IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 4603 / 2006

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: GEORGIA SUSAN CHEAL

Delivered On:	15 May 2014
Delivered At:	Melbourne
Hearing Dates:	22 September 2010 27 January 2012 26 -27 March 2012 12 -13 June 2012
Findings of:	CORONER JACQUI HAWKINS
Representation:	Ms C. Currie on behalf of Jill and Roger Cheal Mr J. Constable on behalf of Professor Nicholas Keks Mr S. Reid on behalf of Dr John Robertson
Police Coronial Support Unit	Senior Sergeant J. Brumby

I, JACQUI HAWKINS, Coroner having reviewed the investigation into the death of GEORGIA SUSAN CHEAL

AND the inquest[1] held by Coroner Hendtlass on 26 -27 March 2012 and 12 -13 June 2012 in relation to this death

At MELBOURNE

find that the identity of the deceased was GEORGIA SUSAN CHEAL

born on 13 August 1975

and the death occurred on 4 December 2006

at 6/32 Summerhill Road, Glen Iris, Victoria, 3146

from:

1 (a) PNEUMONIA

2 COMBINED DRUG TOXICITY (INCLUDING MARIJUANA), SMOKING, PATHOLOGICAL OBESITY, FATTY LIVER AND POSSIBLE EPILEPSY

in the following circumstances:

SUMMARY OF CIRCUMSTANCES

1. Georgia Cheal (Georgia) was a 31 year old youth worker and much loved daughter of Jill and Roger Cheal and sister to Paul. According to her parents, Georgia was an intelligent and well educated young woman. Georgia's family describe her as quite academic and she had a number of qualifications. At the time of her death, she was studying her Masters in Education and also Youth Work at Melbourne University.

2. Georgia was seriously injured in a car accident in February 1997; she suffered fractures of her lumbar spine and a compound fracture of her left ankle. She had 18 subsequent operations which led to a below knee amputation in her left leg in February 2004.

3. The injuries sustained by Georgia in the accident were a turning point in her life. Prior to this Georgia was a healthy young adult who was keen on scouting activities, country skiing, hiking and camping. Mr and Mrs Cheal watched Georgia's physical and mental health deteriorate dramatically in the years that followed.

4. Georgia's medical history was long and complex and included poly-cystic ovarian syndrome, chronic pain, glucose intolerance and obesity, post traumatic stress disorder, multiple surgeries, major depression, anxiety, analgesia dependency, epilepsy and sleep

[1] This finding does not purport to refer to all aspects of the evidence obtained in the course of the investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

apnoea. Consequently she had multiple medical practitioners treating her different conditions.

5. Dr Julie Doswell, her General Practitioner (GP) prescribed a range of medications to her including OxyContin[2], Seroquel[3], Stillnox[4], Lyrica[5], Zoloft[6] and Diazepam[7]. Some of these medications were paid for by the Traffic Accident Commission (TAC) because of the connection with her car accident.

6. She was diagnosed with epilepsy by Professor David Reutens after she had a seizure on 27 April 2006, however Georgia did not follow up her treatment.[8]

7. Georgia was admitted to Delmont Private Hospital (Delmont Hospital) on three occasions in 2006. The last was on 2 September 2006 when she presented as depressed and suicidal with thoughts of self harm. She was discharged on 10 September 2006. Georgia was also seeing John McCaffrey, a psychologist in Dandenong and her last consultation with him was on 8 November 2006.

8. Three months prior to her death, Georgia commenced a relationship with Jamie Bremner who she had met at one of her admissions to Delmont Hospital.

9. On Sunday 3 December 2006, Georgia had a fall at home injuring her right arm. Mr Bremner took her to Camberwell Junction Medical Clinic where she was seen by Dr Doswell. Dr Doswell recommended that she attend the emergency department at Box Hill Hospital for further investigation. There, her arm was x-rayed and found not to be broken but there was a possible tendon rupture or blood clot. Georgia and Mr Bremner did not wait for an ultrasound as recommended. They were given a telephone number to call the next day to make an appointment. She was prescribed rest and analgesia and discharged home.

10. On Monday 4 December 2006, Georgia received a phone call from Box Hill Hospital requesting that she attend as soon a possible for an ultrasound. Prior to attending the

---

2 OxyContin is an opioid analgesic containing the active ingredient oxycodone hydrchloride (also referred to as oxycodone). It is prescribed for moderate to severe chronic pain when other forms of treatment have not been effective.

3 Seroquel, also known as quetiapine, is an antipsychotic medication often used to treat bi-polar disorder.

4 Stilnox, also known as zolpidem, assists with initiation and maintenance of sleep.

5 Lyrica, also known as pregabalin, is an anti-convulsant which is used to control neuropathic pain and epilepsy.

6 Zoloft, also known as sertraline, is a selective serotonin reuptake inhibitor which is used to treat depression, obsessive compulsive disorders, panic disorder and social phobia.

7 Diazepam, sold as Valium, is a benzodiazepine used to treat anxiety.

8 Letter from Cheal family on file dated 15 February 2008

hospital Mr Bremner left her home for a short time and when he returned at 10am found Georgia lying on the bedroom floor not breathing. Mr Bremner called emergency services and commenced cardiopulmonary resuscitation (CPR) until the ambulance arrived.

11. Ambulance officers assumed responsibility for the CPR once they arrived but with the agreement of all emergency personnel present, resuscitation efforts were ceased at 10.18am.

JURISDICTION

12. At the time of Georgia's death, the *Coroners Act 1985* (Vic) (the Act) applied.

13. From 1 November 2009, the *Coroners Act* 2008 (Coroners Act) has applied to the finalisation of investigations into deaths that occurred prior to its introduction.

14. The Coroners Court of Victoria is an inquisitorial jurisdiction.[9] Section 67 of the Coroners Act provides that a coroner must find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.

15. The role of a coroner in this State includes the independent investigation of deaths to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety, and the administration of justice.

16. A coroner may comment on any matter connected with the death, may report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[10]

ASSIGNMENT OF INQUEST FINDINGS

17. Coroner Hendtlass retired on 31 December 2013 without completing the inquest findings in this investigation. The State Coroner of Victoria, His Honour Judge Ian Gray, assigned the completion of this Finding into Death with Inquest (Finding) to me pursuant to section 96 of the Coroners Act.

18. In writing this Finding, I have conducted a thorough forensic examination of the evidence including reading all the witness statements contained within the inquest brief, supplementary statements and exhibits. I have also read the transcript of the directions hearing and the inquest.

---

9 Section 89(4) of the Coroners Act.

10 Sections 72(1) and (2) of the Coroners Act.

CORONIAL INVESTIGATION AND INQUEST

19. Coroner Hendtlass commenced an investigation and held two directions hearings[11] and an inquest into the death of Georgia.

20. Mr and Mrs Cheal requested an inquest be conducted in relation to Georgia's death[12] and wrote a number of letters to the Court outlining concerns they had with Georgia's medical care and management, which assisted in determining the scope of the inquest.[13] Georgia's parents believed she was addicted to OxyContin. They conducted an information gathering exercise and provided much material to the Court including photographs of a number of prescription medications and prescriptions they found at her home after her death.

Viva Voce evidence at the Inquest

21. The following witnesses were called to give *viva voce* evidence at the Inquest:

- Mrs Jill Cheal, mother of Georgia
- Mr Jamie Bremner, partner of Georgia
- Mr Matthew McCrone, Chief Officer of Drugs and Poisons Regulation, Department of Health
- Dr John Cochrane, Medical Practitioner, Brunswick Medical Group
- Dr Peter Blombery, Consultant Vascular Physician
- Mr John Steedman, housemate of Georgia
- Mr John McCaffery, Psychologist
- Dr Nicholas Keks, Consultant Psychiatrist
- Dr John Robertson, Registrar Psychiatrist
- Dr Julie Doswell, General Practitioner, Camberwell Junction Medical Centre
- Dr Michael McDonough, Medical Director, Western Hospital, Addiction Medicine and Toxicology Services
- Associate Professor George Mendelson, Consultant Psychiatrist, Albert Road Clinic

---

11 22 September 2010 and 27 January 2012

12 Letter to Court from Mr and Mrs Cheal dated 27 February 2008

Submissions

22. At the conclusion of the Inquest interested parties were invited to provide written submissions. Counsel representing all of the interested parties provided written submissions, which I have considered for the purpose of this Finding.

Issues investigated

23. Section 67 of the Coroners Act requires me to find:

a) the identity of the deceased

b) the cause of death, and

c) the circumstances in which the death occurred.

IDENTITY OF THE DECEASED

24. I find the identity of Georgia Susan Cheal was without dispute and required no additional investigation.[14]

CAUSE OF DEATH

25. Dr Shelley Robertson, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) conducted a post mortem examination on 7 December 2006. Dr Robertson ascribed the cause of Georgia's death to:

1(a) PNEUMONIA

2 COMBINED DRUG TOXICITY (INCLUDING MARIJUANA), SMOKING, PATHOLOGICAL OBESITY, FATTY LIVER AND POSSIBLE EPILEPSY[15]

26. Toxicological analysis was conducted by Dr Mark Chu, Forensic Toxicologist at VIFM, showing a large number of prescription and non-prescription drugs, including cannabis, Amitriptyline, Nortriptyline, Quetiapine, Zolpiderm, Diazepam, Nordiazepam, Codeine, Morphine and glucose were present in her system.[16] The concentrations of medications were either consistent with or slightly above those expected with normal therapeutic use, however in combination, and in the presence of cannabis, it is possible that they induced toxic effects including reduction in conscious state.[17]

---

14 Statement of Identification completed by Jamie Bremner, partner of Georgia Cheal dated 4 December 2006

15 Exhibit 19 – Balance of inquest brief, p100

16 Exhibit 19 – Balance of inquest brief, p102

17 Exhibit 19 – Balance of inquest brief, p100

27. Of note there was no oxycodone present in the toxicological testing at the time of her death, but this could be because it is metabolised in the body as morphine.[18]

28. Dr Robertson commented that Georgia had a past medical history of epilepsy which may have contributed to her death.[19] This is consistent with Professor Reutens' opinion.[20] However he was not called to give evidence and the cause of death was not raised as a substantive issue at inquest as Coroner Hendtlass stated that she accepted the cause of death as determined by the pathologist.[21]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

29. I do not propose to recount or summarise all of the evidence but rather refer to the parts that are necessary touching upon the relevant circumstances investigated as part of the inquest.

Issues investigated as part of the Inquest

30. For the purpose of this Finding I have considered the following issues:

- Management of Georgia's complex health issues
- Polypharmacy in complex patients
- Coordination of Care
- The permit system for regulating medication
- Illicit acquisition and use of prescribed medication
- Patient disclosure about use of illicit drugs
- Engagement with family members
- Potential prevention opportunities

Management of Georgia's complex health issues

31. Georgia was a complex medical patient. She was being treated for a myriad of physical and mental health conditions by a number of medical practitioners and prescribed multiple medications. Her most significant conditions proximate to her death included chronic pain and major depressive disorder. She had also suffered an epileptic seizure in April 2006 which required further investigations.

---

18 Transcript of evidence, p208

19 Exhibit 19 – Balance of inquest brief, p100

20 Letter to Court from Professor Reutens dated 17 March 2009

21 Transcript of evidence, p8

Chronic Pain

32. Chronic pain was particularly problematic for Georgia in the last year of her life. Dr Blombery, Consultant Vascular Physician, had treated Georgia sporadically for her chronic pain since 1999. She was also seeing Dr Stephen de Graaf, a general pain management specialist.[22]

33. Dr Blombery had diagnosed her with Complex Regional Pain Syndrome Type 1.[23] Professor Mendelson described this as "a syndrome that is associated with persistent pain that appears to be disproportionate to whatever pain might have precipitated it".[24]

34. The management of chronic pain is complex and particularly difficult where there are multiple medical issues to be treated. In Georgia's case, it also involved treatment with highly addictive medications, including OxyContin. Dr Blombery believed Georgia "had a terrible quality of life, and if her pain could be improved then that may help her to improve her quality of life and therefore to reduce her depression".[25]

Major depressive illness

35. A number of events led to an escalation in Georgia's depressive illness in the last year of her life. Professor Keks first saw Georgia in December 2005 and diagnosed her with major depression and chronic pain.[26] Georgia was admitted to Delmont Hospital in a life-threatening crisis and severe pain on three separate occasions as an inpatient in January, September and October 2006.[27]

36. On her last presentation to Delmont Hospital, Georgia was in continuing pain and had recently been excluded from her lifetime commitment to the scouting movement due to her mental ill-health, which caused her profound anguish. She had also recently lost a job. Professor Keks commented that these were overwhelming blows that caused her to feel utterly hopeless and to see no way out other than suicide. It caused her to suffer a relapse of a severe major depressive illness.[28]

---

22 Transcript of evidence, p181

23 Exhibit 10, Statement of Dr Peter Blombery dated 31 October 2011 and Transcript of evidence, p169

24 Transcript of evidence, p467

25 Transcript of evidence, p179

26 Exhibit 14, Statement of Professor Nicholas Keks, p25.4

27 Exhibit 14, Statement of Professor Nicholas Keks, p25.5-6

28 Exhibit 15, Second statement of Professor Nicholas Keks, p4

37. According to Professor Keks, Georgia was at a "high risk of suicide, both with respect to static and dynamic risk factors, at every presentation".[29] His clinical notes indicated clear evidence for a high risk of a fatal outcome from suicide at each of her presentations to hospital.[30]

38. Dr Mike McDonough, an addiction specialist, was highly critical of Professor Kek's care of Georgia and believed he did not accurately assess Georgia's complex medical history.[31]

39. Professor Keks was aggrieved about the criticism directed at his management of Georgia and stated that Dr McDonough was "entirely incorrect in alleging that, individually, [he] did not consider the potential risks associated with [Georgia's] medication regime, and did not weigh such risks against potential benefits".[32] Professor Keks firmly believed that Dr McDonough's comments concerning Georgia's psychiatric treatment bore no relationship to the clinical realities and high risks that were associated with her major depressive illness and acute suicidality.[33]

40. Dr John Robertson, Psychiatric Registrar, had primary care of Georgia at Delmont Hospital and was supervised by Professor Keks. Professor Keks defended the criticism levelled at Dr John Robertson by Dr McDonough saying he was a medical practitioner with many years experience in psychiatry. Professor Keks supported Dr John Robertson's care and considered that he was an excellent registrar.[34] Professor Keks confirmed in evidence that they both collaborated extensively in Georgia's care.[35]

41. Professor Keks confirmed that he was well aware of the analgesics Georgia was taking and the effects of the medication on her mental state, her overall state and her pain.[36] According to Professor Keks to "maintain a therapeutic relationship with Georgia was a serious challenge."[37] He had to give due consideration to her drug interactions, adverse effects and safety issues and balance that with the life threatening nature of her illness and her profound level of suffering.[38]

---

29 Exhibit 15, Second statement of Professor Nicholas Keks, p4
30 Exhibit 15, Second statement of Professor Nicholas Keks, p4
31 Exhibit 15, Second statement of Professor Nicholas Keks, p5
32 Exhibit 15, Second statement of Professor Nicholas Keks, p4
33 Exhibit 15, Exhibit 15, Second Statement of Professor Nicholas Keks, p21
34 Transcript of evidence, p346
35 Transcript of evidence, p278
36 Transcript of evidence, p279
37 Exhibit 19 – Balance of Inquest Brief, p25.7
38 Exhibit 15, Second statement of Professor Nicholas Keks, p6

Epilepsy

42. In April 2006, Professor Reutens confirmed that Georgia had a generalised tonic clonic seizure and recommended an MRI scan of the brain. He stated that if the diagnosis was confirmed then it would be reasonable to start Georgia on antiepileptic medications. The evidence is unclear whether this occurred.

Polypharmacy in complex patients

43. There were many potential difficulties associated with polypharmacy at the time of Georgia's death. The following section addresses issues identified with respect to the prescription of multiple medications to Georgia. This is particularly relevant given the cause of death.

44. Georgia's toxicological results, the Pharmaceutical Benefits Scheme (PBS) records and the medications and prescriptions found at her flat after her death demonstrate that Georgia had been obtaining prescription medications to treat her chronic pain, major depressive illness and other medical problems for a sustained period of time and potentially excessive to her therapeutic requirements.

45. A risk related to polypharmacy is the unknown clinical effects the different combination of medications may have on a person. A stark example of polypharmacy prescription is when Georgia was discharged from Delmont Hospital in October 2006 with eleven different prescription medications.[39]

46. According to Dr McDonough the management of chronic pain in obese patients following traumatic injury is complicated because of the fact that obese patients have an increased risk of abnormal pharmacological responses and pharmacotherapy is often required for the treatment of chronic and disabling pain in many patients.[40] Many of the medications prescribed to Georgia actually carried the risk of metabolic disorder, for example glucose intolerance and weight gain all of which contributed to Georgia's obesity. Patients with obesity are also at an increased risk of cardiac and respiratory disease, particularly sleep apnoea.

47. A risk identified by Dr McDonough was that most of the drugs used in the treatment of Georgia's chronic pain included analgesics or sedative drugs and a variety of other anti-

---

39 Transcript of evidence, p338

40 Exhibit 19 – Balance of inquest brief, Statement of Dr Mike McDonough, p3

neuropathic drugs. He identified that this neuro-inhibition particularly from multiple drugs having such effects, can lead to or cause depressant effects on respiratory and cardiac functioning.[41] Combinations of drugs can be problematic for example when cannabis and OxyContin are used together there is potential for respiratory depressant effects due to the sedating effect of a combination of both.[42]

48. It is difficult to say whether the polypharmacy was appropriate, however the combination of the prescriptions at or slightly above their therapeutic use and the recent use of cannabis contributed to the fatal outcome of this case.

49. The inquest did not investigate how the particular prescription and non-prescription medications Georgia was taking interacted with one another. Rather the evidence relied on the individual practitioner's knowledge of the prescriptions. Therefore there was no scientific evidence as to what interactive effects these drugs may have had with each other.

50. Nevertheless, Georgia would have greatly benefitted from someone with expertise in pharmacology analysing the combination of her medications. This would have facilitated an accurate picture of how her medications interacted and ascertained what clinical effects they may have had. It would also have allowed for clinically appropriate modifications if necessary.

Consideration of Serotonin Syndrome

51. An issue that arose during the course of the inquest was whether Georgia had serotonin syndrome. Serotonin syndrome is a nervous disorder which results from too much serotonin. It can range in seriousness from mild to life threatening with symptoms such as confusion, agitation, restlessness, extremely high body temperatures, fast heart rate, increased reflexes and poor control of movement.[43]

52. Professor Keks suggested it arises out of a combination of certain drugs and produces a state which commences with increased anxiety and tremor, is followed by more agitation, nervousness and increased autonomic arousal, proceeds to generalised organ and system

---

41 Exhibit 19 – Balance of inquest brief, Statement of Dr Mike McDonough, p3

42 Exhibit 19 – Balance of inquest brief, Statement of Dr Mike McDonough, p15

43 Better Health Channel, Fact Sheet – Medicines and side effects, p2 http://www.betterhealth.vic.gov.au/bhcv2/bhcpdf.nsf/ByPDF/Medicines_can_cause_unwanted_side_effects/$File/Medicines_can_cause_unwanted_side_effects.pdf accessed 13 May 2014.

failure, and can progress into an acute brain syndrome, ending up in intensive care.[44] He considered seizures could also be a symptom of serotonin syndrome.[45]

53. Around the time Georgia died she was taking citalopram and amitriptyline which Dr Blombery considered can cause seizures and serotonin syndrome in combination.[46]

54. Professor Keks confirmed that he and Dr John Robertson both considered whether Georgia was suffering from serotonin syndrome however believed it was unlikely due to the modest doses she was being prescribed[47] and because of her general presentation to them.

Importance of monitoring medications

55. Dr Doswell commented that she had become concerned about Georgia's dependency on opioid medications and she had started to enquire about a multidisciplinary approach to rehabilitation with an aim of reducing some of Georgia's medications because she considered some had started to cause problems with Georgia's health. For example, it was thought that Seroquel, an antipsychotic medication used for correcting the chemical imbalances in the brain, may have been causing her to fit.[48]

56. It is important that when a patient such as Georgia is prescribed multiple medications, someone should take responsibility to monitor the combinations of medications and the potential for contraindications. It may be most appropriate for a referral to a pharmacologist.

Coordination of care

Overall Medical Management

57. Georgia's GP, Dr Doswell, had an understanding and appreciation of Georgia's overall medical concerns and confirmed in evidence that she made referrals and was the gatekeeper of Georgia's medical information.

58. However it became apparent through this investigation that there was no formal case management or coordination of care established for Georgia and her numerous health conditions.

---

44 Transcript of evidence, p341
45 Transcript of evidence, p341
46 Transcript of evidence, p177
47 Transcript of evidence, p342
48 Transcript of evidence, p390-391

Georgia was her own Case Manager

59. According to her treating medical practitioners Georgia was intelligent, well-organised[49] and assumed the role of her own quasi-case manager. Professor Keks commented that Georgia was "very assertive [and] ...knew her mind".[50] As an example he stated that she had computerised records of events relating to her medical care. Professor Keks said that this was an extraordinary level of management compared to most patients he sees. He commented that she was "very much in control and sometimes it was a big issue if [they] weren't on the same page as to what to do."[51]

Communication between medical practitioners

60. The evidence indicated that communication between medical practitioners about Georgia was usually conducted formally by letter or facsimile to her GP. Telephone calls between practitioners usually occurred when there was an acute need.

61. There appeared to be some misunderstanding and lack of knowledge about the prescription of certain medications. Dr Doswell never wrote to Dr Blombery and consequently Dr Blombery did not know both were prescribing OxyContin at the same time.[52]

62. Another example of this miscommunication occurred when Georgia was released from Delmont Hospital on 7 October 2006. Dr Doswell was not aware of Professor Keks' decision to reduce Georgia's use of Stillnox due to its potential for addition and prescribed it five days later.[53] Professor Keks' testified that he had discussed this plan with Georgia, however she she had not disclosed it to Dr Doswell who in turn had never received any communication from Professor Keks about this specific plan.[54]

Need for Case Management

63. Chronic disease management involves collaboration and open communication between all treatment providers requiring the use of and reliance on established evidence-based and ethical guidelines.[55] Dr McDonough was very critical of the different doctors and their

---

49 Transcript of evidence, p388-389
50 Transcript of Evidence, p309
51 Transcript of Evidence, p309
52 Transcript of evidence, p203
53 Transcript of evidence, p349
54 Transcript of evidence, p395
55 Transcript of evidence, p489

prescribing methods and noted that he did not see any evidence of a treatment plan by the treating doctors.

64. It would have been beneficial to have one person managing and coordinating the team of medical specialists. GPs are usually the receptor of information and play a key role in the management of complicated patients. Dr John Robertson commented that "we often rely on the GP to be the coordinating person but we understand that in a very busy general practice that's almost an impossible task".[56]

65. Many options of case management were considered at inquest including appointing a case manager, communicating via email and video-conferencing however each suggestion had its own difficulties. A suggestion was made that perhaps the TAC would have been well placed to case manage Georgia, however TAC were not an interested party to the inquest and there was no evidence obtained from them as to their capabilities to provide such a role.

66. Although on Georgia's second admission to Delmont Hospital Professor Keks suggested a case management approach and hoped Dr De Graaf could have assisted. The plan did not come to fruition.[57] It is clear based upon the evidence such a coordinated team-based approach would have provided great advancement to Georgia's medical care and management and it is unfortunate this did not occur.

The Permit System for regulating medication

67. At the time of Georgia's death, legislation and an associated permit system regulated the prescription of Schedule 8 poisons.[58] The permit system was established to coordinate treatment and minimise the risk of concurrent treatment of a patient with the same or similar drugs by different practitioners.[59] Oxycodone is a Schedule 8 medication requiring a permit.

68. The evidence was that a permit to treat a patient with an opioid would be issued where:

- No current permit is in place for another practitioner to treat with the same or a similar drug, except in cases where there is evidence that the risk of concurrent uncoordinated treatment has been minimised; and

---

56 Transcript of evidence, p369

57 Transcript of evidence, p314

58 *Drugs, Poisons and Controlled Substances Act 1981* (Vic)

59 Exhibit 5 – Statement of Mr Keith Moyle dated 18 March 2009 (adopted by Mr Matthew McCrone) p2

- The proposed treatment was for an appropriate clinical diagnosis and there is no apparent risk of toxicity at the proposed dose.[60]

69. The Department had records of the following four permits held in Georgia's name:

- 14 February – 16 May 2002 - Dr Greenwood, Oxycodone 80mg
- 13 October 2003 – 12 April 2004 – Dr Greenwood, Oxycodone 30mg
- 8 March 2006 – 6 September 2006 – Dr Blombery, Oxycodone 40mg (cancelled)
- 19 June 2006 -19 December 2006 – Dr Blombery, Oxycodone, 80mg.[61]

70. However, while the permit system offers the potential to improve medication safety, there are a number of reasons why this goal was not achieved. Counsel for the family submitted that in this instance the permit system failed to ensure that practitioners were prescribing Georgia oxycodone concurrently. Therefore she was able to obtain more than was therapeutically required when she was dependent upon it.[62]

71. In reviewing the evidence, I have identified three main issues associated with the permit system relevant to the circumstances. These issues are:

- Prescription of oxycodone without a permit in circumstances which required one:
  - Continuous treatment for greater than eight weeks
  - Notification of a drug dependent patient
- Concurrent prescription of medication requiring a permit
- Inherent problems with the permit system.

72. To my knowledge these issue have not been resolved since this time.

60 Exhibit 5 – Statement of Mr Keith Moyle dated 18 March 2009 (adopted by Mr Matthew McCrone) p2
61 Exhibit 19 – Balance of Inquest brief, p25.1
62 Outline of Submissions of Roger and Jill Cheal dated 26 October 2012 pp5-6

Prescription of oxycodone without a permit in circumstances requiring one

Continuous treatment for greater than eight weeks

73. At the time of Georgia's death if a medical practitioner did not believe a patient was drug dependent, they could lawfully prescribe oxycodone for a continuous period of eight weeks before required to obtain a permit.

74. The evidence indicates that Georgia was treated with oxycodone by a number of practitioners over a significant period of time and it is likely that the requirements of having a permit were met. I note that Dr Blombery had a permit however other practitioners did not.

75. This requirement was subsequently amended so that the eight weeks of continuous treatment takes into account treatment provided by previous practitioners.[63] This broadened the circumstances for which a treating practitioner required a permit which in turn promoted the coordination of treatment.[64] However it did not address problems arising when practitioners are not aware of previous prescribers.

Notification of a drug dependent patient

76. A medical practitioner was also required to notify the Department if they considered their patient attracted a clinical diagnosis of drug dependency of a Schedule 8 medication.

77. Dr Blombery and Dr Doswell both considered that Georgia was dependent on oxycodone during the period they were each prescribing it to her. Problematically, the Department indicated that there were no records of notifications from any practitioner of Georgia being a drug dependent person.[65]

Concurrent prescription of medication requiring a permit

78. Dr McDonough clarified in evidence that only the permit holder may prescribe the nominated opioid for the period outlined in the permit. Therefore any other doctor prescribing the same drug or another opioid during such a period would be of breach of the drug regulations.[66] Further and most importantly the medical practitioner is potentially placing the patient at risk by concurrently prescribing.

---

63 Exhibit 5 – Statement of Mr Keith Moyle dated 18 March 2009 (adopted by Mr Matthew McCrone) p3

64 Exhibit 19 – Balance of Inquest brief, p25.1

65 Exhibit 5 – Statement of Mr Keith Moyle dated 18 March 2009 (adopted by Mr Matthew McCrone) p2

66 Exhibit 19 – Balance of inquest brief, Statement of Dr Mike McDonough, p8

79. There were approximately three occasions in 2006 where Dr Blombery and Dr Doswell prescribed Oxycodone within 10 to 12 days of each other. For example, on 30 November 2006 Dr Doswell wrote a script for OxyContin and two days later Georgia obtained another script from Dr Blombery.[67]

80. During this period, only Dr Blombery held a permit to prescribe oxycodone to Georgia. Problematically, it appears that Dr Doswell did not understand her legal requirements for the prescription of oxycodone. Specifically, she was under the mistaken impression that she could prescribe oxycodone if Georgia was unable to see Dr Blombery because he held a permit.[68]

81. Dr Doswell agreed that it would have been beneficial for her to have informed Dr Blombery about her prescribing oxycodone. This issue also supports the potential prevention opportunities of real time prescription monitoring which I discuss later in this Finding.

Inherent problems with the permit system

82. Dr McDonough noted that when a doctor applies for a permit, they are able to ascertain if any other doctor holds a permit to treat the patient with the same or similar drug, which then potentially avoids the situation of having dual prescribers of the same medication.[69]

83. However, in practical terms there is weakness in the permit system. Specifically, although a doctor may hold a permit to prescribe oxycodone, another could concurrently prescribe it for up to 8 weeks without being aware of the existing permit. Further, even if they did make enquiries about whether anyone else was prescribing, the information was not immediately available.

Illicit acquisition and use of prescribed medication

84. In addition to concerns about the appropriateness of medication prescribed by individual practitioners, there were concerns that Georgia may have been illicitly acquiring medication. There was also evidence to suggest that some of Georgia's medication was being diverted to other people.

---

67 Transcript of evidence, p391

68 Transcript of evidence, p392

69 Exhibit 19 – Balance of inquest brief, Statement of Dr Mike McDonough, p8

Photos show excessive amounts of medicine

85. Photos provided by Georgia's parents show multiple packets of medication and unfilled scripts found at Georgia's apartment after her death. However, the other evidence before me does not allow a conclusion that these were all being used by Georgia at the time of her death or at any stage concurrently. In addition, given that the medical and PBS records do not reflect excessive prescriptions I am unable to determine on the basis of the photos alone that there was inappropriate access to or use of therapeutic medications.

Prescriptions obtained by phone and provided to people other that Georgia

86. Dr Blombery testified that he provided prescriptions to Georgia for OxyContin over the phone without having seen or reviewed her for some months. Professor Keks was firm that he would never write a prescription without physically seeing a patient.[70]

87. Dr Blombery also admitted providing a script to a person claiming to be Georgia's friend. He originally gave evidence that on 4 December 2006 (which was the day of her death) he was contacted by this friend who later picked up an OxyContin prescription. Although in evidence he clarified that he was incorrect about that date,[71] this again is not an advisable practice. Mr Bremner gave evidence that he had on occasions picked up scripts for Georgia.[72]

88. Based upon the evidence I am unable to say whether these prescriptions were used for Georgia or for an illicit purpose.

Post-dated prescriptions

89. Dr Doswell testified that on 3 December 2006 she provided Georgia with a number of post-dated prescriptions for OxyContin. They were dated approximately nine or ten days apart. Georgia had told her she was going away and would find it hard to find a medical practitioner whilst she was away.[73] Dr Doswell erroneously felt that she was assisting Georgia and was satisfied that a safeguard was in place for Georgia in that she would not be able to present a post-dated prescription to a pharmacist for dispensing.[74] I find prescribing

---

70 Transcript of evidence, p353
71 Transcript of evidence, p173
72 Transcript of evidence, p54
73 Transcript of evidence, p398, 405
74 Transcript of evidence, p399

and post-dating prescription medications to a person known to be dependant on opioid medications a dangerous practice that should be avoided.

Prescription medication in the name of Susan Cheal

90. Georgia's parents found a box of oxycodone dated 3 December 2006 made out to a Susan Cheal from a Dr Lenne. Investigations were unable to identify any medical practitioner by the name of Dr Lenne.

91. The PBS records did not reveal any evidence that a benefit had been provided to a Susan Cheal. This aspect of the evidence raised issues about whether people were taking advantage of Georgia's medical conditions or she was seeking extra prescriptions illicitly. Unfortunately the lack of evidence does not allow me to make such a finding.

Georgia's use of illicit drugs

92. Georgia had a history of self-medicating with cannabis as a way of dealing with her chronic pain. There is evidence that Georgia was regularly using cannabis around the time of her death and this is supported by the results of the toxicology report and the contribution of cannabis to her death.

93. With the exception of Dr Blombery, Georgia's treating practitioners appear to have been aware, to some extent of her cannabis use. Professor Keks indicated that he used to regularly warn her about using cannabis.[75] Dr Doswell indicated that she was aware of Georgia's cannabis use however Georgia never really mentioned it nor did she seem troubled by it.[76] Dr Blombery testified that had he known she was using cannabis, he would have taken her off OxyContin, not so much because of the sedative effect, but he believed polypharmacy was problematic.[77]

94. Many of the doctors who gave evidence at the inquest claimed that they had never seen Georgia drug affected or intoxicated at any stage.[78] Further, most of the medical practitioners indicated that nothing had ever raised their suspicions that she was dependent on illicit drugs.[79]

---

75 Transcript of evidence, p297
76 Transcript of evidence, p390
77 Transcript of evidence, p203
78 Transcript of evidence, p375
79 Transcript of evidence, p491

95. However, although a number of practitioners believed Georgia to be honest in their consultations[80] in hindsight it appears that at times she may not have been. This was compounded by difficulties in maintaining a therapeutic relationship with Georgia when broaching difficult subjects.

96. Due to the crisis-led events and circumstances of seeing Georgia, Professor Keks stated that trust was essential in maintaining a good therapeutic relationship.[81] He further confirmed that Georgia readily became angered with discussions that were confronting.[82]

97. The overwhelming response of the medical practitioners was that Georgia's cannabis use was not considered particularly problematic. My concerns is that, left unchecked, the use of non-prescription drugs like cannabis can have a negative impact when interacting with other drugs and in some cases result in a fatal outcome. Therefore, it must be recognised as an important consideration for medical practitioners prescribing multiple medications.

Engagement with family members

98. Mr and Mrs Cheal observed a dramatic decline in Georgia's general health and wellbeing over a number of years. They indicate that they observed Georgia's noticeable withdrawal from their family. A further frustration and anxiety resulted from not being able to communicate with her medical practitioners and thereby assist in her care.

99. Mr Cheal made some suggestions, which I have given proper consideration, about how this could be done without interfering with a medical practitioner's duty to their patient. They included:

- a process whereby a family member could speak to a nurse and that nurse could pass information about the family member on to the medical practitioner; or
- a patient could sign an agreement allowing the family to speak to the treating doctor; or
- a process whereby a worried family member could communicate a concern to an organisation that could appropriately process the information.[83]

100. Whilst I agree that there is significant utility in family engagement this must necessarily be balanced with the patient's right to privacy. An individual seeking medical assistance has

---

80 Transcript of evidence, p309 & p394

81 Transcript of evidence, p294

82 Transcript of evidence, p294

83 Submission of Roger Cheal attached to Outline of Submissions of Roger and Jill Cheal dated 26 October 2012

autonomy and the right to determine the extent and nature of the involvement of other people in their care.

101. This right to privacy and confidentiality translates into dual ethical and legal obligations on the part of the medical practitioner. In relation to Georgia, Professor Keks was emphatic that she did not want her family involved in her care.[84] Further he believed that any involvement with the family would have caused irreversible damage to his therapeutic relationship with her.[85]

102. Nonetheless, the suggestions provided by Mr Cheal are not inconsistent with already established processes for a patient to provide consent for another person's involvement.

Potential Prevention Opportunities

103. A number of potential prevention opportunities were considered as part of the inquest, including:

- Real-time prescription monitoring
- Co-ordination of care
- Education to health professionals about opiates not being a first line treatment
- Drug screening patients.

Real Time Prescription Monitoring

104. The term real-time prescription monitoring refers to the process of gathering information on prescription medications immediately as they are prescribed and/or dispensed and storing this information in a central electronic database where it can be accessed by clinicians when a patient attends for treatment and by pharmacists when a patient presents a script for a pharmaceutical drug.

105. This is not the first time this prevention opportunity has been recommended in Victoria.[86] During the inquest Mr McCrone referred to a recommendation made by Coroner Olle in relation to implementing a real time prescription monitoring system in Victoria, which would allow prescribers and dispensers to have access to real time prescription information,

---

84 Transcript of evidence, p343

85 Transcript of evidence, p295

86 Victorian Coroners have been recommending real time prescription monitoring since 2002, in findings of Coroner Byrne (Case No: 20011335), Coroner Saines (Case No. 20020097), Coroner Spanos (Case No.20040208), Coroner West (Case No. 20060345) & (Case No. 20104232), Coroner Hendtlass (Case No. 20064659), Coroner Olle (Case No. 20095181), Coroner Jamieson (Case No.20084042) & (Case No. 20122254)

rather than having to go to the Department to seek information which can be up to eight weeks behind.[87] I support this recommendation.

Coordination of Care

106. A proper coordination of care process was missing in Georgia's case. Mrs Cheal provided a letter to the Court and referred to a Pain Management Treatment Program that is offered at the Pain Management Research Institute at Royal North Shore Hospital in Sydney. This program offers a range of multimodal treatment including pharmacotheraphy, neural block techniques, physiotheraphy services, transcutaneous electrical nerve stimulation and individualised clinical psychology services, treating cognitive behavioural problems. In summary, the program offers a coordinated and integrated care program all under the one roof. This is something Mrs Cheal wished was available for Georgia and I agree that such a program would have been useful.

Educating health professionals

107. During the inquest there was discussion about re-educating medical practitioners that opiates should not always be the first line therapy for someone with chronic pain.[88] Mr McCrone suggested it is too easy for a medical practitioner to prescribe addictive opioid medications without considering a more coordinated approach. Given the advancements in this area since Georgia's death and inquest, I make no specific recommendations in this regard except to note that I support the notion that health professionals should look at other ways of enhancing a patient's treatment other than with an easily prescribed opioid medication.

Drug Screening

108. Drug screening patients who are analgesic dependent was also discussed as a possible way of monitoring the amount and levels of prescription and non-prescription medications an individual is taking. Some of the medical practitioners absolutely disagreed with the idea of drug screening and drug testing because it can damage the therapeutic relationship with a patient.[89]

---

87 Transcript of evidence, p99

88 Transcript of evidence, p121

89 Exhibit 19 – Statement of Associate Professor George Mendelson dated 22 February 2012, p5

FINDINGS

109. I accept the cause of death provided by Dr Shelley Robertson and find that Georgia Susan Cheal died on 4 December 2006 from

1(a) PNEUMONIA

2 COMBINED DRUG TOXICITY (INCLUDING MARIJUANA), SMOKING, PATHOLOGICAL OBESITY, FATTY LIVER AND POSSIBLE EPILEPSY

110. Based upon all of the available evidence, I find that the combination of prescription medications taken by Georgia together with her recent marijuana use, contributed to a reduction in her conscious state which led to the pneumonia causing death.

111. Prior to her accident Georgia was a happy, healthy and vibrant young lady with a promising life ahead of her. I acknowledge the enormous grief the death of Georgia has caused her family, particularly her parents. The loss of a child, even as an adult, must be incredibly painful and difficult to comprehend. They experienced Georgia's decline in every aspect of her life over a number of years and felt powerless to help. I acknowledge the frustration the family felt in not being able to better assist Georgia in her medical treatment despite being willing and able to take an active role in her care and management.

112. In making my findings, I acknowledge that Georgia was a complex patient with multiple co-morbidities and presented many difficulties to her treating practitioners particularly in relation to polypharmacy. I find that despite the best efforts of individual medical practitioners, communication about Georgia's condition and prescriptions was sub-optimal.

113. When multiple practitioners are prescribing multiple medications in an uncoordinated fashion there is potential for harm or loss of life. Georgia's death demonstrates the need to case manage and coordinate care with multi-disciplinary teams. I acknowledge that some of the medical practitioners had begun to turn their mind to this issue however for a number of reasons this did not eventuate.

114. I consider a referral to a clinical pharmacologist to analyse interactions and identify potential contraindications between medications would have promoted the efficacy and appropriateness of Georgia's treatment. Unfortunately this did not occur.

115. I find it concerning that despite acknowledging that they thought Georgia was dependent on oxycodone, Dr Blombery and Dr Doswell did not notify the Department of their belief.

116. Based on the available evidence, I find that Professor Keks provided a high standard of psychiatric care and gave proper consideration to the drug interactions when prescribing medications for Georgia and was alert to her welfare and safety. Similarly, I find that the care provided by Dr John Robertson under the supervision of Professor Keks was appropriate and in accordance with proper standards of psychiatric care.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

117. This investigation revealed a range of issues that enabled Georgia to access oxycodone for an extended period of time and which in combination with other prescription medications had the potential for harm. These issues included poor practitioner coordination, sub-optimal (and at times dangerous) prescribing practices and practitioners not having access to information about what other practitioners were prescribing.

118. It has been a number of years since Georgia's death and these systemic issues are the same now as they were then and the death of Georgia is sadly not unique. Pharmaceutical drugs directly contribute to a significant number of Victorian deaths each year.[90] For more than a decade investigating coroners have been identifying poor coordination of care and poor prescribing and dispensing practices as underlying systemic issues in these types of deaths.

119. This has motivated several Victorian coroners over the past 12 years to call for the Victorian Department of Health to establish a real-time prescription monitoring program, most recently by Coroner Jamieson.[91] To date responses from the Victorian Department of Health have indicated their commitment to implement real time prescription monitoring however there has never been a commitment to a timeline.

---

90 Coroner Jamieson noted in her recent finding into the death of Kirk Ardern that they directly contributed to well over 1000 Victorian overdose deaths in the period 2010-2013 alone. Available from: http://www.coronerscourt.vic.gov.au/home/coroners+written+findings/findings+-+225412+kirk+ardern.

91 Finding into the death of Kirk Ardern

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation connected with the death:

1. I recommend that the Secretary of the Victorian Department of Health commit to a timeline for implementation of real-time prescription monitoring in Victoria, to reduce the harms and deaths associated with longstanding systemic health issues including poor coordination of care and inappropriate prescribing and dispensing. This timeline should include a goal that all Victorian prescribers and dispensers have access to real time prescription monitoring capacity within 12 months from the date I publish this finding.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the Finding be published on the internet

I direct that a copy of this finding be provided to the following:

Mr & Mrs Cheal
Professor Nicholas Keks
Dr John Robertson
Dr Julie Doswell
Dr Peter Blombery
Dr Pradeep Philip, Secretary, Victorian Department of Health
The Hon. David Davis MLC, Minister for Health, Parliament of Victoria

Signature:

Jacqui Hawkins

Coroner Jacqui Hawkins
Date: 15 May 2014