IN THE HIGH COURT OF THE REPUBLIC OF SINGAPORE

[2016] SGHC 47

Suit No 820 of 2014

Between

(1) QUEK KWEE KEE VICTORIA (EXECUTRIX OF THE ESTATE OF QUEK KIAT SIONG, DECEASED)
(2) KER KIM TWAY (EXECUTOR OF THE ESTATE OF QUEK KIAT SIONG, DECEASED)

… *Plaintiffs*

And

(1) AMERICAN INTERNATIONAL ASSURANCE COMPANY LTD
(2) AIA SINGAPORE PTE LTD

… *Defendants*

JUDGMENT

[Insurance] – [Accident insurance]

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Quek Kwee Kee Victoria (executrix of the estate of Quek Kiat Siong, deceased) and another
v
American International Assurance Co Ltd and another

[2016] SGHC 47

High Court — Suit No 820 of 2014
Judith Prakash J
13–14, 18–20, 22–27 August; 11 November 2015

29 March 2016 Judgment reserved.

Judith Prakash J:

Introduction

1 On the morning of 4 August 2012, Mr Quek Kiat Siong, aged 50, was found lying on his bedroom floor in a non-responsive state. He was rushed to hospital but pronounced dead shortly after arriving there. The cause of his death was subsequently established as being "Multi-Organ Failure with Pulmonary Haemorrhage, due to Mixed Drug Intoxication".

2 The plaintiffs in this action are the executors of the estate of Mr Quek Kiat Siong ("the deceased" or "Mr Quek"). At the time of his death, the deceased was insured under two personal accident insurance policies which

had been issued originally by the first defendant. Subsequently, the second defendant took over the first defendant's business and obligations under the policies. The plaintiffs sought recovery under the policies on the basis that the deceased's death fell within the terms of the same. The defendants took the view that in the circumstances the policies were not engaged and rejected the claim for the insured sums. The plaintiffs started this action on 31 July 2014 to enforce recovery.

3 The main issue to be decided therefore is whether the deceased's death was caused by a risk covered by the policies.

The policies

4 The first policy was issued in September 2001 and it is known as a "PA24 Hour Plan, Personal Accident Policy". I shall refer to it as the "PA Policy". The sum assured by the PA Policy is $200,000. The second policy was issued in November 2008 and it is known as an "AIA Platinum Protector, Personal Accident Policy". I shall refer to it as the "Platinum Policy". The sum assured by the Platinum Policy is $1m.

5 For present purposes, under Part I of the PA Policy, the defendants provide the assured with a "Loss of Life Accident Indemnity" in the following circumstance:

> When Injury results in loss of life of the Assured within three hundred and sixty five (365) days after the date of the accident …

The term "Accident" is not defined but the term "Injury" is. By the PA Policy:

> "**Injury**" shall mean bodily injury effected directly and independently of all other causes by accident.

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6 Under Part 1 of Section 4 of the Platinum Policy, the defendants provide the assured with "Benefits" in the event of "Accidental Death" in the following circumstance:

> When Injury results in loss of life of the Assured within three hundred and sixty five (365) days after the date of the Accident the Company will pay the Principal Sum for Accidental Death stated in the Policy Information Page.

The terms "Accident" and "Injury" are both defined, *viz*:

> "**Accident**" shall mean an unforeseen and involuntary event which causes an Injury.
>
> "**Injury**" shall mean bodily Injury sustained in an Accident and effected directly and independently of all other causes and therefore not due to illness or disease.

7 Both policies contain clauses providing for a death caused by suicide to be specifically excluded from coverage under the relevant policy.

The pleadings

8 In para 24 of the Statement of Claim, the plaintiffs noted that the cause of death had been attributed to multi-organ failure with pulmonary haemorrhage, due to mixed drug intoxication. Further, post-mortem, four different drugs with elevated levels were found in the deceased's blood and the combined use of these drugs could lead to heart failure and death.

9 In para 27, the plaintiffs averred that the "mixed drug intoxication" was completely accidental and unintentional. The deceased had suffered injuries that were a likely result from drug interactions of his prescribed medications whose toxic serum levels may have been caused by drug–drug interactions. In particular, the deceased's prescribed psychiatric medications

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were at the upper prescribing limit and could act synergistically to potentiate the drug levels recorded in the deceased's toxicology report.

10 By para 28, the plaintiffs averred that the deceased had never displayed any sign of any suicidal tendency or ideation to his family members, friends or Dr Ang, his treating psychiatrist.

11 Only the second defendant filed a Defence to the action. The second defendant denied para 27 of the Statement of Claim and put the plaintiffs to strict proof thereof. The second defendant averred that the consumption of the drugs in respect of the type and/or dosage by the deceased on or about the night preceding his death was not accidental.

12 The second defendant made no admission to para 28 of the Statement of Claim and put the plaintiffs to strict proof of the same. By para 12 of the Defence, the second defendant averred that it was not liable to make any payment to the plaintiffs under the PA Policy and Platinum Policy for the following reasons given in respect of the respective policies:

(a) Under the PA Policy:

(i) the injuries that caused the death of the deceased were not caused by accident and, therefore, were not an event covered by the policy pursuant to section 2(j) of the Terms and Conditions therein; and/or

(ii) the death of the deceased was caused by suicide and, therefore, by an event excluded under section 4(5) of the Terms and Conditions therein.

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(b) Under the Platinum Policy:

(i) the injuries or death of the deceased was not an accident as the same was not caused by an involuntary event and, therefore, not by an event covered by the policy pursuant to section 2(16) of the Terms and Conditions therein; and/or

(ii) the injuries that caused the death of the deceased were not sustained in an accident and, therefore, not by an event covered by the policy pursuant to section 2(17) of the Terms and Conditions therein; and/or

(iii) the death of the deceased was caused by suicide and, therefore, by an event excluded under section 5(5) of the Terms and Conditions therein; and/or

(iv) the death of the deceased was caused by "drug abuse or any other complications arising therefrom; or accidents caused by and whilst under the influence of drugs" an event excluded under section 5(11) of the Terms and Conditions therein.

13 From the pleadings, it is clear that the plaintiffs as the parties seeking to hold the second defendant to its obligations under the policies have the onus of establishing that the injuries resulting in the death of the deceased were caused by a peril insured under the policies, namely, an accident. The plaintiffs accept this and their case is that the deceased's death was an accidental one resulting from the mixed drug intoxication but that such intoxication occurred after the deceased consumed the drugs prescribed to him in the quantities prescribed and that he did not consume extra amounts of the same.

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Mr Quek's story

14 First, I tell Mr Quek's backstory. This will help in understanding the evidence and the submissions.

15 Mr Quek was one of the youngest children in a family of 16 siblings. Despite his junior position in the family hierarchy, Mr Quek played a leading role in the family business. The family business, established by Mr Quek's late father, involves the manufacture and sale of popiah and is carried on in Joo Chiat Road. The premises at Joo Chiat Road ("Joo Chiat house") have, for more than 50 years, served both as the business premises and residence of the Quek family.

16 Mr Quek's parents recognised that he was street-smart, responsible and a savvy businessman. Thus, before the patriarch of the family died in August 2001, he appointed Mr Quek to take over and manage the family business. From that time until his death, Mr Quek ran the business and also managed the estate of his father which included no fewer than 21 real properties. In respect of the business, Mr Quek was assisted by many members of the family including his younger sister, Ms Quek Siew Kim ("Ms Siew Kim"). The first plaintiff, Ms Quek Kwee Kee Victoria, one of the executors of Mr Quek's estate, is also one of his elder sisters.

17 Mr Quek never married. He lived for most of his life in the Joo Chiat house. The first plaintiff and Ms Siew Kim lived there with him.

18 The Joo Chiat house is a fairly old shop-house which is not in very good physical condition. For several years before his death, Mr Quek suffered

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from chronic back pain which was caused, initially, by his years of carrying heavy loads of flour in the course of his work. His back pain was worsened by recurrent falls in the house due to the slippery toilet floor and worn out staircase.

19 In July 2009, Mr Quek consulted Dr Yeo Sow Nam ("Dr Yeo"), a pain specialist, in connection with his chronic back pain. He informed Dr Yeo that he had suffered injuries to his spine from carrying very heavy loads and, as a result, he had recurrent severe spinal back pain and bilateral leg pain, numbness and left-sided neck pain and left arm pain and occasional numbness. His past history included depression, chronic heavy smoking, insomnia and hypercholesterolemia. At the time of his first consultation, his pain was severe (rated 10/10) despite his consumption of a number of pain medicines. Mr Quek complained that he was only able to sit for about 30 minutes at any one time due to his severe pain.

20 Between 2009 and 2012, Mr Quek suffered from multiple episodes of severe back pain which were usually preceded by falls. These injuries gave rise to other medical issues. As a result, Mr Quek had multiple admissions to hospital and was seen there by Dr Yeo and many other medical specialists including a psychiatrist and physiotherapists. Apart from the hospital admission, Dr Yeo saw Mr Quek fairly regularly as an out-patient.

21 According to Dr Yeo, Mr Quek's complex chronic pain condition required ongoing maintenance of medication. He prescribed opioids and, in order to prevent Mr Quek from developing tolerance to the medicine, he rotated the use of various opioids. Mr Quek was treated with such medication from 2009 until his death. Each opioid was weaned down and taken off after a

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period of time before Mr Quek was switched to another for better pain relief. Mr Quek was able to achieve some stability in the dosage of pain medication required and during the six-month period prior to his death there were no increases of dosage in the medicines prescribed by Dr Yeo.

22 In early 2010, Dr Yeo referred Mr Quek to a psychiatrist, Dr Ang Yong Guan ("Dr Ang") to treat Mr Quek's insomnia, depression and anxiety. At that time, Mr Quek complained of poor appetite, restlessness and feelings of frustration due to his failure to recover from his lower back pain. From his interactions with Mr Quek, Dr Ang noted that as a highly responsible man who adhered to traditional Chinese values such as diligence, loyalty and commitment, Mr Quek developed features of "Reactive Depression" and anxiety with insomnia in reaction to his perceived inability to carry out his role in the family business effectively due to his impaired physical condition.

23 Dr Ang treated Mr Quek from 10 March 2010 to 31 July 2012, both as an in-patient and as an out-patient either at his clinic or via telephone consultations. As Mr Quek's condition required a variety of medication, Dr Ang prescribed him a mixture of anti-depressant, anti-anxiety, anti-psychotic and hypnotic drugs. At any one point between 2010 and 2012, he was prescribed with a combination of approximately six to seven types of medicine falling within these categories.

24 Dr Yeo observed that Mr Quek had poor coping strategies which, despite counselling, he did not change. He refused to renovate or change the slippery and dilapidated stairs at home. He also had a strong personality and kept his problems to himself, instead of sharing them with any of his siblings.

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Hospitalisation in July 2012

25 On 2 July 2012, Mr Quek was admitted to Mount Elizabeth Novena Hospital for treatment of his lower back pain, insomnia, anxiety and depression. This was his fifth hospital admission since March 2010. His primary physician during this period was Dr Yeo but he was also co-managed by Dr Ang who saw him very frequently.

26 According to Dr Yeo, Mr Quek had had two falls earlier in 2012, worsening his severe lower back pain. One was a fall at the Joo Chiat house and the other was due to a physical fight with one of his brothers. In addition, he was stressed by a legal suit which he had undertaken against a brother (whom I shall identify by his initials: "QKC") (in all probability the same one he had the physical fight with, though no names were given) to claim back properties which belonged to his father's estate.

27 On his admission to hospital, Mr Quek was treated with a spinal injection and a heat treatment called radiofrequency neuroablation and showed remarkable improvement thereafter. His pain was well controlled and he was able to sleep and look after himself. After two weeks in hospital, he was well enough to go home during the day, in order to attend to his business, returning to the hospital at night. On many days he left hospital early in the morning and only returned for rest and respite in the hospital at night. Dr Yeo was heartened that, during this stay, Mr Quek informed him of his intention to move to a single-storey apartment so as to avoid more falls. Indeed, the length of time that Mr Quek spent in hospital was due to his own and his doctors' desire to give him a respite from the stresses of his daily life and enable him to obtain sufficient rest to strengthen his coping abilities. Physically, he could

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have been discharged earlier than he was but he wanted to remain in hospital for a longer period.

28 According to Dr Ang, when he visited Mr Quek on 3 July 2012, the latter was feeling low in mood and showed symptoms of reactive depression. He also informed Dr Ang of the legal dispute with his brother. Shortly after admission, as a result of successful medical treatment, Mr Quek's pain was reduced and he showed remarkable improvement both physically and psychologically. His emotional and mental outlook improved significantly when he was generally able to sleep well.

29 Mr Quek remained in hospital until 31 July 2012. Dr Ang last saw him there on 28 July 2012 and, according to Dr Ang, on that occasion, Mr Quek was:

> … relevant and rational. He was able to give coherent account of himself and his current predicament which was his impending Court case with one of his siblings. He was able to sleep. Appetite was normal in the morning but not so good in the afternoon. Dinner was fine. He could concentrate by watching news and reading newspaper. His pain was 7 out of 10 (very painful). His mood was not so good as he kept thinking about the Court case. There was no major issue other than the Court case.

30 On discharge, Mr Quek was prescribed with altogether 14 different types of medicine by Dr Ang and Dr Yeo. Dr Ang gave Mr Quek a six-month supply of medication while Dr Yeo provided a six-week supply of medication. It should be noted that none of the medicines prescribed were new to Mr Quek. He had been on them for months before the July 2012 admission, and in the case of some of them for years. The medicines prescribed are as follows:

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By Dr Yeo:

S/No	Prescription	Indications	Dosage
1	Jurnista (Hydromorphone)	Pain medication	1 tablet (16mg) 2 times a day
2	Oxycontin (Oxycodone)	Pain medication	1 tablet (20mg) every morning or nil and only as breakthrough
3	Lyrica (Pregabalin)	Pain medication	2 tablets (150mg/tab) 2 times a day
4	Senna (Sennosides)	Laxative	2 tablets (7.5mg/tab) 2 times a day
5	Pariet (Rabeprazole-Na)	Gastric medicine	1 tablet (20mg) every morning
6	Lipitor (Atorvastatin)	Cholesterol medicine	1 tablet (20mg) every night

By Dr Ang:

S/No	Prescription	Indications	Dosage
1	Remeron (Mirtazapine)	Anti-depressant	2 tablets (30mg/tab) every night
2	Cymbalta (Duloxetine)	Anti-depressant	1 capsule (30mg) 2 times a day
3	Seroquel (Quetiapine)	Anti-psychotic	2 tablets (100mg) every night
4	Zyprexa (Olanzapine)	Anti-psychotic	1 tablet (10mg) every night
5	Valium (Diazepam)	Hypnotic	1 tablet (10mg) every night

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6	Dormicum (Midazolam)	Hypnotic	1 tablet (15mg) every night
7	Lexotan (Bromazepam)	Anti-anxiety	1 tablet (3mg) 2 times a day
8	Stilnox (Zolpiderm)	Hypnotic	2 tablets (12.5mg/tab) every night

After discharge

31 When he left hospital, Mr Quek returned to the Joo Chiat house. His sisters were aware, however, that it was Mr Quek's intention to remove to another property which was located nearby in Everitt Road. The Everitt Road property was a three-storey semi-detached house which belonged to the estate of the patriarch and which was being managed for the family by Mr Quek. He had divided the house into various rooms and had let out rooms on the ground floor. One of the rooms was occupied by one of his nephews, Lucas Lim ("LL"), and the latter's girlfriend. It was Mr Quek's intention to move into the second floor and, for that purpose, he had been buying expensive furniture and moving it to Everitt Road.

32 After his discharge, Mr Quek spent two nights at the Joo Chiat house, namely, 31 July 2012 and 1 August 2012. On 2 and 3 August 2012, he spent the night at Everitt Road house. According to Ms Siew Kim, on both those dates he spent the day in Joo Chiat carrying on the business and only went back to Everitt Road house to sleep. On each of those two nights, he packed his prescribed dosage of medicine for the night into a small plastic Ziploc bag before leaving the Joo Chiat house. The rest of his medicine was kept in a cabinet there. On 3 August 2012, after he had packed his medication, Ms Siew

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Kim walked with Mr Quek to Everitt Road and spent some time with him there before returning home.

33 One of the tenants in the Everitt Road house was Mdm Chee Wai Lian ("Mdm Chee"). Mdm Chee remembered spending about an hour with Mr Quek in the Everitt Road house on the evening of 3 August 2012, between about 8 and 9pm. The conversation was light-hearted and, according to Mdm Chee, Mr Quek looked well and happy. Mr Quek also moved some furniture around in the house and Mdm Chee offered to help him. However, he refused her help, saying he could manage on his own. In the event, he was assisted by another tenant.

34 The next morning, at about 10am, LL entered Mr Quek's bedroom in Everitt Road and found him lying on the floor between the bed and the bathroom. There was some vomit and blood on the floor near him and around his mouth. LL called for an ambulance and this arrived at about 10.43am. On arrival, the ambulance personnel noted that Mr Quek was unresponsive, had no pulse and did not appear to be breathing. He was taken by the ambulance to Changi General Hospital where he was pronounced dead at 11.18am.

Investigations into the deceased's death

35 An autopsy was performed on the deceased on 5 August 2012 by the Health Science Authority ("HSA"). An initial Autopsy Report giving the cause of death as "cardio-respiratory failure pending further investigations" was issued on 7 August 2012. The cause of death was finalised subsequently as being "multi-organ failure with pulmonary haemorrhage, due to mixed drug

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intoxication". A detailed analysis of the deceased's blood was undertaken by the HSA. The analysis detected the following drugs in the deceased's blood: bromazepam, duloxetine, hydromorphone, midazolam, mirtazapine, olanzapine, oxycodone, paracetamol, quetiapine and zolpidem. Most of these drugs were also detected in his bile, urine and stomach contents. According to Associate Professor Teo Eng Swee ("Prof Teo") of the HSA who had supervised the autopsy, four drugs were found to be at elevated levels as follows:

(i) Bromazepam – the post mortem blood level was about 1½ to 2 times the upper end of the therapeutic range.

(ii) Duloxetine – the post mortem blood level was about 10 to 11 times the peak plasma level at steady state with a dose of 80mg/day.

(iii) Mirtazapine – the post mortem blood level was about 2 to 3 times the upper end of the therapeutic range.

(iv) Olanzapine – the post mortem blood level was about 20 times the upper end of the therapeutic range.

36 Due to the circumstances in which the deceased's body was found, a coroner's inquiry was undertaken into the circumstances of his death. The officer in charge of the investigation was Inspector He Yanhuan ("Insp He"). On 5 August 2012, before the autopsy commenced, the deceased was identified to Insp He by the first plaintiff. Insp He asked for the deceased's medication and one of the family members gave him various drugs which he passed on to the HSA. After the names of the medicines were recorded, they were returned to the family. Insp He confirmed that the names of the drugs which later appeared in his report were taken from the packets of medicine

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given to him by the Quek family. The inspector subsequently recorded statements from the first plaintiff, from LL, and from QKC. He also made inquiries with Mr Quek's doctors and obtained reports from them and considered various reports issued by the HSA after it completed the scientific investigations.

37 An Investigation Report on the death of the deceased was submitted to the Coroner by Insp He. In this report it was stated that the Police were of the view that the deceased's drug intoxication was deliberate with the evidence pointing to the deceased wanting to end his own life. A Coroner's Certificate was issued thereafter. The findings of the Coroner were as follows:

> The deceased is Quek Kiat Siong. He was 50 years old. On 3 August 2012 at 11 pm, the deceased was last seen by his nephew. On 4 August 2012 at 10 am, the deceased was found unresponsive in his room. He was conveyed to Changi General Hospital but his condition deteriorated and he passed away at 11.18 am. The deceased was suffering from severe spinal problems and was suffering from depression as he was unable to sleep at night. The deceased was also involved in a tussle over his late father's assets. The cause of death is multi-organ failure with pulmonary haemorrhage due to mixed drug intoxication. Four different drugs were found with elevated levels and the combined use of the drugs could lead to heart failure and death. In all probability the deceased took an overdose of his prescription drugs with the intention of ending his life. [SUICIDE].

38 According to the plaintiffs, Mr Quek's family only found out about the Coroner's verdict on 23 January 2013 when they obtained a copy of the Coroner's Certificate. They were shocked to learn of the Coroner's findings as there was nothing that led them to believe that Mr Quek had intended to end his life.

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The respective positions taken by the parties

39 The plaintiffs' case is that the second defendant breached the policies by wrongfully refusing to pay the insured sums because:

(a) the deceased did not intentionally consume an overdose of drugs and had in fact consumed his medication in accordance with his prescriptions; and

(b) thus, the deceased's death fell within the meaning of "accident" in the two policies.

40 The second defendant's case is that it did not wrongfully refuse to pay the insured sums because:

(a) the deceased must have intentionally consumed an overdose of drugs; and

(b) in any case, the deceased's death was not "accidental" or "involuntary" because the consumption of medication was not an involuntary act.

41 There are both legal and factual issues to be decided in determining whether the plaintiffs should succeed. The legal portion involves the construction of the policies and the determination of whether they cover the risk of dying from the voluntary consumption with prescribed medicine in accordance with the prescription. The factual question is whether on the facts the cause of death was the consumption of such medication. I will deal first with the legal issue before proceeding to the factual issue.

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The Legal Issues

Whether "accident" includes drug intoxication caused by a voluntary consumption of drugs

42 The starting point of the inquiry into the meaning of "accident" must be the policies themselves. However, apart from the fact that the PA Policy contains no definition of the term at all, the definition in the Platinum Policy is, in my view, not exhaustive. Therefore, in both cases recourse must be had to the common law meaning of "accident" which I have mentioned briefly but will consider in more detail in this section.

43 The plaintiffs say that the word "accident" in the context of insurance claims should be construed in its "popular and ordinary sense" which will include an "unlooked mishap or untoward event which is not expected or designed" see *Fenton v J Thorley and Co Ltd* (1903) AC 443. The second defendant does not dispute this definition as being applicable to the peril covered by the PA Policy. In respect of the Platinum Policy, however, the second defendant says that the definition of "accident" as contained in the policy being "an unforeseen and involuntary event" which causes an injury means that an accident must include a result which is unforeseen (or not intended) and an action that is involuntary. Consequently, there would be no accident even if the deceased did not intend to commit suicide (result not intended) as long as the act of taking the medication was voluntary regardless of whether the medicine consumed was in accordance with the prescribed dosage or not.

44 In making this argument, the second defendant also says that the definition in the Platinum Policy must be construed strictly and must override

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any common law definition. In support of its contention, the second defendant relies on *In re United London and Scottish Insurance Company, Limited* [1915] 2 Ch 167. There, an insurance policy excluded liability in cases where death or disablement was caused by "medical or surgical treatment, or fighting, or ballooning, racing, self-injury, or suicide, or anything swallowed, or administered, or **inhaled** [emphasis added]". The Court of Appeal held that the insured, who died from gas poisoning caused by the inhalation of gas from a leak in her kitchen, was not entitled to the insured sum. The court refused to draw any distinction between voluntary and involuntary inhalation even though it found the policy to be onerous to the insured. Warrington LJ put it in these terms at 172:

> The death was caused by noxious gas inhaled, but it is said we are not to read this clause in the policy literally, but we are to import from the context into it this limitation, that it is confined to death occasioned by something voluntarily inhaled, or something inhaled under circumstances which show that the assured voluntarily exposed himself to the danger of inhaling. **I think it only requires to be stated to show how imposible** [*sic*] **it is to import any such limitation into the words of this condition. Directly you depart from the literal meaning of the words you embark upon a sea of difficulties and speculations which ought I think to be avoided.** In my opinion the death in this case was occasioned by something inhaled. It is therefore within the limitations expressed in the condition and accordingly not an accident recoverable for under the policy. [emphasis added]

The second defendant thus says that an "accident" in the present case must include a result that is unforeseen or unintended, and an action that is involuntary; in other words, there would be no accident if the consumption of medication was voluntary, whether or not in accordance with the prescribed dosage and whether or not the deceased intended to commit suicide.

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45 I do not agree with the second defendant. I take the view that a deliberate consumption of drugs which leads to unforeseen clinical effects can be classified as an "accident" within the Platinum Policy.

46 First, the second defendant is guilty of attempting a sleight of hand. "Accident" in the policy is defined as an "unforeseen and involuntary event". It is the same event which must be unforeseen and involuntary. This, in fact, is the result of strict construction – an approach used by the second defendant. A classic example of an accident would be a traffic accident between a vehicle and a pedestrian. Generally, the event of the vehicle colliding into the pedestrian is both unforeseen and involuntary. It would be a mockery if such an event were not considered an accident simply because the pedestrian intended to be walking at a particular place at a particular point in time. In the context of drug intoxication, the consumption of drugs is generally voluntary, but that is analogous to the voluntary passage of the pedestrian described above. The drug interactions within the body are involuntary, but what determines if the resulting drug intoxication is an accident is whether the effects of the drug were foreseen or intended.

47 Second, it is not always the case that when the term "accident" is defined or in some way qualified in the policy that the common law meaning becomes irrelevant. For example, the policy in issue in *Glenlight Shipping Ltd v Excess Insurance Co Ltd* [1981] SC 267 stated that the insured's bodily injury had to be caused "by violent accidental, external and visible means". However, Lord Ross held that the definition meant nothing more than "accident". At 269–270, he said:

> … The phrase "violent accidental, external and visible means" is a somewhat clumsy one, but it has been commonly

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> employed in personal accident policies since the last century. The use of a phrase in these terms was criticised by Lord Cozens Hardy M.R. in *In re United London & Scottish Insurance Company Limited—Brown's Claim* [1915] 2 Ch. 167 at page 170 where he stated "It seems to me seriously open to doubt whether that does not exempt the company on every occasion which is likely to occur." In my opinion, however, the better view of these words is that which is expressed by Professor Ivamy in Personal Accident, Life and Other Insurances (Second Edition), page 28, where he states in relation to this phrase "**So far as the effect of the policy is concerned, these words probably add nothing to the idea conveyed by the word 'accident,' since they merely give expression to the essential features of an accident**. At the same time they serve a useful purpose in making clear the distinction between accidental and natural causes, and thus help to define with greater precision the scope of the insurance." [emphasis added]

In my view, the ideas of involuntariness and unforeseeability are so inextricably linked with the idea of accident that they hardly add anything useful to the meaning of "accident". For example, McGee, *The Modern Law of Insurance* (LexisNexis, 3rd Ed, 2011) ("*McGee*") at para 35.2 refers to these two characteristics of accidents:

> **Meaning of "accident"**
>
> **35.2** This is a question which is a good deal more difficult than might at first appear. It is suggested that the difficulty comes largely from the fact that *the notion of an accident may be regarded as having two principal characteristics. The first is that the event was unexpected and the second is that it is unintended.* … [emphasis in italics added]

48 It therefore becomes necessary to have recourse to the meaning of "accident" at common law to interpret the Platinum Policy as well. On this basis, the word "involuntary" in the definition of the term "accident" in the Platinum Policy must be regarded as describing only the outcome or "event" and not as referring to the action taken that led to the event. Thus, whether the fact that the deceased deliberately consumed the medication is in itself

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sufficient to rule his death not an accident is something that must be determined by the common law.

49 The second defendant concedes that the deceased's death would be an "accident" at common law if it was not the intended result of consuming the medication. I think this concession is correct. The authorities applying these broad principles do not speak with one voice but, on balance, such a death would be "accidental".

50 As a matter of general principle, a voluntary act with unexpected consequences falls within the definition of "accident". It has been recognised that "[a]lmost all accidents have some deliberate actions among their immediate causes" (see the Canadian case of *Martin v American International Assurance Life Co* [2003] SCC 16 at [12]) and what is key is that the *consequences* of the actions that produced death were unexpected. Thus, in that case, McLachlin CJC said:

> 10 The insurers argue that the category of deaths caused by accidental means is narrower, in that it excludes accidental deaths that are the natural effects of deliberate actions. In their view, a death is only caused by accidental means when both the death and the actions that are among its immediate causes are accidental.
>
> …
>
> 12 This view seems to me, however, to be problematic. **Almost all accidents have some deliberate actions among their immediate causes. To insist that these actions, too, must be accidental would result in the insured rarely, if ever, obtaining coverage. Consequently, this cannot be the meaning of the phrase "accidental means" in the policy. Insurance policies must be interpreted in a way that gives effect to the reasonable expectations of the parties**: *Reid Crowther & Partners Ltd. v. Simcoe & Erie General Insurance Co.*, [1993] 1 S.C.R. 252, at p. 269. A policy that seldom

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> applied to what reasonable people would consider an accidental death would violate this principle.
>
> 13 In my view, **the phrase "accidental means" conveys the idea that the consequences of the actions and events that produced death were unexpected. Reference to a set of consequences is therefore implicit in the word "means". "Means" refers to one or more actions or events, seen under the aspect of their causal relation to the events they bring about.**
>
> 14 It follows that to ascertain whether a given means of death is "accidental", we must consider whether the consequences were expected. **We cannot usefully separate off the "means" from the rest of the causal chain and ask whether they were deliberate.** Cardozo J. emphasized in his dissenting judgment in *Landress v. Phoenix Mutual Life Insurance Co.*, 291 U.S. 491, at p. 501, that "[i]f there was no accident in the means, there was none in the result". The converse is equally true: if there was no accident in the result, there can be none in the means. As Cardozo J. went on to say, either "[t]here was an accident throughout, or there was no accident at all". Hence, to determine whether death occurred by accidental means, we must look to the chain of events as a whole, and we must consider whether the insured expected death to be a consequence of his actions and circumstances.
>
> [emphasis added]

51 It should follow that, in principle, the unexpected clinical effects flowing from the deliberate consumption of drugs constitute an "accident". This is generally borne out by the cases.

52 The first and perhaps most directly relevant case is *Martin*. The insured, a doctor, died when he injected himself with an overdose of Demerol, an opiate to which he had become addicted in the course of receiving treatment for his peptic ulcer. The level of Demerol in his blood was at the low end of the range for lethal doses. The Supreme Court of Canada found that the insured did not intend to die despite having voluntarily injected himself with Demerol. Instead, it drew an inference that he miscalculated the amount of

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Demerol his body could tolerate. His death was held to be caused by an "accident" within the policy, which bore the following wording:

> **BENEFIT**
>
> Subject to this provision's terms, the Company will pay the amount of the Accidental Death Benefit … upon receipt of due proof that the Life Insured's death **resulted directly, and independently of all other causes, from bodily injury effected solely through external, violent and accidental means** …

Another crucial observation emerges: the fact that drug intoxication may be intuitively thought of as being internal (rather than "external" and "violent") did not prevent it from falling within the meaning of "accident" in the policy.

53 A second case which permitted recovery under an accidental death and dismemberment insurance plan is *Nichols v Unicare Life & Health Ins Co* 739 F.3d 1176 (8th Cir, 2014) ("*Nichols*"). The United States Court of Appeals for the Eighth Circuit allowed recovery for an insured who died from mixed drug intoxication. The policy there was described in the following terms (see *Nichols v Unicare Life & Health Ins Co* [2012] WL 4060309, unreported at 4):

> The Plan states that accidental death benefits will be paid "if your death occurs under these conditions: 1) **the death is a result of your accidental *injury***; and 2) the *injury* occurred while you were insured by this coverage; and 3) the death occurred within 180 days of injury." [AR UniCare 000361 (emphasis [in italics] in original)] The Plan states: "This accidental death benefit will be paid when we receive due written proof that your death occurred under the conditions stated in this section." [AR UniCare 000361] The Plan does not define the terms "accident" or "accidental," but it defines the term "injury" as "physical harm to the body of an insured person [AR UniCare 000372]. [emphasis added in bold]

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54 A third case, from the New Zealand courts, also reflects this understanding of "accident". In *Groves v AMP Fire & General Insurance Co (NZ) Ltd* [1990] 1 NZLR 122 (affirmed [1990] 2 NZLR 408), the insured had died of an adverse reaction to an anaesthetic given in an operation. Jeffries J rejected the insurers' argument that the administration of the anaesthetic was deliberate, and adopted a test where an accident was an unforeseen, unexpected, extraordinary and unlooked for mishap:

> … This Court's view is that expressed from an earlier decision of that very learned Judge in *Lewis v Ocean Accident & Guarantee Corporation* 224 NY 18; 120 NE 56 (1918) in which he stated the following in a case involving death resulting from puncturing a pimple:
>
> > Unexpected consequences have resulted from an act which seemed trivial and innocent in the doing. Of itself, the scratch or the puncture was harmless. Unexpectedly it drove destructive germs beneath the skin, and thereby became lethal. To the scientist who traces the origin of disease there may seem to be no accident in all this. 'Probably it is true to say that in the strictest sense, and dealing with the region of physical nature, there is no such thing as an accident.' Halsbury, LC in *Brintons v Turvey LR* 1905 AC 230, 233. But our point of viewing in fixing the meaning of this contract must not be that of the scientist. It must be that of the average man. *Brintons v Turvey supra*; *Ismay [Imrie & Co] v Williamson LR* 1908 AC 437, 440. Such a man would say that the dire result, so tragically out of proportion to its trivial cause, was **something unforeseen** [*sic*]**, unexpected, extraordinary, an unlooked-for mishap, and so an accident**. This test – the one that is applied in the common speech of men – is also the test to be applied by courts. [emphasis added]

Whether the inquiry is subjective or objective

55 I now turn to the nature of the inquiry. The cases are clear that the inquiry into whether the result of an action is unforeseen is subjective in the

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sense that it is to be assessed from the insured's perspective. *McGee* at para 35.2 stated that "In both cases [*ie*, in determining whether the event was unexpected and unintended] the matter should be looked at from the point of view of the person suffering the accident." This proposition is clearly borne out by case authority.

56 The Supreme Court of Canada in *Martin* stated that the test is subjective and that the court would consider whether a reasonable person expected to die only if the evidence of the insured's subjective intention was unclear:

> 20 As a starting point, we note that the accidental nature of a particular means of death depends, in ordinary parlance, on the consequences that the insured had or did not have in mind. When we speak of an "accidental" means of death, we normally have in mind a situation in which someone's action has had results that this person did not intend or expect. Unintentional or unexpected death is seen as accidental; intentional or expected death as non-accidental. In *Canadian Indemnity Co. v. Walkem Machinery & Equipment Ltd.*, [1976] 1 S.C.R. 309, at pp. 315-16, Pigeon J. explained the term "accident" with reference to *Halsbury* (vol. 22, 3rd ed.) as "any unlooked for mishap or occurrence" (emphasis in original). Similarly, in Stats, supra, at p. 1164, this Court, per Spence J. quoted Lord Macnaghten's comment in Fenton, supra, at p. 448, that "the expression 'accident' is used in the popular and ordinary sense of the word as denoting an unlooked-for mishap or an untoward event which is not expected or designed". It follows that death is not non-accidental merely because the insured could have prevented death by taking greater care, or that a mishap was reasonably foreseeable in the sense used in tort law. Nor does a death that is unintended become "non-accidental" merely because that person was engaged in a dangerous or risky activity. As this Court emphasized in Canadian Indemnity, supra, at p. 316, the jurisprudence assigns a generous meaning to "accidental", in the absence of language to the contrary in the insurance policy.
>
> 21 The pivotal question is whether the insured expected to die. The circumstances of the death — what the insured said,

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> or did, or did not do — may point to the answer. However, to the extent that the answer is unclear when the matter is viewed solely from the perspective of the insured, the court may consider whether a reasonable person in the position of the insured would have expected to die: *Candler v. London & Lancashire Guarantee & Accident Co. of Canada* (1963), 40 D.L.R. (2d) 408 (Ont. H.C.), at p. 423; *Johnson v. Mutual of Omaha Insurance Co.* (1984), 45 O.R. (2d) 676 (C.A.), aff'g (1982), 39 O.R. (2d) 559 (Ont. H.C.); *Stats.*, supra, at pp. 1164-65.

57 The Court of Appeals in *Nichols* espoused a similar subjective test which had been applied in *Wickman v Northwestern National Insurance Co* 908 F.2d 1077 (1st Cir, 1990) and considered in *Dawn McClelland v Life Insurance Company of North America* 679 F.3d 755 (8th Cir, 2012) at 1182–1183:

> … Under *Wickman,* **an event is an accident if the decedent did not subjectively expect to suffer "an injury similar in type or kind to that suffered" and the suppositions underlying that expectation were reasonable**. 908 F.2d at 1088. "**The determination of what suppositions are unreasonable should be made from the perspective of the insured, allowing the insured a great deal of latitude and taking into account the insured's personal characteristics and experiences.**" *Id.* **If the evidence is insufficient to determine the decedent's subjective expectation, the question is then whether "a reasonable person, with background and characteristics similar to the insured, would have viewed the injury as highly likely to occur as a result of the insured's intentional conduct."** *Id.*
>
> …
>
> In *McClelland,* under the deferential abuse-of-discretion standard of review, we held that the insurance company erroneously denied accidental death benefits to the widow of the insured decedent who died while driving a motorcycle at high speeds with an elevated blood alcohol level. As "evidence" of the deceased's state of mind, the insurance company offered that McClelland had been educated on the dangers of drinking and driving and should have known that death was highly likely to occur in his circumstances. We held that this reasoning was an abuse of the insurer's discretion, and a

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> misapplication of the agreed-upon standard set forth in *Wickman,* because **better and more concrete evidence of McClelland's subjective state of mind on the morning of the accident** (submitted in the form of affidavits from family, friends and witnesses on the day of the accident), **was that he had no intention to die and certainly did not think death was likely to occur as he went on a social mid-Saturday morning motorcycle ride**. *Id.* at 760–61.
>
> Like the insurance company in *McClelland,* **UniCare ignores the subjective evidence submitted by Nichols, and instead makes leaps to get to the "objective" conclusion it desires**. There was no evidence in the record that Dana had developed a tolerance to her medications or that she took all 12 of the missing hydrocodone pills on the night of her death. No evidence suggests that Dana was suicidal. Similar to the motorcycle driver in *McClelland* who had been successfully weaving in and out of traffic at a high rate of speed for over six miles and therefore did not expect to die that day, **Dana had been taking this combination of prescribed medications, as admitted by UniCare, for some period of time. There is no evidence whatsoever that Dana intended to kill herself or thought it likely she would die on May 3, 2010. The subjective evidence, in the form of letters and statements from her husband and parents, suggests otherwise. To the extent that her subjective mind set could still be viewed as uncertain, the objective evidence tended to show that Dana had been ingesting a combination of prescribed medication for some time, and under these circumstances, a reasonable person with Dana's characteristics would not have viewed death as highly likely to occur.** Nor is there a medical determination that the death was "not accidental" as alleged by UniCare. Dana's death falls squarely within the meaning of accident, a word not otherwise defined in the policy, and as viewed under the *Wickman* mandate to consider the situation from the "perspective of the insured, allowing the insured a great deal of latitude and taking into account the insured's personal characteristics and experiences." 908 F.2d at 1088. As the district court aptly stated, "[i]n sum, all of the evidence indicates that Dana's death was the unexpected result of ingesting prescribed medications." …
>
> [emphasis added]

58 In the present case, I take the view that the deceased must be deemed to have expected to die if he deliberately consumed an overdose. He was

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warned by Dr Yeo that the consequences of consuming an overdose of medication could include death. The converse must also be self-evident: the deceased must not have expected to die if he consumed his medication in strict accordance with his prescriptions. Thus if the evidence shows, at least *prima facie*, that death was a result of such normal consumption, then despite the fact that the consumption was voluntary, the deceased's death would still be an accident under the Platinum Policy as well as the PA Policy.

The factual issues

59 The plaintiffs made a number of submissions in support of their contention that the deceased consumed only his prescribed medicines in the prescribed doses on 3 August 2012. I will consider these in turn.

Whether the deceased took his medication in a systematic manner according to his doctors' prescriptions

60 The first submission that the deceased took his medication in a systematic manner was based mainly on the evidence of Ms Siew Kim and the second plaintiff, Mr Ker Kim Tway.

61 Ms Siew Kim testified that the deceased was an organised and systematic man who took his prescribed medication regularly. She also said that the deceased would pack his "nightly prescribed dosage of medication" in a small Ziploc bag before leaving for Everitt Road each evening while the rest of his prescribed medication was kept in his office cabinet in Joo Chiat. It appeared that Ms Siew Kim saw the deceased follow this procedure on two nights, *ie*, 2 and 3 August 2012. After the deceased was taken to hospital on 4 August 2012, Ms Siew Kim found an empty Ziploc bag in his bedroom. She

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also found the rest of his prescribed medicine in his office cabinet and left it there untouched until much later.

62 The second plaintiff who is a pharmacist as well as being the co-executor of the deceased's estate, testified that sometime after the family was alerted to the Coroner's finding of suicide, he asked Ms Siew Kim where the leftover medication was. She then took it out of the cabinet and gave it to him. This was in June 2013. No other medication belonging to the deceased was found apart from this leftover medication which was tendered in court and marked as exhibits P1, P2 and P3. These exhibits contained a total of 2,483 tablets and this total confirmed that the deceased had consumed 61 tablets between his discharge and his death. Such consumption was exactly in accordance with his prescriptions. The plaintiffs submitted that the deceased had more than 2,500 tablets in his possession on 2 August 2012, and if he had intended to kill himself he would have taken all this medication to Everitt Road and consumed as much as he wished to achieve that result. They said that it was evident from the leftover medication that the deceased had not done that.

63 The plaintiffs tabulated the prescribed medicines according to: (a) their batch numbers; (b) the date of manufacture; and (c) the expiry date. They then adduced evidence from the treating doctors. Dr Ang's evidence was that he had matched the batch numbers and the expiry dates of his stock records with those recorded for exhibits P2 and P3 and was able to confirm that the medication in these two exhibits had been prescribed by him and dispensed by his clinic. Dr Yeo testified that he did not possess the details of the batch numbers and the expiry dates but was sure, with a fair degree of certainty, that

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the drugs contained in exhibit P1 came from his clinic. In any event, Dr Yeo's medicines were not those which the second defendant was taking issue with since the levels of these drugs found in the deceased's system were not elevated.

64 There are two points here: the deceased's systematic behaviour and the inferences to be drawn from the amount of medication which the plaintiffs produced in court.

65 Dealing with the first point, the evidence about the deceased's behaviour is not as clear as the plaintiffs submit. This evidence is dependent on the reliability of Ms Siew Kim's statement that the deceased was systematic and packed only the medicines he needed for one night into his Ziploc bag. However, under cross-examination, she confirmed that she did not know exactly what medicines the deceased had packed. Her observation was restricted to seeing him take out some tablets from their packaging and putting them into the Ziploc bag. So she could not say whether the deceased took only one night's dose of each medication or even that he had taken out all the types of drugs that he had been prescribed.

66 Further doubt on the accuracy of Ms Siew Kim's observation is cast by the post-mortem results. According to the HSA Report of 19 September 2012, the following drugs were detected in the deceased's system – in his blood, his bile, his urine and/or the contents of his stomach:

(i) bromazepam;

(ii) duloxetine;

(iii) hydromorphone;

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(iv) midazolam;

(v) mirtazapine;

(vi) olanzapine;

(vii) oxycodone;

(viii) paracetamol;

(ix) quetiapine;

(x) zolpidem; and

(xi) lignocaine.

In fact, most of the drugs named above were found in all four sources from which samples were taken. However, paracetamol was found only in the blood and stomach, and lignocaine (which is an anaesthetic usually applied in gel form) was found only in the urine. There was no trace in any of these samples of pregabalin (Lyrica) a pain medication prescribed by Dr Yeo. The deceased was supposed to take two tablets (150mg/tab) of pregabalin twice a day. Nor was there any trace of his anti-cholesterol medicine, atorvastatin (Lipitor), which he was to take every night. It should also be noted that paracetamol was not one of his prescribed medicines and therefore would not have been in the Ziploc bag if he had put in only the medicines from Dr Ang and Dr Yeo as Ms Siew Kim testified.

67 From the HSA Report therefore, it would appear that the deceased did not take all his prescribed medicines the night before he died. Further, he took medicine which he was not prescribed and which was intended to serve the same purpose as the prescribed medication. Having regard to the strong

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painkillers that the deceased had been given by his doctors, it is a little odd that he also consumed paracetamol. The conclusion that I draw from the HSA Report is that the deceased was not as systematic about taking his medication as the plaintiffs would have me believe. If he had taken all prescribed medicines and those only, pregabalin and atorvastatin would have been found in his system and paracetamol would not have been detected. This conclusion is further fortified by the matters I discuss in [71] below.

68 The next issue is whether the packets of medicine produced in court were indeed the only medications that the deceased had in his possession on the night that he died. In my mind, there is considerable doubt that P1, P2 and P3 were the only medicines in the deceased's possession immediately prior to his death.

69 First, the medicines adduced in court were all in blister strips or similar packaging, neatly packed in plastic bags with different bags for different medicines. They were organised, well labelled, and looked practically untouched. Insp He, however, testified that the medicines that he had been given by the Quek family were given to him in dribs and drabs and were quite messy, quite unlike the neat packets in court. There was no proper labelling or identification. He said also that he returned all medicines given to him to the Quek family. However, there was no medication in court that looked like anything that could have been given to Insp He.

70 Secondly, according to the "Finalised Cause of Death" document dated 28 September 2012 issued by the HSA, prior to the autopsy, 11 types of medication obtained from Mr Quek's family were shown to its officers by the police. These medications were largely the same as those listed in [66] above.

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The differences were that two of the drugs handed over, *viz*, rabeprazole-Na and desvenlafaxine (Pristiq), were not on the list, and paracetamol and lignocaine were on the list but not handed over. Further, pregabalin was neither handed over nor on the list. The significance of these differences is as follows. First, desvenlafaxine was a drug which Dr Ang had prescribed for Mr Quek in February 2012. At that time, Dr Ang gave Mr Quek three months' supply. Although this medication was replaced with duloxetine a month later, obviously Mr Quek retained unconsumed desvenlafaxine tablets in his possession as otherwise the police would not have had any. This raises the possibility that indeed Mr Quek had more medication of various types with him than the batches dispensed on his discharge from hospital in July 2012. The next important point is that no diazepam or pregabalin was given to the police although both were produced in court later. This indicates that not all Mr Quek's medication was handed to the police and that what was given to the police (as seen also from the presence of desvenlafaxine) perhaps came from a different source from the contents of P1, P2 and P3.

71 Thirdly, Dr Ang testified that it was not uncommon for the deceased to have leftover medication from previous prescriptions. Some of the medicines prescribed were optional, to be taken when necessary. The hypnotic drugs midazolam, zolpidem and diazepam fell into this category. Dr Ang stated that in February 2012 he had given the deceased three months' supply of diazepam but in May 2012 the deceased had not asked for a refill, probably because he had accumulated an excess of the tablets. The situation with duloxetine was similar. Dr Ang noted that he had first prescribed duloxetine in March 2012 but that when he re-filled the other prescriptions in May 2012, the deceased had not asked for more duloxetine. He thought that the deceased still

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had a supply of that medicine because he had been prescribed enough for two doses a day but sometimes would take only one dose of the medicine a day. Dr Ang had in fact instructed the deceased that he should measure his mood daily and assess his need for duloxetine accordingly – if the mood was good, he could take the medicine once a day instead of twice. Dr Ang also testified that the deceased sometimes told him expressly what refills of medicine he needed and what he did not need because he still had supplies. It should be noted that Dr Ang emphasised that the deceased knew exactly what medication to take and was a responsible person and was therefore aware of which medications he could omit or juggle the doses of.

72 Fourthly, there are also some questions about the veracity of Ms Siew Kim's evidence that the only medication belonging to the deceased that had been found after his death was that adduced in court in exhibits P1, P2 and P3. She had cleaned the deceased's bedroom after he was taken to hospital and told the court she found no medicine in it but only an empty Ziploc bag. Ms Siew Kim also testified that shortly after the deceased's death she found his remaining medicine in his office cabinet but left it there untouched until the second plaintiff asked her about it almost a year later, in about June 2013. This was despite the fact that she had cleared up all the deceased's other personal belongings and kept them together in one room in the Joo Chiat house. At the time she discovered the drugs it did not cross Ms Siew Kim's mind to tell the police about the medicines that she had found. She said that this was because nobody asked for them. This cannot have been true as the police, in the person of Insp He, did ask for samples of the medicines and did obtain the same from a family member.

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73 Further, in February 2014, Ms Siew Kim made a lengthy statutory declaration in order, according to para 3 of the same, "to provide some information of the circumstances surrounding [the deceased's] sudden death on or around 3 [*sic*] August 2012 and his prescribed medicine that was left behind". In para 17 of the declaration, she stated that she had personally seen the deceased place his nightly prescribed dosage of medicine into a Ziploc bag on 3 August 2012. The balance of his medication was left behind in his office cabinet at the Joo Chiat house. She went on to say in para 18 that "no other medication, bottles and/or packets of the same were found at [the Everitt Road house] and/or [the Joo Chiat house]". She also said in para 20 that she "personally" counted the number of pills that remained at the Joo Chiat house and from this it was evident that the deceased had consumed his prescribed medication in strict accordance with the prescribed daily dosage. No more than four days equivalent of any one medicine was consumed which was consistent with the number of days since the deceased's discharge from hospital.

74 In para 22, Ms Siew Kim said that she understood from her sister, the first plaintiff, that in August 2012, the first plaintiff had informed the police that Ms Siew Kim had thrown away all of the deceased's medicine after cleaning up his room in Everitt Road. In para 23, Ms Siew Kim stated that what the first plaintiff had told the police was inaccurate and in August 2012, the first plaintiff was unaware that the deceased had left all the medicine in Joo Chiat house and had only taken his nightly dose along to Everitt Road when he returned there on 3 August 2012. It was only "recently" (meaning, I suppose, about the time the statutory declaration was made) that the first

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plaintiff had asked about the medication and Ms Siew Kim had informed her that the remaining medication was intact and kept in the Joo Chiat house.

75 There are a number of points to be made about the statutory declaration. First, it is unclear why it was made at all since there was no legal reason for it at the time or any identifiable trigger. This action was not started until some five months later, nor was the existence of the declaration a prerequisite for the commencement of the action. When Ms Siew Kim was asked why she had made it, she was unable to give a coherent explanation though she insisted that it was her own idea to make such a statement.

76 Secondly, her evidence in court differed in some respects from her statutory declaration. She had stated in the declaration that she counted all the medicine personally but in court her position was that the counting was done by the second plaintiff.

77 Thirdly, the statement that the first plaintiff made to the police about the medication that Ms Siew Kim refuted was a statement that the drugs had been thrown away by Ms Siew Kim after she cleaned up the deceased's room in Everitt Road. Ms Siew Kim's evidence in court (and also in the statutory declaration) was that there was no medication at all in Everitt Road when she went there on the morning of 4 August 2012, and all that she could find was an empty Ziploc bag. In court, she said she found one bag, though in the declaration she stated that she had found two empty Ziploc bags. The plaintiffs' position during the action was that there were no drugs found at the scene and that was one reason why it was unlikely that the deceased had taken an overdose. That position could not have been maintained if in fact Ms Siew Kim had thrown away medication found in Everitt Road. It was therefore

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important to the plaintiffs' case to correct the first plaintiff's statement. However, the first plaintiff herself did not testify and explain why she had made an allegedly incorrect statement to the police. Instead, it was Ms Siew Kim who made a statutory declaration explaining the first plaintiff's mistake and who came to court to stand by that explanation.

78 There was no reason given as to why the first plaintiff did not take the stand. I find her reluctance to testify and be cross-examined troubling. At the time of the deceased's death, the first plaintiff was also living in the Joo Chiat house and she could have given evidence on his daily routine and what she knew about his medication and where it was kept and his physical and mental condition at the time. She could have helped identify the family member who gave samples of the deceased's medicine to the police and, perhaps, assisted the court on what had been done with these medicines on their return. She was able to give a statement to Insp He about various matters a few weeks after the death. There could be no doubt about the relevance of the first plaintiff's knowledge had she chosen to testify.

79 The evidence of the second plaintiff was that several months after the deceased's death Ms Siew Kim informed him that there was a large amount of the deceased's remaining medication in his office. The second plaintiff then counted the remaining medication in the presence of the first plaintiff. He stated that based on the tablets that he had counted it was evident that no more than four days' equivalent of any one medicine was consumed. This showed that the deceased had consumed his prescribed medication in accordance with the prescribed frequency and quantity over the four days from his discharge from hospital.

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80 The medications produced in P1, P2 and P3 were those counted by the second plaintiff. It is common ground that the blister strips produced indicate the consumption of only four days' worth of medicine. However, no one is able to confirm that the four days' worth of tablets were removed from the blister strips by the deceased himself before his death or by someone else at some other time. If all the medication had been produced to the police shortly after 4 August 2012, there would have been a better opportunity to ascertain what indeed had been consumed by the deceased. Yet, although Ms Siew Kim knew about the medicine in the office cabinet all along, no one asked her to hand over the medication until June 2013, a time when the second plaintiff was actively seeking evidence to dispute the Coroner's verdict of suicide.

Whether the evidence from the scene of death points to it being accidental

81 The plaintiffs submitted that nothing was seized from the site of the accident. There was no real evidence such as empty phials or empty bottles found in the deceased's room to point to a deliberate overdose. The paramedics who attended to him did not find anything unusual and indicated the type of incident as "Cardiovascular System" rather than "Poisoning/Drug Overdose". The police did not deem it necessary to attend at the scene of the accident either on 4 August 2012 or thereafter. Their main concern was to view the body at the hospital.

82 The plaintiffs argue that the circumstances of the deceased's death pointed to it being accidental. He was found lying on the floor face-down between his bed and the bathroom, with vomit in his mouth and on the floor. Their expert psychiatric witness, Dr Rasaiah Munidasa Winslow ("Dr Winslow"), testified that it would be reasonable to draw the inference

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that the deceased unexpectedly felt nauseous and was heading to the bathroom to throw up when he collapsed. This was to be contrasted with the behaviour of a person who was intending to kill himself – such a person would usually lie on the bed and take an overdose. Furthermore, the autopsy showed that the deceased had followed his doctors' instructions by taking his medication after food as prescribed.

83 To me, the physical evidence is neutral. The alleged absence of any unused drugs or phials at the scene is based on Ms Siew Kim's evidence and I have already indicated the difficulties with that. The paramedics were not called to explain why they classified the death as "Cardiovascular System". The plaintiffs' argument that the position in which the body of the deceased was found excludes the possibility of suicide is speculative. It cannot be established whether the deceased was heading to the bathroom or had come back from the bathroom when he collapsed. As far as what Dr Winslow stated is concerned, when he was cross-examined on the point he agreed that even if the deceased had intended to kill himself and had overdosed, he might still have been trying to get rid of his vomit. This would be just like someone who wants to drown himself but still struggles in the water.

Whether circumstances were going well in the deceased's life and he had made plans for the future

84 The plaintiffs submit that all was well in the deceased's life at the time of his death, as shown by the following:

(a) the deceased's pain was well managed and he had also made numerous plans for the future;

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(b) a few months before his death, the deceased had decided to move into Everitt Road in order to eliminate the risks of recurrent falls in the Joo Chiat house, and just two days before his death, the deceased carried out this move;

(c) the deceased was in high spirits and excited by his move to the newly renovated Everitt Road house which he had personally decorated with expensive and handpicked antique furniture;

(d) he had invested a significant amount of time, money and effort to refurbish the Everitt Road house in preparation for this move;

(e) in mid-July 2012, the deceased had purchased two used luxury cars, a Mercedes Benz 500 and a Volkswagen Tiguan;

(f) the legal suit was progressing smoothly and was close to being settled; and

(g) on the night of 3 August 2012, the deceased had a light-hearted conversation with one of the tenants in Everitt Road and also acted in a fashion that indicated that he planned to continue with his life for example by tending to his potted plants and moving a cupboard into his bedroom.

85 On a consideration of the evidence, it appears to me that although there were pointers indicating positive features in the deceased's life at the material time, overall, the situation was more equivocal than the plaintiffs acknowledge.

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86 The purchase of the second-hand cars in July 2012, whilst the deceased was still spending his nights in hospital, is an indication of his plans for the future at that time. I recognise the significance of the fact that the deceased had never previously owned a motor-vehicle. It was obviously a major step for him to buy a Mercedes Benz, albeit second-hand, for himself. However, Ms Siew Kim did also say that one of the deceased's intentions in purchasing the car was to allow their elder brother to have an opportunity to drive a luxurious car. The second vehicle was not as significant a purchase in my view since the evidence was that the deceased bought it for the use of one of his nephews, Ker Han Hwee.

87 The situation regarding the deceased's move into Everitt Road is more difficult to assess. Dr Yeo had been advising the deceased for more than two years to move into one-story accommodation. He did not take this advice. The intended move to the Everitt Road house would have been a partial improvement in that it was a newer building but the deceased's intention was to live on the second floor and therefore he would still have to navigate stairs. Also, it is not clear whether this was a settled move. August 2012 was not the first time the deceased slept over in Everitt Road. He had been doing so occasionally for some time. Secondly, the evidence as to whether the work on the Everitt Road house indicated firm future plans is somewhat equivocal. The plaintiffs produced bills for furniture purchased and renovations contracted for during the period from February to June 2012, but did not establish exactly how much of the renovation work was carried out. Mdm Chee testified that the only renovation work that she was aware of that was done in Everitt Road was done prior to her moving into those premises. As Mdm Chee had lived in Everitt Road for about five years before the deceased's death, this would mean

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that any renovations carried out in 2012 were too minor to attract her notice. Further, while in 2012 the deceased did make and carry out plans to make the second floor of Everitt Road a more suitable home for himself, these plans were conceived in the earlier part of the year before the deceased's admission and their execution does not indicate the mood of the deceased in July and August 2012.

88 It is more significant that in July 2012, Dr Yeo noted that the deceased was "exceptionally distraught" prior to his admission. Further, although the pain issues were contained early in July 2012, the deceased was not ready to leave the hospital until the end of the month. Dr Yeo said that on 17 July 2012 the deceased still had stress from the family legal tussles and did not feel ready to go home. He would change his mind each week. He would leave the hospital and then come back in because he had decided that there were more things to sort out and he needed time to do this. Dr Ang's observation, as late as 28 July 2012, was that whilst the deceased was rational, relevant and functional in that he could concentrate on watching television and reading the newspapers, his mood was not so good as he kept thinking about the court case with his brother. Further, according to Dr Ang's note at the time, the deceased assessed his pain as "7 out of 10 (very painful)". However, Dr Ang was pleased that the deceased's general and mental condition had seen a marked improvement over the month and he was looking forward to being discharged.

89 The plaintiffs' position that the legal suit was more or less settled by early August 2012 was not supported by any concrete evidence. After being repeatedly pressed on this issue in the witness stand, Ms Siew Kim confirmed

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the settlement took place after the deceased's death but she was unable or unwilling to indicate an exact date.

90 Turning to the deceased's state of mind on the night of 3 August 2012, the plaintiffs rely on the evidence of Mdm Chee and some video footage taken by the CCTV camera at Everitt Road.

91 As stated earlier, Mdm Chee testified that the deceased was in a good mood that night and she had a light-hearted conversation with him. Upon further examination however, it appeared that Mdm Chee knew very little about Mr Quek: she did not know about his medical condition or that he was on heavy medication. Mr Quek never looked sad or depressed to her and he had never told her about such feelings or confided any of his problems in her. She was not aware of his dispute with his brother. Her relationship with him was obviously superficial only as he kept up his face with her as her landlord. Further, Mdm Chee was another person who made a statutory declaration in relation to the circumstances of the deceased's death. She had done this after the first plaintiff told her about the Coroner's verdict of suicide and, she insisted, had done it of her own accord because she felt it was impossible that Mr Quek committed suicide since all along he had been such a jovial person. Given the fact that Mr Quek had suffered numerous bouts of depression over the preceding three years, it is clear that Mdm Chee's knowledge of him was partial and does not give a full picture of the deceased.

92 From Insp He's report, it appeared that LL was the last person to see Mr Quek on the night before his death. He also found the deceased the next morning, having been alerted by his girlfriend that something was wrong. LL obviously knew the deceased much better than Mdm Chee. He was able to

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give a statement to the police but was not called to testify in this action. His evidence would have been useful to establish the deceased's mood that night and his mood and behaviour more generally. Yet, the plaintiffs did not call him and preferred to adduce the evidence of someone who knew very little about the deceased.

93 The CCTV footage that the plaintiffs presented showed Mr Quek moving freely in the Everitt Road house. Dr Yeo was shown the footage and commented that from his movements it appeared that Mr Quek was pain-free at the time. The footage also showed Mr Quek bending his spine and standing and helping to move a heavy cupboard into his room. Dr Yeo commented that these activities were against medical advice and would lead to further pain for Mr Quek, and that one of the reasons that he suffered so badly from pain was that he did not take proper care of himself. The video footage does support the plaintiffs' position that that evening the deceased was in a good mood and apparently pain-free. However, only 38 minutes of footage were disclosed. The rest of the footage for that evening had apparently been deleted. The plaintiffs' reason was that it was unnecessary as it showed nothing significant and, in any case, the footage had only been kept as a memorial of Mr Quek. Be that as it may, the video-feed would have been more useful to the plaintiffs had it not been edited so that no doubts could be raised about what the missing footage showed.

94 I was perturbed by various matters, including the failure of the first plaintiff and LL to give evidence and the apparently "spontaneous" statutory declarations. Overall, I gained the strong impression that the plaintiffs had organised their case in a particular way and had considered very carefully the

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evidence that they would present to the court. I found them less than fully forthcoming.

Whether the deceased had a suicidal ideation

95 Dr Ang's evidence was that whilst the deceased's condition was moderately severe, he had no suicidal tendency or ideation and had never mentioned wanting to end his life or displayed any suicidal behaviour. In Dr Ang's opinion, the deceased suffered from reactive depression. The depression was a reaction to his back pain and consequent inability to manage his affairs. When the pain was reduced, the depression was also alleviated and his mood improved. In 2010, when Mr Quek was hospitalised he was in a lot of pain and would lie in bed the whole day without wanting to talk or watch television or even sit up. However, when his pain responded to treatment, he would be up and about. In July 2012, the deceased was outside the hospital most of the time on home leave, and when Dr Ang saw him in hospital in the evenings his mood would be good. Dr Ang also had a telephone conversation with the deceased on 31 July 2012 during which the deceased said that he did not need to meet Dr Ang personally as everything was fine as far as he was concerned.

96 The plaintiffs called Dr Winslow to give evidence as an independent psychiatric expert. Dr Winslow's opinion was that the deceased did not intentionally overdose on the medication prescribed by Dr Ang and Dr Yeo. In coming to this conclusion, he had considered:

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(a) the fact that the remaining quantity of medication left at home was consistent with the number of days from 31 July to 3 August 2012 that Mr Quek consumed the prescribed medication;

(b) the treating doctors, Dr Ang and Dr Yeo, had confirmed that he was recovering well both during hospitalisation and upon discharge;

(c) Dr Ang's opinion that Mr Quek was not suicidal when last assessed about a week before his demise;

(d) a review of the statements of family members and a tenant who all confirmed that they did not notice any suicidal ideation or behaviour in Mr Quek; and

(e) Mr Quek did not exhibit the usual telling signs of a man who was likely to commit suicide.

97 As far as item (a) above is concerned, Dr Winslow did not have the benefit of the information that emerged in court on previous medication that was in the deceased's possession. In relation to item (d), he did not interview these persons himself and was not able to tell that the tenant's acquaintance with the deceased was superficial. Also, he did not see the statements that other family members had given to the police which showed the deceased in a somewhat different light. In court, Dr Winslow was shown the video footage of the deceased and he thought that the fact that the deceased was looking after his plants in the video coupled with the moving of furniture into his bedroom was a positive sign. He agreed that the deceased's psychiatric condition was moderately severe or severe based on the amount of medication he had been prescribed. In Dr Winslow's view, the doses were very high.

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98 The defendants also called a psychiatric expert, Dr Tommy Tan Kay Seng ("Dr Tan"). He gave an opinion which he premised on the fact that there were high and toxic levels of drugs found in the deceased's body during the post-mortem. As the levels were several times the therapeutic range, it was unlikely that the overdose was accidental. I note that had this not been the case, Dr Tan's ultimate opinion would have been different. On the basis of the medical evidence gleaned from Dr Ang's affidavit of evidence in chief, Dr Tan diagnosed Mr Quek to have had a major depressive disorder which was at least moderately severe and must have been difficult to treat because of the number and relatively high doses of medicines prescribed by Dr Ang. Taking into account facts that indicated that the deceased could have committed suicide and those that indicated that he could not have committed suicide, Dr Tan was of the view that the possibility that the deceased had committed suicide could not be confidently excluded. He also relied on a study which showed that individuals were at high risk of suicide following discharge from psychiatric in-patient care, known as the Bickley study. According to Bickley, 55% of patients discharged from psychiatric in-patient care commit suicide within a week.

99 Dr Ang opined that the Bickley study, and another one called the Hunt study which came to similar conclusions, did not apply because the deceased was not a psychiatric patient. However, both Dr Winslow and Dr Tan disagreed with his definition of the deceased as a non-psychiatric patient. They pointed out that he had a major depressive disorder for which he was being treated with medication. So that made him a psychiatric patient.

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100 Overall, the psychiatric evidence tended to support the plaintiffs' case rather than the defendants'. This was because the deceased had never expressed any suicidal intentions and also because he seemed well when he left hospital in July 2012. However, the doctors were aware of cases, admittedly rare, where persons who had not displayed any suicidal ideation had in fact killed themselves. Further, the pattern established by the deceased in the three or so years preceding his death was that of treatment in hospital for pain and depression resulting in some alleviation of pain and depression followed by recurring pain and depression when the deceased was back home and dealing with the stresses and physical demands of his daily life. These demands and stresses were exacerbated by the deceased's reluctance to confide in others and his lack of care for his body.

Whether the medical evidence indicates that the deceased died from an overdose

Whether the deceased's normal doses of medicine could have killed him

101 The plaintiffs accept that the deceased was a poly-drug user who was prescribed 14 different drugs by his treating doctors. Their case is that the interactions of these drugs at the normal levels at which the deceased consumed them daily could have killed him by provoking an adverse reaction. The question is how likely such a possibility is.

102 A number of experts testified on the possible consequences of drug consumption. The plaintiffs called a forensic scientist, Dr Michael Tay Ming Kiong ("Dr Tay") to testify as to how the deceased could have died from consuming the prescribed doses of medicine. Dr Tay has a Diplome de Docteures Sciences and is a scientist rather than a medical doctor. He worked

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for many years for the HSA. The defendant's expert was Dr Phua Dong Haur, a senior consultant in Emergency Medicine and Clinical Toxicology at the Emergency Department of Tan Tock Seng Hospital. I also had the assistance of Prof Teo who had supervised the HSA autopsy of the deceased.

103 The background against which I should consider this issue is set out neatly in para 11 of Dr Tay's affidavit of evidence-in-chief. The matters stated there were accepted by all the experts. Dr Tay advised that whenever two or more drugs are being consumed there is a possibility of an interaction among the drugs. Although each drug on its own may be safe and effective, interaction of co-administered drugs may increase or decrease the effectiveness or side effects of the drugs. Specifically, potential interactions can exist between duloxetine and mirtazapine, and between duloxetine and oxycodone, and in some severe cases such interactions may result in coma or even death. Further, as Prof Teo noted in his "Final Cause of Death Report":

> … all the drugs detected as stated in the toxicology report, except for paracetamol, can cause drowsiness and doziness. Combined use of these drugs, some of which were at elevated levels, could possibly lead to respiratory depression, leading eventually to heart failure and death.

I should point out that Prof Teo's observation was made in the context of the autopsy findings which he considered showed elevated levels of drugs in the deceased's system. The plaintiffs do not accept that the autopsy findings indicate that the deceased consumed an overdose and this is an issue which I will discuss in the next section.

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104 The plaintiffs base their submission that the deceased's death was caused by consumption of drugs in accordance with his prescription on the following:

(a) The evidence of the psychiatric experts that the deceased was on "high doses" of his psychiatric medicines which were at the "high end of the therapeutic level".

(b) For at least 11 days prior to admission to hospital, the deceased was concurrently prescribed a combined total of 150mg of duloxetine by Dr Ang (90mg) and Dr Yeo (60mg), and it is possible that he was maintained on such high and dangerous doses of duloxetine (the safe limit being 120mg) (I note here that such maintenance does not appear from the July 2012 prescriptions themselves).

(c) Dr Tay set out a number of drug interactions which could cause serious side effects, including between bromazepam and other hyponotic and anti-depressant drugs, between duloxetine and mirtazapine and between midazolam and olanzapine, which Dr Phua agreed with.

(d) Dr Phua agreed with the medical sequence of events that led to the deceased's demise specifically that the drugs caused respiratory depression which led to haemorrhaging in the lungs and ultimately death. He also reported that, other than duloxetine and paracetamol, all the drugs detected in the deceased's system could lead to drowsiness, sedation and, in severe cases, central nervous system depression.

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(e) Dr Teo testified that drugs administered at therapeutic levels could cause death by reason of idiosyncratic side effects, *eg*, an allergic reaction.

(f) Dr Tay stated that the chronic use of drugs could have a cumulative effect leading to an augmented adverse reaction and this would be especially so when the patient was taking drugs which belonged to the same group (such as anti-psychotics and benzodiazepines), which would have resulted in additive and synergistic effects.

105 There are difficulties in the plaintiffs' case. Whilst the possibility of adverse reactions arising from the drugs prescribed to the deceased cannot be denied, the issue is whether in the circumstances of this case such a possibility was likely or was remote.

106 Dr Phua's evidence was that an adverse reaction to drugs taken in therapeutic doses arises when the body fails to metabolise or excrete these drugs properly and not when the drugs remain at therapeutic levels in the blood. He said that if a patient was well maintained on chronic medication for a period of time and subsequently an adverse reaction is suffered, there must be something else that had happened to cause the acute reaction. It would not arise simply from the consumption of the usual dosage. According to him, there are three possible causes of an adverse reaction in someone who was well maintained on chronic medication, namely, (i) an inability to excrete or metabolise the medication because of a sudden failure of the kidneys or liver; (ii) a sudden change in medication or in dosage; and (iii) the body suffering a severe metabolic stress such that it could not cope with the usual medication

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(examples of such stress being major surgery, severe infection and a heart attack). None of these causes applied to the deceased. The forensic evidence of the autopsy was that his kidneys and liver were normal. Further, no sign of kidney or liver dysfunction was observed while the deceased was in hospital in July 2012. Dr Yeo's evidence was that from detailed tests carried out on the deceased there were no signs of him having suffered from any liver or kidney problem. In relation to the second point, there is no evidence of severe metabolic stress prior to death and, thirdly, the plaintiffs' case is that there was no change in medication or dosage and only the usual medications were consumed by the deceased.

107 Apart from Dr Phua's testimony, two other doctors agreed that where a patient has been on chronic medication the likelihood of an adverse reaction occurring is minimal as the patient builds up tolerance. These were Dr Ang and Dr Yeo who were the treating doctors. Dr Ang said that a person on chronic medication gets used to the medication over a period of time and the possibility of adverse reaction is reduced, and Dr Yeo said that the same thing applied to his pain medications and that the increased tolerance to them would reduce any side effects.

108 The doctors' testimony also supports the proposition that if an adverse reaction is to occur from the consumption of a drug, that adverse reaction will manifest itself swiftly and in all likelihood within two weeks of consumption at the latest. Dr Phua explained that because of the half-lives of drugs, the longest taking about 8½ days to be eliminated from the body, the latest that an adverse reaction could take place would be two weeks from consumption. Dr Ang's evidence is that adverse reaction to a drug can be immediate or

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delayed. To him "immediate" means within 24 hours and "delayed" means within a few days to up to two weeks.

109 In the case of the deceased, he had been on cocktails of medication for years preceding his death. Even though duloxetine was a recent introduction, he first started consuming it in March 2012, which means that by August 2012 he had taken that medicine for more than five months. I consider that on the evidence before me, any reaction to the addition of duloxetine to his usual medication would therefore have manifested itself at the very latest by end March 2012. Yet, there was no record in the medical records of this much-treated man that he had displayed any adverse reaction to duloxetine or any other drug whether taken singly or in combination according to prescription.

110 The medical evidence also was that generally, if there is a side effect from taking any particular medication or combination thereof, initially more minor reactions would manifest rather than the patient dropping dead immediately. According to Dr Phua, if the duloxetine level in the blood builds up because of enzyme inhibition, the patient may start to complain of tremors or dizziness. If the olanzapine is building up, he will start to complain of dry mouth or inability to urinate.

111 I have taken note of Dr Winslow's testimony that he was aware of a coroner's case involving a young female patient who suffered a collapse from cardiac arrest in 2011, shortly after taking therapeutic amounts of prescribed anti-depressants and anti-psychotics. Dr Winslow noted that each medication was given in therapeutic doses but it was the combination of medications that provoked side effects leading to cardiac arrest. The plaintiffs rely on this testimony to bolster their argument. However, it was also Dr Winslow's

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testimony that the fatal reaction of the female patient to the medication was a reaction to amitriptyline and chlorpromazine which were first generation medications whilst those given to the deceased were newer and safer. That was also a case where the adverse reaction occurred shortly after consumption. It was not a case where the unfortunate patient had been taking the medication for months. It is thus difficult to place much weight on the case cited by Dr Winslow.

112 In the case of the deceased, Dr Ang testified that in prescribing the various drugs dispensed, he took into account all the doses that the deceased had taken previously and also the possibility of adverse reactions. In his view, his prescription on 31 July 2012 would not have caused an adverse reaction in the deceased if the medicines were taken in the prescribed doses.

113 Dr Tay suggested that the deceased might have had an adverse reaction to his normal drugs. This seems to me to be textbook evidence. Dr Tay is not a physician and therefore had no experience as to the manner in which adverse actions would manifest themselves. In this regard, I prefer Dr Phua's evidence that generally more minor adverse reactions would manifest themselves first and that in any case all such reactions would be observed within two weeks at the latest.

114 It is also significant that the deceased's treating physicians were of the opinion that he could not have died from consuming his medication strictly in accordance with his prescriptions. Dr Yeo testified that he had absolutely no concern that the drugs prescribed to the deceased could have caused his death. There was no evidence of an adverse effect of the drugs on the deceased. One of the reasons for keeping the deceased in hospital was to observe him and

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ensure that the treatments given did not harm him. According to Dr Yeo, his contemporaneous observations indicated that the deceased improved during the hospital stay and there was no reason to be concerned about the medication. His medication had been titrated and adjusted based on need and the absence of side effects. Dr Yeo noted that the drugs prescribed, if given to a new patient in such dosages, would certainly have knocked the person out. This did not happen with the deceased, however, because of the titration process and Dr Yeo was confident that while the deceased was under the care of himself and Dr Ang, there was no concern that, at the prescribed doses, his drugs would cause him harm.

115 Dr Ang did not think it was possible at all that if the deceased consumed the drugs according to Dr Ang's prescription, such consumption would lead to death. I note that both Dr Winslow and Dr Tan considered the dosages of psychiatric medication prescribed for the deceased to be on the very high side. They themselves would be more conservative in prescribing such medicines and would prescribe one drug at one time rather than a combination as Dr Ang did. They observed, however, that Dr Ang's prescription practices are quite commonly adopted in the United States. Significantly, they did not suggest that the prescriptions given were beyond the therapeutic range but accepted that the dosages fell within such range, albeit at the high end of the same.

116 Dr Ang was very confident in his prescription methodology. He told me that he had had several patients for whom he had to prescribe such high dosages because their condition required it. He also confirmed in answer to my question that since the deceased's death and since the Coroner's Report

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was released, he had not changed his prescription practices in any way and was still as comfortable prescribing those medications he had prescribed to the deceased in those combinations as he had been doing before the death of the deceased.

117 On a consideration of the evidence relating to this aspect, I find that on the balance of probabilities the consumption by the deceased of his medications in the prescribed doses would not have created the adverse reactions that resulted in his death.

Whether the deceased consumed an overdose of his medication

118 As would be recalled from para 35 above, the analysis carried out by the HSA of the deceased's blood showed that elevated levels of four drugs were found in his system. The four drugs concerned were bromazepam (1½ to 2 times higher than the therapeutic limit); duloxetine (10 to 11 times higher); mirtazapine (2 to 3 times higher) and olanzapine (20 times higher). This analysis forms the scientific basis for the conclusion that the deceased must have consumed an overdose of these drugs. The plaintiffs say that this would be the wrong conclusion because the likelihood is that the post-mortem levels of the drugs detected in the deceased's blood were not the result of over-consumption but were raised by a natural process that occurs after death known as "Post-mortem redistribution" ("PMR") or by drug interactions leading to an inhibition of metabolism of drugs or impairment of the ability to eliminate drugs or by a combination of both PMR and drug interactions.

119 The plaintiffs relied on the evidence of Prof Teo that post-mortem levels of drugs in the blood may be truly elevated due to the amount consumed

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or spuriously elevated due to other causes. The main cause of spurious elevation would be PMR. Another cause of spurious elevation would be that although the drug was consumed in a normal or slightly higher than normal dose, it was not eliminated from the body and therefore accumulated in the system. The main reason that drugs would not be eliminated would be failure of the liver or the kidneys.

120 Dealing first with spurious elevation caused by the body's inability to excrete drugs, I have already noted that no medical evidence of malfunctioning of the deceased's liver or kidneys was produced. The autopsy showed that the liver and kidneys were normal and although Prof Teo stated that such normality was only a superficial appearance and did not indicate how these organs had actually functioned whilst the deceased was alive, the very fact that they appeared normal would be an indication that there was no advanced kidney or liver disease. As for the actual functioning of the organs, I repeat that the evidence of the treating doctors was that there was no clinical sign that these organs were not working properly. Thus, the hypothesis that the elevated drug levels found in the deceased were due to an accumulation of drugs that had not been excreted over a period of time has, in my opinion, little traction.

121 The PMR issue is more complicated. PMR is the redistribution of chemicals between tissues, organs and bodily fluids after death. This process takes place from the time of death onwards and the rate at which it occurs depends on the conditions in which the body is kept, in particular the ambient temperature. Freezing of the body, in a mortuary for example, would slow down the process considerably.

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122 In the discussion that follows it should be borne in mind that the therapeutic levels of drugs in the body are determined by ante-mortem analysis of plasma. After death, drug levels are assessed from the blood. According to the scientists, what is found in post-mortem blood is not exactly what would have been found in an ante-mortem analysis of plasma and indeed there may be a significant difference between the two. Dr Tay highlighted that significant errors can result from trying to estimate ante-mortem concentrations and dosage from post-mortem measurements. Dr Phua recognised this but asserted that for lack of better data, ante-mortem serum drug level has to be used as a guide to evaluate post-mortem blood results.

123 The plaintiffs submit that PMR had in this case given rise to spuriously elevated drug levels in the body of the deceased. They point out that Dr Phua, the second defendant's expert, agreed that the longer a body is kept at ambient temperatures from the time of death, the greater would be the impact of PMR on the blood levels. In the case of the deceased, the exact time of death was not known but he could have died as early as 2am on 4 August 2012. His blood samples were collected on 5 August 2012 and therefore the time of death could have been 32 hours before collection of the blood samples.

124 Dr Tay's evidence was that the most significant effects of PMR occur during the initial hours of death and he considered that the deceased's body would have been at an ambient temperature for several hours which would have resulted in significant PMR by the time the body reached the mortuary after 11.40am on 4 August 2012. This was up to 10 hours after the deceased could have been clinically dead.

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125 The plaintiffs submit that the scientific studies relied on by Dr Phua were not useful as they mostly dealt with ante-mortem serum samples. They place most emphasis on a study compiled in Finland by Launiainen and Ojanperä (the "Finnish Study"). This study was compiled from post-mortem data gained from autopsy cases and was published in July 2013. According to the Finnish Study, and as explained by Dr Tay, blood levels at the upper percentile concentrations (*ie*, 90, 95 and 97.5 percentiles) are considered to be an indication of overdose whereas the median post-mortem concentrations give an idea of the "normal" post-mortem concentration range. Looking at the results of the analysis of the deceased's blood, Dr Tay concluded that since his blood levels for duloxetine, olanzapine and mirtazapine did not even reach the 90th percentile stated in the Finnish Study, they were not overdose levels. The Finnish Study did not include any data on bromazepam. As such the deceased's blood levels do not, the plaintiffs submit, support a finding that the deceased had taken an overdose of his prescribed medication.

126 Dr Phua considered that as the autopsy was conducted on 5 August 2012, it was likely that blood samples had been taken within 24 hours of the deceased's death or could be regarded as such. Even if the deceased had died in the early hours of the morning, the blood samples would have been taken within 32 hours of death but a shorter period should be considered as the deceased's body was in the mortuary shortly after he was declared dead. The Finnish Study was based on samples collected much later, on average five days after death. Dr Phua stated in his report that not all drugs were affected at a similar rate by PMR. Olanzapine levels remained stable in a series of 15 cases for up to an average of 54 hours but increased by more than 100% after four days when autopsies were delayed. On the other hand, mirtazapine

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levels increased by 147% by 74 hours in a series of 14 cases. In the deceased's case therefore, the blood samples were taken before significant PMR could have occurred for olanzapine and mirtazapine. In his case, the drug level of olanzapine found was, in Dr Phua's opinion, about 6 to 24 times the therapeutic level, that of duloxetine about 3 to 11 times, and that of mirtazapine 6 to 17 times.

127 Dr Phua stated that the current best practice is to minimise the PMR effect by the use of peripheral blood in post-mortem toxicological analysis and to collect the blood early. Both these practices were followed in the case of the deceased as his toxicological analysis was performed on peripheral blood collected during autopsy less than 24 hours from the time of death (the time of death being that noted on the death certificate). I note this and also note that even if the deceased had died at 2am on 4 August 2012, as the plaintiffs theorise, but cannot prove, his body did not remain at ambient temperatures for more than 10 hours thereafter.

128 The opinion of both Dr Teo and Dr Phua was that four drugs were found at elevated levels in the deceased's blood. This conclusion was supported by reference to various scientific papers. The full names of these papers are found in Dr Phua's reports. I shall refer to them as the Baselt Study, the Schulz Study and the Molina Handbook. The Baselt Study indicated that in respect of bromazepam, the data was inconclusive as to whether it was affected by PMR at all.

129 Dr Phua explained that data presented in the Schulz Study formed the most current and comprehensive single source of data for nearly 1,000 drugs. It is widely used and cited in the scientific community including by the

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Finnish Study. In the Schulz Study, drug concentrations in post-mortem femoral blood were compared with therapeutic concentration in plasma. On the basis of Schulz's findings, the levels of all four drugs were above therapeutic levels. Using Schulz's ranges, for olanzapine, the detected level of 0.47 (μg/ml) was in the toxic to lethal range, 5.87 to 23.5 times above therapeutic range. For duloxetine, the detected level of 0.33 (μg/ml) was in the toxic range, about 2.75 to 11 times above therapeutic range. For mirtazapine, the detected level of 0.5 (μg/ml) was 6.25 to 16.7 times above therapeutic range. For bromazepam, the detected level of 0.27 (μg/ml) was above therapeutic range.

130 Another set of reference ranges referred to by Dr Phua was that contained in the Molina Handbook. The Molina Handbook lists reference ranges for drug levels for therapeutic, toxic and lethal levels. Using the Molina Handbook references, the levels of drugs found in the deceased's blood were as follows:

(i) olanzapine – toxic to lethal range.

(ii) duloxetine – 4.1 to 14 times above therapeutic range.

(iii) mirtazapine – toxic to lethal range.

(iv) bromazepam – slightly above therapeutic range.

131 Dr Phua also noted that authors assembling compilations of drug samples often try to use data relating to single drug ingestion. In the case of a single drug being ingested, a much higher level of drug consumption will be needed to lead to toxicity than in the case of multiple drugs being ingested. In a series of suicide cases involving olanzapine, post-mortem olanzapine levels

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ranged from 1.4 to 6.2 μg/ml in cases where only olanzapine had been ingested but the levels were reduced to 0.16 to 0.76 μg/ml in cases where multiple drugs had been ingested.

132 As far as the Finnish Study was concerned, Dr Phua did not find it very useful because it did not contain any information with regards to overdose levels. There is also no indication anywhere in the Finnish Study of any position taken by the authors that it is only when drug levels are found at or above the 90th percentile level that drug overdose should be considered. Further, there is no way to tell from the data in the Finnish Study what the drug levels were in victims of suicide, accidental overdose or other causes of death as the Study did not distinguish between these causes. Additionally, it is not clearly indicated whether death from drug toxicity was due to single drug toxicity or multiple drug toxicity. The drug levels at the higher percentiles in the data in the Finnish Study may have been cases of single drug toxicity and therefore may not be comparable to the deceased's case.

133 The second defendant submits that while the data in the other studies were collated by referring to specific and individual cases where drug levels were determined according to the known circumstances of their consumption (*ie*, whether therapeutic or overdose), the Finnish Study was not based specifically on individual data but on a relative comparison of a broad spectrum of cases. This method of study has inherent weaknesses, including that of skewing of data.

134 They note also that Dr Teo, who was called as the plaintiffs' witness, testified that the deceased's olanzapine level of 0.47 μg/ml was the highest that he had ever seen in his 20 years of practice as a pathologist. They contend

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that this alone indicates that the deceased's olanzapine level was beyond therapeutic levels and in the fatal range. However, the olanzapine levels in the Finnish Study have the mean level at 0.41 μg/ml, while the 90th percentile is at 0.6 μg/ml. Therefore, when compared against the Finnish data, the deceased's olanzapine level appears to be just slightly above the mean level and way below the overdose level as proposed by Dr Tay. This comparison itself shows that the data in the Finnish Study are skewed and do not render a just and accurate analysis of the drug levels. I find this argument persuasive.

135 As for Prof Teo, the second defendant notes that he preferred to rely on other studies, including Schulz and Baselt, rather than the Finnish Study. The second defendant points out, and I accept, that Prof Teo was certain that the levels of the four drugs were elevated in the deceased. He stated in evidence that he had taken great care to be factual in his reports and all that he had said was that the blood levels were elevated which was a fact. He averred that compared to the literature that was available, the blood levels were elevated. Prof Teo did not speculate on why the levels were elevated but he was confident enough in his analysis to state the fact of elevation in his reports to the coroner and others.

136 Having considered all the evidence, I am satisfied that, on a balance of probabilities, the elevated levels of drugs found in the deceased's blood were truly reflective of his consumption of drugs and were not spurious elevations. I find, therefore, that the deceased had consumed overdoses of at least olanzapine, duloxetine and mirtazapine. The evidence in relation to bromazepam is less clear cut but it is possible that he consumed a slightly higher dose of that drug than he should have.

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Conclusion

137 In concluding that the deceased overdosed, I am relying not only on the scientific and medical evidence, but on the circumstances generally as indicated in earlier paragraphs of this judgment. Notwithstanding that on the night before his death the deceased did not display any signs of being suicidal, he must have deliberately consumed excess medication.

138 As I have come to the conclusion that the deceased probably deliberately consumed more medication than he should have, and that this was the cause of his death, I cannot find his death to have been caused by an accident falling within the policies. Accordingly, the plaintiffs' claims herein must be dismissed with costs.

Judith Prakash
Judge

Melanie Ho, Chang Man Phing and Tang Shangwei
(WongPartnership LLP) for the plaintiffs;
Lim Tong Chuan and Wee Tze Sing Joel (Tan Peng Chin LLC)
for the defendants.

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