CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 28th, 29th and 30th days of November 2017, the 1st and 4th days of December 2017 and the 23rd day of May 2018, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Claudia La Bella.

The said Court finds that Claudia La Bella aged 28 years, late of 86 Crozier Avenue, Newton, South Australia died at Newton, South Australia on the 29th day of June 2014 as a result of aspiration of gastric contents complicating laxative abuse. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

1.1. Claudia La Bella died on 29 June 2014. She was 28 years of age at the time of her death. An autopsy was carried out by Dr John Gilbert of Forensic Science South Australia who gave the cause of death as aspiration of gastric contents complicating laxative abuse[1], and I so find.

2. The evidence of Claudia's husband

2.1. Claudia's husband gave evidence at the Inquest. He said that in April 2012 Claudia told him that she had cancer and that it was terminal. He said that he was shocked to hear this and wanted to know about her treatment, but she would not allow him to see the doctor, saying that he should go to his work and that she would let him know what happened. He said that by mid to late 2013 he became more insistent about seeing Claudia's doctor or getting her to obtain a second opinion, but she was insistent that she would not allow this and that she would deal with the matter by herself. He said that he trusted his wife and he did not think that she was deceiving him in anyway. She

[1] Exhibit C1a

drove herself to appointments. He said sometimes she would ask him to pick her up after treatment which he would do and then later he would walk to the hospital to get her car from the hospital carpark. He said that that occurred on six occasions. He said that Claudia and her mother were very close and that her mother was a nurse. Claudia told them that the cancer was terminal and that she had three to five years to live. Everyone in the family was made aware of the diagnosis, as were family friends. Over time Claudia lost weight and lost her appetite. She never ate carbohydrates and mainly ate soups and broths. Towards the end she would eat no solid food saying that it was hard to keep the solids down. Claudia took what Mr La Bella thought was medicine in the form of tablets. She would take up to six tablets a day that he would see. He said that he was buying her boxes of Dulcolax[2] from the pharmacy and was not aware of her taking any other medications apart from the Dulcolax. Claudia told him that the Dulcolax was to flush toxins out of her body from the chemotherapy treatment that she was having for her cancer. He said that she was losing her hair and that it was getting thinner. He said that he bought the Dulcolax for her weekly and that there was always a supply in the house of at least two to three boxes and towards the time of her death, 10 to 15 boxes. He said that on one occasion he bought 15 boxes in one go. Mr La Bella said that the majority of the time the same person served him at the pharmacist. He said that the person who served him at the pharmacy would ask him about his wife's cancer and was aware that she was undergoing treatment for that disease. It was Mr La Bella's understanding that the doctor would inject the chemotherapy treatment into the laxative tablets and that the purpose of this was to enable the chemotherapy to be delivered as well as the laxatives and the purpose of the laxatives was to flush toxins from the chemotherapy drug out of the body. This was the story given to Mr La Bella by his wife. He understood that the doctor treating her for the cancer was the person who was 'injecting' the tablets with chemotherapy drugs.

2.2. Mr La Bella was asked whether his wife ever mentioned an eating disorder and he replied that he knew that she had been picked on for her weight when she was at school. He said that he did see his wife vomit regularly after the cancer diagnosis, as many as two or three times per week. She complained of stomach pains as well which were associated with the vomiting.

2.3. Mr La Bella gave evidence of his wife being hospitalised at the Royal Adelaide Hospital (RAH) within two weeks of her death. She had been complaining of severe

[2] Dulcolax is a laxative

stomach pain for which she took Buscopan which did not work. He said that she needed to go to the hospital and he took her. He was not aware that she had seen her general practitioner that day or that her general practitioner had referred her to the RAH herself. He said that as far as he was aware he was the person who initiated the visit to the RAH.

2.4. He said that while at the RAH where his wife was admitted as an inpatient for two days, she told him not to mention anything about her cancer condition and he complied with her wishes. He was with her when they went to the Emergency Department and returned the next day, by which time she was in another ward. He stayed that day with her and said that no-one approached him or talked to him about his wife's condition. He came back that same night and talked to the night nurse about the soccer, but not about his wife's condition. He said that the staff did not ask him any questions about his wife. He said that he did not bring any laxatives into the hospital and was not aware of anyone else doing so. He said that his wife discharged herself from the RAH, but promised to see a doctor during the week. He said that his wife was not happy with the treatment she had received in the hospital and was advised to stay, but she said that she did not want to die in hospital.

2.5. Mr La Bella said that he and Claudia had talked about her dying and the question of a will and their daughter's schooling was also discussed. He said that they expected that she was going to die as a result of her cancer diagnosis, although he always held out some hope. He said that he only discovered that his wife did not have cancer when he saw the autopsy report of Dr Gilbert.

2.6. Mr La Bella also said that Claudia's employer accused her of taking money[3]. He said he did not know how much was involved. He said that Claudia paid the majority of the household bills out of her earnings and that at times the laxatives were costing up to $500 per week and that the cost of that was met from her cheque account. He said that he did not have access to her cheque account and never saw the amount standing to its credit.

2.7. Mr La Bella was asked about his wife's insistence at the RAH that nothing be said about her cancer. He said that he thought that it was strange, but only in the back of his mind. He said there was no discussion with him about an eating disorder nor did he hear any such discussion between Claudia and the doctor, or if he did he had no memory of it.

[3] This occurred after her death

3. The evidence of Dr Clare Frawley

3.1. Dr Frawley is a general practitioner. She saw Claudia for the first time on 18 June 2014 when she was brought in by her mother in a wheelchair. Claudia asked her mother to leave during the consultation. Dr Frawley said she looked very unwell, that she was dehydrated and underweight and appeared to be scared. Dr Frawley said that she did not have an opportunity to speak to Claudia's mother alone and that at that stage she would not have done so. She said that it was her view that Claudia needed to get to an Emergency Department as soon as possible. Dr Frawley asked Claudia how she thought she had lost weight and Claudia denied that it was an eating disorder. Dr Frawley said that she did not push that subject and instead focussed on getting Claudia to agree to go to hospital. Dr Frawley made a note that Claudia 'denies any intentional weight loss'. She said that there was no altered mental state evident and that Claudia's mother did return at the end of the consultation at Dr Frawley's request so that she could be reassured Claudia's mother would take her to the RAH. Dr Frawley wrote a letter of referral to the RAH which was in the following terms:

> 'Thank you for seeing Claudia aged 28 for abdominal pain, nausea, vomiting and weight loss over the past 6 months. Claudia states this is unintentional but has been having intermittent nausea vomiting> 6 x per day and diarrhoea. Last self weigh was reported to be 42kg now today at clinic 35kg.
>
> Locum review 1 week ago started on abx ? which for UTI. She has not otherwise had any medical reviews in 2 years.
>
> PMHx : Current Problems
>
> Dec 2009 Subfertility;F - Anovulation, ?cause
>
> *clomid*
>
> Meds : nil reg
>
> Allergies : No Known Allergies' [4]

3.2. Dr Frawley provided the letter of referral to Claudia to take to the hospital herself. She gave evidence that she did not include in the letter a specific request for a psychiatric examination or a request for the RAH doctors to consider the possibility of an eating disorder. She explained that this was a deliberate strategy because Dr Frawley was concerned that if Claudia read the letter of referral and saw references to eating disorders or psychiatric examination she might be frightened off and choose not to attend the RAH. However, after Claudia left the surgery Dr Frawley rang the Emergency Department consultant to add Claudia to the expected patient list. She said

[4] Exhibit C15, page 12

that she was very worried about Claudia and she remembered saying that there was a need for a mental health review because she suspected an eating disorder.

3.3. Dr Frawley next saw Claudia on 23 June 2014. Claudia was alone on that occasion. Dr Frawley knew that she had been admitted to the RAH and was surprised that she was not still there. However she looked hydrated and could mobilise and appeared to be reasonably well, but was obviously underweight. Dr Frawley at that point did not have a copy of a discharge summary from the RAH. That is not surprising because the discharge summary appears not to have been prepared until 28 June 2014 and the copy in the medical notes of Dr Frawley[5] was a facsimile copy from the RAH received on 3 July 2014. That was after Claudia's death.

3.4. Dr Frawley said that she rang an RAH registrar to find out what had happened with Claudia. She said that in the conversation with the registrar no mention was made of a CT scan taken during the admission and she was not told that the CT scan report contained the following sentence:

> 'Numerous rounded densities in the stomach are compatible with tablets. Several dozen are noted. Correlate with medical history.' [6]

Dr Frawley said that if she had known about that information from the CT report she would have considered detaining Claudia under the Mental Health Act 2009 and that she would have been '*a bit more aggressive*'[7] with her follow-up. She discussed the case with a more senior practitioner at her practice who agreed with her plan. Her plan was to order urgent bloods to make sure Claudia's potassium levels had stabilised and then to arrange an endoscopy/colonoscopy which had been recommended by the RAH. She said that these latter investigations were urgent and so she rang around and managed to get an appointment for Claudia at the North Eastern Community Hospital on 26 June 2014. Dr Frawley discussed with Claudia that she would need to obtain a preparatory kit for the endoscopy/colonoscopy from Dr Lidums' rooms and she agreed to collect them. Dr Frawley said that she was planning to run Claudia's case past the state-wide eating disorders unit if the scopes showed no abnormality. Dr Frawley said that Claudia was very dismissive of any conversation about eating and quickly changed the focus. She would not engage on that subject. Dr Frawley was aware that Claudia

[5] Exhibit C14, page 22
[6] Exhibit C15, page 1
[7] Transcript, page 81

had disengaged in the past when unhappy with a general practitioner and she did not want that to happen again.

3.5. Dr Frawley said that on 26 June 2014 she spoke to a person from the eating disorders unit and I note that there is an email on Dr Frawley's casenotes[8] from the Statewide Eating Disorder Service advising of the opportunities for a referral to that service. Dr Frawley was also aware on that day that Claudia was to be having her endoscopy/colonoscopy investigations so she rang Dr Lidums' rooms and was informed that Claudia had not attended. Dr Frawley then tried to call Claudia on her mobile but received no answer. She asked her practice nurse to follow-up. She said that on 27 June 2014 the practice nurse made a call to Claudia but there was no answer. Dr Frawley had arranged for Claudia to attend her clinic on 30 June 2014 to follow-up the results of the endoscopy/colonoscopy that had been planned for 26 June 2014. 30 June 2014 was a Monday and the weekend intervened. On the Sunday night Dr Frawley was contacted by police to advise of Claudia's death.

3.6. At no time in her dealings with Claudia or her mother was Dr Frawley informed of Claudia's alleged diagnosis of cancer.

4. Claudia's admission to the Royal Adelaide Hospital

4.1. In summary we know that Claudia's attendance at the RAH came about as a result of her visit to Dr Frawley with her mother on 18 June 2014. It is interesting that Mr La Bella thought that it was he who had initiated the visit to hospital because his wife did not inform him about her visit to the general practitioner earlier that day, nor did he find out from Claudia's mother. It seems quite clear to me that Claudia went to extraordinary lengths to be secretive about her health and about any appointments around the topic of her health. In a normal environment one would expect mother and husband to be aware of the general practitioner visit earlier in the day, and the plan to visit the RAH. It seems to me that Claudia actively discouraged any such communication thus making it all the harder to deduce what was actually going on with her health. Not only was this a problem for family members, but as will be seen, it was clearly a problem for those in the health system who were attempting to assist Claudia.

4.2. Dr Drysdale gave evidence at the Inquest. He was a consultant physician at the RAH. For the purposes of his evidence he reviewed the RAH notes. His independent

[8] Exhibit C14

recollection at the time of giving evidence was very superficial apart from a relatively clear recollection of a conversation he had with Claudia after his final consultation with her. He said that he understood she arrived on the acute medical ward where he was consulting at 2220 hours on 18 June 2014 having arrived at the hospital at around 1330 hours that day. He said that his resident medical officer (RMO), Dr Cherian, would have reviewed Claudia in the Emergency Department at 1930 hours that day. He said that a CT scan was carried out at 2320 hours and although there was no note of his having done so within the medical notes[9], Dr Drysdale would have reviewed her at some time in the afternoon of 19 June 2014. He explained the lack of a note recording that event as being attributable to his RMO having been distracted and not having done the note. He said that he could not remember what happened that afternoon, but noted that his statement to the police[10] which was given on 23 September 2014, not long after the event, did contain an account of what occurred in his review on the afternoon of 19 June 2014. Relying on that account he said that Claudia described six months of epigastric pain, dysphagia and vomiting resulting in an ability to keep food down. She also described bloodstained bowel actions and denied intentional weight loss, an eating disorder or laxative abuse. On examination she was severely underweight, her pulse was 88 and the blood pressure was $^{110}/_{60}$. There was generalised epigastric discomfort on palpation of her abdomen and she had received intravenous fluid overnight to treat hydration that was evident on admission. He was unable to recall if she was an engaging or reluctant historian. He said that he would have been aware of the referral letter from Dr Frawley and the notes made by the RMO, Dr Cherian, the previous day.

4.3. Dr Drysdale said that the symptoms as described did not lead him to a clear explanation. He said it was a very undifferentiated presentation and that many things can cause weight loss, diarrhoea and dehydration. He said that dysphagia also can be caused by many things. As to the reference to blood in the faeces, he remarked that it was indicative that there were potential issues at both ends of the gastrointestinal system. Dr Drysdale could not remember whether his RMO presented him with any explanation as to why she had not presented earlier, nor could he remember if Mr La Bella or any other family member was present during his review. He did meet Mr La Bella the following morning though. He said that Claudia forbade him to talk to her mother at the initial consultation on 19 June 2014. She explained that this was because of her past medical history when her mother had gone behind her back to speak to her general

[9] Exhibit C15
[10] Exhibit C19a

practitioner in the past and she did not want that to happen again. She did not say that he was not permitted to speak to her husband however. Dr Drysdale noted that all of the blood levels were elevated but this was not surprising given her level of dehydration. He said the potential possibilities included an underlying malignancy or metabolic problem.

4.4. Dr Drysdale said that at the time of his review on the afternoon of 19 June 2014 he would have been aware of the outcome of the CT scan done the previous night. He said that he would have looked at the images in the nurses' station and would have been aware of the contents of the report referring as it did to numerous rounded densities in the stomach being compatible with tablets with several dozen noted. He said he would have also been aware of his RMO's note describing them as 'dozens of tablets in the stomach'[11] and also his RMO's note that Claudia's explanation of these were that they would have been Buscopan, Panadeine Forte and analgesia from her mother which she had taken before coming to hospital. Dr Drysdale commented that the densities were still in the body of the stomach and that they did not appear to have left the stomach and he wanted to know what they were. He said that he thought that Claudia's explanation that they were Buscopan, Panadeine Forte and analgesics from her mother was somewhat unlikely. He said that if they were analgesics it would be highly unlikely that Claudia would have been sitting there talking to him 24 hours later. He said that a prior patient of his had scans of a similar appearance which turned out to be seeds. He said that he may not have been getting the truth from the patient, but that the doctor/patient relationship required trust and that it was up to him to think of explanations. He said he could not be sure how long the tablets had been there, but did not recall if he thought of the possibility that they were laxatives.

4.5. Dr Drysdale said that he was aware of Dulcolax which he described as a stimulant/irritant laxative which is enteric coated so that it passes through the acidity of the stomach and is metabolised in the large intestine. Its purpose is to directly cause contraction of the muscles of the colon and to secrete mucus.

4.6. He was asked whether if he had known that the densities were in fact Dulcolax on 19 June 2014 they would have explained her symptoms. He said that all of her symptoms were consistent with Dulcolax with the exception of the dysphagia (difficulty swallowing). He said if he had been aware that they were Dulcolax an endoscopy may

[11] Exhibit C15, page 53

still have been necessary to check for an explanation for the dysphagia and because of the bleeding from the bowel. He said that he talked to Claudia about the densities and she said that they were Buscopan, Panadeine Forte and analgesia from her mother as she had told everybody else.

4.7. Dr Drysdale said that he had an open mind at that point and had no reason to believe that Claudia was misleading him. He said that there was something unusual in the CT scans and that he had to work it out. He said he knew that it was not the potentially lethal analgesics that she had mentioned because if it had been she would not have been sitting there talking to him. His differential diagnosis at that point was that there was something limiting the ability of the stomach to empty, possibly ulcer, inflammatory bowel disease and in the back of his mind maybe an eating disorder. He said that his job was to exclude a medical cause and therefore an eating disorder was a lesser consideration in his mind.

4.8. Dr Drysdale was not aware that since 2012 Claudia had been telling her family that she had cancer and in particular, ovarian cancer. He said that in terminal ovarian cancer cases that he has seen the patients tend to have very large distended abdomens.

4.9. When he next saw Claudia on 20 June 2014 at 10am she was still in the acute medical ward. At that consultation he was informed that Claudia wanted to be discharged but he advised against this. He presented the worst case scenario to her which was the possibility of her heart stopping as a result of the potassium levels she was exhibiting. His interpretation of those levels was a result of her having received four litres of saline overnight and he said that he needed to introduce potassium to bring her back to the normal range. Her body weight was dangerously low and that in itself is a risk of mortality. He said that keeping her in hospital to increase her food intake was part of his plan, but he did not recall telling her a timeframe that he wanted her to remain for. He said that it was highly unlikely that he would have mentioned anorexia because they were trying to get her to stay in hospital and not to leave. He said that they enlisted the support of her husband to ensure she complied with taking potassium tablets. Dr Drysdale said that when he left her his RMO and the intern and he discussed whether she could be detained under the Mental Health Act. He said that when it came to considering whether she might have a mental illness they ‘stumbled’. He said there was no clear cut diagnosis of mental illness. He said if she had an eating disorder then that would qualify as a mental illness. However that stage had not yet been reached.

He said the tests of whether her actions posed a potential harm to herself would be met, but that there were less restrictive ways of dealing with this and therefore he could not lawfully detain her. He said his plan was that her potassium replacement would commence in hospital and that she would be released to the general practitioner to arrange for the endoscopy/colonoscopy that was still required. He said that he did not recall whether any thought was given to a referral to a psychiatric team for an opinion. He said that at the time of giving evidence he still did not know that she could be lawfully detained and noted that a lot of doctors would simply sign an inpatient treatment order (ITO) and leave the psychiatrist to pick up the pieces the next day.

4.10. Dr Drysdale was asked about the fact that Dr Frawley did not receive the discharge summary until July 2014 and he said that he was concerned about that. He said that he expected that there would be an immediate attempt to telephone the general practitioner and that he instructed his team to do that[12]. He said he had expected that to happen immediately or the same day. Commenting on the fact that the general practitioner did not receive the discharge summary until 3 or 4 July 2014 he remarked that the medical service at the RAH runs over capacity which leads to paperwork suffering. He said that in his private practice his discharge letters go the same day he sees the patient. Dr Drysdale said that he had taken steps to ensure the discharge summary despatch rate improved and that at the time of giving his evidence it depended on the situation. When the department was at 110% capacity, 95% of summaries were sent within 24 hours of discharge and 100% within 48 hours. However, he said that a month before giving his evidence the statistic was much worse.

4.11. Dr Drysdale said that he was not aware of a phone call having been made by Dr Frawley to the Emergency Department. He said that if he had been aware that the general practitioner had suspected an eating disorder that would have changed his approach. He said that what they were seeing in the CT scan report did not match the picture they saw clinically. In other words, the patient did not appear to have consumed what she said she had consumed. He also said that she said that she had obtained the tablets from her mother, but they were forbidden from speaking to the mother. He said that if he had known the tablets were in fact laxatives he would have obtained a psychiatric review straight away.

[12] By which he meant his registrar and intern

5. Embezzlement

5.1. The evidence revealed also that from approximately 2009 Claudia had been embezzling money from her employer. It is unnecessary to elaborate upon this, but it is relevant in that it fed into her desire to act deceptively, which was part of her medical condition. Claudia was unfortunately engaged in multiple deceptions around her medical condition, her medical appointments and to add to all of that, she was also involved in deceptions involving her employer and money. These multifactorial deceptions were clearly related to her mental condition as the expert in this case, Dr Naso, later comments.

6. The expert report of Dr Maria Naso

6.1. The Court was assisted by the provision of an expert report from Dr Naso who is a consultant psychiatrist[13]. Dr Naso described Claudia's circumstances as complex and rare. She presented with a concurrence of an eating disorder, most likely anorexia nervosa, and a severe presentation of factitious disorder which in its severest manifestations is known as Munchausen syndrome and Munchausen by Proxy. Dr Naso said that eating disorders have the highest mortality rate of any mental illness and that severe presentations of factitious disorder are rare and Dr Naso herself had only encountered two previous cases of Munchausen syndrome in her career, one of which involved a patient falsely claiming a diagnosis of terminal cancer for the purpose of getting medical attention. In Claudia's case her deception included calculated measures to avoid medical scrutiny and Dr Naso characterised Claudia's falsifications as being deep.

6.2. Claudia's claim of terminal cancer, of which no evidence was found at autopsy, and which was clearly a deception on her part, afforded her the opportunity to deny the existence of her eating disorder. There was a ready explanation for Claudia's emaciated appearance in that her family all believed that she was dying from terminal cancer and in fact there was an expectation that she would die. When she said to her husband while in hospital that she did not wish to die in hospital, it was consistent with his belief that she had terminal cancer. Therefore, when she wanted to be discharged from the RAH, he supported that decision because of her wish not to 'die in hospital' as a result of

[13] Exhibit C20

cancer, even though he was also reluctant for her to be leaving what represented the best opportunity for her to have proper medical care in a tertiary hospital.

6.3. Dr Naso said that people with anorexia or bulimia are very anxious to avoid a diagnosis of those conditions. She said:

> 'They're terrified, I can't … explain to you enough just how terrified they are of gaining weight.' [14]

6.4. Dr Naso was of the opinion that when Claudia wanted to discharge herself from the RAH she should have been detained under a Level 1 Inpatient Treatment Order under the Mental Health Act 2009. She was also of the view that the treating team should have initiated a psychiatric liaison consult which could have taken place within an hour or two in Dr Naso's opinion.

6.5. Finally it was Dr Naso's opinion that Claudia's long-term prognosis would have been poor from a psychiatric point of view[15].

6.6. In summary Dr Naso said that factitious disorder is very difficult to diagnose and that there is a very real concern for practitioners that they risk attributing psychological or psychiatric symptoms to what is in fact an undiagnosed medical condition. The possibility that Claudia had both anorexia nervosa and factitious disorder together, combined with the fact that these psychiatric conditions are complex and difficult to treat showed the difficulties involved in this case. Dr Naso said:

> 'Mrs La Bella had created an inescapable torment. She was embezzling money and had faked a terminal illness. Her options were limited. She either had to die due to the illness, tell the truth, or have a miraculous recovery, thus rousing family suspicions. The last two options would have led to great shame, possibly family estrangement and abandonment (the opposite of what the sick role was affording her), suicidal ideation/intent and possibly severe legal repercussions. The avoidance of the fall from her position of being all good may have ultimately made any psychiatric treatment difficult.
>
> The earlier that Eating Disorders and Factitious Disorders are diagnosed, the better the overall prognosis.
>
> In the short term, if Mrs La Bella had been placed on an ITO and diagnosed correctly, she may not have passed away with what was ultimately an acute medical condition. Long term, the treatment would have been complex, but possibly with the support of family she may have been able to get into remission. What needed addressing was her low self-esteem and her desperate need for attention and love. ' [16]

[14] Transcript, page 313
[15] Transcript, page 360
[16] Exhibit C20, page 15

6.7. I intend to recommend that in cases of severe weight loss where there is any suspicion of an eating disorder, there must be a referral to the psychiatric liaison service and that must be triggered as a matter of urgency if the patient wishes to self-discharge. In addition, that where a patient is discharged against medical advice, but with an expectation that they will be treated by their general practitioner in the community, a personal discussion between a member of the treating team and the general practitioner is mandatory before the patient leaves the hospital.

7. The Chemist King evidence

7.1. The evidence of Jessica Cutting

Ms Cutting worked on the retail side in the Chemist King pharmacy that the Dulcolax was predominantly purchased from. She said that in her three years in the pharmacy she never saw anyone else make bulk purchases of laxatives. She said there was a practice within the pharmacy of referring unusual or odd purchases to a pharmacist. She was responsible for maintaining appropriate levels of stock on the retail floor. She was ultimately responsible for ordering the Dulcolax. She had a recollection of seeing Claudia purchasing five boxes of Dulcolax a week in mid 2013. She learnt this of her own observations and from the staff in the pharmacy. She said that over the last 9 to 10 months the amount of Dulcolax purchased by Mr or Mrs La Bella increased to 25 to 30 boxes. She said that she spoke to the pharmacist, Ms Tan, when the first bulk order was made. She said that she spoke to Ms Tan on three occasions in total. She said that on the first occasion she told Ms Tan that there was a gentleman at the register who wanted to buy 10 to 15 boxes and that the patient had cancer and that Ms Tan had said yes to the sale. Ms Cutting said that she accepted Ms Tan's advice. She was asked about the advice on the Dulcolax container which recommends the dose of one or two per night and claimed that she had never looked at this when she dealt with the purchases and confined herself to seeking Ms Tan's advice. She denied the suggestion that she had not in fact asked Ms Tan for advice. Ms Cutting claimed that she told Ms Tan that the laxatives were for the treatment of cancer.

7.2. Ms Cutting was an unimpressive witness. She was asked if before this matter she was aware of connections between laxative abuse and eating disorders and she said that she was not[17]. She was asked about a statement she gave to the police initially when she

[17] Transcript, page 227

said 'we all thought she had an eating disorder'[18] and she was asked why they thought she had an eating disorder. Her reply was '*she was just very thin*'[19]. Ms Cutting was asked if she thought that there was a connection between the purchases of laxatives and the possibility of an eating disorder and she said that she did not[20]. It was suggested to her that it was not the case that she was completely ignorant of the link between an eating disorder and laxative abuse until the Inquest and she answered '*yes*'[21]. Then at pages 231-232 of the transcript she conceded that she had been well aware of a connection between laxative abuse and eating disorders for a very long time, possibly as far back as when she was a teenager and certainly when she was working in Chemist King in 2014[22]. She was asked why she told an untruth and she did not provide any satisfactory explanation[23], preferring to suggest that she did not think to put the laxative abuse and the hypothesis about anorexia together[24]. In my opinion she was plainly attempting to mislead the Court and avoid responsibility for selling large amounts of laxatives to Claudia or her husband when she was well aware that Claudia likely had an eating disorder.

7.3. <u>The evidence of Ms Tan</u>

By contrast with Ms Cutting, Ms Tan was an impressive witness. She obtained her Bachelor of Pharmacy in 2008 and was a pharmacist manager at the Chemist King pharmacy where Ms Cutting worked and where Claudia and Mr La Bella obtained the laxatives. She said that it was part of her role to provide advice to retail staff about over the counter medications and their potential interaction with other medications. She said that Ms Cutting did the majority of the ordering for over the counter medications and that she herself did the order for medications that required dispensing. Ms Tan was well aware of the appropriate dosage and usage for Dulcolax as a medication. She noted that it should be used only in the short term unless there is a chronic issue with long-term opioid painkillers which cause constipation. She said that she had never been asked to approve an order for Dulcolax or any unscheduled drugs. She said that she would not ordinarily be involved in the sale of Dulcolax unless a customer asked about interactions. She said that she had not been asked about bulk sales of Dulcolax and that

[18] Exhibit C21
[19] Transcript, page 228
[20] Transcript, page 229
[21] Transcript, page 230
[22] Transcript, page 231
[23] Transcript, page 231
[24] Transcript, page 231

she did not know Claudia La Bella, even by sight. She had never heard of the provision of laxatives to a lady who had cancer, nor about a lady who kept buying a lot of laxatives. Ms Tan said that Ms Cutting had never asked her about the sale of Dulcolax to Claudia La Bella. She said that Ms Cutting may have asked her questions generally about Dulcolax but never about large quantities of it, nor about its sale in bulk. She certainly was never asked about the sale of 15 to 20 boxes of 200 Dulcolax tablets. She said that if she had been asked about the sale of more than one or two boxes of Dulcolax at a time she would have asked questions. She said that maybe people who live in the country might stock up on certain things and she would have said yes for two boxes in such a situation, but she would not have agreed if the person had come back again the next week. In her opinion it should have been sufficient for a year. She said that if a person had come back in to buy a second box having bought one recently on the grounds that they had lost the earlier one, she might find that believable. She said that 15 to 20 boxes would raise alarm bells. She said that nobody needs that quantity. She said no-one ever asked her to sign off on purchases of big orders of Dulcolax from suppliers. She said that if she had had the feeling that something was not quite right she would definitely intervene and talk to the patient to get more information. She said that one woman asked about laxatives for weight loss and she told her that laxatives do not give you weight loss. She said that if the patient cannot tell her they are constipated she can refuse the sale and that if the patient's account does not add up she will ring the doctor to check up. Ms Tan said that she was shocked when she found out about the number of Dulcolax tablets that were being sold from the pharmacy to Claudia La Bella. The first time she was aware of it was when the police came to interview her. She was asked why she would not be aware of the sale of Dulcolax at that rate and she explained that as she was not involved in the ordering of over the counter medications, it would be entirely possible that she would never become aware of it. In short, Ms Tan denied Ms Cutting's version of events and denied that Ms Cutting had consulted her in relation to these purchases to Claudia and Mr La Bella.

7.4. Conclusion

I have no hesitation in accepting the evidence of Ms Tan in preference to that of Ms Cutting and I find that Ms Tan had no knowledge of these sales. Had she done so I am very confident that she would have made appropriate enquiries.

8. Recommendations

8.1. Pursuant to section 25(2) of the Coroner's Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

8.2. I make the following recommendations which are directed to the South Australian Minister for Health and Wellbeing and the Australian Government Department of Health, Therapeutic Goods Administration:

1) I recommend that in hospital presentations or admissions involving cases of severe weight loss where there is any suspicion of an eating disorder, there must be a referral to the Psychiatric Liaison Service and that must be triggered as a matter of urgency if the patient wishes to self-discharge;

2) I recommend that where a patient is discharged from hospital against medical advice, but with an expectation that they will be treated by their general practitioner in the community, a personal discussion between a member of the treating team and the general practitioner is mandatory before the patient leaves the hospital.

3) I recommend that Dulcolax and like medications be classed as pharmacist only medications, the safe use of which requires professional advice. They should not be available for self-selection from pharmacy shelves or online stores and purchases should only be made following consultation with the pharmacist.

8.3. In addition I draw this Finding to the attention of the Pharmacy Board of Australia, the Pharmacy Guild of Australia, the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine.

Key Words: Eating Disorder; Laxative Abuse;

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 23rd day of May, 2018.

State Coroner