risk Management at the Alfred Hospital Ms Keren Day
The Alfred Hospital, Ms Sarah Larwill
NSW Poisons Information Centre
VIC Poisons Information Centre
Australian Commission on Safety and Quality in Healthcare

Signature:

AUDREY JAMIESON
CORONER
Date: **5 February 2019**