IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2017 005904

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Linda-Jane Margaret Tatterson
Date of birth:	29 May 1977
Date of death:	22 November 2017
Cause of death:	1(a) Combined drug toxicity (clomipramine, sertraline, diazepam, and quetiapine)
Place of death:	62 Contingent Street, Trafalgar, Victoria, 3824

INTRODUCTION

1. On 22 November 2017, Linda-Jane Margaret Tatterson was 40 years old when she was found deceased in her home in circumstances suggestive of suicide. At the time, Ms Tatterson lived at 62 Contingent Street, Trafalgar with her husband, Sean Tatterson.

2. Ms Tatterson had a history of intermittent asthma, anorexia, depression, and obsessive-compulsive disorder. Her regular prescription medications included clomipramine (a tricyclic antidepressant), diazepam (an axiolytic), quetiapine (an anti-psychotic), budesonide/formoterol and salbutamol (for asthma). Ms Tatterson had been trialled on mood stabilisers without effect.

THE CORONIAL INVESTIGATION

3. Ms Tatterson's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. Victoria Police assigned an officer to be the Coroner's Investigator (**CI**) for the investigation of Ms Tatterson's death. The CI conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Linda-Jane Margaret Tatterson including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

8. On 22 November 2017, Linda-Jane Margaret Tatterson, born 29 May 1977, was visually identified by her husband, Sean Tatterson who signed a formal Statement of Identification to this effect before a member of Victoria Police.

9. Identity is not in dispute and requires no further investigation.

Medical cause of death

10. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on Ms Tatterson's body in the mortuary on 27 November 2017 and provided a written report of his findings dated 24 January 2018.

11. The post-mortem examination revealed superficial abrasions around the neck and chin, possible bruising on the anterior aspect of the neck, small strap muscle brises, soft tissues bruise adjacent to the right superior thyroid horn, laryngeal mucosal petechiae, and focal haemorrhage at the upper thoracic spine. These findings are non-specific and of uncertain significance and are not thought to have caused or contributed to Ms Tatterson's death.

12. Dr Bouwer found no significant natural disease that may have caused or contributed to the death.

13. Routine toxicological analysis of post-mortem samples detected clomipramine (~ 0.7mg/L in blood, ~117mg in stomach contents),[2] sertraline (~0.7mg/L in blood, ~0.2mg in stomach

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Fatalities from clomipramine overdoses have been associated with blood concentrations ranging from 0.54-2.1mg/L.

contents), diazepam (~0.04mg/L) and its metabolite nordiazepam (~0.2mg), and quetiapine (~0.02mg/L).

14. Dr Bouwer noted that the combined administration of sertraline and clomipramine may increase the plasma concentration of clomipramine. Furthermore, the combined administration of diazepam, clomipramine, and quetiapine may additively increase the central nervous system and respiratory depression effects of these drugs.

15. Dr Bouwer advised that it would be reasonable to attribute Ms Tatterson's death to *combined drug toxicity (clomipramine, sertraline, diazepam and quetiapine).*

16. I accept Dr Bouwer's opinion.

Circumstances in which the death occurred

17. Ms Tatterson had several intentional overdoses in the 2014-2016 period during which she was commenced on clomipramine which appeared to have a positive effect on her mood and weight. Her psychiatrist, Dr Keith Adey, felt that Ms Tatterson was a high-risk patient due to her impulsivity, denial of the severity of her illness, and control issues, and that she required frequent increases in her medication to treat her symptoms.

18. On 6 November 2017, Ms Tatterson attended her final consultation with Dr Adey who noted that, by this stage, she was on 200mg of clomipramine and 600mg of quetiapine. As Ms Tatterson was approaching the maximum recommended dose of clomipramine, Dr Adey discussed weaning her off and switching to sertraline over the coming weeks.

19. On 10 November 2017, Ms Tatterson attempted another overdose after finding the lockbox in which her medications were kept. She purchased a hacksaw and opened the box, subsequently describing this to her General Practitioner (**GP**), Dr Michael Kunze, as an impulsive act.

20. On 13 November 2017, Ms Tatterson spoke to Dr Kunze, reporting side effects from the sertraline including constipation and urinary hesitance. On 14 November, she told Dr Kunze that she had spoken to Dr Adey who had advised that her sertraline dose should be increased to 200mg. This conversation was not documented in Dr Kunze's clinical notes.

21. On 20 November 2017, Ms Tatterson attended a consultation Dr Kunze, where she reported feeling flat and experiencing suicidal ideation but denied any concrete plans or intent. Dr Kunze spoke with Dr Adey who recommended an increase in her sertraline. Dr Kunze spoke with Ms Tatterson about her safety plans, arranged a follow-up in two days' time, and made

a referral to the Latrobe Regional Health Acute Community Intervention Service (**ACIS**) at Ms Tatterson's request, with plans for an assessment to occur the following day.

22. On 21 November 2017, ACIS clinician Simone Koops attempted to contact Ms Tatterson and left a message requesting a return call. Mr Tatterson rang back in Ms Tatterson's presence and Ms Koops offered an assessment time of 1.00pm on 22 November 2017 but Ms Tatterson declined. Matters were left on the basis that Mr Tatterson he would speak to his wife and call Ms Koops back.

23. During the evening, Ms Tatterson did not notice anything unusual about his wife. They went to bed at about 7.30pm. At about 5.15am, Mr Tatterson woke to the sound of the alarm and discovered that Ms Tatterson was unresponsive, stiff, and blue in colour. He called 000.

24. Ambulance Victoria (**AV**) paramedics responded a short time later and verified that Ms Tatterson was deceased.

25. No suicide note was found at the scene. According to Mr Tatterson, after a previous overdose, he had told her that there was no need to leave a suicide note. Empty blister packs of medication dispensed on 15 November 2017 were found near the deceased. It is unclear how Ms Tatterson was able to access her these medications given the arrangements in place to limit her access.

CPU REVIEW

26. To assist with my investigation into the death of Ms Tatterson, I asked a Mental Health Investigator from the Coroners Prevention Unit[3] (**CPU**) to review the clinical management and care provided to Ms Tatterson, including her access to the prescription medications that resulted in her fatal overdose on 22 November 2017.

27. The CPU reviewed several sources of evidence, including the coronial brief of evidence, Ms Tatterson's Medical and Pharmaceutical Benefits Scheme records, medical records from Trafalgar Medical Centre and Latrobe Regional Health, as well as statements and records from Dr Adey and Dr Kunze.

[3] 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

Referral to public mental health services

28. Based on the available information, including Ms Tatterson's frequent appointments with Dr Kunze and Dr Adey during the October-November 2017 period, there was no indication for Dr Kunze to refer Ms Tatterson to public mental health services during this time.

29. After Ms Tatterson disclosed her overdose on 10 November 2017 (but denied any ongoing suicidality), Dr Kunze completed a physical examination and Ms Tatterson attended a consultation with Dr Adey the following day. It is unlikely that a physical examination and a consultation with a psychiatrist would have occurred within 24 hours had a referral been made to a public mental health service.

30. Ms Tatterson's overdose was not an unusual presentation for her, and she did not present with an ongoing intent to suicide, expressed remorse for her actions, and therefore did not appear to present with acute risks requiring immediate inpatient admission.

31. Based on the information provided, there is no indication that Ms Tatterson required a more urgent response than that requested by Dr Kunze when Ms Tatterson agreed to a referral to ACIS. Furthermore, given her voluntary status, Ms Tatterson was unable to be compelled to attend compulsory treatment as there was no evidence that she was at any risk of imminent harm. Additionally, it is likely that she would have declined a voluntary admission to a community in-patient unit had it been offered.

Access to medication

32. Ms Tatterson had a prescription for clomipramine dispensed on 15 November 2017, which was written by Dr Kunze on 11 October 2017. A prescription for sertraline (written by Dr Kunze on 20 November 2017) was found at the scene, along with several prescription medications prescribed by Dr Kunze and Dr Adey.

33. Dr Kunze stated that his usual practice was for Ms Tatterson's prescriptions to be either provided direction to Mr Tatterson or left at the front desk for him to collect. With regards to the prescriptions found in Ms Tatterson's possession, Dr Kunze could not definitively recall whether he had provided them directly to her. However, given her history and risk level, Dr Kunze did not believe this to be the case.

34. It is possible that Ms Tatterson's access to her medications could have potentially been limited via the use of Webster packs.[4] Dr Kunze stated that he did not recall discussing this option with her. Additionally, Ms Tatterson previously had difficulty collecting limited amounts of medication due to her work schedule and was also concerned about stigma as she had several friends who worked at the pharmacy. Relevantly, Ms Tatterson's dog was also prescribed tricyclic antidepressants and the prescribing and dispensing of this was not within Dr Kunze's control.

35. As such, it was felt that Mr Tatterson taking responsibility for collecting and storing Ms Tatterson's medication adequately addressed the concerns about her access to excessive medication. As Ms Tatterson had previously voiced her dissatisfaction with limited dispensing of medication, it was reasonable for Dr Kunze to seek an alternative means of restricting Ms Tatterson's medication, which was confounded to an extent by the need for her to consent to any restrictions, and her non-compliance (for example by her breaking into the locked box in which medications were kept).

36. Due to his responsibility for dispensing her medications, Mr Tatterson was present during many of Ms Tatterson's appointments during which the importance of limiting access to medications was discussed. Also discussed were the serious consequences of Ms Tatterson overdosing, and her occasional deceptive actions to access medications. The most recent consultation being on 15 November 2017.

37. Dr Kunze believed that Mr Tatterson had a good understanding of the importance of restricting Ms Tatterson's medication, and that he had opportunity to seek advice if he had questions or concerns. Mr Tatterson was cognisant of the need to seek medical attention in the event of an overdose, including contacting her GP and acute mental health services.

38. Dr Kunze stated that he spoke with Mr Tatterson following Ms Tatterson's death, who confirmed that he had collected all her prescriptions apart from the last repeat of her clomipramine which Mr Tatterson had left with the pharmacy and had been filled by Ms Tatterson without his knowledge.

39. An informal arrangement was in place whereby Ms Tatterson's sister-in-law, who worked at the pharmacy, was aware of her restrictions. However, she was not working on the day that

[4] A Webster pack typically limits dispensing to one weeks' worth of medication (though this can vary) and the additional medication dispensed from that prescription remains at the pharmacy. The use of a Webster pack must be done with the consent of the patient and usually incurs an additional cost to the patient.

Ms Tatterson had the prescription dispensed. It appears that the other pharmacy employees were unaware of the arrangement and did not prevent Ms Tatterson from collecting her prescription.

40. Further medications, including diazepam, sertraline, and quetiapine were located unsecured in Ms Tatterson's residence. Given that Mr Tatterson had been extensively educated about the need to restrict his wife's access to medication by Dr Kunze, it is unclear why a large amount of medication was apparently located in areas that Ms Tatterson could easily access.

41. Another option would have been for Dr Kunze to refer Ms Tatterson for a Domiciliary Medication Management Review (**DMMR**), also known as a Home Medicines Review (**HMR**). This is a Medicare Benefits Schedule item for patients living in the community which can only be initiated by a patient's GP after assessing the patient's need for the service. The goal of a DMMR is to maximise a patient's benefit from their medication regimen and prevent medication-related problems through a multidisciplinary approach, involving the patient's GP and preferred community pharmacy. It may also involve other members of the health care team, such as nurses in community practice or carers.

42. The DMMR process utilises the specific knowledge and expertise of each of the health care professionals involved. In collaboration with the GP, a pharmacist comprehensively reviews the patient's medication regimen in a home visit. After discussion of the pharmacist's report and findings, the GP and patient agree on a medication management plan. The patient is central to the development and implementation of this plan with their GP[5] so the success of such a plan would have been dependent on Ms Tatterson's cooperation.

43. Ms Tatterson's final appointment with Dr Adey was on 6 November 2017, with a further review scheduled for 11 December 2017. Ms Tatterson told Dr Kunze that she spoke with Dr Adey via phone on 14 November 2017 and was advised to increase her sertraline to 200mg. However, this interaction was not documented in Dr Adey's medical record. Dr Adey stated that, if he had decided to increase Ms Tatterson's sertraline dose as an exercise of his own clinical judgement, he would have increased it to 100mg first, and then to 200mg after eight days if necessary.[6]

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[5] The Department of Health, Medication Management Reviews, https://www1.health.gov.au/internet/main/publishing.nsf/Content/medication_management_reviews.htm> , accessed 25 November 2019.

[6] Ms Tatterson was commenced on 50mg sertraline on 6 November 2017, and she advised Dr Kunze that Dr Adey told her to increase the dose to 200mg eight days later on 14 November 2017.

Disposal of medications

44. Dr Adey stated that he did not have discussions with Ms Tatterson or Dr Kunze about restricting her access to medications, or disposing of previous medications, and that it is not a usual practice of his to dispose of previous/excess medications. Dr Adey noted that it is the patient's responsibility to dispose of unwanted medications, and that most people, including those suffering from severe depression, do so in an appropriate manner. Dr Adey acknowledged that individuals with severe personality disorders have been known to hoard their tablets to enable feeling in control and able to commit suicide at a time of their choosing.

45. The experience in this jurisdiction arising from overdose-related deaths demonstrate that it is not unusual for non-current medications to be found at the scene, indicating that many people do not, in fact, dispose of excess medications. While Dr Adey is correct in that it is the patient's responsibility to dispose of superseded medications sensibly, it is also good practice for a treating doctor or prescriber to prompt a patient to return all unwanted medications to a pharmacy for appropriate disposal.[7]

FINDINGS AND CONCLUSION

46. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.[8] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

47. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Linda-Jane Margaret Tatterson, born 29 May 1977;

[7] Bergen, P., Hussainy, S., George, J., Kong, D. and Kirkpatrick, C. Safe disposal of prescribed medicines. Australian Prescriber, 2015, accessed 18 November 2019.

[8] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an 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 issues had 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 inferences…'.

b) the death occurred on 22 November 2017 at 62 Contingent Street, Trafalgar, Victoria, 3824;

c) the cause of Ms Tatterson's death is *combined drug toxicity (clomipramine, sertraline, diazepam and quetiapine)*; and

d) the death occurred in the circumstances described above.

48. Ms Tatterson had a longstanding history of overdoses and had expressed suicidal thoughts to Dr Adey during her sessions, including during their last session on 6 November 2017. However, she had also admitted that previous overdoses resulted from impulsive actions. Ms Tatterson's behaviour appeared normal to her husband the night before her death and she left no suicide note. The available evidence relevant to intent does not satisfy me to the applicable standard that Ms Tatterson took an excessive quantity of her prescription medications with the intention of ending her life.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments on matters connected with the death, including matters relating to public health and safety or the administration of justice.

1. While it is the responsibility of patients to sensibly dispose of previous and excess medications, it is also the responsibility of prescribers to educate patients and to prompt compliance. This is particularly important when access to previous and excess medication poses a risk to the patient, such as a risk of overdose whether intentional or otherwise. When changing medications, a patient is likely to have an accumulated stock of the superseded medication and it is good practice for clinicians to prompt patients to dispose of such medications safely.

2. Another option for healthcare professional to consider, particularly when treating challenging patients and/or patients with a history of poor medication compliance and/or overdose, is the DMMR or HMR, which can provide a structure within which individuals and their families can be assisted to dispose of old medications safely and to provide additional support and education for care givers in the home environment.

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

Sean Tatterson, Senior Next of Kin

Dr Philippa Hawkings, Latrobe Regional Hospital

Dr Michael Kunze

Dr Keith Adey

Leading Senior Constable Lisa Lambert, Victoria Police, Coroner's Investigator

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 12 January 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.