QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Margaret Ann Cahill**
TITLE OF COURT:	Coroners Court of Queensland
JURISDICTION:	CAIRNS
FILE NO(s):	2017/4101
DELIVERED ON:	14 May 2021
DELIVERED AT:	CAIRNS
HEARING DATE(s):	8 September 2020, 15-16 & 18 December 2020, 11 May 2021
CORONER:	Nerida Wilson, Northern Coroner
CATCHWORDS:	Coroners: inquest, 60mgs intramuscular morphine injection prescribed by general practitioner; morphine interaction with tapentadol and other central nervous system suppressants; mixed drug toxicity; medical management by general practitioner; doctor / patient relationship; post intra-muscular morphine observations by general practitioner and caregiver husband; delayed emergency response.

REPRESENTATION:

Counsel Assisting the Coroner:	Mr J. Crawfoot
Counsel for Mr Brian Cahill:	Mr M. Dalton i/b Preston Lawyers
Counsel for Dr Barbara Gynther:	Mr G Diehm Q.C. and Ms S. Gallagher i/b Meridian Lawyers
Counsel for RN Abigail Heath:	Mr A Luchich by i/b Meridian Lawyers

Contents

Publication

Section 45 of the *Coroners Act 2003* ('the Act') provides that when an inquest is held, the coroner's written findings must be given to the family of the person in relation to whom the inquest has been held, each of the persons or organisations granted leave to appear at the inquest, and to officials with responsibility over any areas the subject of recommendations. These are my 49 page findings in relation to Margaret Ann Cahill. They will be distributed in accordance with the requirements of the Act and published on the website of the Coroners Court of Queensland.

The inquest

Non-publication Order made at Inquest

1. I order as follows:

   The personal contact details of all witnesses including telephone numbers and residential addresses not to be published.

Background

2. The deceased, Mrs Margaret Ann Cahill (née Cooper) was born on 9 June 1956 and died on 13 September 2017 aged 61 years.

3. Margaret was married to Brian Cahill (Mr Cahill) and together they resided together at an address at Redlynch, a suburb of Cairns.

4. Margaret had a complex medical history including chronic neck pain, diabetes (non-insulin dependent), asthma, depression, and colitis of the bowel that had necessitated a colectomy and insertion of a colostomy bag.

5. Her primary general medical practitioner was Dr Barbara Gynther, a GP with the McLeod Street Medical Centre (the medical centre). Their clinical relationship had been in place since 2008, some nine years prior to these events. Margaret attended on other practitioners within the medical centre from time to time. Margaret's medical management included comprehensive prescription drug therapy for her pain and other conditions. She was an engaged patient with a demonstrated capacity to

monitor her own health and the capacity to understand the responsible consumption of her medications.

6. Margaret was a qualified nurse and was employed as a nurse assistant at the McLeod Street Medical Centre.

7. On 11 September 2017 Margaret attended upon Dr Gynther, in company with her husband, clearly in distress and suffering from "*severe, acute, catastrophic pain*", She arrived prior to 8.30a.m. and at 8.35a.m. she was administered a 60mg intramuscular (IM) injection of morphine by a practice nurse when directed to do so by Dr Gynther. Margaret was sent home by the GP in the care of her husband. She remained sedated and bedbound for remainder of the day. Dr Gynther contacted Mr Cahill on three occasions during the day to check on Margaret, her last call was on or about 7.00pm. At around midnight Mr Cahill noted that Margaret "*did not seem right*" and was unable to detect her breathing.

8. At 1.09a.m. on 12 September 2017, some sixteen and a half hours after the administration of the IM morphine, Mr Cahill called Triple 0. Queensland Ambulance Paramedics arrived at 1.24a.m. Margaret was by then in cardiac arrest and conveyed to the Cairns Hospital and admitted to the Intensive Care Unit with multiple organ failure. She did not regain consciousness.

9. Margaret was pronounced deceased at 10.30a.m. on Wednesday 13 September 2017.

Issues for Inquest

10. The following issues were set for Inquest:

    1. The findings required by s.45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how they died and what caused their deaths.

    2. The circumstances surrounding Margaret Cahill's pain management including the administration to her of:

        I. Intramuscular morphine on 11 September 2017; and
        II. Tapentadol on 11 September 2017.

    3. Whether in all the circumstances the initiation of the emergency medical response by Margaret Cahills caregiver was sufficiently timely.

Relevant Legislation

11. Pursuant to s.45 of the *Coroners Act 2003* I must, if possible, make findings as to:

    a) Who the deceased person is;
    b) How the person died;
    c) When the person died;
    d) Where the person died; and
    e) What caused the person to die

12. I must not include within those findings any statement that a person is, or may be:

    a) Guilty of an offence; or
    b) Civilly liable for something.

13. Whilst I retain a discretion to conduct an inquest into a reportable death, I must be satisfied that it is in the public interest to do so. In deciding whether it is in the public interest to conduct an inquest I may consider:

    a) The extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future; and
    b) Any guidelines issued by the State Coroner about the issues that may be relevant for deciding whether to hold an inquest for particular types of deaths.

Standard of Proof

14. The particulars a Coroner must if possible find under section 45 need only be made to the civil standard but on the sliding Briginshaw scale. That may well result in different standards being necessary for the various matters a Coroner is required to find. For example, the exact time and place of death may have little significance and could be made on the balance of probabilities. However, the gravity of a finding that the death was caused by the actions of a nominated person would mean that a standard approaching the criminal standard should be applied because even though no criminal charge or sanction necessarily flows from such a finding, the seriousness of it and the potential harm to the reputation of that person requires a greater degree of satisfaction before it can be safely made.

15. The paragraph above was specifically contemplated by the Court of Appeal with apparent approval. The Court went on to state:

> *Two things must be kept in mind here. First, as Lord Lane CJ said in R v South London Coroner; ex parte Thompson, in a passage referred to with evident approval by Toohey J in Annetts v McCann: …an inquest is a fact finding exercise and not a method of apportioning guilt … In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use. Secondly, the application of the sliding scale of satisfaction test explained in Briginshaw v Briginshaw does not require a tribunal of fact to treat hypotheses that are reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not.".*

Witnesses appearing at Inquest

16. A total of nine (9) witnesses were called to give oral evidence at Inquest as follows:
    i. Mr Brian Cahill
    ii. Abigail Heath [Registered Nurse]
    iii. Dr Christopher Pitt [Royal College General Practitioners]
    iv. Professor Olaf Drummer [Forensic Toxicologist]
    v. Ms Dorothy Kelly
    vi. Dr Barbara Gynther [General Practitioner]
    vii. Dr Paull Botterill [Senior Staff Specialist Forensic Pathologist]
    viii. Dr Stephen Vincent [Consultant Thoracic and Sleep Physician]
    ix. Mr Mark Little [Consultant Clinical Toxicologist / Emergency Physician]

Background

17. Margaret worked consistently in paid and voluntary positions for the 38 years preceding to her death. Between 1992 and 1999 she worked as a State Enrolled Nurse in Cheltenham, Victoria. Thereafter she worked in administrative and marketing roles.

18. In March 2004, Margaret commenced work as a Medical Receptionist at the McLeod Street Medical Centre on a permanent casual basis. Between contracts her employer renegotiated the job description and duties with her. During her employment at the Medical Centre Margaret held various roles including:

    a) Nursing Assistant (January 2009)
    b) Medical and Clinical Assistant (from November 2012);
    c) Clinical and Clerical Assistant (2014)
    d) Assistant in Nursing – Grade 3 (from March 2015)
    e) Assistant in Nursing – Grade 3 (from July 2015)
    f) Assistant in Nursing – Grade 3 (from April 2017)

19. During her time at the medical centre Margaret did not obtain or renew her qualifications as an Enrolled Nurse however she did obtain various professional competencies including asthma management, blood glucose measurement, cold chain management and infection control.

20. At the time of her death Margaret remained employed as a Nurse Assistant although she was working reduced hours, and subject of a medical certificate exempting her from work, on account of her own health issues.

21. Margaret was described by Dr Gynther as hardworking, expressive, and a "*good, decent person*". In her first statement to the coronial investigation Dr Gynther also described Margaret as a '*valued colleague and friend'*.

22. During her employment at the medical centre there were two instances of workplace disputes.

23. The first instance arose in July 2013 and related to a variation in Margaret's working hours and a grievance with directions and management style of the then Practice Manager. Those issues were resolved in a meeting on 2 August 2013 during which an agreement was reached with respect of Margaret's work hours and how interactions between various staff members should be conducted.

24. The second instance arose in July 2015 and related to allegations of workplace bullying by Margaret. The matter was also resolved internally.

25. In relation to that second instance Dr Gynther advocated for Margaret. On at least one occasion Dr Gynther contacted Margaret out of hours to discuss the workplace issues.

26. It was necessary at Inquest to understand the ethical and professional responsibilities and boundaries relevant to the relationship between Margaret and Dr Gynther, and whether Margaret's medical management was compromised if so. I refer to those matters further in these findings.

Margaret's pain management

27. On 31 August 2017, following a consultation with Dr Gynther, Margaret was prescribed the following medications to assist managing her ongoing and quite severe neck pain:

- Palexia SR (200mg)
- Diazepam (5mg)
- Palexia SR (50mg)

28. Palexia SR is a 'brand name' for the drug Tapentadol, an opioid analgesic that is listed as a 'controlled drug' under Schedule 8 of the *Poisons Standard*, a legislative instrument that classifies various medicines.

29. Over the course of the next 10 days Margaret self administered those medications. Mr Cahill says he monitored the doses of Tapentadol as it was a new medication and he wanted to keep track of the times they were administered. Margaret achieved varying levels of pain relief over this time. The pain she was experiencing also interfered with the quality of her sleep.

30. On the morning of 11 September 2017, Margaret informed Mr Cahill that she was experiencing worsening pain, she described it "*like a knife in her back and shoulder*". As a result Mr Cahill initiated a call to Dr Gynther (at 7:11am). The circumstances of that call, and the nature of the information exchanged was a matter of evidence at inquest. However, on either Mr Cahill or Dr Gynther's evidence, I accept and find that Dr Gynther told Mr Cahill to bring Margaret to the medical centre straight away to be seen as her first patient for that day prior to her scheduled first consultation at 8.30am.

31. Mr Cahill and Margaret arrived at the Medical Centre at about 8:20am that morning. The circumstances of this consultation, and the nature of the information exchanged was a matter of evidence at inquest. On either Mr Cahill or Dr Gynther's evidence, I accept and find that Margaret was exhibiting symptoms consistent with genuine pain and as previously described to Dr Gynther by Mr Cahill.

32. Dr Gynther deposed:

> "*[she] walked into my room with her eye squeezed shut, guided by [Brian]. She was in extreme pain with a rigid neck. She looked extremely tired …*".

33. Mr Cahill deposed:

> "*Margaret was able to walk into the surgery pretty much unassisted. Margaret was hunched over a bit because of the pain and I held her hand and walked with her to the surgery … we met Dr Gynther in the hallway and went to her room*"

34. Margaret's pain, when she first entered the Medical Centre, was also observed by a Registered Nurse employed at the Medical Centre, Abigail Heath. Nurse Heath gave evidence at Inquest.

35. It is uncontested that as a result of this consultation, Dr Gynther made a clinical decision for Margaret to be administered 60mg of Morphine by way of intramuscular (IM) injection. In addition to the injection, Dr Gyther also prescribed Margaret 'Ordine' an additional 10mg/ml mixture (morphine hydrochloride) for "*pain breakthrough*". This was to be administered orally depending upon the timing and severity of returning pain symptoms, but only in consultation with Dr Gynther.

36. Dr Gynther did not administer the injection herself and instructed RN Heath to do so. The intramuscular morphine was administered at about 8:35am. After that injection Margaret was monitored by another Registered Nurse, RN Helen Sadler for about 15 minutes. During that monitoring period Mr Cahill attended the pharmacy located next door to the medical centre and purchased the Ordine. Mr Cahill was absent from Margaret for about 10 to 15 minutes. Upon obtaining the Ordine, he collected Margaret and they returned home (about 8:50am).

Margaret arrives home

37. The car ride home was between 20 and 30 minutes (arriving home between 9:10am and 9:20am). Mr Cahill physically assisted Margaret from the car to their bedroom where he says he placed her in the bed, pulled a sheet over her and left her in that position to sleep.

38. Margaret's son Robbie arrived soon after and he entered the bedroom to say hello to his mother. He recalls the bedroom being darkened and

the airconditioner on. He recalls his mother lying on the bed under covers flat on her back with her head on a pillow. His mother turned to him when he entered the room and said "*Who are you, what is going on*" Mr Cahill responded that it was Robbie and she then said "*Hello darling, how are you*". Robbie then left his mother to sleep because he was aware she was in significant pain. He recalls her voice being clear but slow (consistent with previous experience with his mother after she took significant doses of pain killers) and he was therefore not concerned. He later popped his head in to say goodbye by about 11.30a.m. and saw that she was sleeping.

39. Dr Stephen Vincent a Consultant Thoracic and Sleep Physician, in his oral evidence to the inquest identified that Margaret's presentation at this time was consistent with the effects of a CNS (central nervous system) depressant. He opines, if assessed against the Glasgow Coma Scale Margaret was then likely to be around 12 (out of a maximum of 15 eye, verbal and motor skills). Her cognitive function was intact, she was sleep deprived and the opioids by then would have been taking effect.

40. It is uncontested that as the day progressed, Dr Gyther made three calls to Mr Cahill to check on Margaret's progress. These calls were made at 9:30am, 4:08pm and 7:03pm. The circumstances of these calls, and the nature of the information exchanged, is referred to further in these findings. Mr Cahill deposed that he made regular checks / visual observations of Margaret during the day. Mr Cahill deposed that Margaret did not rouse again, she did not take in fluids, and in fact did not move from the position she was first placed in, during the 15 ½ hour period from arrival home at 9.30a.m to calling Triple 0 at 1.09a.m on 18 September 2017.

41. Mr Cahill went to bed at some point late in the evening but says did not go to sleep out of concern for Margaret. "*At some point around midnight*" he looked over to check on Margaret and observed that "*she just didn't seem right*". On closer examination he was unable to detect Margaret breathing. Mr Cahill initiated a call to the Queensland Ambulance Service (QAS) via 'Triple0'. That call was received at 1:09am on Tuesday, 12 September 2017.

42. Mr Cahill commenced cardiopulmonary resuscitation (CPR) as instructed by the operator. QAS Paramedics arrived at the house at 1:24am and took over CPR. Margaret was in cardiac arrest but responded to the administration of Adrenaline. Margaret was transferred to the Cairns Hospital where she presented to the Emergency Department at about 2:05a.m. and underwent further treatment and

examination. Blood tests revealed Margaret had multiple organ failure. She was admitted to the Intensive Care Unit (ICU) at 4:21am.

43. Notwithstanding further attempts at medical intervention Margaret did not regain consciousness and her condition continued to decline.

44. Margaret was pronounced deceased at 10:30am on Wednesday, 13 September 2017.

Medical History

45. Margaret was a heavy smoker for thirty years before ceasing in 2008.[1]

46. Margaret's health issues included, but were not limited to:

a) Lower back pain;
b) Acute cervical radiculotherapy;
c) Nerve root compression affecting the C6 vertebra of her spine (located in the neck);
d) Depression;
e) Asthma;
f) Type II diabetes non insulin dependent;
g) Iron deficiency resulting in anemia.

47. Additionally, Margaret was diagnosed with ulcerative colitis for which she underwent colectomy and ileostomy surgery in 1998.[2]

48. For the purposes the coronial investigation the most relevant health issue was the nerve root compression affecting the C6 vertebra. It was for this condition that Margaret was ultimately treated with opioid analgesics.

49. The first documented presentation in relation to Margaret's C6 nerve root compression was in November 2013. A subsequent MRI of the C6 (initiated by Dr Gynther) confirmed the presence of a bulging disc that was causing significant narrowing of the left C6 foramen.

50. The nerve root compression was initially treated with osteopathy. Following a "*flare up*" in June 2014 there was further conservative management.

[1] Letter of Dr Jessica Fulton dated 23/11/2016 per MSMC notes at page 302 of 319
[2] MSMC Patient Records at page 3 of 319

51. An additional flare up in January 2017 resulted in Margaret being treated with opioid analgesics.

52. In the month prior to her death (August 2017) Margaret's nerve root compression was further treated by way of CT-guided nerve root block, whereby a CT scanner is used to precisely identify the position of an injection of a local anesthetic and steroid to provide symptomatic relief.[3]

Pharmaceutical History

53. Upon review of Margaret's patient records from the Medical Centre it appears the first instance where she was prescribed pain medication was on 19 October 2009, by Dr Gynther.

54. Margaret's Pharmaceutical Benefit Scheme (PBS) prescription history, and clinical records, confirm that in the following years leading up to her death, she was prescribed Panadeine Forte and Temazepam on a recurrent basis. Both drugs are restricted drugs under Schedule 4 of the *Poisons Standard* and can only be obtained on prescription.

55. The clinical records did not always articulate a rationale for her continued prescribing with the drugs Panadeine Forte and Temazepam. In some instances, the drugs were prescribed upon email request from Margaret, without consultation. There were also instances where requests for prescription were made by other employees (on behalf of Margaret), again without consultation.

56. Noting as I have that the issue with respect of the nerve root compression of the C6 vertebra was first documented in November 2013, it was not immediately apparent what the clinical basis for the prescription of Panadeine Forte had been in the preceding four years.

57. For the period between June 2014 and January 2017, it appeared from the Medical Centre records that there was a period of dormancy with the C6 vertebra, however in January of 2017 there was a "*flare up*". Following that flare up, Margaret was treated with opioid analgesics.

58. These prescribing practices and the recurrent nature of the prescriptions enlivened relevant considerations for the coronial investigation, including:

[3] MSMC Patient Records at page 3 of 319

a) Whether the basis for continued treatment with those drugs was adequately disclosed;
b) Whether Margaret may have been 'drug dependent'; and
c) Whether the manner the prescriptions were obtained were appropriate.

Prescribing and Monitoring of Tapentadol (Palexia SR) to Margaret Cahill prior to 11 September 2017

59. On 24 July 2017 Margaret consulted with Dr Gynther in relation to her cervical radiculopathy. During that consultation Margaret disclosed that she had been experiencing severe left arm and neck pain for which she had attended the Cairns Hospital on 22 and 23 July 2017. She had been prescribed Endone (oxycodone) that had alleviated her pain symptoms.

60. It was apparent that Mr Cahill was present during this consultation as the progress notes document a concern raised by him regarding Margaret's use of Endone. Dr Gynther reassured him with respect to that medication. She prescribed Oxynorm 10mg capsules to be taken after meals after 4-6 hours for severe pain. Dr Gynther also arranged for an MRI, it appears this was the first MRI since 2013 to detect what if any changes in the C6 may have been precipitating Margaret's pain in this instance.

61. On 31 July 2017 Margaret had a further consultation with Dr Gynther in relation to the C6 nerve root compression (cervical radiculopathy). Margaret disclosed that the pain was "*dragging on*" but she was taking Panadeine Forte only as she was "*not willing to risk the oxycontin away from home*". This was an example of Margaret's ability to self-regulate her use of medication, as identified by Dr Pitt (an expert engaged by the Coroners Court to review the care and treatment provided by Dr Gynther to Mrs Cahill).

62. A treatment pathway was developed for Margaret that involved an image guided nerve root steroid injection to the C6.

63. The nerve root injection was performed on 10 August 2017 at the Cairns Hospital.

64. On 14 August 2017, Margaret sent the following email to Dr Gynther:

> "*Hi Barb, all went well on Thursday. A bit traumatic and painful, but fairly good result Had 2 panadeine Forte before bed around 10.00p.m. and slept till around 2.00am for pee. Back to sleep till 5.30am. Very happy. I'd say the result is around 80% better. Just a low grade ache in the left shoulder and neck. Managing on panadeine forte 6- 8 hrly. Results and report from OLD XRay should be in later today. If you have a chance I need a script for the hormone patches, not urgent*
> *Thanks again my saving angel.*"

65. The nerve root injection provided relief for a period of time.

66. On 31 August 2017, Margaret attended Dr Gynther in relation to her nerve root compression. Dr Gynther documented: "*Marg in tears, beyond coping – pain*". Margaret was then prescribed the following:

    a) Diazepam (sedative / muscle relaxant) 5mg Tablet (50) – 2 tabs once home
    b) Palexia (tapentadol) SR 200mg Tablet (28) – 1 tab 12 hourly for severe pain
    c) Palexia SR 50mg Tablet (28) – 1 tab one hour after the Palexia 200mg if still severe pain

67. This was the first occasion Margaret was prescribed Palexia although it was not the first time she had been prescribed or administered opioid analgesics. I refer to the following matters deposed to by Dr Gynther as to her clinical basis for prescribing the Palexia:

> "*Mrs Cahill had a known opioid tolerance. Over my years of care for Mrs Cahill, she was reliant on Panadeine Forte 8 tablets per day to manage her chronic and debilitating pain. This equates to Codeine Phosphate 240mg daily. Prescribing a lower starting dose of Tapentadol in light of this would have provided ineffective medical management of a patient with severe and debilitating pain, at a level that I had never observed her experience before, and for which she declined to present to Hospital and was unable to be reviewed by a specialist orthopaedic surgeon for a number of days. It was for this reason that on 31 August 2017, I provided Mrs Cahill with a prescription for Tapentadol 200mg slow release to be taken twice daily and a prescription for Tapentadol 50mg slow release to be taken as a dosage of 1 tablet one hour after the Palexia 200mg if Mrs Cahill was still experiencing severe pain*"

68. Relevantly, a progress note on the same date, and timed at 5:45p.m recorded details of a follow up telephone call made by Dr Gynther to Margaret:

> "*marg took meds at 2 .30 PM, still weeping with pain*
> *so told her to take another200 mg, I will ring in an hour. Brian not home yet, will be soon.*"

69. Mr Cahill deposes that "*because of these new medications*" he commenced a running diary of the medication that Margaret was taking so that he could keep track of how much had been administered and the time between doses.

The Medication Diary

70. I **find** that the diary maintained by Mr Cahill is not a document upon which I can rely. The evidence bears out that notations were not made contemporaneously.

71. Apart from strike throughs and alterations, the timing of the Tapendatol on 31 August cannot be accurate noting that Margaret spoke with Dr Gynther who recorded in progress notes at 5.45pm that Margaret took 'meds' at 2.30pm and Dr Gynther told her at about 5.45p.m. during a phone discussion to take another 200mg. Mr Cahill was not then home.

72. Mr Cahill's evidence at inquest was that he personally administered every tablet of Tapendatol to Margaret. Dr Gynther deposes she was not aware of this level of engagement by Mr Cahill and it was not necessary noting Margaret's capacity to medically manage herself, and her medications.

73. Margaret maintained her employment until 31 August 2017, and thereafter due to her opioid therapy, she chose to no longer work and became more housebound in order to manage her periods of sedation.

74. Mr Cahill had not previously kept a diary for any of Margaret's drug therapy, notwithstanding Margaret's extensive and long-term prescription medication regime. At inquest the following descriptions were applied to her:

    i. Very responsible with medications (by her husband);
    ii. A '*law unto herself*' who would '*know what was best for herself*' (by work colleague and friend Dorothy Kelly);

iii. An ability to manage her own medication and an understanding of the interaction between medications (Dr Gynther).

75. I am of the view that whilst Margaret was capable and responsible in relation to her medication, she was also reliant on her husband. He was actively engaged with her medical appointments. He made all efforts to ensure appointments when referrals were made (noted in the GP progress notes) and he assisted Margaret at home including trying to massage painful areas to provide her relief. He presented as having a sound general knowledge of Margaret's medical issues and her treatment and medication. He contacted Dr Gynther when Margaret was intolerable pain (also noted in the GP progress notes).

76. Of the Tapentadol prescribed on 31 August 2017, Mr Cahill documented that 6 Palexia SR 50mg had been administered, and 22 Palexia SR 200mg.

77. Whilst the first page and entries of that diary is not dated it likely referred to doses administered on 31 August 2017 as this was the first occasion Margaret was prescribed the medication and the next entry was dated 1 September 2017.

78. The first entry documents the following administration of Diazepam and Palexia:

2:30	Diazepam 5mg x 2 Paxeia SR 200mg x 1
3:45	Palexia 50mg x 1 (I note this entry appears to have initially read as 5.45)
5:15	Diazepam 5mg x 2 Palexia SR 200mg x 1
7:00PM	*As instructed by Dr + if necessary if the pain does not ease crush 1 x Palexia 50mg + take with jam etc.*
7:50	*1 x Palexia SR 50mg crushed with jam*

79. With the benefit of Dr Gynther's progress notes I find these entries could only have been written by Mr Cahill retrospectively, based on information that was provided to him by Margaret. Dr Gynther's progress notes record that Mr Cahill was not home at 2.30pm or 5.45.

80. The final entry, referring to the crushing of 1 x Palexia 50mg in jam requires additional comment. Dr Gynther's progress notes make no

reference to this form of administration. In her statement Dr Gynther deposed she did not give advice about crushing the medication on 31 August 2017. She did however make such a suggestion on 7 September 2017 in the context of an additional presentation by Margaret.

81. Mr Cahill's medication diary reflects that between 1 September 2017 and 5 September 2017, Margaret continued to administer Diazepam 5mg and Palexia 200mg within the 12 hour cycle, as prescribed. Relevantly, there was only one subsequent occasion when Margaret administered a 'top up' dose of Palexia SR 50mg, at 12am on 2 September 2017. This entry suggests it may originally haven been written as 7am but overwritten as 12am. This tends to reinforce a view that these entries were not always contemporaneous with the administration of the medication.

82. These notes also suggest Margaret was likely achieving some therapeutic benefit from the Palexia SR 200mg on its own as she was not regularly using the 50mg top up dose.

83. There was a change in Margaret's condition on 6 September 2017. Mr Cahill's medication diary, documents the following:

6:30AM	Diazepam 5mg x 2 Paxeia SR 200mg x 1
6:30pm	NONE

84. I note the following progress note created by Dr Gynther the following day (7 September 2017):

> "*phone call 30 min ago Marg sobbing in background.* ***Mr Cahill told me*** *[my emphasis] the pain had flared severely after massage and acupuncture yest. pm. req i contact Dr Morrey again running out of the 50 mg palexias*"

85. It is not apparent on the progress note, what time that telephone consultation occurred.

86. Mr Cahill's medication diary for 7 September 2017 is as follows:

1200	Diazepam 5mg x 2
~~06 50~~ AM	Paxeia SR 200mg x 1
0100	Palexia SR 50mg x 1 Crushed up in jam

11.45	Palexia SR 200mg x 1 Diazepam 5mg x 2
~~11~~ 12.40PM ~~12;40AM~~	Palexia SR 50mg x 1 Crushed into jam
8:40PM	Diazepam 5mg x 2 Paxeia SR 200mg x 1

87. It was apparent from the entries on this day that there changes to time entries and reinforces my view that the entries were not contemporaneous with the administration of medication.

88. Following this telephone consultation, Dr Gynther developed the following treatment plan:

> ***Dose of Palexia SR 50mg Tablet changed from 1 tab one hour after the Palexia 200 mg if still***
> ***severe pain to 1 tab extra if still severe pain****. [my emphasis]*
> *Prescription printed: Palexia SR 50mg Tablet (Tapentadol hydrochloride) 1 tab extra if still severe*
> *pain*
> *Letter written to Dr Chris Morrey re. Severe again.*
> *Letter to Dr Chris Morrey printed.*

89. Dr Gyther's letter to Dr Morrey of 7 September 2017 is the first and only occasion she referred to the 50mg Palexia being crushed. Dr Gynther deposed as follows:

> "*I mentioned the crushing of the tablet in my letter of request to Dr Morrey to bring Mrs Cahill's appointment forward. The reason why I suggested that she crush the 50mg tablet was because due to the complete removal of her colon, and dependence on an ileostomy bag, Mrs Cahill had a rapid gut transit time, such that I was concerned that the 200mg SR tablet would not in fact yield that full dose to Mrs Cahill as it was quickly excreted*"

90. Dr Gynther's letter to Dr Morrey read as follows:

> *Dear Dr Morrey,*
>
> *Margaret seemed to be managing with Palexia 200 mg SR, bd, some episodes of the 50 mg SR, crushed- for extra analgesia, and a lot of diazepam,*

Today, after a massage and acupuncture yesterday afternoon, she is in agony again. Her husband is going to contact your office, and I have advised him to dose her up again with another crushed 50 mg, repeated after an hour if necessary.

I would be grateful if you are able to see her any sooner that you have already kindly fitted her in.

91. Whilst a prescription for Palexia SR 50mg was written by Dr Gynther on 7 September 2017, it was ultimately never dispensed. I am not informed of the circumstances as to why that prescription was not dispensed. Mr Cahill has not deposed to any of the events on 7 September 2017 and the medication diary does not refer to the telephone consultation with Dr Gynther in this instance or the change to the timing of the administration of the Palexia SR 50mg in relation to the 200mg.

92. I **find** that Dr Gynther's progress notes are a truthful and accurate reflection of the matters discussed during the call on 7 September 2017.

93. If I was to accept the medication diary as accurate then I must also accept the following:

a) There was a failure to administer any pain relief to Margaret (whether by herself or her husband) on the evening of 6 September 2017, notwithstanding that she was experiencing a "*severe*" pain flare up in response to massage and acupuncture that afternoon; and

b) Depending on when the telephone call to Dr Gynther was made, Margaret had been administered no more than 5 of the Palexia SR 50mg tablets that had been originally prescribed to her six days earlier (on 31 August 2017). This meant Margaret would have had a further 23 tablets still available to her and therefore should not have been low on supply.

c) Regardless of the time the telephone call to Dr Gynther took place, the administration of the Palexia SR 50mg dose on 7 September 2017 reflects the original prescribing pattern of 31 August 2017, namely "*1 tab one hour after the Palexia 200mg if still severe pain*" and does not reflect the change that was made Dr Gynther removing the requirement to wait one hour after administering the Palexia SR 200mg before administering the 50mg.

d) At 8:40pm on 7 September 2017, Margaret was administered a dose of Palexia SR 200mg less than 12 hours after the earlier dose. The dose would have been administered some 9 hours after the earlier dose (documented as 11:45[pm]) contrary the instructions as issued on 31 August 2017. It is additionally concerning that Margaret administered a top up dose of Palexia SR 50mg in that intervening 9 hour period.

94. Between 7 September 2017 and 11 September 2017, Mr Cahill's medication diary records only one further occasion when Margaret was administered a 'top up' dose of Palexia SR 50mg, being at 4am on 10 September 2019. Mr Cahill deposes that Margaret was still experiencing pain at this time, following an earlier administration of Palexia SR 200mg at 6:45pm on 9 September 2017, and on that basis the 50mg dose was administered.

95. Mr Cahill deposes that Margaret took her "*normal*" dose of Palexia SR 200mg on 10 September 2017 but during that night Margaret "*was in a lot of pain and woke up crying at times. I tried to massage her neck to relieve that pain however that didn't seem to have any effect*".

Attendance on General Practitioner 11 September 2017

96. Mr Cahill maintains in his evidence that "*At 6:45am on the 11th of September 2017 Margaret had her normal prescription of 2 tablets of Diazepam and 1 tablet of 200mg Palexia*".

97. The first entry in the medication diary for 11 September 2017 appears to read as 6:05am (and not 6.45a.m. as was adopted at inquest).

98. And further "*After this dose Margaret told me that her pain was still getting worse. Margaret described it like a* ***knife in her back and shoulder*** *. At 7:11am I rang Dr Gynther on her mobile. I said words to the effect 'Margaret has is (sic) still in a lot of pain all night and didn't sleep. I've given her medication at 6:45am and it's not working*"

99. Mr Cahill remain steadfast during oral evidence and maintained the accuracy of the version he provided to the Queensland Police after Margaret's death.

100. If I am to accept the medication was administered at 6:45am as deposed, then I must also accept:

a) There was a period of only 26 minutes that allowed for the medication to take effect (before calling the doctor); and
b) There was no attempt to administer a top up dose of Palexia SR 50mg, medication that would have still be available to Margaret at that time, would have been consistent with the prescribing instructions, and arguably had demonstrated some effectiveness based on earlier entries in Mr Cahill's medication diary and the clinical progress notes.
c) That despite the suffering experienced by Margaret during the preceding evening the diary does not reflect any administration of Palexia 50mg as provided for by Dr Gynther for breakthrough pain. Mr Cahill cannot explain why Palexia had not been administered to Margaret.

101. It is uncontroversial that a phone conversation did take place between Mr Cahill and Dr Gynther. Dr Gynther deposes to the following:

> "*On 11 September 2017 at approximately 7.15am, I received a phone call from Mr Cahill who informed me that Mrs Cahill had experienced another sleepless night as a result of* ***extreme neck and left arm pain*** *[my emphasis]. Mr Cahill advised me Mrs Cahill's appointment with Dr Morrey had been brought forward to Wednesday morning, 13 September 2017 (two days away). I advised Mr Cahill that Mrs Cahill should present straight away to McLeod Street Medical or to the Cairns Base Hospital. I asked Mr Cahill what medication Mrs Cahill had ingested.*
>
> *Mr Cahill stated that Mrs Cahill had taken two (2) Diazepam. I specifically recall that I asked Mr Cahill if Mrs Cahill had taken any medication other than Diazepam. I did so with the knowledge that I had recently prescribed Mrs Cahill Tapentadol for her recently aggravated, severe pain. Mr Cahill confirmed that she had not. I advised Mr Cahill that Mrs Cahill should come straight to McLeod Street Medical and not take any other medication. I advised that I would see Mrs Cahill as my first patient for the day.*"

102. The evidence deposed to by Mr Cahill and Dr Gynther is crucially at odds with respect to whether or not Dr Gynther was fully informed of the nature of the medication that had been administered to Margaret that morning.

103. It is uncontroversial that Margaret and Mr Cahill both attended in person at the Medical Centre for the consultation with Dr Gynther. Dr Gynther places this consultation at 8:20am. Mr Cahill does not depose to the time but states he went there "*straight away*" after the call.

104. Once in the consultation, Mr Cahill deposed to the following conversations:

> "*Dr Gynther, Margaret and I spoke about seeing the specialist [Dr Morrey] on Wednesday. Dr Gynther said words to the effect 'if the current medication isn't working then I can give you an injection of morphine for the short term and an oral dose to take as needed'. Dr Gynther also suggested giving Margaret Amaxalon for anti-nausea. I believe that Dr Gynther medtion (sic) that it would be a 60mg dose and that the morphine was only for a short term period. The oral dose of the liquid morphine that she prescribed was 12mls*."

105. Dr Gynther deposed to the following:

> "*I recall asking Mrs Cahill what medications she had taken that morning. Mrs Cahill indicated that she had only taken two (2) 5mg Diazepam. I asked again whether Mrs Cahill had taken* ***any other medication****. I was advised that she had only taken Diazepam and nothing else. This is reflected in my consultation note for 11 September 2017, which provides "...Has already had 2 of 5mg Diazepam". Therefore, it was my understanding that Diazepam was all that Mrs Cahill had consumed prior to the consultation, and that she had not taken any opioid medication for at least 12 hours*"

106. I find that Dr Gynther's contemporaneous progress notes from this consultation are consistent with the conversation she deposed to having. I reproduce that progress note in full:

> "*Medical Certificate given from 07/09/2017 until15/09/2017.*
> *Prescription printed: Ordine 10 mg/mL Mixture(Morphine Hydrochloride) 12 mls 2 hourly for pain breakthrough*
> *Ferrograd C 325mg;500mg Tablet ceased.*
> *Morphine 60 mg IMI and 10 mg maxolon*
> *Has already had 2 of 5 mg diazepam.*
> *Prescription printed: Maxolon 10mg Tablet(Metoclopramide Hydrochloride) 1 tds prn for nausea*
>
> *Marg/ Brian rang 7.15 this am re Marg no sleep, Extreme neck and left arm pain.*
> *Appt Dr Morrey has been brought forward to Wed morning ie 13th*

Said come straight in/ Other option is CBH
8.20 am
Brought in by Brian.
In a bad way.
neck muscles very tight again.
Analgesia as above, I will contact her this evening by phone, Brian to ring me if need."

107. After the consultation Dr Gynther prepared the scripts for 60mg morphine and Ordine 10mg/ml. Dr Gynther instructed RN Heath to administer the morphine. RN Heath deposes that she verified those instructions as she considered the 60mg dose to be high. Dr Gynther agrees that "*Mrs Heath queried the dosage of morphine with me. I instructed that a higher dose was required as a result of Mrs Cahill's severe pain and opioid tolerance*".

108. RN Heath deposed that both Mr Cahill and Margaret entered the room.

> "*I continued to prepare the medication, ensuring the correct needles, drugs, doses and client, and noted the medications in the [Medical Centre] Controlled Drugs register (stock count). Dr Gynther returned to the room and handed Mr Cahill a prescription and said to him "you can fill this next door before you take Margie home" [referring to the pharmacy next door to the Medical Centre]. I did not know what this prescription was for. At that time, I asked Dr Gynther to check the drugs and doses that I had prepared and she did so. She agreed that what I had prepared accorded with what she had prescribed*".

109. RN Heath adminstered the dose at 8.35a.m and was not aware of Margaret potentially having been administered Tapentadol or Diazepam at an earlier time. RN Heath deposes:

> "*As a general practice nurse in a private setting, it was not my role to check a patient's medication history prior to their administration (based upon a doctor's orders). This is something that a doctor would ordinarily check*".

Medications Located at the Redlynch Residence

110. On 13 September 2017, officers with the Queensland Police Service photographed medication at the Redlynch residence. Police located the

bottle of 10mg/ml Ordine that had been prescribed and dispensed on 11 September 2017, it was unopened.

111. In relation to the Tapentadol that was prescribed on 31 August 2017, Police located a box of Palexia SR 50mg (28 tablets); and a box of Palexia SR 200mg (28 Tablets) on the kitchen bench. Both boxes were labelled, confirming they had been prescribed to Margaret, by Dr Gynther on 31 August 2017.

Box of Palexia SR 50mg (28 Tablets) containing:

- 3 x Blister sheets each holding 7 tablets (a total of 21 tablets)
- 3 Tablets had already been dispensed from one sheet only leaving 18 tablets remaining

112. A fourth blister sheet of Palexia SR 50mg was located in Margaret's bedside table. 3 Tablets had been dispensed from it meaning there were 4 tablets remaining. In relation to this sleeve of medication I find that it was not accessed by Margaret at any time after her return on home on 11 September. It's location buried in the bedside drawer was not suggestive of any recent access.

113. These six tablets (dispensed) would reconcile with Mr Cahill's medication diary.

Box of Palexia SR 200mg (28 Tablets) containing:

- 2 x Blister sheets each holding 7 tablets (a total of 14 tablets)
- 6 Tablets had already been dispensed from 1 sheet and tablet from the other leaving 7 tablets remaining

114. In the case of the Palexia SR 200mg there should be another two blister sheets to account for 28 tablets. Three possibilities are therefore open to me:

a) All of the 14 tablets that had been on those blister sheets had been dispensed and the blister sheets discarded, meaning a total of 21 tablets had been administered;
b) None of the 14 tablets on those blister sheets had been dispensed and they cannot be accounted for, in which case only 7 tablets were ever administered; or

c) Some, but not all of the 14 tablets on those blister sheets had been dispensed and the remaining tablets cannot be account for, in which case no less than 8 but no more than 21 tablets were ever administered.

115. On any of those possibilities Mr Cahill's medication diary does not reconcile as it records a total of 22 of these tablets being administered, one **extra** (my emphasis) than can be accounted for. There is the possibility therefore that one of the 200mg tablets, documented by Mr Cahill as having been dispensed, was in fact not dispensed. This further adds to my concern regarding the (in)accuracy of the diary, giving rise to the likelihood of its reconstruction after events have taken place.

Post -mortem examination and toxicology results

116. An external and internal autopsy was performed by Senior Staff Specialist Forensic Pathologist, Dr Paull Botterill on 14 September 2017.

117. At 1.67m height and 97.6kg weight, Margaret had a body mass index (BMI) of 35 kg/m².

118. The external examination did not identify any signs of recent significant injury. The only evidence of internal injury subcuticular hemorrhage over the anterior upper chest wall and multiple anterior rib fractures. Dr Botterill opined these were consistent with resuscitative chest compressions and I find that to be the case. No other internal injuries were identified.

119. The internal macroscopic examination was largely unremarkable, although the following features warrant comment:

a) Margaret's heart weighed 482g, which was greater than 'normal limits';
b) Her lungs had features of congestion and expressible oedema;
c) Her liver was markedly congested; and
d) Her kidneys were pale, but otherwise unremarkable.

120. Subsequent microscopic examination confirmed a serious lung infection and congestion, some heart muscle scarring and fatty liver change.

121. Of relevance were the results from an ante-mortem blood sample, taken at 2:33am on 12 September 2017 after Margaret presented to the Cairns Hospital:

Analyte	Result
Alcohol	Not detected (less than 10mg/100ml)
Diazepam	0.17 mg/kg
Nordiazepam	0.06 mg/kg
Total Morphine (Morphine plus Morphine Glucuronides)	1.1 mg/kg
Citalopram	0.20 mg/kg
Desmethylcitalopram	0.03 mg/kg
Lignocaine	Detected < 0.1 mg/kg
Metoclopramide	0.12 mg/kg
Tapentadol	0.43 mg/kg

122. Dr Botterill identified that the Tapentadol was of itself in the potentially lethal range. With respect of the presence of the other drugs, Dr Botterill commented as follows:

> "*Although none of the other individual medications and substances identified on toxicological analysis was at a level sufficiently high to result in death in isolation, it is likely that there was a more-than-additive accentuation of the respiratory depression associated with multiple analgesic and sedative agents, in turn leading to the development of pneumonia and other organ impairment*"

123. The cause of death was then given as:

> 1. DIRECT CAUSE:
> Disease or condition directly leading to death:
>
> *(a)* ***MULTIPLE DRUG (Tapentadol, Morphine, Diazepam, Citalopram) INTOXICATION***

124. I accept and adopt that cause of death for the purpose of these findings.

Review of care and management provided by Dr Gynther – [Dr Christopher Pitt expert report]

125. To understand the ethical and professional considerations that were interwoven with Margaret's clinical treatment and her prescription history I requested and was provided a report by Dr Christopher Pitt, a specialist in GP practice.

126. Dr Pitt holds appointments with the Royal Australian College of General Practitioners (RACGP) Qld as the Assessment Panel Chair, Faculty Executive and Council Member. He also holds an appointment with the national RACGP body's Council of Assessment. Dr Pitt continues to practice as a GP and holds a number of teaching positions.

127. Dr Pitt is an independent expert and does not have any personal or professional relationship with either Dr Gynther, or Margaret.

128. In preparing his report Dr Pitt had access to a statement that Dr Gynther had prepared in relation to her treatment of Margaret, contemporaneous clinical notes spanning Margaret's full treatment history at the McLeod Street Medical Centre, a copy of Margaret's PBS schedule and a report by Associate Professor Peter Pillans prepared on behalf of Dr Gynther and attached to her statement.

129. The statement of Dr Gynther and the report of Associate Professor Pillans were both prepared independently of the Coroner's Court (via her lawyers).

Terminology

130. There has been an evolution in the terminology used in the context of 'drug dependence' and 'addiction', and Dr Pitt emphasizes that those terms and others can sometimes be conflated [when they should not be], or simply confused with each other.

131. In strict terms, Dr Pitt identifies 'dependence' as a pharmacological state that develops during chronic drug treatment in which drug cessation elicits an abstinence reaction (withdrawal). In Queensland, the term 'drug dependent person' is defined by the *'Health Act 1937*' as a person:

> a) *who as a result of repeated administration to the person of controlled or restricted drugs or poisons –*
> *i. demonstrates impaired control; or-*
> *ii. exhibits drug-seeking behavior that suggests impaired control; over the person's continued use of controlled or restricted drugs or poisons; and*
> b) *who, when the administration to the person of controlled or restricted drugs or poisons ceases, suffers or is likely to suffer mental or physical distress or disorder.*

132. 'Dependence' is different to 'tolerance'. The latter refers to the response a person may develop to a drug dose, whereby over time an increased

dose of the drug may be required in order to achieve the same affect originally produced by the lower dose.

133. Dr Pitt identifies that 'dependence' and 'tolerance' are different to the concept of 'addiction'. The concept of 'addiction' has since been superseded by the disease entity of 'substance use disorders' the criteria for which are set out in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

Prescribing Practices

134. For the period between 5 March 2012 and 3 April 2017 (1964 days) a total of 18 prescriptions for Pandeine Forte were dispensed to Margaret by Dr Gynther. This amounted to a total of 4100 tablets, noting that there were multiple occasions where one prescription might account for more that 200 tablets on a single occasion.

135. Margaret's average daily use was therefore 2.1 tablets per day which is below the recommended daily dosage (eight per day).

136. For the period between 23 July 2012 and 28 July 2017 (1873 days) a total of 23 prescriptions for Temazepam (a benzodiazepine to induce sleep) were dispensed to Margaret by Dr Gynther. This amounted to a total of 575 tablets.

137. Margaret's average daily use was therefore 0.3 tablets per day which is below the recommended daily dosage (no more than three tablets per night).

138. Upon review of that information, Dr Pitt was of the view that Dr Gynther's prescribing practices to Margaret were neither excessive nor inappropriate.

139. Dr Pitt acknowledged that in some instances, prescriptions were sought (by email) and obtained without consultation, however as a starting proposition, it is lawful for any general practitioner in Australia to provide continuing prescriptions to a patient without having a consultation including those drugs that are classified as Schedule 8 under the *Poisons Standard*. Notwithstanding that a consultation is not lawfully required in order to prescribe, there are clinical considerations that must still be brought to bear, including:

- Avoiding polypharmacy;

- Reviewing patients on long-term medications; and
- Being aware of "*drug-seeking*" behaviour.

140. In that regard Dr Pitt considered that by virtue of Margaret being an employee of the Medical Centre, there was capacity for Dr Gynther (and other medical practitioners) to monitor Margaret to a greater extent than would be afforded to other patients, on an almost daily basis.

141. Dr Pitt acknowledged that the prescribing of medication to Margaret (or any patient), outside of a formal consultation setting, could to a layperson, appear irregular or contrary to norms. However, it was Dr Pitt's opinion that such a practice was reasonable, subject to the use of clinical considerations as discussed above, and that in Dr Gynther's case, her use of such prescribing practices were of an acceptable standard, and in accordance with peer professional opinion.

Was Margaret Cahill a 'Drug Dependent' Person

142. Using the definition of 'drug dependent', as provided in the *Health Act 1937*, and having the benefit of Margaret's PBS schedule and GP progress notes, Dr Pitt formed the opinion that Margaret was not a 'drug dependent' person. He states:

    a) *I do not consider that Ms Cahill's pattern of use of either Panadeine Forte, temazepam, or any of the other medications prescribed to her demonstrated impaired control.*

    b) *Nor do I consider, based on the information available to me, that Ms Cahill exhibited drug-seeking behaviour that suggested impaired control.*

    c) *While it is likely that Ms Cahill would have suffered mental or physical distress or disorder if her analgesic medications were ceased, that would have been due to the persistent C6 nerve root impingement, and not the withdrawal of the medication.*

143. Dr Pitt was also of the opinion that Margaret had demonstrated a capacity to voluntarily reduce her dose of the medications Panadeine Forte and Temazepam when not required and there was no evidence to suggest that she experienced any reaction upon cessation of medication.

144. Dr Pitt was also of the opinion there was no evidence that Margaret suffered from a substance abuse disorder, as defined in the DSM-5.

145. Margaret was Dr Gynther's patient from 2008, first presenting with severe pain in May 2010, and various muscular aches and pains sporadically every year thereafter. I note it was the progression of a painful disc bulge condition that ultimately bought Margaret to Dr Gynther on 11 September. From the records Margaret experienced quite a rapid decline into acute pain from the time of her CT guided nerve root injection on 10 August. By then her drug therapy had progressed from (amongst other medication); Panadeine Forte to IM Morphine 30mgs (2012) Oxynorm / Endone to a combination of Tapendatol (from 31 August) and 'a lot of diazepam (to use Dr Gynther's words)'.

Professional and Personal Boundaries

146. A robust doctor-patient relationship is at the core of all good medical care. The relationship between individual doctors and patients will be unique.

147. Professional boundaries define the limits of a relationship between two people.

148. Professional boundaries more often exist on a spectrum as opposed to being "*lines in the sand*". The 'harmful and exploitative' end of that spectrum is more recognizable to most whereas the 'milder' end of the spectrum may require more interpretation.

149. Notwithstanding a level of ambiguity that exists at different parts of the spectrum, Dr Pitt identifies that whilst 'boundary crossings' may be identified as those which transgress the "*strictest definition*" of the limits of a professional relationship, this does not mean that every boundary crossing is 'exploitative'. In instances where a professional may have gone beyond the limits of their relationship with their client, those boundaries might be further broken down into three of the following categories:

    a) Non-exploitative;
    b) Potentially exploitative; and
    c) Boundary violation

150. The Medical Board of Australia provides guidance in relation to professional boundaries. Section 3.14 of their Code of Conduct provides:

> "*Whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship. In most cases, providing care to* ***close friends, those you work with and family members is inappropriate*** *because of the lack of objectivity, possible discontinuity of care, and risks to the doctor and patient. In some cases, providing care to those close to you is unavoidable. Whenever this is the case, good medical practice requires recognition and careful management of these issues*"

151. Dr Gynther was alive to this issue. In her December 2018 statement she deposes:

> "*I had taken steps to encourage Mrs Cahill to see a different GP other than myself, particularly when issues arose with respect to workplace harassment in her role as a nurse at McLeod Street Medical. Mrs Cahill did attend another GP at a different medical practice for a period of time, but advised me that she was not entirely happy with their treatment of her and pleaded that I continue to treat her. I was concerned that Mrs Cahill would not have appropriate medical management of her complex medical problems if I refused to treat her at the time. Consequently, Mrs Cahill continued to be treated by various GPs at McLeod Street Medical … However, I accept that this arrangement was not in accordance with clause 3.14 of the Code. I am highly committed to avoiding such treatment relationships in the future unless they are unavoidable*."

152. Whilst Dr Gynther herself considered that her treatment of Margaret had not met the standard required of her by the Code of Conduct, Dr Pitt, in his independent review of the matter took a broader, and different view of the situation in which Dr Gynther was placed.

153. Dr Pitt opined:

> "*I do not consider that Dr Gynther's provision of care to Ms Cahill was improper or inappropriate, nor do I consider that Dr Gynther's performance was below the acceptable standard of care as determined by peer professional opinion.*"

154. Dr Pitt based his opinion on the following factors:

- Dr Gynther's overall successful management of Margaret's chronic medical problems;

- Dr Gynther's successful management of sudden escalations of those conditions;
- Encouragement given by Dr Gynther to Margaret to seek alternative GP care; and
- Margaret exercising patient autonomy when accessing treatment from Dr Gynther.

155. Dr Pitt also considered there was no evidence of any exploitative aspect to the treatment provided to Margaret and that Dr Gynther's treatment was very much in accordance with the standard of her peers. To the contrary, Dr Pitt was of the opinion that Margaret ultimately achieved stable, optimum and beneficial management of her chronic conditions through her therapeutic relationship with Dr Gynther.

156. Dr Pitt further considered that the relationship that did exist between Dr Gynther and Margaret was not that of a "*close personal relationship*" for the purposes of the Code of Conduct. Dr Pitt comments:

> "*In the specific context of [Margaret] and Dr Gynther, while there was a dual therapeutic and collegiate relationship, there remained a specific power and role differential. Dr Gynther and [Margaret's] relationship appears to have been more platonic than close. Also, Dr Gynther and [Margaret's] relationship was not personal, but professional*"

157. Contrary to Dr Pitt's analysis, and with the benefit of a broader perspective obtained via the inquest process, I have reservations about the doctor patient relationship in this case. relationship.

158. By 11 September Dr Gynther in her own words, considered Margaret a '*valued colleague and friend of mine*'. In Dr Gynther's oral evidence when questioned about Margaret's practice of requesting scripts for her and her son Robbie without a consultation (via internal emails at the medical centre during her periods of employment) Dr Gynther volunteered in oral evidence that it was ' *a slight nudge of the boundary*' and that she '*wouldn't do this for very many other patients at all'*.

159. I am of the view that by 11 September, and for some time prior, the relationship between Dr Gynther was enmeshed (perhaps to a degree that Dr Gynther did not appreciate) and had become blurred. Margaret was a patient, she was also an employee, and she was considered by Dr Gynther to be a friend. Dr Gynther supported and advocated for Margaret during internal workplace disputes. Margaret pleaded with Dr

Gynther to continue to treat her, apparently not trusting any other doctor, or the local tertiary Level 5 Cairns Hospital, because of Margaret's perception that the hospital did not provide her with the level of pain relief she believed she required, or discharge her with adequate paperwork.

160. Those matters should have been red flags to Dr Gynther. Margaret's unwillingness to accept advice to attend the hospital for care as an alternate to engaging with the medical centre, Dr Gynthers view that Margaret had many complex aspects, and Dr Gynther's view that if she didn't provided care and treatment for Margaret she may not then obtain the care and treatment she required, was, in my view, misguided and the very reason she should or could have stood back from treating her.

161. The only clinician overseeing Margaret's pain management and dispensing Schedule 8 opioids in the immediate lead up to September 11, was Dr Gynther. The supply of Schedule 8 opioids to a patient requires a vigilance that is only possible with clear boundaries in place. By then those boundaries between Dr Gynther and Margaret were blurred.

162. Dr Gynther herself accepts the arrangement was not in accord with the Medical Board Code of Conduct. I agree with her characterisation.

Oral evidence of experts

163. At the conclusion of the Inquest in December 2020 I took oral submissions from all Counsel. Thereafter, I requested clarification of an aspect of Dr Olaf Drummers (a Forensic Toxicologist) evidence. Thereafter, I commissioned a report from a specialist Thoracic and Sleep Physician (Dr Vincent). In response to that report, Dr Gynther via her legal representative commissioned a private report from an Emergency Physician and Clinical Toxicologist (Dr Little). I was greatly assisted by the additional input from those specialist physicians.

164. On 11 May 2021 the inquest reconvened to take in the oral evidence of those experts. The issue that had not by then been settled, setting aside the oral evidence of Dr Gynther and Mr Cahill, was whether it could be established the time that the last tapentadol was consumed by Margaret (to establish if the tapentadol had been consumed before or after the IM injection) and if her presentation during the day of the 11th was indicative of an acute medical state (unconsciousness / coma) that should have been detected.

165. The level of tapendatol in ante-mortem bloods taken at the Cairns Hospital was in the potentially lethal range and with reference to the conclusions of the forensic pathologist, "*although none of the other individual medications and substances identified on toxicological analysis was at a level sufficiently high to result in death in isolation, it is likely that there was a more-than-additive accentuation of the respiratory depression associated with multiple analgesic and sedative agents, in turn leading to the development of pneumonia and other organ impairment*"

166. The post mortem results (and results of ante-mortem bloods) required scrutiny against the backdrop of:

a) Mr Cahill's evidence that Margaret last consumed a 200mg Tapentadol SR some 19 hours prior taking of ante-mortem bloods;

b) Dr Gynther deposing to no knowledge of Margaret consuming Tapendatol on 11 September, either prior to prescribing a 60mg IM injection of morphine, or anytime thereafter;

c) The possibility that Margaret progressed to an unconscious / comatose and / or a hypotensive state and if so, whether that could or should have been detected by either Dr Gynther or Mr Cahill prior to emergency services being called at 1.00a.m. on 12 September.

Progression into unconsciousness and coma

167. I accept the evidence of Dr Vincent and generally accepted by Dr Little that Margaret demonstrated an emerging unconscious state from about 9.30am when first placed in bed after her arrival home. The nature of her interaction with son Robbie suggests to Dr Vincent a GCS of about 12 at 9.30a.m. By 11.30a.m. she was unresponsive.

168. She had little sleep in the preceding days and her presentation was in keeping with the effects of consumption of CNS depressants including the 60mg IM morphine which by then would have been taking effect. From that point Mrs Cahill progressively moved to coma. She was unable to interact verbally. She had no ability to move physically.

169. In the comatose state bought on by CNS depressants her organs started to fail and her brain was profoundly affected.

170. Mrs Cahill was also affected by a hypotensive state, evidenced by pallor and sweatiness. Her hypotensive state (which of itself can cause a reduced level of consciousness) was independent of, although running parallel to, her decline in consciousness as a result of the overdose. She was by then severely narcotised as a result of the effects of three CNS depressants, tapentadol, morphine and benzodiazapines. She was not eating or hydrated.

171. Dr Gynther erroneously concluded no concern when she could hear Margaret snoring in the background during her discussions with Mr Cahill throughout the day.

172. Margaret's slide into unconsciousness progressively during the day of 11 September and her increasingly hypotensive state precluded Margaret from adequately metabolising the narcotics. Her decline in function led to organ failure, respiratory and cardiac arrest. She was in a very bad way.

173. Margaret's decline was not detected by Mr Cahill. He checked in on his wife from time to time. He accepts in evidence that she did not drink, toilet or rouse throughout the day, she sweated profusely and remained in exactly the same position without moving. He also noticed spittle around her mouth from time to time.

174. Dr Gynther's was reassured to hear Margaret snoring throughout the day. Mr Cahill says he did not hear Margaret snoring and did not in fact take the calls from Dr Gynther in the bedroom. I unable to reconcile these conflicting versions.

175. Dr Gynther says when she spoke to Mr Cahill she could hear Margaret snoring in the background and believed Margaret was displaying the expected effects of sleeping off the morphine and catching up on sleep from the night before. This assessment led Dr Gynther into error. Mr Cahill was reassured by Dr Gynther's assessment.

176. Dr Gynther's assessment was entirely based on limited information from Mr Cahill and the sound of snoring. Appropriate and adequate assessment required taking of vitals including, pulse, blood pressure, respiratory rate and oxygen saturations. I find no evidence these vital signs were taken or recorded either at the McLeod Street Medical Centre prior to Margaret's discharge, or at any later time. Instead Margaret was discharged into the care of her husband, a non-medically trained person.

177. Dr Gynther was not alert to an opioid overdose despite Margaret not rousing, in fact not moving, over a period of some 10 hours from her first to last phone call with Mr Cahill. Dr Gynther advised Mr Cahill to give Margaret a reduced dose of the oral morphine (ordine) when she finally woke. (I accept that Dr Gynther was not aware that Margaret had taken earlier tapentadol).

178. Dr Vincent deposed that the presence of snoring did not preclude a comatose state. Snoring he deposes, operates via an inspiratory and expiratory cycle, and will not exclude coma.

179. Dr Vincent says it would be unusual for a person not to rouse 2 to 3 times in an 8 hour period. Dr Vincent suggested the best way to assess Margaret's state would have been to request to speak with the patient herself during a phone call. I accept that opinion.

180. Margaret was not a healthy woman. She suffered depression, she had a BMI of 35 (outside a healthy range), a stoma, she was a non insulin dependent diabetic, and (as concluded post mortem), her heart was outside normal limits and weighed 482 grams. Her kidneys at the time of and immediately prior to her death were markedly impaired (I accept that damage also evolved from the time of her presentation to the hospital). Throughout the day of 11 September she hypotensive, and she was sliding into unconsciousness. She was not metabolising or clearing the opioids thereby bringing about the onset of her opioid toxicity and consequent pulmonary oedema, multi organ failure, respiratory and cardiac arrest.

181. The level of the tapendatol, and the level of morphine, in the antemortem toxicology results, is logically explained by the failure of the opioid analgesics to metabolise. (That is the drugs must pass through a set of metabolic pathways so as to be excreted). Instead, unexpected levels of tapendatol (at a reportedly fatal level), and morphine, were present in blood samples 18 and 19 hours respectively, after consumption.

182. The relevant experts agreed:

- 60mg IM morphine exceeds a usual therapeutic dose;
- 60mg IM morphine is a large dose;

183. I accept those opinions.

184. At the conclusion of the expert evidence I discounted the possibility that Mrs Cahill physically had the capacity to take any tapentadol from

9.30a.m. given her unresponsive state. I therefore find that no tapentadol was consumed by or administered to Mrs Cahill at any time after her arrival home on 11 September.

Margaret's prior consumption of tapendatol

185. I accept the evidence of Brian Cahill, that Margaret consumed 1 x 200mg Tapentadol SR tablet within half an hour prior to him contacting Dr Gynther on her personal mobile phone at or about 7.15am on the morning of September 11 2017.

186. I find that Dr Gynther proceeded to prescribe a 60mg intramuscular injection of morphine at the McLeod Street Medical Centre at or about 8.30am on 11 September 2017 and she was **not** then seized of relevant information that Margaret had consumed a 1 x 200mg Tapentdol (or any tapentadol) at or between 6.45 or 7.00am or anytime that morning.

187. I find that Dr Gynther asked general or non specific questions directed to Mr and or Mrs Cahill in relation to medications consumed by Mrs Cahill that morning and recorded the response in her progress notes for 11 September 2017 as "already had 2 of 5mg diazepam'. Those progress notes were made retrospectively because Dr Gynther says her original notes were lost in the system and later re-instated by an IT person.

188. Only at inquest in 2020 did Dr Gynther further amplify the nature and extent of these conversations, and for the first time in this investigation she deposed (in her oral evidence) to specifically asking Brian during their earlier telephone call, and Margaret in the surgery before the IM injection, if tapentadol had been consumed, and that on both occasions, she was advised no (at first by Brian and then by Margaret).

Failure to ask about Tapentadol

189. I do not accept that Dr Gynther posed questions (to either Brain or Margaret Cahill) specific to tapendatol. The best evidence for this must be the statement Dr Gynther provided to this investigation and prepared by experienced medico- legal lawyers dated 7 December 2018.

190. That statement is otherwise meticulous in every respect and provides as follows (the **emphasis** is mine):

> " *I recall asking Mrs Cahill what **medications** she had taken that morning …. I asked again whether she had taken any **medication***".

191. At no time does Dr Gynther therein specifically say she asked Margaret or Brian about tapentadol.

192. There is in my view, a material difference in asking oblique or generalised questions, and directly questioning a patient about specific medication. The tapendtadol was prescribed by Dr Gynther, it was a very new regime and changed only days before by Dr Gynther on 7 September so that Margaret no longer had to wait one hour in order to take a 50 ml top up for break through pain, Dr Gynther knew Margaret had access to the opiate, and that she was taking it 12 hourly, whilst formulating a clinical course in respect of administering 60mg IM morphine.

193. A essential exploration between the doctor and the patient required direct questioning in relation to tapendatol including asking the exact time it was last taken, perhaps also confirming with her husband as he was present, and then recording the responses specifically in the practitioners contemporaneous progress notes. I find that none of those processes occurred. Best practice would protect both the doctor and the patient.

Non disclosure of the tapendatol

194. I find that neither Brian Cahill nor Margaret Cahill disclosed to Dr Gynther that Margaret had consumed tapentadol that morning despite knowledge that she had done so.

195. For reasons known only to them, and not apparent to me, at no time did Margaret or Brian advise Dr Gynther that Margaret had consumed a 1 x 200mg Tapendatol at or between 6.45and 7.00am that morning, although they specifically told the G.P. that Margaret had consumed 2 x 5mg diazepam in response to general questions put to them about her consumption of medication.

196. I do **not** accept Mr Cahill's evidence that he told Dr Gynther Margaret had consumed tapendatol. I cannot explain how it was that Dr Gynther came to be appraised of the diazepam by the Cahills, and yet not the tapentadol. How did one come up in conversation and not the other? The evidence on this point is perplexing.

197. Mr Cahills (*Justices Act*) statement to police was taken on the day his wife died. He provides a clear, cogent, chronology of events, and he specifically deposed:

- to advising Dr Gynther (at 7.11a.m.) at paragraph 47: "*I've given her medication at 6.45a.m and it's not working*".

- at paragraph 49: "*I drove Margaret to the McLeod Street Medical Surgery*".

- at paragraph 50: "*Margaret was in pain, however was alert and not dopey or anything like that. I don't think that the drugs had kicked in yet*".

198. On the face of the evidence, Dr Gynther was alerted to the tapendatol. However, I would then have to accept that Dr Gynther, if alerted (as Mr Cahill disclosed to police and the Court) to the tapendatol, thereafter a) disregarded the information and a) failed to record the information and b) proceeded to prescribe 60mg IM morphine regardless.

199. I am of the view that if the tapentadol had been disclosed, Dr Gynther would have recorded it (as she did the diazepam) and would not have made the decision to prescribe the 60mg IM.

200. I also note that Mr Cahill did not alert the attending QAS officers to the Margaret's consumption of tapendatol, nor did he alert the Cairns Hospital upon her admission.

201. It may be that the Cahill's did not disclose the consumption of tapendatol (to their GP) because they were not asked directly about tapentadol, and in their sleep deprived state, against the background of Margaret's manifest pain and suffering, the oversight was not deliberate, but a matter of inadvertence or misunderstanding in the confusion of the events of the day. I note the doctor was cold called on her personal mobile phone, she was rushing to work and dealing with a patient in chronic pain.

202. There is no evidence Margaret actively sought escalation in pain treatment that day; there is nothing in evidence to suggest Margaret or Brian had prior awareness that she was to be administered a dose of morphine during the attendance at the medical centre that morning. The clinical course was determined by Dr Gynther and advised during the face to face consultation.

203. Notwithstanding other concerns I raise herein regarding Dr Gynther's care and treatment, I accept that Dr Gynther would not have embarked on the clinical course to administer the single shot 60mg IM Morphine

had she been so advised. At all times Dr Gynther proceeded to prescribe on the basis that Margaret had **not** consumed tapentdaol. She was shocked to learn after Margaret's death that the toxicology results revealed a potentially fatal level of tapentadol and she could not reconcile this with the information conveyed to her.

Clinical decision making re: administration single dose 60mg IM Morphine

204. That Mrs Cahill had consumed tapendatol prior to attendance at the medical centre, was a separate and distinct issue to the subsequent decision making and administration of 60mg IM morphine by the doctor.

205. Dr Gynther had not ever previously prescribed 60mg IM morphine for any patient. I inferred from the evidence of all experts they had not personally prescribed or administered a single dose 60 mg IM morphine – despite their extensive experience across many settings including emergency and specialist fields.

206. I established at inquest that such an extreme clinical course is unusual, if not unheard of, within a GP setting (The court heard from Dr Little an emergency medicine specialist that such doses might be reserved for oncology patients or those stung by the poisonous irukandji jellyfish). It was therefore incumbent on the GP in this case to take the required time and give proper consideration to all relevant factors.

207. Upon review of the evidence I am of the view that the blurred doctor patient boundaries in this case precluded the scrutiny that one might ordinarily expect. Margaret requested an emergency consultation that day, Dr Gynther placed her at the head of her queue. The IM injection was administered within few minutes of the Cahill's arriving at the surgery.

208. The Cahill's were in an out of the practice within 20 minutes, and that included the 15 minute visual observation post injection by a Nurse while Mr Cahill attended a pharmacy next door to purchase the ordine (and was questioned by the pharmacist about the 'high dose').

209. I am left without a real sense of the rationale and basis for Dr Gynther's decision to administer a 60mg IM. I do not have any evidence that an in depth consultation took place and that all was properly explained to Margaret (and the Cahills generally) about the administration of 60mg IM, which posed risks whatever the circumstances.

210. Nurse Heath recalls Dr Gynther saying something like "*we have to nip this in the bud* (in her statement) or "*we have to knock this on the head*" (in oral evidence). Nurse Heath was aware of doses as high as 45mg administered within the practice by others. She was conscious that 60mg was a high dose and questioned Dr Gynther on two occasions "*60mg of morphine, are you sure*".

211. By way of explanation at inquest and in her statement to the court, Dr Gynther deposed to administering to Margaret in February 2012 (5 and a half years prior to these events) a 30mg IM morphine for abdominal pain and that she had tolerated it and it had assisted her pain. Dr Gynther says that previous occasion, and her subsequent drug therapy reassured her that Margaret was opioid tolerant. The doctor assessed Mrs Cahill's pain as genuine and extreme and I accept that to be the case.

212. I do not however understand how the tolerance of IM 30mg morphine some 5 years prior, and more recently to other drug therapy, informed Dr Gynther's decision to just double the amount of the last dose of IM morphine to administer in a single shot. The progress notes for the last consultation are scant.

213. The options open to Dr Gynther when considering the administration of IM morphine significantly above a normal therapeutic dose included:

- Seeking advice from another senior doctor at the medical centre;
- Contacting the local Cairns Hospital to discuss (or any hospital);
- Redirecting Mrs Cahill to the Hospital (noting that Margaret was scheduled for another guided root injection in coming days);
- Redirecting Mrs Cahill to another doctor within the practice for treatment;
- Refusing to treat Mrs Cahill;
- Familiarising herself with administration of morphine protocols (a number of accepted clinical protocols are found by way of an internet search)

214. Dr Gynther made a decision that was not informed by anything other means to prescribe one single 60MG IM morphine and send Mrs Cahill home. The dose was not titrated. Cursory visual observations were made by a practice nurse over a period of 15 minutes and no vitals were taken before Mrs Cahill was sent home in the care of her non medically trained husband.

215. I find that by 9.30am Margaret was displaying the effects of narcotic sedation, although was rousable and conscious. I find that by 11.30am (when Robbie said goodbye and saw his mother sleeping) Margaret was no longer verbal, she could not be physically roused. The progressive effects of the drug toxicity took hold and to use Dr Botterill's words 'created *a vicious cycle of impaired breathing, leading to worsening body tissue oxygenation, in turn leading to impaired cardiac function".*

216. I find that Margaret Cahill's decline would have been detected in an appropriate medical setting such as a hospital where observations and vital signs would have been taken regularly and indicated known red flags. She would also have then had immediate access to (not limited to) antidotes for opioid overdose, ventilation and emergency medical care *in situ*.

217. I find Margaret Cahills death was preventable.

Summary and Concluding Comments

218. On 17 September 2017 Margaret and Brian Cahill attended upon Dr Gynther McLeod Street Medical Centre, having made those arrangements directly with Dr Gynther one (1) hour prior by way of direct contact with her. Margaret was then in debilitating pain and had not slept properly, or at all, the previous evening.

219. Before determining a clinical course Dr Gynther posed general questions to Margaret to assess if she had consumed medication.

220. Margaret did not disclose in the conversation that she had in fact consumed tapentadol within 1 ½ hours prior to the consultation. The reasons for her non disclosure remain unclear. Mr Cahill maintained a position at inquest which I do not accept, that he told Dr Gynther Margaret had taken tapendtadol.

221. The lack of direct questioning by Dr Gynther specifically in relation to the consumption of tapentadol, and the lack of candour by the Cahills exposed both Dr Gynther and Margaret to a medical crisis that resulted in Margaret's untimely death,

222. Without knowing Margaret already had a Schedule 8 opioid on board, Dr Gynther prescribed a single shot 60 mg IM injection which was administered by a clinic nurse who questioned the dose, and the instructions, on two occasions.

223. In addition to the 60mg IM, Dr Gynther prescribed the opiate Ordine 10mg mixture – 12mls administered 2 hourly for pain breakthrough during periods Margarete might wake during the day

224. Margaret did not wake.

225. Margaret was placed in bed by her husband at around 9.30a.m and progressively from that time on she fell into a narcotised state she did not take in fluids, food, or rouse at all anytime during the day. Spittle and some phlegm exuded from her mouth (by 7.00 p.m.). She became hypotensive and eventually comatose, her organs shut down and oxygenation to her brain slowed. She went into a respiratory arrest and then a cardiac arrest prior to 1.00a.m. on 12 September some 16 and a half hours after the administration of the morphine and approximately 17 hours after consuming tapendatol (and diazaepam).

226. Ante mortem bloods taken on admission to the Cairns Hosptial within one hour of her admission reflect both morphine and tapendatol at above expected levels - the tapendatol level being in the potentially lethal range

227. Life saving measures by then were futile and Margaret was provided care and comfort until her death.

228. A Senior Staff Specialist Forensic Pathologist concluded her cause of death as a multiple drug intoxication. "*It is likely that there was a more than additive accentuation of the respiratory depression associated with multiple analgesic and sedative agents (tapentadol, morphine, diazepam, citalopram), in turn leading to the development of pneumonia and other organ impairment"*, leading to and causing Margaret's death.

229. The inquest into Margaret's death examined these tragic circumstances

230. I find three errors of clinical judgement by Dr Gunther contributed to the circumstances of Margaret's death.

231. First was the blurred boundary that existed around their doctor patient relationship.

    I. Margaret was an was an employee of the practice.

    II. Margaret aligned herself with Dr Gynther to advocate on her behalf in workplace disputes.

III. Margaret conversed with Dr Gynther by internal work email requesting prescriptions for herself and her son

IV. She asked other employees to communicate with Dr Gynther seeking scripts on her behalf

V. She had progressed through various drug therapies and at time of her death was prescribed schedule 8 opiates.

VI. Margaret initiated calls to Dr Gynther after hours or via the doctors personal mobile telephone.

VII. Margaret was described by Dr Gynther as a valued colleague and friend and Dr Gynther herself accepts that the Medical Board Code of Conduct was transgressed as it clearly stipulates not to treat employees and friends.

232. I accept that in isolation these issues may not have violated the doctor patient relationship, however at the conclusion of this inquest I am of the view that the therapeutic relationship between a doctor and a patient is weakened when the totality of these factors exist when treating a patient who is also a consumer of Schedule 8 opioids.

233. The medical centre was alive to the possibility of these complex employee / doctor alliances. The evidence suggests (as given by Dr Gynther) that Margaret crossed out a clause in her employee contract so that she could **not** be precluded from being treated at the McLeod street Medical Centre (apparently sanctioned by other practitioners although I have no evidence that was the case), contrary to the intention of the clause, that employees could not be treated at the practice.

234. I am troubled that Margaret did not accept Dr Gynther's advice to utilise a hospital or a different practitioner. Dr Gynther held a view she was the only person that understood Margaret's complex issues and available to treat her. Dr Gynther's understanding of Margaret's complex personal, medical and psychological factors was no doubt both a benefit and a burden as her treating general practitioner. Ethical boundaries exist to ensure objectivity. I accept that Dr Gynther was in a very difficult position.

235. Dr Gynther has since retired prematurely. It is impossible to comprehend the professional and personal strain bought about by these events on a senior general practitioner of otherwise high standing, reputation and regard throughout the profession and the community.

236. Second was the lack of specific questioning about Margaret's last use of tapentadol, and separately, the decision to administer 60 mg IM morphine within a general practice setting. I set out those circumstances earlier in these findings.

237. Third was discharging Margaret home into the care of her non medically qualified husband and then failing to recognise that Margaret was narcotised and not just sleeping. I set out of those circumstances earlier in these findings.

Referrals

238. The Office of Health Ombudsman is focussed on protecting the public and maintaining professional standards, it is appropriate noting my findings that I refer this matter to the Office of Health Ombudsman.

Recommendations

239. The issues arising in this coronial investigation warrant consideration of a standardised protocol or policy in relation to the administration of morphine within a general practice setting.

240. The McLeod Street Medical Centre subsequent to these events, created an internal policy that precludes nurses administering IM morphine exceeding 20mg, and caps doctor administration of IM morphine at 30 mg within the general practice setting. Guidelines regarding observations are also provided.

241. My review of various comprehensive clinical guidelines produced by the Royal College of General Practitioners (including a publication titled Prescribing Drugs of Dependence in General Practice)and the Australian Medical Association indicates that versions may be already available to modify or revise for distribution by peak bodies to general practitioners throughout Queensland, specifically dealing with best practice for the administration of morphine within a general practice setting, and including post care.

242. I make a recommendation that the Royal Australian College of General Practitioners Queensland, join with other relevant peak professional bodies to establish (if not already available) and distribute a comprehensive clinical guideline specifically addressing best practice for the administration of morphine in a general practice setting and including post care.

243. I understand that not all general practitioners are members of the RACGP and will also provide a copy of these findings to the Rural Doctors Association of Queensland, the Australian Medical Association (Qld), APHRA and OHO noting the spirit and intent is to inform and educate general practitioners as to best practice

Condolences

244. On behalf of the Coroners Court of Queensland I express my sincerest condolences to Margaret's family. Her husband Brian, and to her biological family including her daughter Kerry, son Robbie, and her sister Patricia who have been stanch advocates for Margaret since her death.

245. Nothing can be said or done to that will alleviate the pain of Margaret's grieving family.

246. The tragic circumstances leading to Margaret's death are a coalescence of poor judgement and human error by well meaning people who cared deeply about her.

Findings required by s. 45

Identity of the deceased – Margaret Ann Cahill

How she died – On 17 September 2017 Margaret and Brian Cahill attended upon Dr Gynther McLeod Street Medical Centre, having made such arrangements directly with Dr Gynther one(1) hour prior by way of direct contact with her. Margaret was then in debilitating pain and had not slept properly or at all the previous evening. Before determining a clinical course Dr Gynther posed general questions to Margaret to assess if she had consumed medication. Margaret did not disclose in the conversation that she had in fact consumed tapentadol within 1 ½ hours prior to the consultation. The reasons for her non disclosure remain unclear. Mr Cahill maintained a position at inquest which I do not accept, that he told Dr Gynther Margaret had taken tapendtadol. The lack of direct questioning by Dr Gunther specifically in relation to the consumption of tapentadol and

the the lack of candour by the Cahills and exposed both Dr Gynther and Margaret to a medical crisis that resulted in Margaret's untimely death, Without knowing Margaret already had a Schedule 8 opioid on board, Dr Gynther prescribed a single shot 60 mg IM injection which was administered by a clinic nurse who questioned the dose, and the instructions, on two occasions. In addition to the 60mg IM, Dr Gynther prescribed the opiate Ordine 10mg mixture – 12mls administered 2 hourly for pain breakthrough during periods Margarete might wake during the day Margaret did not wake. She was placed in bed by her husband at around 9.30a.m. and progressively from that time on she fell into a narcotised state she did not take on fluids, food, or rouse at all anytime during the day. She became hypotensive and eventually comatose, her organs shut down and oxygenation to her brain slowed. She went into a respiratory arrest and then a cardiac arrest sometime before 1.00a.m. on 12 September some 16 and a half hours after the administration of the morphine and approximately 17 or so hours after consuming tapendatol (and diazaepam). Ante mortem bloods taken on admission to the Cairns Hosptial within one hour of her admission reflect both morphine and tapendatol at above expected levels - the tapendatol level being in the potentially lethal range. Life saving measures by then were futile and Margaret was provided care and comfort until her death. A Senior Staff Specialist Forensic Pathologist concluded her cause of death as a multiple drug intoxication. "*It is likely that there was a more than additive accentuation of the respiratory depression associated with multiple analgesic and sedative agents (tapentadol, morphine, diazepam, citalopram), in turn leading to the development of pneumonia and other organ impairment"*, leading to and causing Margaret's death.

The inquest into Margaret's death examined these tragic circumstances I find three errors of clinical judgement by Dr Gunther contributed to the circumstances of Margaret's death. First was the blurred boundary that existed around their doctor patient relationship. Second was the lack of specific questioning about Margaret's last use of tapentadol, and separately, the decision to administer 60 mg IM morphine within a general practice setting. I set out those circumstances earlier in these findings. Third was discharging Margaret home into the care of her non medically qualified husband and then failing to recognise that Margaret was narcotised and not just sleeping.

Place of death – Cairns Base Hospital CAIRNS QLD 4870 AUSTRALIA

Date of death– 13 September 2017

Cause of death – 1(a) MULTIPLE DRUG (*tapentadol, morphine, diazepam, citalopram*) INTOXICATION

I close the inquest.

Nerida Wilson
Northern Coroner
CAIRNS