CITATION:	*Inquest into the deaths of Erfinna Patricia Lay & John Weston Quirk* [2007] NTMC 009
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Coronial
FILE NO(s):	D0075/2005 D0177/2005
DELIVERED ON:	18 May 2007
DELIVERED AT:	Darwin
HEARING DATE(s):	14 - 15 November 2006 30 November 2006 11 December 2006
FINDING OF:	Mr Greg Cavanagh SM

CATCHWORDS:

Deaths resulting from Acute Multiple Drug toxicity, Prescription drugs, Medical treatment prior to death

REPRESENTATION:

Counsel:

Assisting:	Ms Helen Roberts
Dr Duthie:	Ms Sally Sievers
Mrs Quirk:	Ms Vanessa Farmer

Judgment category classification:	B
Judgement ID number:	[2007] NTMC 009
Number of paragraphs:	47
Number of pages:	22

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

In the matter of an Inquest into the deaths of

No. D0075/2005 **ERFINNA PATRICIA LAY**
ON 4 MAY 2005
AT 8 / 17 FRANCIS STREET, MILLNER

and

No. D0177/2005 **JOHN WESTON QUIRK**
ON 8 OCTOBER 2005
AT 31 MAY STREET, LUDMILLA

FINDINGS

(18 May 2007)

Mr Greg Cavanagh SM:

1. This Inquest inquired into the deaths of two young people, Erfinna Lay and John Quirk, both of whom died during 2005. The circumstances of their deaths were such that they were reportable to the Coroner pursuant to s.12 of the *Coroners Act*. The holding of a public Inquest was at my discretion pursuant to s.15 of that *Act*. Section 14(4) provides that I may direct more that one death be investigated at one Inquest.

2. These young people were living together in a relationship at the time of Erfinna Lay's death in May 2005. Secondly, both deaths related to prescription drug overdoses and both deceased young people were being treated by the same General Practitioner, Dr Douglas Duthie. For those reasons I held the Inquest into both deaths at the same time. Families of both young people attended the three hearing days and participated in the Inquest. Mr Quirk's family were legally represented by Ms Vanessa Farmer, who asked questions and made submissions on their behalf. Ms Lay's family, including her parents, her sister and her grandmother attended the

Inquest. Mrs Lay put a number of questions to witnesses and raised matters for my consideration through my Counsel Assisting, Ms Helen Roberts. Ms Sievers sought and was granted leave to appear on behalf of Dr Duthie.

3. I heard oral evidence from several witnesses including; Constable Koum; Brevet Sgt Lade; Dr Bruce Rounsefell; Dr Williamson; Dr Sinton and Dr Duthie. I also had before me the brief of evidence compiled by the investigating police with respect to each of the deaths and a number of medical records, reports and statements totalling about 15 exhibits.

4. Section 34 of the *Coroners Act* sets out the matters that an investigating Coroner is required to find, if possible, at an Inquest:

> "(1) A Coroner investigating -
>
> (a) a death shall, if possible, find -
>
> (i) the identity of the deceased person;
>
> (ii) the time and place of death;
>
> (iii) the cause of death
>
> (iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act
>
> (v) any relevant circumstances concerning the death"

5. Section 34(2) of the *Act* operates to extend my function as follows:

> "A Coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

FORMAL FINDINGS

6. On the basis of the tendered material and oral evidence at the Inquest I am able to make the following formal findings as required by the *Act*.

Formal Findings – Ms Erfinna Lay

(i) The identity of the deceased was Erfinna Patricia Lay, born on 1 April 1983 at Darwin in the Northern Territory of Australia.

(ii) The place of death was 8 / 17 Francis Street, Millner. The date of death was 4 May 2005, between midnight and 7:00am.

(iii) The cause of death was Aspiration resulting from Acute Multiple Drug Toxicity.

(iv) Particulars required to register death:

1. The deceased was female.

2. The deceased's name was Erfinna Patricia Lay.

3. The deceased was Australian.

4. The cause of death was reported to the Coroner.

5. The cause of death was confirmed by post-mortem examination and was Aspiration resulting from Acute Multiple Drug Toxicity.

6. The pathologist was Dr Terence John Sinton of Royal Darwin Hospital.

7. The deceased's mother was Valerie Patricia Lay and her father's name was Francisco Spirito Santo Lay.

8. The deceased resided at 8 / 17 Francis Street, Millner.

9. The deceased was unemployed at the time of death.

10. The deceased was born on 1 April 1983.

Formal Findings – Mr John Quirk

(v) The identity of the deceased was John Weston Quirk, born on 20 October 1977 in Brisbane, Queensland.

(vi) The place of death was 31 May Street, Ludmilla. The time was Saturday 8 October 2005 between 9:00am and 1:00pm.

(vii) The cause of death was Acute Multiple Drug Toxicity.

(viii) Particulars required to register death:

1. The deceased was a male.

2. The deceased's name was John Weston Quirk.

3. The deceased was an Australian.

4. The cause of death was reported to the Coroner.

5. The cause of death was confirmed by post-mortem examination and was Acute Multiple Drug Toxicity.

6. The pathologist was Dr Terence John Sinton of Royal Darwin Hospital.

7. The deceased's mother was Barbara Dawn Quirk and his father's name was Robert Graham Quirk.

8. The deceased resided at 13 May Street, Ludmilla.

9. The deceased was unemployed at the time of death.

10. The deceased was born on 20 October 1977.

CIRCUMSTANCES SURROUNDING THE DEATH OF ERFINNA PATRICIA LAY

7. Erfinna Lay was 22 years of age at the time of her death. She met her boyfriend John Quirk when she first started University in Darwin and the couple had been living together since sometime in 2000. Her medical records show that she first visited Dr Duthie in May 2001.

8. In his statement dated 6 November 2006, Dr Duthie said that the medical diagnoses he was treating Ms Lay for included personality disorder; depression; anxiety disorder (with severe panic disorder and agarophobia); and chronic head pain. He explained in his statement and in his oral evidence that her psychological problems proved significant especially in terms of her ability to comply with suggested treatment options. During the time she was treated by Dr Duthie, Ms Lay was prescribed a generally regular regime of codeine phosphate for chronic headaches; Xanax (alprazolam) for an anxiety disorder and diazepam also for anxiety / sleep disorders.

9. On 4 October 2001 Ms Lay was admitted to the Cowdy Ward at Royal Darwin Hospital after an overdose on medication. Between 2002 and 2003 she and Mr Quirk spent approximately 18 months in Queensland before returning to Darwin and returning to the care of Dr Duthie.

10. In October 2004 and April 2005 Ms Lay had hospital admissions with an overdose of medication. On both occasions (as with the October 2001 admission) the medication was prescribed for Mr Quirk and not for Ms Lay. On each occasion when she discussed what had occurred with her GP, and consistently with the hospital notes, she did not verbalise an intention to take her life, rather some level of self harm borne of an anxiety or depressive disorder.

11. It is of note that when Ms Lay did take overdoses, she did not use her own medication but medication prescribed to Mr Quirk. Dr Duthie was aware of

this and was aware of allegations by each of his patients that the other was at times using his or her medication. Dr Duthie said that towards the end of 2004 and into the beginning of 2005 the issue of controlling Ms Lay's access to Mr Quirk's medication emerged. Although some physical strategies were considered, such as Mr Quirk keeping his medication locked away from Ms Lay in the home, in general Dr Duthie preferred a strategy which emphasised "self responsibility". In terms of the suggestion that each were using the others' medication on a regular basis he said this: (transcript 30.11.06 - p.20)

> "Yeah, this was a new issue. This was another complicating thing in the management, and of course the other side to it John was more or less doing the same thing. Yeah, when that was reported obviously this was, you know, alarm bells, 'What was going on?' But having talked through it quite considerably with both parties there was a lot of game playing going on, and we emphasise strongly the basis of our dealings, the honesty, the value of the trust between us which is essential for dealing with such people. Yeah, there were admissions that some of it was game playing and so on. I mean the other thing is that both Erfinna and John kind of valued their tablets so much that it was almost unthinkable that they would stand back and let the other party partake of their pills. So really, yes, it comes up, it came up, we looked at it in detail, and I was not convinced that it was a major problem. That a lot of it was game playing and that when really focus screwed down on the honesty issue there was a back down by both of them to say, 'Well, no, that wasn't really the case generally speaking'."

12. The evidence shows that Ms Lay generally demonstrated a reluctance to engage with counselling for therapeutic purposes. The doctors, including Dr Duthie, regarded this as a feature of her borderline personality disorder. Despite referrals at the hospital, or by Dr Duthie on occasions, she appeared not to obtain benefit from psychological therapy.

13. Ms Lay was at home with John Quirk during the day and on the evening before she died. On the morning of 3 May 2005 she had spent a couple of hours working at her mother's business. Mrs Lay said:

> "she started at 9:30am and finished at 11:30am. She seemed fine other than appearing sleepy. I dropped her off at her unit after work. She told me she was going to have a sleep."

14. Mr Quirk's recollection of the day is that he and Ms Lay went to the movies, had some coffee, purchased some groceries and came home and cooked a meal. It appears likely that he was somewhat reconstructing this harmonious domestic day given the extremely untidy appearance of the apartment when the police attended. Photographs taken on 4 May 2005 indicate a somewhat less ordered existence, with scraps of snack food such as toast being the only food evident. These matters are of little significance. I find that Ms Lay and Mr Quirk spent a reasonably ordinary evening together and it was similar to that described by Mr Quirk.

15. At 11:00pm or midnight John Quirk took 25ml of Chloral hydrate in order to sleep. The Chloral Hydrate was prescribed for him by Dr Duthie and he had filled a prescription that day, collecting 2 bottles. He said in his statement, that he then slept solidly until 10:00am. Ms Lay was awake watching television in their bedroom at the time he went to sleep. When he got up in the morning, after about an hour (although he was somewhat vague about the time) he checked on Ms Lay and saw that she was non responsive. He called an ambulance but she was already deceased at that time.

16. The toxicology results show that Ms Lay had taken a potentially lethal dose of Chloral Hydrate. Mr Quirk said in his statement that he had noticed in the morning that the top of one of the Chloral Hydrate bottle was smashed on an angle and it was empty. This was a bottle that he said was full when he went to bed, that he had collected from the Pharmacy that day. I note that Mr Quirk gave this information to Police at a time when he did not know of the Toxicology results. It is consistent with those results.

17. There is no evidence to suggest that Ms Lay did not voluntarily take the Chloral Hydrate. I also note that she would have been generally aware of the risks of Chloral Hydrate overdose, having been previously admitted to

hospital having taken such an overdose. However, there is no evidence that Ms Lay took the Chloral Hydrate with an intention to cause her own death. It seems to me more likely that she took it with an attempt to anesthetise anxious or bad feelings and tragically on this occasion it caused her death by Aspiration.

18. Dr Sinton, the Forensic Pathologist who carried out the autopsy, explained that Aspiration is essentially breathing regurgitated stomach contents into the lungs. Drug toxicity interferes with brain function which then depresses reflex functions, such as the one that might wake a person before or during vomiting.

19. Ms Lay was a very young woman at the time of her death. The central issue at the Inquest was her medical management and whether or not there was some other way of managing her problems that may have been more successful. Dr Duthie indicated that he continued the regime that Ms Lay was on for the time that he saw her because she did not wish to take other medication and she was generally resistant to psychiatric intervention. Dr Duthie acknowledged that Ms Lay had some level of dependency on the medication and an apparent inability to solve her problems. After each of the two overdoses leading up to her death, there was no significant change in her medical management, nor any implemented strategy to limit her access to Mr Quirks medication.

20. With respect to both deceased, I obtained additional expert opinions from two South Australian doctors, each of whom gave evidence before me. Dr Paul Williamson is the Senior Medical Practitioner at Drug and Alcohol Services South Australia and has been with the Drug and Alcohol Service since the early 1980's. Some of his work includes training of GPs' in managing drug and alcohol use disorders. He has done some consultancy periods in Darwin and Alice Springs. His primary concerns were –

1. The amount of Benzodiazepines prescribed to Ms Lay on an ongoing basis;

2. The prescription of Codeine on a long term basis for long term headaches;

3. A lack of methods to control access to medication.

21. Dr Williamson expressed concern about the large overall sedative dose of Benzodiazepine that Ms Lay was taking on a regular day. Certainly this would have been the reason that her mother often observed her being very sleepy. Dr Williamson said in evidence that he believed there ought to have been stricter controls on the amount of medication available to Ms Lay on a regular basis: (transcript 14.11.06 - p.41-42 my emphasis)

> Now if I could – so following on there to .4 in your letter you note that given her, that is Erfinna Lay's, chronic history of anxiety, referral to the Tamarind Centre may provide some useful support for her but it is unlikely she electively pursue such treatment. You mentioned earlier cognitive behaviour therapy and other non-drug therapies as a method of treating anxiety disorders. How or – in terms of training GPs or education for GPs, how would you say a patient is best managed in a situation where he or she apparently won't cooperate with any non-drug therapy for their problems?--- Okay. I've reviewed some of the other letters on this and I'll include some of – what's his name, the doctor from Adelaide – Dr Rounsefell's comments. I think that Dr Duthie did attempt quite a lot of counselling with both patients. I've written that and it is very clear that he did that in a concerned and supportive way. I think we should mention that right at the start. He did refer her to Tamarind Centre and she didn't go and I probably would share Dr Rounsefell's opinion that she probably had a personality disorder and was probably lacking in insight and lacking in preparedness to have such treatment. I think Dr Duthie may have mentioned in one of his reports that she did at times – and I maybe confusing her with John Quirk – that she may have attempted to have counselling at time when backed off when it got a bit hard, and that's often the case that that happens. So I think give that she may not have been at the time particularly amenable to such cognitive behavioural treatment I would have thought that supportive counselling from Dr Duthie and **from my point of view, very strongly, the supervision of the medication through probably more frequent pick up and**

dispensing at the pharmacy would have been a useful thing. I also have written there that **there were a number of occasions when she took overdoses** or reported certain irregularities with her prescriptions and these include the fact that John might have been taking her medications as well, **which probably demanded some action, I think, in terms of either reducing the amount prescribed or controlling access more strictly.**

On that subject, doctor, one of the complicating aspects perhaps, that it appears as evidence that particularly in overdose situations this patient, Erfinna Lay, was taking drugs – not the drugs prescribed for her but in fact drugs that she accessed that were prescribed for John Quirk, her partner. That would add some levels of complexity, would it not, in terms of limiting her access to somebody else's prescription mediation as opposed to her own?---Yes, it might and I guess there would be a particular problem if there were different doctors prescribing for those two different people. In this case there was one doctor prescribing and I think the opportunity was there to control access for both people. I didn't actually see a discussion with either of the people about why various people were using drugs that weren't supposed to be used. **I also think if someone was taking an overdose on any sort of sedative you've got to be very careful about the sedatives that they're actually prescribing for her, whether she's using them or not.**

In terms of controlling access to the drugs, you mentioned more frequent pick ups from the pharmacy. How does that work in practice?---Well it's fairly simple, you just write on a prescription that someone is prescribed, let's say Alprazolam, 2 milligram tablets, three per day or four per day, whatever it was, dispensed on alternate days and you ring up that pharmacy and you make that – and you say pick up at this particular pharmacy – I don't know where she picked up but Trower Road I believe it was – ring up Trower Road pharmacy, they are very used to that sort of thing, they are a methadone dispensing pharmacy, I know for a fact, they are used to giving things out on a daily basis. There may have been some extra administration charge applied, I'm not sure, but they would be well versed in how to give out drugs on a more frequent basis."

22. Dr Duthie gave evidence that he did not consider Pharmacy pickups of Ms Lay's medication until early 2005. At that time he decided it was not an appropriate option: (transcript 30.11.2006 – p.18 my emphasis)

> "Let me take you forward?---Yeah, so we'll go forward to like the end of 2004 into 2005, excuse me, where at the end of 2004 there

was an episode where she had again ended up in hospital as a result of abusing medications and again in April. So during that period this became an issue of how to control her access to John's medications. Now this is actually a very complex issue in that firstly it started with the whole problem that Erfinna had and how we were going about to try and manage it. **The fact that self harm is a prominent feature of people with Erfinna's particular set of conditions and that it is extremely difficult to manage, but the advice about it is that the way one must try to manage it is to encourage self responsibility, is to encourage the person themselves to take control of the situation.** To do anything else does more harm than good in the end. If you take, for example in this case, if we just took the pills away she would find another way to harm herself. **So that was therefore the idea particularly highly controlled like daily pick up of tablets would have been counter productive to that basic strategy which is in the end was the most important part of what we were trying to do.** What then – the other side of that what we really then concentrated on was saying that, 'All right be that as it may while we're working on that we perhaps ought – obviously ought to deal with the availability of the medication'. But of course that was (inaudible) over the fact that we had to deal with John on that issue. And what we really came to was that what we needed to do about that was control the medications in the home because that's the primary problem. So we dealt with John on that as saying, 'Well, look, we really need somehow to deny Erfinna's access to your medications', and we talked – after the October 2004 incident we talked about that and came up that we were going to look at that. The first thing that I remember John – John was a very enthusiastic kind of guy and he was always thinking and he would come up with ideas and he came back and he said he solved it. He got a backpack and put all the drugs and carried them around with him all the time, and that had obvious problems. But at least he was willing to try. We then basically the – what we were trying to put in place was some kind of locked cupboard drawer; get a box with a lock on. I remember John had seen a safe in Big W, or something, he was going to buy a little safe. I said, 'Fine', that was the strategies we were going to put in place. Now unfortunately, of course, it was not in place by early May 2005. Things always took a long time with John. That was the strategy; obviously it wasn't in place in time to solve that problem."

23. Both Dr Rounsefell and Dr Williamson said that limited Pharmacy pickups of medication were a control option that ought to have been considered by Dr Duthie. Dr Williamson was firm in his criticism that they not only ought to have been considered but ought to have been implemented. With regards to Ms Lay's death it is a complicating feature that the medication on which

she overdosed both on the occasion of her death, and on previous occasions, was prescribed to Mr Quirk. As quoted above, Dr Duthie said that he had discussed with John Quirk, options for controlling Ms Lay's access to his medication. These matters do not appear in Dr Duthie's medical notes at all. Nor does he raise them in his original interview with Sgt. Anne Lade, which took place, on 1 February 2006, after the death of both young people. In that interview Dr Duthie said that there were lots of discussions about the issue of using each others medication and "in the end we said to them right, what I will do, I will add up both lots and the total will never exceed the sum of the two, so if one used all the others then they would be short". It is difficult in the absence of detailed medical notes to be certain of the extent of the discussion that took place, and be confident about over what period they took place and how many times the suggestions (which were obviously not taken up) were made by Dr Duthie to his patients about caution with their medications. The discussions notwithstanding, it is apparent that Ms Lay continued to abuse medication.

24. Both expert witnesses expressed the view that more active efforts to reduce overall prescriptions to Ms Lay should have been attempted. Dr Duthie submits through his counsel that part of management strategy was to "discuss" with Ms Lay the "rationalisation" of her medications. This did not result in a reduction in prescriptions in fact. Having said this, I accept the importance of Ms Sievers' submission that it cannot be said that controls over Ms Lay's medication would have prevented her from accessing Mr Quirk's medication and consequently preventing her death.

25. Dr Duthie gave clear evidence that it was his view that one of the most important aspects of Ms Lay's management was for her to develop self responsibility. This mandated against controlling her access to medication (either hers or Mr Quirk's) by external means. On the other hand, both Drs' Williamson and Rounsefell said that greater controls ought to have been in place. Having said that, they both acknowledged that Dr Duthie obviously

took a great deal of time and care in his efforts to counsel and manage Ms Lay's complex problems.

CIRCUMSTANCES SURROUNDING THE DEATH OF JOHN WESTON QUIRK

26. John Quirk was born in Brisbane in 1977 and moved to the Northern Territory in about 1998. His medical history from about that time records a significant use of Benzodiazepines and in June 1999 he was referred to the Tamarind Centre with anxiety attacks and Benzodiazepine dependency. Then in 2000 a witnessed seizure led to a diagnosis of epilepsy and from then onwards a variety of anti-seizure medication was prescribed over the years, primarily by Dr Duthie. This resulted in the prescription of Benzodiazepines at some stage. Dr Duthie explained that it took about 15 months to finally stabilise Mr Quirk (with respect to seizures) on Lamotrigine and Clonazepam. The trip to Queensland followed with Mr Quirk returning to Dr Duthie around September 2003. Dr Duthie said that between September 2003 and April 2005 he was dealing with a number of issues with respect to Mr Quirk: (transcript 30.11.2006 – p.25-26)

> "I then just take you to dealing with the time period September 2003 to April 2005. What conditions were you treating him for and what was the management plan that you had in place for him?---Again as with Erfinna this was the period where we kind of came to terms with what he had and over a period of time made, you know, an assessment of what was going on and the ramifications, the full dimensions of the problems. Essentially in neat terms we came – there were three problems that we had settled down to and that was his chronic pain, head pain syndrome, his anxiety panic disorder and the epilepsy they were the three, kind of, the diagnostic labels. So again it was a matter of saying, 'Well what are we going to do? What is the strategy?' Well the – again the first priority was symptom control. Now of the epilepsy that was already in place and that was under control. That wasn't – with epilepsy nothing is ever concrete, it's never black and white, but for that period of time that was stable. It had taken a long time to achieve it. That was in place subject to review, but that was controlled. His chronic head pain was controlled with the Codeine. That would be subject to review, but that was fine. And so the anxiety was still in that early period probably the first

area, and so again that's where we got to introducing the Alprazolam and getting him stable in that regard and again that was the symptom control side of it and this with John, particularly with John, was really the – John was kind of good to work with in a lot of ways, he was responsive, he was positive, he was willing to try, and so the strategy was, 'Well we'll try. We'll work with you over time to develop better ways of coping', he was wanting to attend university so building his life skills, building a future for himself. That was kind of the strategy. And again the same kind of contract rules or agreement with John, you know, that we would be – have to monitor him for the – that we felt on an ongoing basis that the medication was helping. That there was no unacceptable negatives and side effects, whether there was no evidence of the abuse, overuse, doctor shopping etcetera, and that there was this ongoing commitment to our relationship, honesty in it, and that we were committed to working to change. That was the really important aspect of his management.

Can I just take you back in time there's one additional medication which you've omitted from the control that you were using at that time and that's the Chloral Hydrate. Are you able to assist the Coroner with how that came to being prescribed and issues around that, please?---Yeah, basically he – he had been on that prior to him coming up from Katherine. That was a kind of long term one that he used to help him sleep, which sleep can be a real problem when you're using the Benzodiazepine group, and he'd been using that apparently safely for very many years. It was not one that we were overly happy about him going on using and that was certainly our priority one to get him off and he agreed and so on, but it was there."

27. The history of Mr Quirk's drug dependence was stable overall, for a long period of time until the death of Ms Lay. At that time his drug use patterns began to change. In July 2005 John Quirk's mother rang Dr Duthie to advise him that John Quirk had ended up in hospital after overdosing on Choral Hydrate. He was advised there had been two hospital admissions. He then ceased prescribing Choral Hydrate for John Quirk. He next saw Mr Quirk on 5 August 2005. Dr Duthie said in evidence that at this time John Quirk had been referred from the Casualty Department of the hospital to the Alcohol and other Drug Unit and "all his medication had been ceased abruptly, against all the guidelines, without any real support in place, no real long time – no acute or long term management for his withdraw and

subsequent dealings with the problems that were left. So here he was back on my lap in really a very bad state."

28. Dr Duthie emphasised his concern about what he described as the "ceasing" of all medication by the Alcohol and other Drug Unit, and the significant effect he believed this had on his patient's progress. I found this characterisation unusual. It was in fact the case that the hospital doctors had declined to prescribe any further medication (aside from Diazepam) for Mr Quirk after his emergency admission. He had been advised to see his GP. There was no reason why John Quirk could not have gone to see Dr Duthie at anytime during the few weeks leading up to 5 August seeking another prescription. He was not an inpatient at the Unit and had every option to come and request Dr Duthie assist him, as Dr Duthie indicated he was prepared to do.

29. Mr Quirk saw Dr Duthie again on 8 August 2005 and on that day Dr Duthie decided to prescribe Doloxene for some severe head pain. He decided not to return to the use of Codeine, as he believed that in the preceding three weeks Mr Quirk may have gone through the worst of Codeine withdrawal symptoms. Although it doesn't appear in the notes, he gave evidence that he again warned John Quirk about not mixing alcohol and Doloxene.

30. 12 August was the next occasion that John went to see Dr Duthie. The medical notes record "Doloxene script lost. Replaced." In evidence in chief about that Dr Duthie said: (transcript 30.11.2006 – p.31)

> "So then we move forward to 12 August and there's a recording there of a Doloxene script being lost. Are you able to assist the Coroner by putting that in the context of that consultation and who it was you dealt with or how he was when you dealt with him on that day?---My recollection is that he was a bit better, I mean there was some slow progress through there so he was a little bit less focussed on the urgency of what was happening to him. There was this business that he couldn't remember what he'd done with his Doloxene script, and so there was some – and again that was a pretty long discussion – a long consultation and we went through all that and, you know, look, the issues related to that. That was mainly – I mean there was some

other couple of issues there, as you see, which we dealt with on that day."

31. The Pharmacy records show that the script dated 8 August 2005 was actually presented and filled on 8 August 2005. It was put to Dr Duthie by Counsel Assisting that the fact (now known) of the script having been presented indicated that what John Quirk had told Dr Duthie on 12 August, namely that the script had been lost, was untrue: (transcript 30.11.2006 – p.40)

> "So that when he came to see you on the 12th it was not true that he lost his script he'd actually presented on the day he'd last seen you?---Yes.
>
> So that was what he told you now you realise – you subsequently realise it was false in relation to that?---Well unless he meant that he'd lost some of the tablets of course. Well it's still a possibility that he lost some of the tablets and had none left.
>
> THE CORONER: Well you there - what did you think he meant? Do you think he meant – when he said to you he lost the script, he lost the script, or what?---I have trouble recalling. I don't really recall the extent of that discussion.
>
> MS ROBERTS: Well if I just show you – if I show you your notes it maybe have got on there on 12 August 2005 the note says, 'Doloxene script lost, replaced'? ---Mm mm.
>
> Does that assist you in relation to what he might have told you?---Not really, no, no. I mean certainly as we've said there in the first bit at that time John was probably not cognitively not functioning that well, you know, he had been - - -
>
> THE CORONER: But, doctor, if he had said to you he'd lost the pills you would have written, 'He lost some pills' wouldn't you?---Maybe, sir.
>
> You wouldn't have said – you wouldn't have noted something, 'Lost script', surely unless he said he'd lost the script as opposed to losing the pills?---Yeah, I think I used those terms interchangeably."

32. Dr Duthie's evidence was that he would not necessarily accept that John Quirk was not telling him the truth, rather that he, the GP, may have made such careless notes that he would use the terms "script" and "tablets"

interchangeably. This is in contrast with the evidence he gave about Erfinna Lay who had also on one or other occasion lost either her prescription or her tablets. In evidence about that he drew a very clear distinction between the loss of tablets and the loss of a script repeat (which he considered a less serious issue). He said in evidence while referring to his medical notes: (transcript 30.11.2006 – p.16)

> "here it is quite clear that she didn't lose her pills, she lost the repeat bits"

33. On 13 August John Quirk was admitted to hospital with an apparent overdose of Doloxene. Dr Duthie could not locate a note of his discussion with John Quirk about this occurring but he did recall that he found out about it and did discuss it with him. On 22 August Dr Duthie's notes read "Doloxene 50 in 10 days!". Dr Duthie denied that his exclamation mark meant that this was a lot of use, rather he said it was to confirm the fact that John was "doing fine". Nevertheless, he gave John another 50 tablets telling him that they ought to last for one month. It appears that the apparent overdose did not cause Dr Duthie to reconsider prescribing the Doloxene: (transcript 30.11.2006 – p.41)

> "How did to your knowledge of the overdose affect your attitude to the ongoing prescription of the Doloxene?---Well when I had ascertained to the best I could the facts of the overdose from both John and from the relevant hospital doctor as stated previously it was – it was not a – it was quite clear that it was not a suicide attempt. It wasn't a deliberate overuse, it had been a kind of part I could understand in terms of cognitive function at the time, and that he had managed to just take too many.
>
> Did you the reduced cognitive function give you any serious concerns about the ongoing possibility of accidental overdose?---Well of course although that was in that initial period, but that's – it did – it did improve very rapidly."

34. On 9 September (18 days later) he received another prescription. On 15 September he returned to Dr Duthie explaining he had lost all his tablets in an argument with his new girlfriend who had refused him re-entry to her unit

where the tablets were located. Another prescription was given. A final prescription was given on 6 October over the telephone. Dr Duthie maintained that he had no concerns about John Quirk's use of Doloxene, even looking back over the pattern with the further knowledge he has now, particularly about the prescription not in fact being lost: (transcript 30.11.2006 – p.43)

> MS ROBERTS: I take it that the combination of one allegedly lost script, one set of lost tablets, and one accidental overdose in the period of less than two months are not a combination of events that you would now say indicated a risky pattern of behaviour on behalf of John in relation to the Doloxene?---There were irregularities. They were problems in using that management. I think we dealt with them appropriately at the time. If you're saying were they sufficient reason to abandon that course, obviously I decided they were not. I mean the other problem was had we decided Doloxene was not to be given, what else were we going to do? So, no, basically, no."

35. John Quirk died having taken an overdose of Doloxene, combined with use of alcohol. He had returned from a party in the early hours of the morning on 8 October 2005. He was then living in his mother's home. He spoke to his mother and her friend around 9:00am and he seemed to them to still be under the effects of alcohol. He returned to bed and he was found later that day, deceased. There is no evidence at all that he took the Doloxene with the intention of self harm. Dr Sinton's evidence was that the alcohol would potentiate the effects of the Doloxene. However, he was a young man who had demonstrated recent erratic drug taking behaviour, who had access (by means of a prescription given over the telephone) to a sufficient amount of Doloxene to cause his death.

36. Dr Williamson expressed concern about a number of matters and with respect to the Doloxene he said: (transcript 14.11.2006 – p.45)

> "I think the other concern was the frequency of prescribing of Doloxene. And as you can see in paragraph 9 here, Dr Duthie did say that, you know, 50 tablets had been used in 10 days rather than the required 30 and it's got to be 30 days and self responsibility and yet in 18 days and again another six days, out come another 50 tablets

> and then the guy's had a Doloxene overdose on 13 August and the prescription of Doloxene is still occurring without supervision. I think, you know, this is I think the thing that really worries me in this situation. Now here's a guy who just about killed himself or made some attempt earlier and yet he's got as much access if not more, after the event."

37. Dr Rounsefell noted, initially in his report:

> "in the last two months, therefore, there was firstly an acceleration of complaint of headache, secondly one episode of reporting of a lost prescription, one episode of reporting of lost tablets, and an episode of a prescription being filled that does not coincide with a visit (in fact the day before his death)."

38. Dr Rounsefell noted that other options available included referral to a pain specialist or drug dependence clinic, reduction of total medication, or limited pickup of medication.

39. Dr Duthie said that he did not consider that limited pickup or reduction of the Doloxene was necessary with respect to John Quirk at anytime:

> "I don't think I really considered it because again it was a matter of was there a case for that, was there a case for restricting it, was John acting responsibly, did I have any cause to be concerned about his usage or certainly about the chances of him being suicidal etc. And because I had no real concerns of that I did what I did."

40. I then asked Dr Duthie whether he conceded any validity in the criticisms made by Dr Williamson and Dr Rounsefell of his management of John Quirk and he said this: (transcript 30.11.2006 – p.43)

> "THE CORONER: Of your management of Quirk?---Well I'm certainly not going to say that I did everything perfectly right and so on, we certainly tried. Look it's a situation where if I was talking to either of those doctors there would be a lot to talk about. I mean what I've – I can't really say is that on looking back even now that I made any major management mistakes with the strategy that I put in place, that the carrying out of that strategy to the best of my ability served my two patients well.
>
> So you don't see now and you certainly didn't see then and you don't see now that it was necessary or needed or it would have been

prudent to have controlled the dispensations by the chemist of that drug?---Sorry, sir, do you mean the Doloxene specifically?

Yes?---Basically, no. I mean because both then and now I had no reason to believe that the Doloxene was going to be a problem.

CONCLUSIONS

41. Each of these young people died in tragic circumstances; after a self administered overdose on prescription medication. In Ms Lay's case the medication was not that prescribed for her, but prescribed for her boyfriend John Quirk. Ms Lay presented a complex set of psychological problems for treatment and was, with no disrespect to her, a difficult patient to manage. There is insufficient evidence for me to conclude that her death was intentional. It can only be attributed to a combination of a number of different underlying causes.

42. Mr Quirk was a drug dependent young man, who appeared to have no significant psychological problems but did have an acknowledged drug dependency. He made efforts at various times to manage this dependency, however those fledging efforts were significantly derailed by the death of his partner Ms Lay. After Ms Lay's death the evidence shows an increasingly erratic pattern of drug taking by Mr Quirk, significantly, overdoses which had not occurred in the preceding several years that he had been taking similar medication. Despite indications of a more erratic pattern, Dr Duthie continued to prescribe Doloxene when it was requested by Mr Quirk and ultimately Mr Quirk took an overdose of that drug. In Mr Quirk's case, there is no evidence that he intended to take a fatal overdose. I conclude that it was in his case accidental.

43. Both Dr Rounsefell and Dr Williamson were critical of Dr Duthie's management. In particular, they said that further control over the availability of the medication for the patients ought to have been instituted. Ms Sievers made extensive and well considered submissions on behalf of Dr Duthie addressing each of the aspects of the experts' criticism, and

discussing in detail the factual matters surrounding each significant event in the management of the two patients. She sought to persuade me that Dr Duthie's management decisions on each occasion and overall, were equally valid as those alternative strategies put forward by the South Australian doctors.

44. One particular issue remained in dispute. That was the practicality of arranging for the patient to pickup medication on a daily or weekly basis at a Pharmacy, rather than being entitled to fill the entire prescription at once. Both the South Australian doctors said that this was possible and the evidence is that although it may be more frequent for S8 medication, it is certainly possible for benzodiazepines by arrangement with a Pharmacy. I find that it could have been done. However, Dr Duthie felt that it was not appropriate as he was of the view that "patient autonomy" or "patient self responsibility" was a more important feature of management for each of these patients.

45. Ms Sievers' made the submission that whilst Dr Duthie did not consider Pharmacy pickup appropriate with respect to Mr Quirk, this should not necessarily be a matter for criticism, as "that the most important control that was in fact [in place] was the therapeutic relationship and rapport that Mr Quirk had with Dr Duthie". However, while Dr Duthie certainly enjoyed the advantage (over Drs' Williamson & Rounsefell) of knowing the patients, it appears that he did not enjoy the advantage of objectivity with respect to considering other management options for Mr Quirk. Dr Duthie's evidence was that even in hindsight he does not concede that he made any major management mistakes and his view remains that his management strategy "served [his] two patients well". I agree with Ms Sievers submission that the Coronial jurisdiction is not about apportioning blame. I would not in any event make findings of negligence, breaches of professional conduct or the like. However, in the circumstances of this case I feel it is appropriate that I refer the material to the Medical Board for their consideration. I have

before me two experts who have said that there ought to have been stricter control over the availability of prescription drugs to each of these two patients. Ms Sievers has taken issue on behalf of her client with the tone used by Dr Williamson, particularly in his written reports. I accept that to some degree, however, I found Dr Williamson in his oral evidence to be frank, and willing to carefully consider and address matters put to him in cross examination. In the end, both Dr Williamson and Dr Rounsefell maintained essentially the same point of view.

46. I consider that the appropriate forum for determining whether there ought be any formal criticism of Dr Duthie's management of these patients is a forum in which these matters are considered by his peers, I consider that I have the jurisdiction and the power to refer these matter to the Medical Board for its consideration. I do not propose to recommend that any particular action be taken. Whether or not the matter is further investigated is a decision properly made by the Medical Board.

47. Accordingly, I make no recommendations pursuant to section 35 of the Coroners Act. I refer these findings to the Health Professions Licensing Authority for its consideration. Any of the tendered material and or the transcript of evidence will be available upon the request of that Authority.

Dated this 18th day of May 2007

_____

GREG CAVANAGH
TERRITORY CORONER