



**CORONERS COURT  
NEW SOUTH WALES**

<b>Inquest:</b>	Inquest into the death of Christine Drinnan
<b>Hearing dates:</b>	14-18 October 2013, 28 October- 1 November 2013, 25-29 November 2013 and 23 September 2015
<b>Date of findings:</b>	23 October 2015
<b>Place of findings:</b>	NSW Coroners Court, Glebe
<b>Findings of:</b>	Magistrate C. Forbes, Deputy State Coroner
<b>Catchwords:</b>	CORONIAL LAW-Cause and manner of death- Drug toxicity- Prescription drugs-care and treatment-Whether doctors appropriately prescribed
<b>File number:</b>	2010/435644
<b>Findings:</b>	I find that Christine Drinnan died between 29 and 30 April 2010 at 6 Casuarina Place, Narellan Vale, NSW. I am satisfied the cause of her death was multi drug toxicity. The manner of her death was misadventure.
<b>Representation:</b>	<p>Dr K. Stern SC, Counsel Assisting instructed by Ms J Geddes, Crown Solicitors Office</p> <p>Mr M. Lynch representing Dr Nguyen and Dr Higginbotham</p> <p>Mr P Rooney representing Narellan Amcal Pharmacy trading as Narellan Priceline and Narellan Chemist</p> <p>Mr G. Gregg representing Dr Shute</p> <p>Mr G. Doherty representing Dr Wankhede and South Western Sydney Local Health District</p> <p>Mr B de Mars representing the Drinnan family</p>

IN THE STATE CORONER'S COURT  
GLEBE  
SECTION 81 CORONERS ACT 2009

**REASONS FOR DECISION**

**Introduction**

1. In October and November 2013 I held concurrent inquests that dealt with four separate prescription drug overdose deaths. After hearing the evidence from independent expert doctors in relation to the death of Christine Drinnan I suspended the inquest into her death and referred the matter pursuant to s.78 *Coroners Act 2009* to the Director of Public Prosecutions. I have received a response from the Director of Public Prosecutions that no proceedings will be commenced and accordingly I now resume this inquest pursuant to s.79 *Coroners Act 2009*.
2. This inquest concerns the death of Christine Drinnan who was found at her home with dangerous quantities of addictive prescription medication in her system. Her treating doctors had prescribed the medication. There is no clear evidence that she intended to take her own life.
3. The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:
  - (a) the identity of the deceased;
  - (b) the date and place of the person's death;
  - (c) the physical or medical cause of death; and
  - (d) the manner of death, in other words, the circumstances surrounding the death.

Section 82 of the *Act* also permits a Coroner to make recommendations that are considered necessary or desirable in relation to any matter connected with a death, including that which relates to issues of public health and safety.

4. The issues in this inquest have been confined to the care and treatment of Ms Drinnan. The broader issues relating to prescribing and dispensing of prescription medication have been dealt in the findings I delivered on 27 June 2014 in relation to the three inquests I heard concurrently with this matter. Those findings are available on the website for the State Coroner's Court of New South Wales.
5. Four expert medical practitioners provided opinions in this matter, being:
  - i. Dr Christopher Ryan, psychiatrist;
  - ii. Dr Alex Wodak, addiction specialist;
  - iii. Dr Ross MacPherson, pain specialist; and
  - iv. Dr Hester Wilson general practitioner.

### **Facts and background**

6. Ms Drinnan died at her home.
7. Police officers located a significant amount of prescription medication belonging to Ms Drinnan at her home. This included an open bottle of Ordine 10 mg (Morphine – Schedule 8) oral solution prescribed to be taken 2 ml every 4 hours. The bottle had been supplied 24 hours earlier, but 60 ml appeared to be missing. This greatly exceeded the prescribed dosage of 12 ml in a 24 hour period. The list of other medication identified comprised: Epilim (Sodium valproate) 500 mg (28 remaining), 200 mg (pack of 200 – 151 remaining), Campral 333 mg (10 tablets remaining), Amoxil 500 mg (pack of 20 – 10 remaining), Panamax (Paracetamol) 500 mg (pack of 100, 68 remaining), Seroquel (Quetiapine Fumarate, Schedule 4) 200 mg (pack of 120, 20 remaining, another pack 7 remaining), Seroquel 25 mg (20 remaining), Ibuprofen 200 mg (pack of 48, 10 remaining), Cymbalta 60 mg (pack of 28, 25 remaining), Stemetil (Prochlorperazine – dopamine receptor antagonist, Schedule 4, pack of 25, 23 remaining) 5 mg (25 tablets), Senokot (laxative) 7.5 mg, Spiriva Tiotropium (18 remaining) Naltrexone 50 mg (pack of 30). Unfilled scripts for Pethidine, Morphine, Seprin forte and a receipt for a private prescription of Antabuse were also found. One of those prescriptions, a prescription from Dr Higginbotham for 5 Pethidine ampoules 100 mg/2ml, was dated 1 May 2010, the day after Ms Drinnan was found dead. (Dr Higginbotham's clinical records curiously record, against 1 May 2010 "*Peth Amp x 5*").
8. No suicide note or anything indicating an intention to self-harm was found.

9. There is ample evidence that Ms Drinnan had drug dependence issues that were longstanding and deep rooted. She also had problems with alcoholism.
10. These issues had many serious ramifications for her family. Her son described occasions when he had to supervise his mother's medications as a 15 year old child, his efforts to prevent his mother driving while under the influence of alcohol or drugs, occasions when he had to resuscitate his mother, and steps he took to liaise with pharmacists in relation to his mother's overdoses. One of the tragic aspects of this inquest was his evidence of feeling powerless to help with his mother's problems and the extent to which he felt let down by her treating doctors.
11. Ms Drinnan's daughter also described numerous times that her mother overdosed and required medical treatment. She says there was always a large amount of prescription medication and alcohol around the house.
12. Ms Drinnan had plans for a trip with her daughter.
13. Whilst the family recognise that the stockpiling of medication in the period prior to her death may have been an indicator that their mother may have been planning to take her own life, they do not know whether or not her death was self-inflicted.

### **Cause and Manner of Death**

14. A post mortem was conducted by Dr Brouwer on 3 May 2010. Dr Brouwer concluded that Ms Drinnan died from multi-drug toxicity. Toxicology identified a lethal level of morphine, toxic levels of pethidine and quetiapine, therapeutic/non-toxic levels of several benzodiazepine drugs and a high level of alcohol. The level of morphine was described by Dr Brouwer as probably the highest free morphine level that she had ever encountered in a post-mortem blood sample. No oxycodone was detected in the post mortem blood sample although substantial doses of this drug were issued to Ms Drinnan in April 2010. Dr Brouwer explained in her oral evidence that in determining cause of death she had had regard to the fact that there was no other natural pathology that could have caused the death.
15. In Dr Wodak's opinion, Ms Drinnan died from overdose of morphine in combination with pethidine, quetiapine, benzodiazepines and alcohol, all of which are central nervous system depressants. Dr Wodak says that in his view there is a possibility that the fatal overdose was intentional, but an accidental overdose cannot be excluded. He says that the number and type of prescriptions that Ms Drinnan had written for her in her last month of life suggest a

deliberate accumulation of a stockpile of powerful drugs to end her life, but says there is no other evidence to support this.

16. In the light of all of the evidence I am satisfied on balance that the cause of death was multi-drug toxicity and as there is no clear evidence that the death was intentionally self-inflicted that the manner is best described as misadventure.

### Prescribing and medical history

17. The evidence in this case makes it clear that Ms Drinnan's death occurred following many years of her being prescribed an array of addictive prescription medication. That prescribing was from a number of different doctors, but primarily from Ms Drinnan's general practitioner, Dr Higginbotham.
18. Medicare records show that Ms Drinnan also saw a number of other general practitioners. In the period from February 2010 until her death in April 2010 she also saw Dr Nguyen, Dr Holloway, Dr Perwaiz, Dr Ghaly, Dr Helou, Dr Wellington, Dr Louka, Dr Kapoor and Dr Wassef.
19. The volume of medication prescribed and supplied to Ms Drinnan, in particular during the last few months of her life, is alarming. She was in Campbelltown Hospital from 30 January to 12 February 2010, and in the Sydney Clinic from 23 March 2010 – 9 April 2010, and received oxycodone in Camden Hospital on 16 April 2010. The following prescriptions were on top of those given during her hospital admissions:

#### Oxycodone

Prescribed date	Dispensed date	Prescription drug	Quantity	Prescribed dosage	Prescribing doctor	Pharmacy name
15/04/10	15/04/10	oxycodone hydrochloride 5 mg tablet, 20	20	1 tablet three times daily when required	John R Higginbotham	Narellan Chemmart Pharmacy
16/04/10	16/04/10	oxycodone hydrochloride 40 mg tablet: modified release, 28 tablets	20	1 tablet twice daily	John R Higginbotham	Narellan Chemmart Pharmacy; PBS
17/01/10	17/04/10	oxycodone hydrochloride 80 mg tablet: modified	20	1 tablet twice daily	John R Higginbotham	Narellan Chemmart Pharmacy; PBS

		release, 28 tablets				
10/04/10	19/04/10	oxycodone hydrochloride 80 mg tablet: modified release, 28 tablets	20	1 tablet twice daily	John R Higginbotham	Mount Annan Soul Pattinson Pharmacy; PBS
19/04/10	19/04/10	oxycodone hydrochloride 80 mg tablet: modified release, 28 tablets	20	1 tablet twice daily	John R Higginbotham	Narellan Chemmart Pharmacy; PBS
NK	19/04/10	oxycodone hydrochloride 5 mg tablet, 20	10	1 tablet four times daily when required	Dr Swamy	Narellan Amcal Chemist
NK	21/04/10		10	1 tablet four times daily when required	Dr Naraya	Mount Annan Soul Pattinson Pharmacy
22/04/10	22/04/10	oxycodone hydrochloride 80 mg tablet: modified release, 28 tablets	20	1 tablet twice daily	John R Higginbotham	Mount Annan Soul Pattinson Pharmacy; PBS
23/04/10	23/04/10	oxycodone hydrochloride 80 mg tablet: modified release, 28 tablets	20	1 tablet twice daily	John R Higginbotham	Narellan Chemmart Pharmacy; PBS
<b>Total</b>			160			

(Ms Drinnan was not identified in the Medicare Prescription Shopping Information Service. This is despite the fact that she was supplied oxycodone, a restricted benefit on the PBS available only in a pack of 20 (or 28) and for severe disabling pain not responding to non-narcotic analgesics. In an 8 day period she was supplied 120 tablets, six times the permitted dose, on the PBS. In total, she was supplied 160 oxycodone tablets during this period)

Morphine (Prescribed by Dr Higginbotham)

NK	29/01/10	Morphine hydrochloride		1	10mg/ml	5 ml twice daily	Mount Annan Soul Pattinson Pharmacy
10/04/10	10/04/10	Morphine hydrochloride	morphine hydrochloride 10 mg/mL oral liquid, 200 mL	1	10mg/ml; 200ml	2ml every 4 hours when required as directed	Narellan Chemmart Pharmacy
NK	12/04/10	Morphine hydrochloride		1	10mg/ml	2 ml every 4 hours when required	Mount Annan Soul Pattinson Pharmacy
NK	13/04/10	Morphine hydrochloride		1	10mg/ml	2 ml every 4 hours when required	Mount Annan Soul Pattinson Pharmacy
NK	17/04/10	Morphine sulfate	morphine sulfate 30 mg/mL injection, 5 x 1 mL ampoules	5	30mg/ml	as directed by doctor	Blooms The Chemist Camden
19/04/10	19/04/10	Morphine sulfate	morphine sulfate 30 mg/mL injection, 5 x 1 mL ampoules	5	30mg-1ml	For Doctor's Use	Narellan Chemmart Pharmacy
NK	29/04/10	Morphine hydrochloride		1	10mg/ml; 200ml	2ml every 4 hours when required	Mount Annan Soul Pattinson Pharmacy

(The PBS website has a caution listed for Morphine, warning that the risk of dependence is high. In tablet form it is a restricted benefit, only available for chronic severe disabling pain not responding to non-narcotic analgesics)

Diazepam (Prescribed by Dr Higginbotham except for 11 April 2010)

16/11/09	17/11/09	diazepam 10 mg/2 mL injection, 5 x 2 mL ampoules	10	as directed by doctor
4/12/09	17/12/09	diazepam 10 mg/2 mL injection, 5 x 2 mL ampoules	10	For Doctor's Use
4/01/10	20/01/10	diazepam 10 mg/2 mL injection, 5 x 2 mL ampoules	10	For Doctor's Use
1/02/10	12/02/10	diazepam 10 mg/2 mL injection, 5 x 2 mL ampoules	10	For Doctor's Use
25/02/10	25/02/10	diazepam 10 mg/2 mL injection, 5 x 2 mL ampoules	10	For Doctor's Use
9/04/10	9/04/10	diazepam 10 mg/2 mL injection, 5 x 2 mL ampoules	10	For Doctor's Use
10/04/10	10/04/10	diazepam 5 mg tablet, 50	50	as directed by doctor
11/04/10	11/04/10	diazepam 5 mg tablet, 50	12	1 tablet at night when required
NK	12/04/10		50	as directed by doctor
13/04/10	13/04/10	diazepam 5 mg tablet, 50	50	as directed by doctor
23/04/10	23/04/10	diazepam 10 mg/2 mL	10	For Doctor's Use



		injection, 5 x 2 mL ampoules		
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Pethidine (prescribed by Dr Higginbotham)

16/11/09	16/11/09	Pethidine-MX AMP	5	100mg-2ml	For Doctor's Use
4/12/09	4/12/09	Pethidine-MX AMP	5	100mg-2ml	For injection as directed by doctor
18/12/09	18/12/09	Pethidine-MX AMP	5	100mg-2ml	For injection as directed by doctor
4/01/10	20/01/10	Pethidine-MX AMP	5	100mg-2ml	For Doctor's Use
1/02/10	12/02/10	Pethidine-MX AMP	5	100mg-2ml	For Doctor's Use
23/02/10	23/02/10	Pethidine-MX AMP	5	100mg-2ml	For Doctor's Use
1/03/10	4/03/10	Pethidine-MX AMP	5	100mg-2ml	For Doctor's Use
12/03/10	12/03/10	Pethidine-MX AMP	5	100mg-2ml	for injection as directed by doctor
9/04/10	9/04/10	Pethidine-MX AMP	5	100mg-2ml	For Doctor's Use
13/04/10	13/04/10	Pethidine-MX AMP	5	100mg-2ml	as directed by doctor
23/04/10	23/04/10	Pethidine-MX AMP	5	100mg-2ml	For Doctor's Use

20. In 2008 Ms Drinnan was identified on neuropsychological testing as having moderate deficits without aspects of memory and an abnormal discrepancy between verbal and non-verbal functioning. The possibility of hypoxic brain injury secondary to overdose was also identified.

21. She was admitted to the Sydney Clinic on four occasions: 16 June 2008 (after a charge of driving under the influence of alcohol), 12 June 2009 (to prevent destabilisation of her

bipolar disorder after recent alcohol abuse), 10 July 2009 (to avoid drinking) and 23 March 2010.

22. In May 2008 Ms Drinnan collapsed in Dr Nguyen's surgery and was found to have a full bottle of diazepam and uncapped needles and syringes. This opens the possibility that she was administering injections herself.
23. Since 2000, she had over 24 admissions to hospital, including 15 for drug overdose. In 2010, in the months before her death Ms Drinnan was admitted to hospital via the Emergency Department three times.
24. On one of those admissions, on 29 January 2010 Ms Drinnan was taken by ambulance to the Emergency Department at Campbelltown Hospital with decreased level of consciousness and a respiratory rate of ½ pm. She was given narcan with good effect. She said that she had had Ordine 20mls between 1400 and 1800 hours, which she took for cough suppressant and also that she took oxycontin for muscle spasms. The ambulance records said that she was unconscious and hypoventilating. The nursing notes record Ms Drinnan saying that she had taken "Ordine (which she rarely takes) for her cough but accidentally took too much as she doesn't have a measuring spoon". She was discharged on 30 January 2010.
25. Then on 30 January 2010 she again was taken by ambulance to the Emergency Department at the Campbelltown Hospital on account of an overdose of quetiapine. On 1 February 2010 she was scheduled as she posed a chronic risk of self-harm. She was admitted and remained in hospital until 12 February 2010 for follow up with her psychiatrist and contact over the weekend. She was noted on review by Dr Divakaran on 1 February 2010 to say that she had been drinking 1 bottle of vodka a day since last few weeks and to have had neck pain for which she was given mersyndol, oxycontin and pethidine injections "*but has been abusing prescription medications*". However, on 3 February 2010 on review by Dr Wankhede she denied using any opioid analgesics and said she drank alcohol occasionally. A discharge summary dated 15 February 2010 reported that Ms Drinnan had been reviewed by the Drug and Alcohol team who could not provide much help as she "is still in the phase of denial". The summary also stated that, considering the risk of overdose, she had been commenced on Sodium Valproate (Epilim) and commenced on Acamprosate (medication for alcohol dependence).

## **Dr Higginbotham**

26. Ms Drinnan saw Dr Higginbotham about 160 times from 1998-2010 and his handwritten notes are brief.
27. On 64 occasions from 2002 to 2010 he prescribed pethidine to Ms Drinnan, often five ampoules at a time. She was receiving the pethidine by way of injections. In addition, Dr Higginbotham prescribed benzodiazepines at 38 consultations (sometimes giving diazepam – valium - intramuscularly), and a range of other medications including morphine, oxycodone, antidepressants, antipsychotics, mood stabilisers and anti-addiction drugs.
28. Ms Drinnan had been an inpatient admission to the Sydney Clinic from 23 March 2010 to 9 April 2010 on account of drug and alcohol issues. After her discharge, in the last three weeks of her life some of the medications dispensed to Ms Drinnan from Dr Higginbotham's prescriptions are as follows:

### *Morphine*

1. 200mL 10mg/mL oral Ordine, 10/4/2010
2. 10mg/mL oral Ordine, 12/4/2010
3. 10mg/mL oral Ordine, 13/4/2010
4. 5 ampoules of morphine sulphate 30mg/mL, 17/4/2010
5. 5 ampoules of morphine sulphate 30mg/mL, 19/4/2010
6. 200mL 10mg/mL oral Ordine, 29/4/2010

It is significant that the Ms Drinnan was found with an open bottle of Ordine on the table next to her. The bottle contained 10mg/mL oral solution, prescribed to be taken 2mL every 4 hours. Dr Higginbotham had prescribed this medication the previous day. Approximately 60 to 70mLs were missing from the bottle.

### *Pethidine*

1. 5 ampoules, 100mg-2ml, 9/4/2010
2. 5 ampoules, 100mg-2ml, 13/4/2010
3. 5 ampoules, 100mg-2ml, 23/4/2010

### *Oxycodone*

1. 20 x 5mg tablets, 15/4/2010
2. 20 x 40mg tablets, 16/4/2010
3. 20 x 80mg tablets, 17/4/2010
4. 20 x 80mg tablets, 19/4/2010
5. 20 x 80mg tablets, 19/4/2010
6. 20 x 80mg tablets, 22/4/2010
7. 20 x 80mg tablets, 23/4/2010

Total of 140 oxycodone tablets in 8 days (the highest prescribed dosage being 3 tablets per day).

*Diazepam/Valium*

1. 5 ampoules, 10mg/2ml, 9/4/2010
2. 50 x 5mg tablets, 10/4/2010
3. 50 x 5mg tablets, 12/4/2010
4. 50 x 5mg tablets, 13/4/2010
5. 5 ampoules, 10mg/2ml, 23/4/2010

Total of 150 tablets and 10 ampoules of diazepam in 8 days.

29. In the period leading up to her death on 30 April 2010, and subsequent to her discharge from Sydney Clinic on 9 April 2010, Dr Higginbotham's clinical records show Ms Drinnan attended him on 9, 10, 11 (or 12), 13, 15, 16, 19 x 2, 21, 22, 23 and 29 April. There is also the erroneous entry for 1 May.
30. Each of the independent experts were highly critical of Dr Higginbotham's treatment and prescribing to Ms Drinnan. The care provided by Dr Higginbotham was described as being little other than writing repeated extensive prescriptions.
31. Dr Wilson identified that there was no documentation to suggest that Dr Higginbotham had made any attempts to control the supply of prescription medication to Ms Drinnan. In her oral evidence she said that the ongoing use of oxycontin and morphine and the injectable morphines and valium and history of alcohol dependency would alert a doctor to the possibility that Ms Drinnan was dependent. In this regard, Dr Wilson's oral evidence that the escalation in the final weeks of Ms Drinnan's life would indicate to a doctor that "it's not working ... this is not safe" was particularly cogent.
32. Dr Higginbotham failed to investigate the cause of apparent pain which was recorded in his clinical records as the justification for prescribing opioids. As pointed out by Dr Wilson, there was no evidence in Dr Higginbotham's notes of any comprehensive assessment of Ms Drinnan's chronic pain conditions. There is no indication that Ms Drinnan had a medical condition that warranted the opioids.
33. Dr Higginbotham treated Ms Drinnan with short acting opioid injections which, according to Dr Wodak, have not been considered an acceptable form of management for at least two decades. In oral evidence Dr Wodak said that "I think the profession has pretty well come to the conclusion that there is no place for pethidine in modern medicine". He said that that view had been widely held for at least 10 years. Dr MacPherson, expert in pain management, shared Dr Wodak's view of pethidine. He said that the use of pethidine has been discouraged by all manner of agencies and specialists for at least the last ten years, as it is a dangerously

addictive drug which has no advantages over other opioids in terms of pain management. He says that in literature distributed to pain management specialists, the role of pethidine especially in pain management has been roundly criticised and it has been removed from the national health schemes and doctors bag supplies years ago.

34. Dr Wilson criticised Dr Higginbotham's prescriptions of pethidine as "hard to defend". She also said that there did not appear to be any good indication for injectable morphine in Ms Drinnan's clinical history.
35. Dr MacPherson also queried the appropriateness of prescribing Ordine liquid as an agent for pain management given Ms Drinnan's history and how easily this could lead to a drug overdose compared to taking tablets. Dr MacPherson gave evidence that a 200ml bottle of Ordine sulphate would equate to a fatal overdose. And that 1-2g would be a dangerous and likely fatal amount. In the month before Ms Drinnan's death, Ordine was dispensed to Ms Drinnan four times, using scripts from Dr Higginbotham. On the day before she died he prescribed 200ml 10mg oral Ordine. When she was found she had an opened bottle of Ordine next to her.
36. Dr Wilson also raised the need for a high index of suspicion where there are reports of scripts having been lost or destroyed, as was the case with Ms Drinnan.
37. Dr Higginbotham wrote a prescription for pethidine ampoules, and recorded an attendance by Ms Drinnan, on a date which post-dated her death. This is clearly an unacceptable practice. It also appears that Dr Higginbotham prescribed pethidine on 1 February 2010 at a time when Ms Drinnan was an in-patient at the Sydney Clinic.
38. There is no doubt Dr Higginbotham was aware of Ms Drinnan's drug dependence and history of overdoses. He had received a discharge summary from Waratah House in 2008 referring to her "poly substance misuse" and "high risk to directly/indirectly kill herself".<sup>1</sup> He had also received a letter from her psychiatrist, Dr Shute that referred to "at least 15 overdoses" and in particular two overdoses of medication shortly after 27 January 2010<sup>2</sup>. In February 2010 Dr Higginbotham's own notes recorded an accidental overdose on Ordine.<sup>3</sup> On the 14 April 2010 a discharge referral was sent to Dr Higginbotham from Camden Hospital stating "drug overdose in past-ordine/?oxycontin".<sup>4</sup>

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<sup>1</sup> Vol. 4 p410AW

<sup>2</sup> Vol. 4 p389, p372

<sup>3</sup> Vol. 1 Tab 25 p16

<sup>4</sup> Vol. 4 p366-367

39. As Ms Drinnan's doctor, Dr Higginbotham should have known she was at very high risk of a future fatal drug overdose.
40. The prescriptions Dr Higginbotham wrote for Ms Drinnan, particularly for opiates in the weeks leading up to death were described by the experts as "concerning" (Dr Ryan), "reprehensible and professionally negligent", "indefensible" (Dr Wodak) "exceptional", "excessive" (Dr MacPherson,) "hard to defend" and "she's a really high risk in terms of safety. It doesn't make sense to me to be doing this amount of prescribing. It's a very high level... It doesn't make sense. It means it's not working... you'd have to be thinking...this is not safe" (Dr Wilson).
41. The experts described the standard of medical care/conduct Dr Higginbotham provided "placed the public at risk of serious harm" (Dr Ryan) and was "deeply unimpressive" (Dr Wodak). Dr MacPherson stated that if the injectable morphine, diazepam and pethidine were left in the control of Ms Drinnan, this would be "a serious breach of standard patient care".

#### **Dr Nguyen**

42. Between February 2002 and April 2010 Ms Drinnan was seen regularly by Dr Nguyen. He administered intramuscular injections of pethidine, valium and morphine which had been prescribed by Dr Higginbotham. He also prescribed medication. He referred her to Dr Shute for admission and stabilisation for bipolar disorder and drug abuse, especially alcohol and medication including pethidine, valium and mogadon.<sup>5</sup>
43. Dr Wilson identified that Dr Nguyen administered medication prescribed by Dr Higginbotham and saw Ms Drinnan as a general practitioner on many occasions , but did not contact Dr Higginbotham to discuss his concerns. Dr Wilson said that the issue with Dr Nguyen is one of making sure that the treatment of a patient is justified and is appropriate. She said "it seems to me that what Dr Nguyen was doing was just being the administrator of a drug that had already been prescribed". She described it as "unfortunate" that Dr Nguyen did not think "this is not best practice. I am going to talk to Dr Higginbotham. I'm going to not continue this, because I don't think it's helping". Dr Ryan was also disappointed Dr Nguyen didn't identify problems that Ms Drinnan had; he did not take sufficient responsibility as a general practitioner to seek to deal with those problems and instead unjustifiably limited his appreciation of his role.

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<sup>5</sup> Vol 5 tab 1 p.3.

## Dr Shute

44. Ms Drinnan was also under the care of Dr Shute, psychiatrist who first started treating her in 2008 at the Sydney Clinic and then in his private counselling rooms. His evidence is that he was only aware of, and treating her for, alcohol abuse.
45. There were significant discrepancies between the medication that Dr Shute believed Ms Drinnan to be taking, and the medication which she was being prescribed by Dr Higginbotham.
46. This highlights one of the difficulties inherent in providing clinical care to a patient such as Ms Drinnan, the problem of ensuring that the history being provided is accurate.
47. On 15 February 2010 Dr Shute noted her current medications as Seroquel, Cymbalta, Naltrexone, Campral, Epilim, and Antabuse. He said she was in good spirits and “we agreed that her medications should remain unchanged as she was not experiencing any problems with the current regime.” In fact, at that time, Ms Drinnan was being prescribed medications, including morphine, pethidine and benzodiazepines.
48. Dr Shute says that he never suspected that she may have been obtaining prescription drugs of dependence outside of the Sydney Clinic or his private practice. He says that he saw no evidence of abuse of prescribed medication and that they had a good rapport and a trusting doctor-patient relationship.
49. His assertions in that regard are somewhat surprising. In 2008 he prepared a psychiatric report on her where he noted that she had taken at least 15 overdoses requiring hospitalisation<sup>6</sup>.
50. In the few months prior to her death she was seen by him on 21 December 2009, 28 January 2010, 15 February 2010 and 25 February 2010. Included in his notes was a discharge summary which indicated that Ms Drinnan had taken an overdose on prescription medications in the context of ongoing psychosocial stressors and polysubstance misuse. He should have been well aware that this was a patient with a history of abuse of medication.
51. He agreed that with hindsight he should have checked what medication she was being prescribed. His evidence reveals the dangers of relying upon a patient’s own account in circumstances such as those of Ms Drinnan when there was an easy and non-intrusive means

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<sup>6</sup> Ex 1 Vol 5 tab 1 p 42

of checking the veracity or circumstances of her account, by making enquiries of her general practitioner.

52. Dr Shute said that Ms Drinnan had specifically asked him not to speak to her mother or son however he did not document that in his notes.
53. Dr Shute's insistence that he had "to take into regard what people say not what others say about them" was surprising and not a convincing explanation for not relying upon such information to inform his treatment decisions, and decisions about whether or not to inquire further in relation to possible prescription drug abuse. In particular from 2010, when Dr Shute knew that Ms Drinnan had two admissions to hospital for overdoses in a short space of time, it was disappointing that Dr Shute relied merely upon what he saw of Ms Drinnan without making further inquiries. Whilst Dr Shute in oral evidence asserted that privacy concerns prevented him from contacting Ms Drinnan's family or the hospital to find out more, I do not accept this as a reasonable explanation. He was clearly willing to write to her general practitioners Dr Higginbotham and Dr Nguyen on a regular basis setting out his treatment of Ms Drinnan without any privacy concerns. He was also receiving information from treating general practitioners, psychiatrists and hospitals. I am satisfied he could have contacted them about his ongoing care of Ms Drinnan without any privacy concerns.
54. Dr Shute said that he never suspected that Ms Drinnan was obtaining drugs of dependence from her general practitioner, but that it would have made "an enormous difference" if he had been aware of that. He said he would not have prescribed naltrexone, and the whole emphasis of her treatment would have changed from focussing on alcohol to focussing on drugs of dependence with the aim of having no drugs of dependence at all. He also would probably have picked up the telephone to her general practitioner.
55. Dr Wodak's view was that in the light of the lack of progress for Ms Drinnan Dr Shute could have made more inquiries himself, including of Ms Drinnan's general practitioner. He said Dr Shute could have telephoned the general practitioner to inquire about Ms Drinnan as regards the medication that she was being prescribed.
56. Dr Shute had an unquestioning reliance upon the veracity of Ms Drinnan's account to him without seeking any corroboration or making further inquiries.
57. Dr Shute prescribed naltrexone to Ms Drinnan. Naltrexone has the effect of blocking opiates such that they have no effect. According to Dr Wodak, if naltrexone is prescribed for alcohol abuse then an experienced psychiatrist such as Dr Shute should inquire or warn the patient



about opioids, as naltrexone will cause a “severe, debilitating, nasty opiate withdrawal”. Further, if a patient has been taking naltrexone then resumes opioids then there is a six to eight-fold greater chance of death from drug overdose because the patient’s tolerance for opioids has diminished whilst taking the naltrexone. Dr Wodak said that even a ten day period can diminish tolerance to opiates.

## **Conclusion**

58. The circumstances leading up to the death of Ms Drinnan show that she and her family were let down by the medical profession. The tragic consequences for her children and her mother have been clearly described at this inquest. Her son’s efforts to communicate with his mother’s doctors and pharmacists, to understand what medications and why she had been prescribed them were met with frustration and a common attitude that his mother’s privacy prevailed over her and the family’s safety.
59. Her son gave evidence of the dangers he and his sister met when being driven by his mother under the effects of alcohol and prescription drugs. His successful attempt to have his mother’s driving license suspended was thwarted by Dr Shute’s uncritical and ill-informed support of her getting her licence back.
60. She saw ten general practitioners after her discharge from hospital in February 2010, six of those were from 20 April until her death on 29 or 30 April 2010.
61. There was a clear failure of practitioners communicating with each other or addressing Ms Drinnan’s clear dependence on prescription medication.
62. She was particularly let down by Dr Higginbotham. Dr Higginbotham was her general practitioner for 12 years. He was aware that she was a very vulnerable patient. He was aware of her potential cognitive impairment, her addiction to alcohol, her psychiatric issues, her impulsivity, her past history of numerous overdoses and the overall high level of risk that Ms Drinnan would consume dangerous amounts of her medication with alcohol. It is of particular significance that he was aware of a recent overdose involving Ordine liquid. Dr Higginbotham prescribed dangerous amounts of medication with this awareness in a form which greatly increased the risk of overdose.
63. The expert evidence suggests that Dr Higginbotham’s care of Ms Drinnan fell far below that of a reasonable doctor. The use of expressions by the experts like “indefensible” “reprehensible” and “exceptional” suggest that the failures involved a significant departure from what would have been expected of him in the circumstances.

64. In those circumstances I am of the opinion that a copy of these findings should be provided to the Health Care Complaints Commission.

**Findings under s 81 Coroners Act 2009**

I find that Christine Drinnan died between 29 and 30 April 2010 at 6 Casuarina Place, Narellan Vale, NSW. I am satisfied the cause of her death was multi-drug toxicity. The manner of her death was misadventure.

Magistrate Carmel Forbes  
*Deputy State Coroner*