OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Maxwell John MARSHALL**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
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FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, control of prescription medication, the role of the Drug of Dependence Unit, autopsies by Government Medical Officers

REPRESENTATION:

Counsel Assisting:	Ms Jennifer Rosengren
Dr Richard Heath:	Mr David Tait, SC (instructed by United Medical Protection)
Drugs of Dependency Unit:	Mr Andrew Ross (Crown law)

Findings of the inquest into the death of Maxwell John Marshall

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The *Coroners Act 2003* provides in s45 that when an inquest is held, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These are my finding in relation to the death of Maxwell John Marshall. They will be distributed in accordance with the requirements of the Act and a copy placed on the website of the Office of the State Coroner.

Introduction

Maxwell John Marshall was discovered by police deceased in his residence at Mt Coolum on 9 December 2003.

These findings seek to explain how the death occurred and consider whether any changes to Queensland Health policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. They also consider whether the professional conduct of Mr Marshall's doctor should be referred for the consideration of the Queensland Medical Board.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

When Mr Marshall was discovered deceased in his residence by police, the cause of his death was not immediately apparent. As such, a cause of death certificate could not be issued and the matter was reported to a local coroner for investigation.[1]

When that investigation became protected, the local coroner requested that I assume responsibility for the matter as it was more expeditious for the necessary expert witnesses to be briefed and consulted from this office.

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

[1] s8 (3) (e) defines "*reportable death*" to include deaths where a death certificate has not been issued, and is not likely to be issued. Section 7(2) requires that such deaths be reported to a police officer who in turn is required to report the death in writing to a Coroner.

It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires. [2]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[3] However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or is or may be civilly liable for something.[4]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[5]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[6] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[7]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[8]This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[9] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

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[2] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[3] s46
[4] s45(5) and 46(3)
[5] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[6] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[7] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[8] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[9] (1990) 65 ALJR 167 at 168

The investigation

I will now say something about the investigation of Mr Marshall's death.

Mr Marshall was located by police deceased on 9 December 2003. An investigation commenced immediately and the matter was reported to the local Coroner at Maroochydore.

Police observed Mr Marshall's residence to be in an untidy state. Numerous empty medication packets were found throughout the unit. The medication was identified as Oxycontin and the dosage amount was noted to be 8 x 80 mg daily. Regrettably, the attending officers did not take possession of the medication nor compile a list of the quantities or dates on the packaging. Further the reporting officer did not make inquiries with the doctor who had prescribed the drugs to ascertain anything of Mr Marshal's medical history. An error on the form 1 concerning the medical history contributed to the autopsying doctor being materially misled. These deficiencies will be brought to the officer's attention to ensured they do not recur.

Contact was made with Mrs Jones to inform her that her brother had passed away. It was established that she had last spoken to her brother on 5 December 2003.

Enquiries were made with Mr Marshall's neighbours in an effort to establish when he had last been seen. A neighbour reported that they had not seen Mr Marshall for over a month. Mr Marshall last attended upon Dr Heath on 27 November 2003. Dr Heath was the prescribing doctor for the medication Oxycontin located at Mr Marshall's residence.

On 16 December 2003, an autopsy was conducted at the Nambour Hospital by Dr John Scott, a government medical officer. Dr Scott concluded that Mr Marshall's death was caused by drug toxicity due to Oxycodone and alcohol ingestion.

Correspondence between my office and Dr Scott in relation to the cause of Mr Marshall's death led Dr Scott to amend the autopsy finding by deleting the reference to alcohol as contributor to his cause of death. On reflection, Dr Scott concluded that the presence of alcohol was most likely a post mortem reaction.

Expert reports have been obtained by my office in an attempt to reach a definitive conclusion in relation to the cause of Mr Marshall's death. The extensive process of obtaining opinions from relevant experts contributed to the delay in conducting this inquest.

The inquest

A pre-hearing conference was held in Brisbane on 11 December 2006. Ms Rosengren was appointed Counsel Assisting. Leave to appear was granted to Dr Alun Richards of the Drugs of Dependence Unit, which is a division of Queensland Health, and Dr Richard Heath the deceased man's treating general practitioner. The family of Mr Marshall was not separately represented but they consulted with those assisting me before and throughout the inquest. The inquest then proceeded over three days commencing on 29 January 2007. Thirteen witnesses gave evidence and forty-eight exhibits were tendered.

The evidence

I turn now to the evidence. Of course I can not summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Family Background

Mr Marshall was born in Victoria on 15 March 1955 making him 48 years of age at the time of his death. Mr Marshall was a serving member of Victoria Police from 1978 to 1985 achieving the rank of Senior Constable. He was married in 1980 and divorced in 1986. There were no children of this relationship.

After he left the police service, Mr Marshall took up residence with his mother and grandmother to care for them and to assist with the family business, a large and busy TAB agency. His father had died in 1983 and the business was too much for his mother to manage alone. Mr Marshall's mother suffered a brain haemorrhage and battled cancer; after a long struggle, she passed away in February 2000. Mr Marshall's grandmother died shortly afterwards in August 2000. Mr Marshall was their primary carer during their illnesses.

This must have been a very difficult periods for Mr Marshall because, as detailed below, he was also suffering from ill-health during most of this period.

Following the death of his mother and grandmother, Mr Marshall relocated from Victoria to Mt Coolum in early 2001.

Mr Marshall had two siblings. His eldest sister, Ms Roseanne Jones was close to him throughout their lives. She and her husband were very supportive of Mr Marshall throughout the period of his illness.

Medical history in Victoria

In the early 1990's, Mr Marshall was diagnosed with Guillain-Barre syndrome, an auto immune condition in which the sufferer's nerves are attacked by the body's immune system. As a result, the nerve insulation or myelin is damaged and signals are delayed or otherwise changed. The disease causes spreading paralysis, muscular weakness and strange sensations as the sensory nerves of the skin are affected. Some sufferers spontaneously recover whilst others are left with permanent disabilities which can include neuropathic pain and numbness of limbs.

It appears that Mr Marshall was not fortunate in this regard. He suffered continued severe neuropathic pain as a consequence of the syndrome. Records indicate that Mr Marshall was prescribed Doloxene in the 1990's. It was the opinion of his treating doctor at that time that he became dependant on prescription medication. Mr Marshall was also a participant in the methadone maintenance program between 1994 and 1995.

Mr Marshall moves to Queensland

In early 2001 Mr Marshall relocated to Queensland to live. Dr Heath became Mr Marshall treating doctor on 29 March 2001 when he was first consulted in relation to Mr Marshall's pain management issues. Mr Marshall complained of severe

headaches and back pain and gave a history of suffering post Guillain- Barre symptoms. He advised Dr Heath that he was taking up to 14 Doloxene tablets per day and that he had also been prescribed Endone. Dr Heath prescribed him Endone, 5 mg tablets one to two tablets every four to six hours when necessary, Proladone 30 mg suppositories, one each night and Doloxene 100 mg capsules, one to two capsules every four to six hours when necessary.

On 5 April 2001, Dr Heath wrote to Dr David Taylor of the Special Health (Drug Dependency) Services Unit as a result of his concern regarding Mr Marshall's significant narcotic tolerance, asking for suggestions regarding treatment options.

Dr Heath advised the Drugs of Dependence Unit (the DDU) of his treating of Mr Marshall as he was required to do on account of his having come to the conclusion that it was likely that he would be prescribing Mr Marshall Schedule 8 drugs for in excess of eight weeks. In its acknowledgement, the DDU requested a copy of Dr Taylor's report which Dr Heath had told them he was seeking. Further requests for Dr Taylor's report were made by the DDU on 14 June and on 28 June 2001. These letters prompted Dr Heath to again request Dr Taylor to review Mr Marshall but it seems this never happened.

Dr Heath wrote to the DDU on 29 June 2001 advising that he had sent a reminder to Dr Taylor. He also informed the Unit that there was no evidence that Mr Marshall was doctor shopping or engaging in criminal activity and that his medication had been varied. The Unit corresponded with Dr Heath on 4 July 2001 and asked to be kept apprised of any developments in relation to Mr Marshall's management.

On 15 July 2001, Dr Taylor wrote to Dr Heath and informed him that the Special Health Services did not have the clinical capacity to accept any referrals for management of chronic pain and that he had passed the referral on to the DDU for its advice in relation to a further referral. The Unit recommended to Dr Taylor that the Royal Brisbane Hospital Pain Clinic might be able to help. This advice was also sent to Dr Heath.

On 26 July 2001, Dr Heath wrote to the DDU and suggested that Mr Marshall be reviewed at either the Sunshine Coast or Brisbane Pain Clinic and assessed by the Adult Mental Health Service. He sought an alteration of his prescribing "authority" to withdraw Doloxene and substitute Oxycontin 20mg twice a day.[10] The Unit acknowledged Dr Heath's correspondence and requested copies of the pain clinic report and Adult Mental Health report when they were received.

In September, Dr Heath wrote to the DDU advising that Mr Marshall was stabilised on 240mg per day of Oxycontin and that he would "*gradually reduce the narcotic dosing over the next four months*."

In November 2001, Dr Heath referred Mr Marshall to Dr Yaksich at the Noosa Hospital for participation in a pain management program. Mr Marshall attended upon Dr Yaksich who concluded that he would be a good candidate for a three week pain

[10] The DDU's authority was only required if Mr Marshall was assessed by Dr Heath as being "a drug dependent person" within the terms of s5 of the Health Act 1937. It was unclear from his evidence whether he appreciated this.

management program. Mr Marshall was offered a placement in a pain management program however indicated to staff that he would "*get back to them*" which he did not. It seems the outcome of this referral was not followed up by Dr Heath. A letter from the hospital was sent to him but was not received.

Mr Marshall's use of Oxycontin continued and on 9 November it was increased to 320 mg per day when he reported that the dose of 240 mg was insufficient to control his pain.

This dose remained unchanged until October 2002 when for two days it was reduced to 160 mg per day becuase Dr Heath considered that Mr Marshall was developing a tolerance for the drug and was taking it in excess of the prescribed rates. However, Mr Marshall suffered symptoms consistent with withdrawal and therefore Dr Heath immediately increased the dose to 400 mg daily. On 14 January 2003 Mr Marshall again complained that his current dose was not managing his pain and Dr Heath further increased it to 480 mg daily.

In January 2003, the DDU wrote to Dr Heath requesting an update of Mr Marshall's management and a copy of any specialist reports. It doesn't seem that Dr Heath replied to that letter but in February 2003, following discussions with Dr Martin of the Dural Family Medical Practice in New South Wales, Dr Heath wrote to the DDU requesting they "*please withdraw my authorisation for prescribing to this patient*"[11] as Mr Marshall was by then residing in New South Wales. The DDU acknowledged that advice and requested that Dr Heath inform then should Mr Marshall return to his care.

Recent Medical History in New South Wales

In January 2003 Mr Marshall travelled to Sydney to be with his sister and her family. In early February he sought treatment from Dr Martin, a general practitioner at the Dural Family Medical Practice.

He told Dr Martin that he was dependant on Oxycontin but had left his medication at home. Dr Martin contacted Dr Heath and was informed that Mr Marshall's prescription was six, 80 mg tablets per day and that he was not due for another prescription for two weeks. Dr Martin prescribed 20 tablets of Oxycontin and referred Mr Marshall to the Hornsby Drug and Alcohol Service.

A few days later, Mr Marshall again attended upon Dr Martin complaining that he had run out of his medication. Dr Martin prescribed Mr Marshall enough medication for the remainder of his three week stay in Sydney.

Mr Marshall attended the Castle Hill Mental Health Service on 11 February 2003. During an examination by a J Ashcroft (who's occupation is not apparent on the material but whom I assume to be a mental health practitioner of some description) he gave a history of symptoms associated with post Guillain-Barre syndrome, as well as a recent and past history of depression. A plan was established which

[11] As mentioned earlier no authority was needed unless Mr Marshall was a "*drug dependent person.*" It seems likely that he was and that it was for this reason that Dr Heath sought the granting and withdrawal of his right to prescribe him Schedule 8 drugs but it is less clear that the DDU had a similar understanding of the circumstances of the case.

included referrals to a neurologist and pain clinic however there is no evidence that these referrals were made or acted upon.

On 13 February 2003, Mr Marshall attended upon Dr Martin to obtain another prescription for Oxycontin and indicated that he had consulted a psychologist at the Castle Hill Mental Health Service. When Mr Marshall consulted Dr Martin on 17 February 2003, he requested that Dr Martin become his usual prescriber as he intended on relocating to Sydney on a permanent basis.

On 24 February 2003, the necessary paperwork was completed by Dr Martin to enable him to become Mr Marshall's authorised prescriber. Dr Martin was contacted the following day by the New South Wales Health Department and advised that he had been granted authority to prescribe oxycodone sustained release (of which Oxycontin is a type) conditional upon the dose not exceeding 480mg per day. This authority was valid until 1 August 2003. The Department also advised Dr Martin that no extension would be approved unless an assessment of Mr Marshall by a multi-disciplinary pain clinic and/or drug and alcohol unit supporting an extension was provided.

Dr Martin explained the terms of the authority to Mr Marshall during a consultation on 27 February 2003. Mr Marshall signed a patient contract agreeing he would not attend other doctors seeking this medication. At this time, a referral was also provided to Dr Elizabeth McCusker, a neurologist.

Mr Marshall attended upon Dr McCusker on 7 March 2003. He was assessed however refused to be admitted to the Westmead Hospital. Dr McCusker provided a written report to Dr Martin indicating that in her view, Mr Marshall's symptoms possibly extended beyond those of post Guillain-Barre syndrome. She said in evidence that she considered it difficult to be sure of the appropriate treatment for Mr Marshall as she was not convinced his pain was necessarily related to his much earlier episode of Guillain-Barre syndrome.

Dr Martin referred Mr Marshall to Dr Wilsey, a pain management specialist at the Westmead Pain Clinic on 28 March 2003. Mr Marshall confirmed his appointment with Dr Wilsey and requested a further script to allow him to travel to Queensland and arrange his affairs. After consultation with the New South Wales Health Department, Mr Marshall's request was denied.

Mr Marshall returns to Queensland

Mr Marshall returned to Queensland and Dr Heath's care in April 2003. On 9 May 2003, Dr Heath commenced him on a trial of Neurontin, a non narcotic medication. Dr Heath gave evidence that he intended to halve the dose of Oxycontin during this time, however he had concerns that Mr Marshall would inappropriately increase his dose. For this reason, Dr Heath stated that he continued to prescribe a dose of 480 mg per day during the trial. Mr Marshall reported on 30 May 2003 that Neurontin was unsuccessful in treating his pain and a decision was made by Dr Heath cease the trial. Following the failure of the trial, Dr Heath increased Mr Marshall's Oxycontin dose to 680 mg per day and he remained on this dose until his death.

The DDU wrote to Dr Heath on 2 September 2003 requesting a report in relation to Mr Marshall. Dr Heath had not advised them that Mr Marshall had returned to his care but the DDU obviously became belatedly aware of this as a result of the dispensing pharmacists sending them copies of the relevant prescriptions as he/she was required to do when dispensing Schedule 8 drugs. Dr Heath did not respond to that letter. Mr Marshall's dose of Oxycontin remained unchanged. He was last seen by Dr Heath on 27 November 2003.

The death is discovered

Mr Marshall's sister, Roseanne Jones spoke to her brother on 5 December and he told her he was unwell but he declined her offer to call a doctor. When she had not heard from him by 9 December and he did not answer his telephone she became concerned and contacted police requesting that a welfare check be carried out.

Police attended Mr Marshall's residence at approximately 10.45pm and found him deceased on the floor of his bedroom. The investigating officer gave evidence that it looked like Mr Marshall had fallen out of bed. She further noted a large quantity of empty Oxycontin packets scattered throughout the unit, however, she did not compile details of dates on which the drugs had been dispensed or the quantities involved.

When completing the initial report of the death that was sent to the coroner and the doctor who would perform the autopsy the officer listed "*mild* "*motoneuron disease*" under "*Known medical history.*" It seems that this error resulted from miscommunication between the investigating officer and Mrs Jones. The reporting officer made no inquiries of Dr Heath despite his name appearing on the drug packaging.

Mrs Jones came to the Sunshine Coast on being advised of her brother's death and identified his body at the Nambour hospital.

Autopsy evidence

Although Mr Marshall was discovered dead on 9 December 2003, it appears the relevant documentation was not submitted to the coroner by the investigating officer until 12 December 2003. The order for autopsy was issued by the local coroner on this date however the autopsy was not performed until 16 December 2003. It appears the reason for the delay in the autopsy being carried out related to scheduling/timetabling issues within the mortuary. This lengthy delay may have compromised the effectiveness of the autopsy as post mortem changes continue to occur even when the body is refrigerated.

At the completion of the examination a post mortem certificate was completed by Dr Scott which indicated the cause of death was unable to be established until toxicology results were received. Dr Scott did note a left posterior subdural haematoma and atherosclerotic changes in the aorta and other coronary arteries. He reserved his opinion on the cause of death pending the results of the toxicology analysis. When those became available in March 2004 showing oxycodone in the blood at a level of 1.7 mg/kg and alcohol in the urine 39 mg/100ml, Dr Scott concluded that the cause of Mr Marshall's death was drug toxicity due to oxycodone and alcohol ingestion. It appears that Dr Scott formed this view based on his findings

at autopsy, information received from the investigating officer and the toxicology results. He frankly conceded that he assumed this to be the cause of death as a result of the information contained in the initial police report, in particular the mention of motoneuron disease which he considered would not cause pain that would warrant such strong analgesics but might precipitate suicide. There were a number of significant failing with respect to the autopsy which I shall detail later in these findings.

Information was received from Mrs Jones that indicated Mr Marshall did not consume alcohol. Further, the investigating officer reported that no alcohol was located in Mr Marshall's residence. Dr Scott was asked to reconsider his cause of death finding having regard to this additional information. Following this Dr Scott concluded that the presence of alcohol in the urine was most probably a post mortem reaction. Accordingly, he amended the post mortem certificate by deleting the reference to alcohol.

Expert evidence

A number of expert witnesses were called in these proceedings with a view to establishing whether the cause of death had been correctly identified having regard to Mr Marshall's medical history.

Professor Drummer of the Victorian Institute of Forensic Medicine was consulted for his opinion in relation to the general and long term effects of Oxycontin ingestion at the stated levels and the significance of the toxicology findings.

Professor Drummer advised that Oxycontin is widely used to treat neuropathic pain in non-cancer patients and such patients often develop a tolerance to the drug. He indicated that the toxic or lethal level of Oxycontin is dependant upon the degree of a person's tolerance to the drug and that there is no clear toxic or fatal concentration. Professor Drummer concluded that having regard to Mr Marshall's medical history, it is entirely possible that the cause of his death was something other than the toxic affects of oxycodone. Unfortunately, having regard to the limited detail provided in the autopsy report, he concluded that it may not be possible to determine the cause of Mr Marshall's death.

Dr Ellis, a forensic pathologist recently employed by Queensland Health in the Sunshine Coast area, also gave evidence in relation to these issues. He concurred with Professor Drummer's evidence that given the lack of information recorded in the autopsy report, a definitive conclusion could not be reached.

In particular the lack of evidence concerning the location and method by with the blood samples were collected meant that little reliance could be placed on them to determine the blood concentrations at the time of death. Further the failure to thoroughly examine the cranial haemorrhage and surrounding tissue meant that it could not be excluded as a possible cause of death; the same applied to the failure to microscopically examine the heart tissue and related arteries.

I am satisfied that there is no evidence of any foul play or the involvement of any third party in the death.

Regrettably, I conclude that I am unable to determine the cause of death.

Findings required by s45

I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with the last of these issues, the circumstances of Mr Marshall's death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the death.

Identity of the deceased	The deceased person was Maxwell John Marshall
Place of death	He died at 2/3 Power Court Mt Coolum, Queensland
Date of death	He died between 5 - 8 December 2003
Cause of death	Undetermined

Concerns, comments and recommendations

Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

The circumstances of Mr Marshall's death, in my view, raise the following issues for consideration from this perspective:-

- Was Dr Heath's response to Mr Marshall's medical issues appropriate?
- Did the DDU adequately discharge its responsibilities in this case?
- What level of pain management services are available in the Sunshine Coast and are they adequate to address community needs?
- Was the autopsy undertaken in this case adequate? If not what are the reasons for the deficiencies and what can be done to rectify the problem?

Was Dr Heath's response to Mr Marshall's medical issues appropriate?

Dr Turnbull, an experienced general practitioner, and Professor Cramond, an expert in pain management medicine, both gave evidence regarding their opinions of Dr Heath's management of Mr Marshall.

Dr Turnbull considered Mr Marshall was a very challenging and difficult patient to treat given the neuropathic pain he experienced, in conjunction with his narcotic dependency. Both Dr Turnbull and Professor Cramond were complimentary of Dr Heath's success in transferring Mr Marshall from a number of short acting narcotics

to one long acting narcotic (Oxycontin), and for managing to stabilise his dose for periods of time.

Both Dr Turnbull and Professor Cramond recognised Dr Heath's attempts to refer Mr Marshall to alternative pain management therapists and regarded the limited services available as being an impediment to these referrals. They also noted no evidence of doctor shopping by Mr Marshall and indicated this factor as another positive outcome of Dr Heath's treatment: he had managed to develop an effective therapeutic relationship with Mr Marshall.

Dr Turnbull and Professor Cramond also concurred that Oxycontin was the appropriate medication to be prescribed to Mr Marshall for neuropathic pain. They were both of the view that a dose of 640 mg daily was very high and that further efforts could have been made by Dr Heath to have Mr Marshall access other specialist services.

Dr Heath failed to follow up Mr Marshall's referral to Dr Yaksich. Had this been done, Dr Heath would have been aware that a placement was available to Mr Marshall in a pain clinic locally and could have discussed this with Mr Marshall.

It was observed by the experts that no attempt was made by Dr Heath to establish the cause of Mr Marshall's pain. A history of Guillain-Barre syndrome was given by Mr Marshall however no attempt was made by Dr Heath to investigate the reliability of this information. Insufficient attempts appear to have been made by Dr Heath to obtain Mr Marshall's past medical files from Victoria or from Dr Martin in New South Wales following his return in Queensland in 2003.

Just criticism has been made of Dr Heath's note taking and general file management. It seems that an inadequate system was in place to enable incoming correspondence to be attached to patient files. This is evidenced by the number of documents missing from Mr Marshall's file and his failure to respond to requests for information from the DDU. Dr Heath gave evidence that these systems have been somewhat rectified in recent times with the introduction of increased technology in his practice.

It is also of concern that after treating Mr Marshall for nearly three years his daily intake of Oxycontin had increased from an initial dose of 240 mg per day to 640 mg per day, a dosage that Dr Richards advised was in the top 1% of prescriptions issued for this drug in Queensland during the relevant period. Indeed it may even have been higher as the records show that between 30 May and 27 November, a period of 180 days, 1,920 80 mg tablets were dispensed – an average of 10.66 80 mg tablets per day.

All of the experts who gave evidence acknowledged that it was undesirable for patients to remain on high doses of Oxycontin for extended periods and indeed as noted above, Dr Heath predicted he would reduce the 240 mg dose in a matter of months. In this regard he clearly failed.

There is also a basis for concern about Dr Heath's response to the regulator, the DDU. He gave evidence that whilst it would have been prudent to decrease Mr

Marshall's dose of Oxycontin during the trial of Neurontin in May 2003, he chose not to. He advised the Court the reason for this decision was that he thought Mr Marshall was "self prescribing", i.e. Mr Marshall was exhibiting impaired control of his drug intake. There is no doubt that throughout much of the period that Dr Heath was treating Mr Marshall he was likely to suffer mental or physical distress if he ceased taking Oxycontin. Despite these circumstances Dr Heath did not seek the approval of the DDU to prescribe him controlled drugs. Dr Heath also failed to notify the Drug of Dependence Unit upon Mr Marshall's return from New South Wales in May 2003 when he certainly intended to prescribe controlled drugs to Mr Marshall for in excess of eight weeks.

Although Dr Turnbull in his report referred to Dr Heath's treatment of Mr Marshall as "*exemplary*", in view of the concessions he made when giving evidence about aspects of that treatment which could have been better and have regard to the concerns detailed above, I do not accept that assessment as persuasive or reliable.

I consider it appropriate that the Medical Board of Queensland review Dr Heath's professional conduct in relation to this patient and I will refer to it the information gathered during the coronial investigation.

The adequacy of the contribution of the DDU

The Drugs of Dependence Unit is a division of Queensland Health. The Unit's role and responsibilities are derived from the *Health Act 1937* and the *Health (Drugs & Poisons) Regulation 1996*. The aim of the unit is to minimise harm to the public from inappropriate use of controlled drugs by providing a monitoring, investigative, enquiry and research service. These aims are primarily achieved by regulating the prescribing of major narcotics by general practitioners and providing advice as to alternatives.

Schedule 8 drugs such as Oxycontin, require greater controls than other prescription drugs due to the tendency of people using them for any extended period to develop dependence on them. The obligations imposed by the legislation on a doctor prescribing Oyxcontin fall into two categories. If a doctor intends to prescribe a patient Oxycontin for a period in excess of two months, they are required to notify the chief executive of the Department of Health in the approved form.[12] Alternatively, if a doctor is of the view that a patient is drug dependant within the meaning of section 5 of the *Health Act 1937*[13], the doctor is precluded from prescribing Oxycontin without approval of the chief executive of the Department of Health.[14]

Dr Alun Richards, who at the relevant time was the director of the DDU, gave evidence that the Unit's role was one of monitoring prescribing by, at times, referring

[12] Section 120 *Health(Drugs and Poisons) Regulations 1996* – in practice the advice is given to the DDU

[13] Section 5 of the *Health Act 1937* defines a drug dependent person to mean 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 behaviour 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.

[14] Section 122 *Health(Drugs and Poisons) Regulations 1996* – the authority has been delegated to the Director of the DDU.

poor prescribing patterns to the Medical Board as a professional standards issue. Further, the Unit is responsible for providing clinical advice when requested and authorising doctors to treat drug dependent patients by attempting to place limits on drug seeking behaviour. He stressed that the Unit did not exist to manage patients' clinical needs as this task was best undertaken by their general practitioner.

It appears that in Mr Marshall's case, the Drug of Dependence Unit contributed little to the monitoring and control of Dr Heath's prescribing practices. When Dr Heath contacted the Unit on 26 July 2001 seeking clinical advice, none was received. In September 2001, Dr Heath indicated to the Unit that he intended to reduce Mr Marshall's dose of Oxycontin from the then current level of 160 mg over the succeeding four months. When he failed in this regard, and indeed over the next two and half years increased to dose fourfold, the DDU took no action.

In early 2003 Mr Marshall resided briefly with his sister in New South Wales. While Mr Marshall was under the care of a general practitioner there, he was referred to and seen by a number of specialist services. Upon notifying the NSW Health Department of his intention to prescribe Oxycontin to Mr Marshall, the GP was issued with the relevant authority. This authority was for a specified period of time and stated an extension was conditional upon Mr Marshall's attendance at a pain management clinic. The steps taken by the New South Wales Health Department to monitor Mr Marshall's use of the drug and his response to them seem to suggest a superior system prevailed in that state at that time. It was difficult to get Dr Richards to reflect upon this. He seemed more inclined to react defensively to any critiquing of the DDU's performance.

Upon Mr Marshall's return to Queensland and Dr Heath's care in April 2003, he was again prescribed Oxycontin in very high doses up until his death some eight months later. The only action taken by the DDU during this period was to send Dr Heath a letter in early September 2003 that was never answered. It is the case that Dr Heath failed to notify the Unit that he had resumed caring for Mr Marshall but the DDU had access to all prescriptions filled for Schedule 8 drugs.

Of course I only have evidence in relation to the performance of the DDU in relation to this one patient. It may be that its poor performance in this case was an aberration.

Recommendation 1 - Audit of the effectiveness of the Drugs of Dependence Unit

I recommend that the internal audit section of Queensland Health conduct a sample audit of files from the DDU relating to Schedule 8 drugs to ascertain whether the unit is adequately discharging its statutory responsibilities.

The availability of pain management services on the Sunshine Coast

In 2001 when Dr Heath referred Mr Marshall to Dr Taylor for expert treatment in relation to pain management, he was advised that there was no clinical capacity to accept new patients. A recommendation was made that Mr Marshall be referred to the pain management clinic at the Royal Brisbane Hospital. The recommendation is obviously impractical for some patients residing in the Sunshine Coast area requiring pain management services.

It seems that now, in 2007, the situation is not dramatically different. Whilst the Sunshine Coast area now has a part time pain management service, its functions are limited by factors such as lack of dedicated allied health staff, lack of access to multi-disciplinary ancillary support, and lack of dedicated in-patient beds. Dr Tania Morris, a specialist anaesthetist who is currently undertaking specialisation in pain management, is one of two specialists operating the pain management clinic in the Sunshine Coast area. She indicated in evidence that the service does not adequately meet the magnitude of community needs and suggested that already there is a backlog of patients that will not be cleared until May 2008.

The balancing of competing priorities in the allocation of public health care resources is beyond the competence of this inquest. However, I feel obliged to draw attention to these startling data.

The adequacy of the autopsy

The autopsy on Mr Marshall's body was performed by Dr Scott, an experienced general practitioner who has been a government medical officer since 1975. With all due respect to Dr Scott, I am of the view that the autopsy report was inadequate and opportunities to more effectively investigate the cause of death were lost. For a start the report was very brief – less than 100 words - and many basic details such as the height and weight of the deceased were omitted. Further, although a subdural haematoma was detected, no detail of its size, shape, likely age or precise position was recorded. It is also of concern that the summary and interpretation section which should be used to explain the bases of the doctor's conclusion as to the cause of death was left blank. No neuropathology was performed and no record was made of the site of the blood sampling.

It seems that Dr Scott was misled by inaccurate information in the report of the death provided by the police service that indicated motoneuron disease as the only medical history. This disease would not normally result in Oxycontin use and Dr Scott therefore assumed that the numerous medication packets he was told were found in Mr Marshall's unit were evidence of drug abuse. It is of concern that the doctor came to this conclusion before he had received the results of the toxicology analysis and before he had made adequate inquiries about the deceased's medical history that might have led him to come to a different conclusion.

Dr Scott says that after he received the toxicology results he contacted the toxicologist who had issued the certificate and she advised him that the results were within the fatal range. This is also of concern as the evidence of Professor Drummer, whose expertise I accept, is to the effect that little reliance could be placed on the blood concentration alone: more information about the deceased person's history, both in terms of his Oxycontin tolerance and other medical conditions would need to be factored in. According to Professor Drummer, one could only be confident of the drug being the operative cause of death if all other reasonable causes were excluded.

The toxicologist in question gave evidence that she could well have given the advice that Dr Scott claims to have received from her. Although it is her practice to warn

inquirers that drug tolerance has to be taken into account when considering blood morphine levels she could not say she had done so in this case.

I do not consider that these deficiencies were the result of any lack of professional application or commitment by Dr Scott: rather in my view he was simply not adequately trained to undertake an examination of the kind necessary in this case and there was no effective system in place to alert him or anyone else involved in the matter of this problem. Although he was been performing autopsies for many years he has had very little training in what is a highly specialised procedure much of which can only be learnt from close observation. Dr Scott gave evidence that he had only ever seen part of one autopsy performed by a forensic pathologist.

Dr Scott performed the examination in compliance with an order issued by a local coroner pursuant to s19 of the *Coroners Act 2003*. Subsection 7 of that provision requires that the order be directed to a doctor who is listed in the guidelines issued by the state coroner that seek to align the skills of the doctor with the complexities of the case being considered.

The guidelines stipulate that doctors who do not have specialist pathologist qualifications should only conduct internal autopsies in "*simple cases*" and give as examples accidents, suicides and natural deaths. Dr Ellis pertinently pointed out that it is often very difficult to tell before an autopsy is undertaken whether the case is simple or not.

Dr Scott has been conducting autopsies since long before these guidelines were introduced pursuant to the *Coroners Act 2003*. He said that it had always been his practice not to become involved in autopsying suspected homicides or SIDs cases. If other cases that were referred to him appeared more complex than his limited expertise would allow him to deal with adequately, it was his practice to advise the reporting police officers to refer the matter to the John Tonge Centre where it would be dealt with by a forensic pathologist.

With the benefit of hindsight, it would appear that this case should have been dealt with in that way. Although it is primarily the responsibility of the coroner issuing the autopsy order to ensure that it is directed in accordance with the guidelines, coronial investigations are very much interdisciplinary in nature and coroners therefore depend upon feedback from doctors as to whether a particular autopsy is one which the doctor is sufficiently expert to undertake.

It is noteworthy that the autopsy order in this case was issued less than two weeks after the new coronial system commenced and that since that time a very experienced forensic pathologist, Dr Ellis, has commenced duty at the Nambour Hospital. I am confident that he will provide assistance to local coroners and government medical officers on the Sunshine Coast to address the problems highlighted by this case.

It is my responsibility as state coroner to ensure that the coronial system is operating effectively state-wide. I therefore intend to review the arrangements that currently exist to assist local coroners and government medical officers make better informed decisions about who should undertaken particular autopsies. I will consult with the

chief forensic pathologist and the director of the clinical forensic medicine unit in this regard.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
6 February 2007