CORONERS ACT, 1975 AS AMENDED

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 11th, 12th and 13th days of October 2004 and the 18th day of November 2004, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Tracey-Lee Cunningham.

I, the said Coroner, find that Tracey-Lee Cunningham aged 26 years, late of 27 Clarke Terrace, Angaston, South Australia died at Angaston, South Australia on the 24th day of May 2001 as a result of morphine toxicity complicated terminally by bronchopneumonia. I find that the circumstances of her death were as follows:

1. <u>Introduction</u>

1.1. At about 7:30am on Thursday 24 May 2001 Mrs Cerrie-Marie Gower went to wake her daughter, Tracey-Lee Cunningham. Mrs Gower had been staying with her daughter overnight while her husband, Allan, was at work. Both Mrs Gower and Mr Cunningham had been concerned at her condition. She had been showing signs of over-sedation.

1.2. Mrs Gower described what had happened overnight:

> 'Later that night, I went over to Angaston to stay with Tracey-Lee as Allan had to go to work that night. I arrived at their house at about 7:00pm. When I walked into the house, I saw Tracey had been making a coffee, but had fallen asleep in the process.
>
> I got her to bed between 7:30pm and 8:00pm. She went straight to sleep. She was snoring and her breathing was rattly. I could also hear her sort of half crying. This was early in her sleep. From the time I arrived that night until the time I put her to bed, I never saw her take any medication. She never got out of bed and snored all night. At 8:45pm that night I just laid in the same room as Tracey-Lee. I noticed the crying had stopped. I left her room at about 2:45am on Thursday 24th May 2001, and went and sat

in the lounge room. About 5:00am, I noticed the snoring had stopped and thought that the medication had worn off and she was just resting.'
(Exhibit C4a, p3)

1.3. An ambulance was called and Paramedic Chris Robson attended. He examined Mrs Cunningham and found that her pupils were fixed and dilated, and there were no signs of heart or respiration activity. He pronounced her life extinct.

2. Cause of death

2.1. A post-mortem examination of the body of the deceased was performed by Dr J D Gilbert, Forensic Pathologist, on 25 May 2001 at the Royal Adelaide Hospital. During the course of the examination, Dr Gilbert obtained samples which were analysed toxicologically.

2.2. The report of Ms Heather Felgate, Forensic Scientist, disclosed the following results:

> '1. The blood contained:
> (1) 0.47 mg morphine per L. (potentially lethal)
> (2) 0.70 mg venlafaxine per L. (greater than therapeutic level)
> (3) approximately 0.7 mg O-desmethylvenlafaxine per L. (greater than therapeutic level)
> (4) approximately 0.2 mg diazepam per L. (non-toxic/therapeutic)
> (5) approximately 0.3 mg nordiazepam per L. (non-toxic/therapeutic)
> 2. The urine contained:
> (1) Morphine
> 3. Alcohol was not detected in the blood.
> 4. Monoacetylmorphine was not detected in the urine.'
> (Exhibit C3a)

2.3. Dr Gilbert attributed the cause of Mrs Cunningham's death to morphine toxicity complicated terminally by bronchopneumonia. He commented:

> '1. Death has been attributed to morphine toxicity complicated terminally by bronchopneumonia. The blood contained a potentially lethal level of morphine as well as a greater than therapeutic level of venlafaxine (antidepressant) and therapeutic levels of diazepam (Valium) and its metabolite, nordiazepam. Morphine was also identified in the urine. Monoacetylmorphine was not found in the urine consistent with administration of morphine in the form of morphine as opposed to heroin. No alcohol was identified in the blood.
> 2. There were no injuries or other markings on the body to indicate the involvement of another person in the death.

3. No pre-existing natural disease that could have caused or contributed to the death was identified at autopsy.'

(Exhibit C2a, p4)

2.4. Professor Olaf Drummer, an eminent Forensic Pharmacologist and Toxicologist, has provided me with a report concerning the circumstances of Mrs Cunningham's death. I will discuss the report in more detail later. For present purposes, Professor Drummer's conclusion was as follows:

> 'In summary, the circumstances and pathology/toxicology results support a cause of death from the toxic effects of excessive morphine in combination with other prescribed drugs.'
>
> (Exhibit C15, p5)

2.5. Dr Martin Robinson, a Consultant Neurologist who has also provided me with a report, agreed. He said:

> 'Her death can be attributed to the problems of respiratory depression, as well as to aspiration pneumonia, the latter as evidenced by the finding of gastric contents within the main airways and reports of vomitus being found in her oral cavity at the time of death. The respiratory depression almost certainly is due to the effects of morphine which is clearly outlined in the report of Professor Olaf Drummer, with which I fully agree.'
>
> (Exhibit C14, p1)

2.6. In all the circumstances, I accept these opinions and find that the cause of Mrs Cunningham's death was morphine toxicity complicated terminally by bronchopneumonia.

3. <u>Background</u>

3.1. Tracey-Lee Cunningham was a 26 year-old mother of three who lived with her husband Allan in Angaston, in the Barossa Valley of South Australia.

3.2. Her mother, Mrs Cerrie-Marie Gower, said that Mrs Cunningham had been suffering from migraine headaches since she was a child of 7. The headaches became more frequent as she grew older (Exhibit C4a, p1).

3.3. Mr Allan Cunningham said that his wife had suffered periodic migraine headaches since he had known her. He said that she also became depressed after the birth of their first child in 1996, and with each subsequent birth in 1998 and 1999.

3.4. Mr Cunningham said that his wife was 'quite restless and discontented' (Exhibit C12a). They had moved to Mt Gambier, Whyalla and Queensland in turn, before returning to the Barossa Valley in January 2001.

3.5. It is clear that Mrs Cunningham had the tendency to abuse prescription drugs. In particular, she was abusing pethidine until she was detected forging a prescription in March 2001. Mr Cunningham said that she was seeing various doctors in order to obtain prescriptions (so-called 'doctor-shopping'). He said:

> 'The drugs seemed to be making Tracey worse. The depression was just getting worse as were the headaches and the drugs were getting on top of her.
>
> She wasn't getting any help and the doctor would prescribe more drugs.
>
> For about one and a half months she was being prescribed various different doses of drugs and appeared to be permanently drugged-out.
>
> It seemed to me that she was taking too many drugs and she seemed to think so as well, but the doctor said she wasn't taking too much and he continued to prescribe these medications.
>
> She would take morphine tablets or have injections of morphine for her migraines.'
>
> (Exhibit C12a, pp3-4)

4. **Recent medication history**

4.1. Dr Peter Clements, a General Practitioner at the Kapunda Medical Practice, had known Mrs Cunningham since 1988. Along with other doctors in the practice, he had treated her many times.

4.2. There was ample evidence before Dr Clements that Mrs Cunningham had a drug-seeking personality. For example, there is an entry in the practice clinical record on 8 September 1995 that Mrs Cunningham was seeking pethidine for her headaches. The doctor wrote:

> 'Advised of pethidine dependency needs to go to Drug Dependency Unit?'
>
> (Exhibit C10)

4.3. There is no indication that Mrs Cunningham ever did go to a drug dependency unit. Indeed, she was still being prescribed pethidine in 2000 and 2001.

4.4. Some significant events in 2000-2001 were as follows:

- On 28 September 2000 Mrs Cunningham alleged that she had her bag stolen and had lost her prescriptions. New ones were written for Panadeine Forte and Maxolon;

- On 13 October 2000 and 17 November 2000 she received intramuscular injections of pethidine;
- Mr and Mrs Cunningham went to Queensland in early January 2001 but had returned to Angaston by 29 January. On 5 February 2001 she received another dose of pethidine for ‘migraine’;
- On 12 February 2001 Mrs Cunningham complained of migraine, tinnitus, dizziness and passing out. She was referred to Dr Norton, a Neurologist. Panadeine Forte was prescribed, but on 14 February 2001 she returned saying she had lost the prescription and another one was provided. On the same day, she returned again saying she had lost the prescription, and a further one was provided;
- On 23 February 2001 Mrs Cunningham returned to the practice saying that one of the children had put her tablets down the toilet. Further prescriptions for Paradex and Effexor (an anti-depressant) were written;
- On 26 February 2001 Mrs Cunningham presented in ‘crisis’ with migraine. She refused admission to hospital. The doctor was clearly worried about suicide as he or she noted:

  > 'Can’t handle situation .. living with friends .. depressed .. declines admission .. with people → should be safe'
  >
  > (Exhibit C10)

  She was given pethidine, Maxolon, and saying that her child had destroyed the last one, another prescription for Paradex. This explanation was the same as the one given on 23 February, but further opiate medication was provided nonetheless. On the following day she was referred to the Barossa Valley Mental Health Service (‘BVMHS’);
- On Sunday 11 March 2001 Mrs Cunningham presented to Kapunda Hospital at 12:30pm, having been discharged that morning from the Lyell McEwin Hospital, having suffered a ‘? miscarriage’ on 9 March. She was complaining of migraine and vomiting. She was given pethidine and Maxolon and remained at the hospital until 6:10pm, when further pethidine was given. She went home, but re-presented later, when further pethidine was given at 11:20pm on Dr Van Dissel’s instructions. She was then admitted to hospital;

- On 26 March 2001 Mr Guy Ewing, a local pharmacist, telephoned Dr Van Dissel. Dr Van Dissel noted:

> 'Tracey has been abusing Paradex .. gaining scripts from (other doctors) as well as (Kapunda Medical Practice). Recently forged a script (number) from 50→100'
>
> (Exhibit C10)

4.5. Change of approach

When Dr Clements learned of Mr Ewing's advice, he contacted Mrs Cunningham and had a long discussion with her on 26 March 2001. The clinical record rather cryptically records:

> 'Long consultation re the above
> Counselling
> Needs CBT (Cognitive Behavioural Therapy)
> Ian Ward (from BVMHS) to be contacted'
>
> (Exhibit C10)

4.6. In oral evidence, Dr Clements explained in more detail what transpired:

> '… I discussed the - first of all the inappropriateness of the way she had been treating herself and being treated in the past. I discussed with her the issue of wellness versus sickness and that much of her behaviour had become a sickness behaviour and that we needed to try and get her to approach things from the point of view of a wellness base. I discussed with her the inappropriateness of doctor seeking or seeing a variety of doctors to seek medications and she certainly agreed on that day that this was not appropriate and that she would cease that. I discussed with her the depths that had (been) reached in order to come to the point of altering prescriptions and having been allegedly forging, although at that time she still denied that. So I discussed with her the need to take a completely different approach and that approach needed to be multifocal and I acknowledged that we would still need a medication base to approach her headaches to get some control but that would be better achieved with taking something on a regular basis rather than an ad hoc basis. And that we needed to avoid, as far as possible, the injectable narcotics. I said to her that I felt she needed to embark on some cognitive behavioural therapy, which I felt was the most likely method to achieve success in terms of her sense of well-being and thereby avoidance of headaches and a general improvement in her happiness in life. I put it to her and she agreed that in the first instance we needed to have a management plan that we agreed on and we then undertook a verbal contract, that contract being that she would see one doctor, that she chose that doctor to be me and I agreed because I'd known her for a very long time, I thought that was appropriate. We'd already discussed that within the practice and one of us needed to take responsibility and that we would embark on a plan of regular review, involvement of the mental health nurse to initiate some cognitive behavioural therapy, along with myself. We would initiate slow-release morphine on a regular basis at a small dose in order to gradually build-up to a point where we had analgesic success and without side-

> effects. That was the strategy that we agreed to on that day on 26 March and that was a strategy that was going to involve trust on both sides. So certainly she needed to trust that I would take her complaints of pain seriously and I needed to trust that she would do the right thing, as evidenced by our verbal contract.' (T91-93)

4.7. Despite this agreement, Mrs Cunningham attended at Kapunda Hospital at 5:25pm that evening, 26 March 2001, complaining of migraine. On Dr Clements' directions, she was given a further 100mgs of pethidine.

4.8. Later that evening, Mr Cunningham telephoned the hospital, at his wife's request, seeking more pethidine. Another practitioner was contacted and approved the administration of Chlorpromazine instead. Dr Clements was contacted and said that it was not appropriate to provide further medication unless she was admitted. Mrs Cunningham refused admission, so the further medication was not given.

4.9. On 28 March 2001 Mrs Cunningham presented again at 1:15pm complaining of 'migraine headache'. Dr Clements prescribed 100mgs of pethidine intramuscularly. He noted:

> 'Released through her husband. She may NOT have further Rx (medication) without ADMISSION. Please adhere to this and ensure I do too.'
>
> (Exhibit C10)

4.10. At 9:50pm that same night, 28 March 2001, Mrs Cunningham attended at Kapunda Hospital complaining of 'migraine headache'. She agreed to be admitted, and Dr Clements authorised pethidine and Largactil in 50mg doses, to be repeated no more than twice overnight.

4.11. Later that evening Mrs Cunningham told hospital staff that she had tried to slash her left wrist with a knife but couldn't because it hurt too much. Hospital staff took appropriate measures to prevent further self-harm while in hospital.

4.12. When Dr Clements saw Mrs Cunningham next morning he commented in the clinical record:

> 'Cry for help but not really happy to receive it.'

He directed that Mrs Cunningham be observed for a further four hours, and directed that she receive no more pethidine.

4.13. Consistent with this ‘no more pethidine’ policy, on 30 March 2001 Dr Clements prescribed 10-15mg morphine, administered intravenously every four hours, to deal with Mrs Cunningham’s headaches.

4.14. On 31 March 2001 Mrs Cunningham received Panadeine Forte and morphine throughout the day, and regularly after that until 2 April 2001 when Dr Clements discharged her.

4.15. During this admission, Mrs Cunningham was reviewed by Mr Ian Ward, a Community Mental Health Nurse with BVMHS. A teleconference with a Psychiatrist, Dr Fiona Hawker, was arranged for 5 April 2001.

4.16. The teleconference was duly conducted on that date. Mrs Cunningham, Mr Ward and Dr Hawker took part. Dr Hawker telephoned Dr Clements afterwards, and then wrote a detailed, three-page letter expressing her opinion. She referred to Mrs Cunningham’s ‘increasing symptoms of anxiety’ with a variety of physical symptoms; her ‘significant stresses’ resulting from the move to Queensland and her miscarriage; her disappointment at abandoning her hopes for a career as an optometrist; and her less than ideal relationship with her parents and husband.

4.17. Dr Hawker described Mrs Cunningham’s symptoms as follows:

> 'Tracey has been struggling particularly for the last month or so, with increasing symptoms of anxiety. She is aware of high levels of anxiety, with nausea being almost constant. This has lead to very poor appetite with associated weight loss. She has episodes of diarrhoea and more recently times of palpitations. She is often shaky, her concentration and attention are impaired and her mood is generally low. Her sleep is disturbed with both initial insomnia and frequent and early waking. Not surprisingly she is having increasing problems with general functioning. I understand that last week she became actively suicidal and tried to cut her wrists but stopped when she found it too painful. She now feels more like just withdrawing from everything, rather than being suicidal.'
>
> (Exhibit C10)

At no point does Dr Hawker mention dependence on opiates, doctor shopping, or even her migraines. Her only mention of drug related issues is as follows:

> 'A vicious spiral has occurred that medication hasn’t been able to effectively stem. She did find Valium 2.5mg TDS helped but because she was feeling better with it, and because she was concerned that she might become addicted to it, she stopped it after only a few days, and threw the rest of the tablets away.'
>
> (Exhibit C10)

4.18. Dr Hawker recommended treatment in the form of:

- Medication – Effexor and Epilim in increased doses, and Valium;
- Anxiety management – literature and self-help, with help from Mr Ward;
- Psychotherapy – counselling from Dr Clements and Mr Ward;
- Marital support – support and involvement of Mr Cunningham;
- Counselling – avoidance of slipping into a disabled 'patient' role.

Significantly, Dr Hawker made no mention of, or suggestions for treatment in relation to Mrs Cunningham's drug dependency.

4.19. Dr Clements said he regarded the teleconference as crucial. He said to Detective Brown when interviewed on 7 May 2002:

> 'A. The teleconference was the linchpin to this whole plan. I was struggling, clearly my initial - our initial contracting was already struggling in the first day after it occurred. Tracey was really having trouble sticking to the contract.
>
> Q. In what regard.
>
> A. Well you made the comment yourself, that she presented the same night requesting intramuscular analgesia. So as well meaning as she may have been, at least in a physical sense she was struggling terribly, to come to terms with the importance of contract.
>
> …
>
> A. This was clearly a person who was - who was struggling enormously with her life generally, not just with pain. She required psychiatric support, she required psychiatric assessment and that would involve a three pronged attack, part of it was me. So from a - from a day to day medical care that would be me, so on discharge ... arranged to see me in a week. It would involve the mental health nurse to see her as often as he deemed appropriate at her home. I can't comment on how often that happened, that's in his notes and it involved - and meet the involvement of the psychiatrist to over-view the thing, primarily to give me advice and Ian Wood advice about the next best way to go in managing this - this really struggling patient. '
>
> (Exhibit C13a, pp13-14)

4.20. After the teleconference, Mrs Cunningham continued to attend Kapunda Hospital and Dr Clements' surgery regularly seeking pain relief. She received morphine, Valium, and Panadeine Forte on a regular basis.

4.21. On 24 April 2001 Mrs Cunningham presented at Dr Clements' surgery with migraine, and marriage difficulties with her husband. His notes read 'PAIN diabolical'. He

gave her a prescription for MS Contin (slow release oral morphine capsules) 10mg twice daily, and for Ordine 5mg (morphine syrup). Dr Clements explained:

> 'That was - on that occasion I - we initiated the use of MS Contin. Made a decision together that the more appropriate way of pure pain management at this time and safer way, was to use long acting, as low dose as possible, Morphine - orally. Clearly the issue with using orally - oral Morphine is that you need to establish a dose. That's done by using, generally done anyway, by using liquid Morphine in prescribed doses, and controlled doses in order to establish a 24 hour dose from which to work, and that dose can be a plan. That was to reassess the dose requirements in 48 hours, to adjust that up or down accordingly and until we reached a point where twice a day, long acting Morphine would control the pain so we could continue with more effective counselling, family support if that was appropriate, use of anti-depressants if that was appropriate, involvement of other people as we did, as we were trying to do. Now this involved the withdrawal of all other analgesics and Tracey clearly understood the direction that we needed to head in order to do this.'
>
> (Exhibit C13a, p15)

4.22. Dr Clements arranged that Mrs Cunningham would contact him in two day's time in order to adjust the dose up or down.

4.23. On 25 April 2001, the next day, Mrs Cunningham attended Kapunda Hospital and was administered 15mgs of intramuscular morphine, in addition to the oral morphine she had presumably taken.

4.24. On 26 April 2001, Dr Clements prescribed 30mg morphine sulphate tablets (Kapanol), compared with the 10mg he had prescribed on 24 April 2001. On 27 April 2001 the syrup prescription was repeated, and on 3 May 2001 Kapanol was prescribed.

4.25. Mrs Cunningham continued to receive morphine in various forms throughout May 2001.

4.26. On 21 May 2001 at about 3pm, Mrs Cunningham presented at Kapunda Hospital with migraine. Dr Clements authorised an intramuscular injection of 15mgs morphine over the telephone. At 7:30pm the same day, she presented at Kapunda Hospital again and this time was seen by Dr Clements who noted 'another migraine'. She also told Dr Clements that she had 'lost scripts', presumably for morphine, so he wrote some more (Exhibit C13, p4).

4.27. As to the fact that Mrs Cunningham had received two injections of morphine in one day, and that the requirements for morphine were ongoing, Dr Clements said:

> 'The 21st was a bad day and clearly that was an issue. The 10th was a bad day, the times in between those she didn't present at all as far as I'm aware to me or to this practice. So they were concerning days and you'll know by my letter of the following day, that I was very concerned about these issues.
>
> …
>
> And what we were working towards was stopping the injections completely, getting off the Morphine only because the Morphine wasn't proving useful in the way I'd hoped it would. Not because I felt it was dangerous to her, and dealing with the aspects of her life which were the most important issues. But dealing with those issues required dealing with other issues as well, namely the pain. You can't - couldn't - and you could never separate those issues with anyone. What we could do was involve other people which is what we'd done, what we continued to do and what I continued to plan to do the following day.'
>
> (Exhibit C13a, pp21-22)

4.28. Mr Allan Cunningham said that when he arrived home from work at about 5pm on 21 May 2001 his wife was ‘drugged out’. She was ‘drooling’ and ‘couldn’t talk properly’ (T12). He said that when she wanted to return to Kapunda Hospital for more morphine, he refused to take her because in his opinion she had already had too much (T14). She then arranged for a friend of theirs to take her back to the hospital.

4.29. Dr Clements said that he gave Mrs Cunningham ‘lots of counselling’ during the latter visit. He denied in evidence that she appeared intoxicated, pointing to his note ‘O/E CNS ✓’ (on examination, central nervous system normal). After this consultation, Mrs Cunningham received another injection of morphine, on Dr Clements’ instructions.

4.30. Mr Cunningham said that when his wife returned home after the second injection, she was ‘totally out of it’. He said that she was falling over, and falling asleep standing up. He put her to bed, and she slept until 4pm the next day.

4.31. At some time that evening, prescriptions written by Dr Clements for Mrs Cunningham that day were dispensed from the Gawler Pharmacy of Mr Kym Potger. The prescriptions were for Valium, Maxolon, Kapanol and Ordine (see Exhibit C7c). Whether or not she consumed some of this morphine in addition to the two intramuscular injections she received that day cannot now be known. It may be that she did, in view of Dr Clements’ insistence that she was not intoxicated when he saw her that evening (T104), and yet she was intoxicated by the time she arrived home.

4.32. At some time either later on 21 May or early on 22 May 2001, Dr Clements returned a telephone call from Mr Cunningham about the 21 May visit. Mr Cunningham admits that he was 'irate' that Dr Clements had given his wife the second injection. Dr Clements agreed to see her after surgery on 22 May 2001.

4.33. Events of 22 May 2001

Mr Cunningham said that his wife slept until 3pm on 22 May 2001, at times snoring very loudly (Exhibit C12a, p5). He said that she was still visibly intoxicated when she got up (T14).

4.34. Mrs Cunningham went back to see Dr Clements at about 6pm that afternoon. He had fitted her in after a day's consulting, and he was due to commence five weeks' leave the next day.

4.35. Mr Cunningham contradicted himself about whether Mrs Cunningham went with her parents (Exhibit C13), or with him (Exhibit C13a). He took with him all of the medication Mrs Cunningham had in her possession in order to remonstrate with Dr Clements about how many narcotics she had access to, and the condition she had been in the previous evening (T17).

4.36. Dr Clements admitted that Mrs Cunningham showed signs of intoxication on 22 May 2001. He said:

> 'A. On this occasion she was quite as described. She was tired, she was slurring her speech, she was - I think spaced out is a good description. She was still able to carry on a conversation with me which made sense, she was still able to take on what I was saying to her and she was able to respond to my confrontations to her. But she was certainly not in any way like I'd ever seen her before.
>
> Q. How much time did you spend with her on this occasion.
>
> A. Well this was something between an hour and an hour and a half, it was a very long consultation as ever, probably no longer than many of them. But - and a lot of that was taken up sort of confronting her with the issues that, you know, it was clear to me that at least on this occasion she had, by one method or another, taken more medication than I'd prescribed for her. I was upset with her, I felt betrayed myself, I felt that the trust that I'd placed in her had been let down and I certainly let her know that. I told her that the whole business of taking the morphine now needed to be abandoned and we needed to look for another way of doing that. I suggested to her that she would be better off in hospital, that she was in a difficult state to go home. She refused. I addressed that with her a number of times that evening. She absolutely refused. I told her that I had considered having her detained and in fact as I continued to consider it I felt the grounds were not quite there. I tried again to get her into hospital, she again refused and she said that her mother would be able to look after her if I felt that was important. I said to her that I would be arranging

> for the mental health nurse to see her the following day as a matter of urgency and that I was dictating a letter at that - as soon as she walked out, and that I felt that the very least she needed was another urgent teleconference with the psychiatrist and that that was the direction we now needed to take, that we needed psychiatric involvement and that things were really very difficult at that time.' (T106-T107)

4.37. Following this consultation, Dr Clements dictated a long letter to Ms Sandy Shilling of the BVMHS in the absence on leave of Ian Ward. He mentioned her possible over-use of narcotics, her relationship problems, her husband's concerns about intoxication at home. The letter concluded:

> 'I did think that Fiona Hawker might be the right person to become re-involved with her and I am wondering if, at least while Ian is away, you might be able to pick up the reins as a matter of some urgency. In fact, I have asked Allan to ring the service in two days to emphasis the urgency, given that he is concerned, quite rightly, that she is still driving, and in her excessively tired state that this could be dangerous. He is also worried that she may overdose, either advertently or inadvertently and has stated to me on one occasion that she has talked about 'ending it all'.
>
> I am greatly concerned about Tracey and I really do need your help as a matter of some urgency.'
>
> (Exhibit C13e, p2)

4.38. Dr Clements said that he knew that Mrs Cunningham had been opening the Kapanol and MS Contin capsules and consuming the contents in order to obtain a 'kick or a high' rather than long acting pain relief. He said:

> 'It was another issue that added to my concerns about the way she was managing things.'
>
> (Exhibit C13a, p25)

4.39. Despite these major concerns about Mrs Cunningham, Dr Clements decided that she was not detainable within the meaning of the Mental Health Act 1993. He said:

> 'Well you know, it's always a concern. Someone's made even a feeble attempt to suicide, then you know, you have to take that seriously as I did. This is obviously the reason why the teleconference was organised. Certainly at the time I saw her after the wrist cutting episode, and I have to say it was very minor physically, I don't believe at that time she was detainable, neither did the mental health nurse, neither did the psychiatrist when she saw her. On the 22nd, we've discussed the other times and I don't think there was any thought that she was detainable at that time. On the 22nd clearly I thought she was safer being hospitalised. I was aware that other people were going to be with her at home, I didn't feel that she was suicidal, I didn't feel that that was the risk that we were facing. But I felt strongly enough to want very early involvement with the psychiatric team and that meant as very much as quickly as possible.'
>
> (Exhibit C13a, p27)

4.40. Events of 23 May 2001

Mr Cunningham said that his wife was still 'a little intoxicated' when she awoke at about 11am that morning. Dr Clements' letter had been received by the BVMHS, and Registered Mental Health Nurse Louise McLean attended and spoke to her. In her rather short statement, Ms McLean said:

> 'I subsequently attended their home that morning. Tracey got out of bed to see me. She complained of being very tired – 'just needing to sleep all the time'. She was reactive and congruent with no evidence of any psychosis or suicidal ideation. She was having ongoing difficulties with her general functioning.'
>
> (Exhibit C6a)

4.41. An appointment was made to see Mrs Cunningham again the following week.

4.42. Mr Cunningham said that his wife seemed affected by drugs throughout the balance of that day. Mrs Gower said that her daughter was unable to remember if she had taken her medication or not, and she was thereby exceeding the dosage. She telephoned Dr Clements' partner, Dr Max Van Dissel, at 5pm on 23 May 2001 but the call was not returned.

4.43. Mr Cunningham left for work at about 7pm that evening. As I have already outlined, Mrs Gower put her daughter to bed at about 7:30pm and could hear her snoring and 'rattly' breathing and half-crying. She snored all night until about 5am. At about 6am, Mrs Gower telephoned the Kapunda Hospital because she wanted her daughter admitted. She said:

> 'I had very real and serious concerns about the condition she was in and the effects of the medications she was on. These effects included falling asleep suddenly, even when doing dangerous things like lighting a cigarette over the hotplate, or using her dryer.'
>
> (Exhibit C4a, p4)

4.44. Tragically, her daughter was beyond help at this stage. At 7:30am, when Mr Cunningham returned from work, his wife was already deceased.

5. Issues arising at inquest

5.1. I heard evidence from Dr Martin Robinson, a Consultant Neurologist, who provided me with a very helpful report (Exhibit C14). As I have already mentioned, Dr Robinson agreed with the opinions of Dr Gilbert and Professor Drummer that the cause of Mrs Cunningham's death was respiratory depression and aspiration pneumonia due to the effects of morphine.

5.2. Dr Robinson told me that patients are frequently referred to neurologists on the basis that they have been suffering chronic or frequent acute headaches. He said the majority of these headaches are idiopathic, in other words there is no apparent pathology to explain them. He observed that the longer the patient's history of such headaches, the less likely it is that they will find a cause for them (T157).

5.3. Dr Robinson said that patients who suffered acute headache pain such as Mrs Cunningham are exceptionally difficult to treat, and a range of drugs are utilised. However he was very clear that if a patient consulting him is receiving narcotics, the first step is to remove that medication. He said that if a patient is unwilling to agree with this, he would encourage them to be admitted to a hospital so that the withdrawal can be supervised appropriately. He explained that narcotics can perpetuate, rather than alleviate the patient's symptoms (T158). In relation to Mrs Cunningham, he said:

> 'It is very easy in retrospect and when reading the various reports in front of me to say that narcotics should not have been prescribed in this case. Nevertheless I do not feel that a consultant neurologist would have embarked on a management plan of chronic Morphine administration for such a case. (I feel it is highly likely that this patient was suffering either from rebound headache, psychogenic pain disorder or drug seeking behaviour or possibly combinations of all three) and the provision of morphine only served to escalate the problem.
>
> …
>
> In this case I feel that Dr Clements was trying to do his best for the patient, however once he embarked on the prescription of regular narcotics the patient's demands only seemed to escalate, forcing Dr Clements into a corner where he either had to continue on his treatment program which entailed further narcotic administration, or perhaps stopping them altogether which he was loath to do (even though he states that he did not feel she had drug dependency). This escalating state of affairs ultimately led to her death.'
>
> (Exhibit C14, pp3-4)

5.4. Indeed, Dr Robinson offered the opinion that Mrs Cunningham's presentation in an 'increasing obtunded state' (particularly, the evidence suggests, on the evening of 23 May 2001):

> 'should have alerted Dr Clements to the possibility of drug toxicity which could have been reversed by the appropriate use of agents such as Naloxone. I feel that Dr Clements did recognise the difficulties that were occurring and he clearly was making attempts to reduce her morphine dose in a controlled manner, however the amount of narcotic that Dr Clements thought he was prescribing and the amount she actually consumed as per the report of Professor Drummer are clearly quite disparate.'
>
> (Exhibit C14, pp4-5)

5.5. When cross-examined by Mr Stanley, counsel for Dr Clements, Dr Robinson acknowledged the difficulties of General Practitioners practising in the country. However he pointed out that if Dr Clements was unable to gain control of Mrs Cunningham's condition, he could have considered referral to a pain clinic or to a psychiatrist on an urgent basis. I accept his opinion about that. It is not as if Kapunda is a particularly remote region of South Australia, and it would have been relatively easy for Mrs Cunningham to have accessed facilities in the metropolitan area. Dr Clements' argument that there are often long waiting lists associated with such referrals (T109) seems a little disingenuous, in view of the fact that Mrs Cunningham's problems with headaches and drug dependence had been apparent since 1995.

5.6. What was of particular concern to me was that Dr Robinson, who is a very experienced specialist, described the quantity of morphine being prescribed to Mrs Cunningham as 'phenomenal', and beyond the scope of his expertise (T181). That being so, I find that it was even further beyond the scope of Dr Clements' expertise.

5.7. Dr Robinson acknowledged that management of Mrs Cunningham would have been extremely difficult, particularly when she presented in 'crisis'. However, he said that narcotics are simply not useful in the treatment of chronic headaches, and that once Mrs Cunningham's doses of narcotics started increasing he would have 'lost my nerve'. He said:

> '… there seemed to be an acute phase in those last few days where things were clearly quite different and she was clearly affected by the medication. I suppose the amount of narcotic that was given in the month leading up to her death was large and it's easy to say that it could have been curtailed a long time before that and you know I suppose that's probably what I would have done, I would have bailed out of the narcotic treatment a lot earlier before those doses were ever achieved.' (T178)

5.8. Toxicology

I also heard evidence from Professor Olaf Drummer, a Forensic Pharmacologist and Toxicologist who is head of Scientific Services at the Victorian Institute of Forensic Medicine, and Adjunct Professor in the Department of Forensic Medicine at Monash University in Victoria. Professor Drummer is highly qualified in his field and is recognised across Australia as an expert in the analysis of drugs and poisons and in the interpretation of their biological effects. Professor Drummer's report is Exhibit C15.

5.9. Professor Drummer analysed in detail Dr Clements' prescription of narcotics to Mrs Cunningham, particularly in the last month of her life. As I have already mentioned, he agreed that the post-mortem and toxicology findings are consistent with the effects of drugs which depress respiration. He said:

> 'The presence of pulmonary oedema (heavy lungs) and bronchopneumonia are common features associated with this form of respiratory distress.
>
> The presence of significant amounts of morphine in her blood indicates that her respiratory distress was probably caused by morphine, a drug well known to depress respiration.
>
> The observation of her heavy breathing (paragraph 21) further supports that the deceased was in respiratory distress during the early part of the night of the 23rd May.'
>
> (Exhibit C15, p4)

5.10. Professor Drummer calculated that in the last month of her life, Mrs Cunningham had <u>access to</u> about 7.3gms of morphine in total, or an average of at least 250mgs per day. Whether she consumed all of that can never be verified. A breakdown of this medication is as follows:

'Morphine Tablets (Kapanol, MS Contin)	4 scripts, 4x20 tablets (20mg) (=1600 mg)
Morphine Tablets (Kapanol, MS Contin)	1 script, 20 tablets (30mg) (=600 mg)
Morphine solution, 5mg/mL (Ordine)	3 scripts, 3x200mL (=3000 mg)
Morphine solution, 10mg/mL (Ordine)	1 script, 1x200mL (2000 mg)
IM injections	5 injections totalling 90 mg'

> (Exhibit C15, p4)

5.11. Professor Drummer pointed out that not only did Mrs Cunningham have access to morphine, she also had access to other central nervous system depressant drugs including anti-depressants such as Valium. These drugs would have contributed to the toxic effects of the morphine. He pointed out that on 21 and 22 May 2001 she was showing clear signs of toxicity from morphine or other central nervous system depressant drugs. He said:

> 'What opportunities there were to intervene against the patient's will I am not in a position to comment on. At the very least the husband should have been warned of possible danger signs to allow him to bring her to hospital if her condition worsened. However, in the circumstance of her claiming that she had taken all of her morphine, her slurred speech and unsteady gait and her background she should have been treated as a potential drug overdose.'
>
> (Exhibit C15, p5)

5.12. Dr Clements asserted in oral evidence that he did warn Mr Cunningham to be alert to any breathing problems. He said:

> 'I said that if there was a deterioration in her breathing, if her breathing became deeper, slower and noisier, that we should - he should certainly contact the hospital or me and he should come back - and should bring her back.' (T125)

Dr Clements could not remember whether anyone else was present. He said that he expected Mr Cunningham to pass the information on (T126).

5.13. Dr Clements made no reference to this warning when he spoke to Detective Senior Constable Brown on 7 May and 13 November 2002, even though he gave highly detailed explanations for his actions in those interviews. Mr Stanley did not suggest to Mr Cunningham when he was cross-examining that such warnings were given. I have grave reservations about whether they were. However, I am unable to find, on the balance of probabilities, that they were not.

5.14. Whether, if such warnings were given, they would have affected the outcome is a matter of speculation. Mr Cunningham and Mrs Gower were clearly worried about Mrs Cunningham. Mrs Gower telephoned the Kapunda Hospital at 6am on 23 May 2001. By that time it was probably too late. I doubt that anything would have been done any earlier, even if the warning had been given, since snoring was not equated with breathing difficulties.

5.15. Although he acknowledged many difficulties in making an accurate estimation of the dose required to achieve a particular post-mortem concentration, Professor Drummer said:

> 'However, a dose of over 100mg is very likely in several hours to a day prior to her death, and quite possibly as much as 200mg.'
>
> (Exhibit C15, p5)

In oral evidence, he said he thought it was most likely that Mrs Cunningham took such a dose of morphine within an hour or two of going to bed on the evening of 23 May 2001 (T208).

5.16. Professor Drummer made the following points in relation to Dr Clements' prescription of morphine:

- Mrs Cunningham had a history of severe migraine and depression with previous attempts at self-harm;

- She was also showing signs of drug dependency (having regard to the frequency of her requirement for drugs, forging of scripts, claims of lost scripts, etc);
- The prescription of large amounts of morphine, even in small individual doses, to such a patient is highly risky given its very high toxicity rating;
- Morphine was being administered intramuscularly, and by both quick-acting morphine liquid and by long-acting tablets. He said:

  > 'It is hard to see the merit of this because the amount of morphine the patient is using will be poorly controlled and will have a high potential for the patient to over medicate even if she did not seek to harm herself.'
  >
  > (Exhibit C15, p5)

- There should have been a much stricter control of her morphine use. He said:

  > 'Appropriate dosing with a sustained release form of morphine should have achieved some beneficial outcomes without resorting to additional use of oral morphine solutions and IM injections. Alternatively, IM injections alone could have been used with use of other anti-migraine therapies.'
  >
  > (Exhibit C15, pp5-6)

5.17. Professor Drummer conceded to Mr Stanley that the size of the doses of Kapanol and MS Contin prescribed by Dr Clements were not high (T218), but pointed out that it was the overall quantity of morphine which was the issue, rather than the size of the dose.

5.18. <u>Detention</u>

Dr Clements said that, in his opinion, Mrs Cunningham did not meet the criteria for detention under the Mental Health Act 1993 on the evening of 22 May 2001. Dr Robinson conceded that Dr Clements was in the best position to make that judgment at the time, and that it is difficult to criticise the decision in retrospect (T161). In those circumstances, I do not criticise Dr Clements for failing to detain Mrs Cunningham that evening.

5.19. This issue is somewhat academic, in any event, since Mrs Cunningham was visited by the Mental Health Nurse Louise McLean the following day, and was not showing any overt sign of distress at that time. Even if Mrs Cunningham had been detained the previous evening, by next day it was likely that any detention order would have been revoked.

6. Conclusions

6.1. On the basis of the evidence before me, I find that Mrs Cunningham's death was caused by morphine toxicity complicated terminally by bronchopneumonia.

6.2. It is not possible for me to find whether or not Mrs Cunningham deliberately overdosed her morphine medication. Although she was in severe distress (either as a result of her chronic headaches or depression or both), there is also evidence that she was often in a state of befuddlement as a result of her narcotic medication. It is quite possible that any overdose was accidental. Further, I take into account Professor Drummer's comments that the ingestion of fast-acting intramuscular and liquid morphine with long-acting tablet or capsule morphine (whether or not she was opening the capsules and thereby obtaining faster effects) would be extremely difficult to predict.

6.3. I find that the prescription of large quantities of narcotic analgesics in Mrs Cunningham's circumstances, in particular the facts that it was clinically inappropriate and that she had an obvious drug dependency, was inappropriate, for the reasons expressed by Dr Robinson and Professor Drummer. I do not accept that, in making this finding, I am 'pillorying' Dr Clements, as Mr Stanley suggested in his final address. It is my duty to make a finding about the cause and circumstances of Mrs Cunningham's death. I do not believe that the above finding goes further than that.

6.4. I also find that Mrs Cunningham presented a number of very difficult treatment challenges to Dr Clements, in that the combination of her physical symptoms, a psychiatric overlay and complicated family dynamics made her an extremely difficult person to treat.

6.5. While I accept the difficulties faced by General Practitioners confronted with a difficult patient such as Mrs Cunningham in times of crisis, in my opinion Dr Clements should have realised at a much earlier time that he was out of his depth in terms of treating Mrs Cunningham, and should have sought expert help by referring her to an appropriately qualified specialist (a psychiatrist, a neurologist or both), to deal specifically with the issue of the role of prescription medication in the treatment of her complex condition.

7. Recommendations

7.1. Dr Clements said that it was not possible for him to verify Mrs Cunningham's claims (made on several occasions) that she had lost prescriptions. He said that if it had been possible to check whether or not the prescription had been dispensed, he could have refused to issue a replacement prescription (T111).

7.2. Mr Stanley submitted that this is a serious concern, and that it should be possible either for the South Australian Department of Health, or the Commonwealth Health Insurance Commission to establish a process whereby doctors could obtain that information. Of course, in order to be useful, the information would need to be available quickly.

7.3. A further possible alternative would be to require a dispensing pharmacist to advise the prescribing doctor (either by facsimile or by email) that certain potentially dangerous drugs had been dispensed.

7.4. It is not possible for me to ascertain the feasibility of these suggestions, but I agree that it is an issue worth investigating. I recommend that the Minister for Health investigate the feasibility of a scheme whereby medical practitioners could check whether a prescription for a dangerous drug has been filled or not, in order that they might avoid over-prescribing to a drug-seeking patient.

Key Words: Medical Treatment - Medical Practitioner; Morhpine Toxicity

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

Seal the 18th day of November, 2004.

Coroner

Inquest Number 37/2004 (1261/2001)