IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 003263

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Judge John Cain, State Coroner
Deceased:	Amanda Jane Harris
Date of birth:	23 September 1981
Date of death:	7 July 2018
Cause of death:	1(a) Stab wound to the right chest
Place of death:	5 Maria Court, Cranbourne North, Victoria, 3977
Keywords:	Intimate partner homicide; family violence; mental health; tramadol

INTRODUCTION

1. On 7 July 2018, Amanda Jane Harris was 36 years old when she was fatally stabbed by her then partner, Mr Daniel Eckersley. At the time of her death, Ms Harris lived in Cranbourne North with Mr Eckersley.

2. Ms Harris and Mr Eckersley met in 2001 and moved in together shortly afterwards. The couple had three children together, a son and two daughters aged nine, five and two years old at the time of the fatal incident.

3. Mr Eckersley had an extensive substance abuse history in his teenage and early adulthood years, with alcohol and cannabis use continuing until around three weeks prior to the fatal incident. He began using alcohol at age 10[1] or 13[2] and began using cannabis at age 13 or 14. He would binge drink multiple times per week.

4. Mr Eckersley was reported to have used 2-4g of high potency cannabis daily, which he grew for his own use. He used amphetamines from ages 16-21, injecting up to $100 of speed at a time with his peak use being 2-3 times per week over a one-year period. He reportedly used heroin from ages 15-21 followed by a high dose of prescribed methadone for an unknown period of time, and briefly relapsed into heroin use when his mother died in 2004. During the same time period, he used quetiapine, flunitrazepam (Rohypnol) and other benzodiazepines that he sourced illegally. He also used LSD, magic mushrooms, ecstasy, cocaine and sniffed paint on a few occasions.[3]

5. Mr Eckersley had no known history of mental illness or sustained treatment from mental health services. He was prescribed an antidepressant by his treating GP in September 2016 with no further prescriptions provided and no future reviews of compliance or efficacy. A K10 Scale[4] was completed however no review of psychiatric symptoms or mental state was documented when this was prescribed.

6. Around 2007, Mr Eckersley sustained an injury to his left knee. In January 2015 this injury was exacerbated by a workplace injury at Coles Supermarket where he worked as a baker. He made a Workcover claim which was initially rejected, but accepted after he appealed and the decision

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1 Psychiatric report by Dr Andrew Carroll.

2 Psychiatric report by Dr Danny Sullivan.

3 Psychiatric report by Dr Andrew Carroll; Psychiatric report by Dr Danny Sullivan.

4 The Kessler Psychological Distress Scale (K10) is a 10 question clinical tool designed to measure psychological distress in the general population. The K10 does not provide a mental health diagnosis.

was overturned. He gradually returned to work from August 2015 and returned to pre-injury duties by January 2016.

7. On 23 August 2016, Mr Eckersley left work early after telling colleagues that he had hurt his knee again. Mr Eckersley submitted a Workcover claim for an injury which was rejected and he was on long-term leave without pay while he appealed the Workcover decision.

8. Mr Eckersley had originally been prescribed Tramadol for pain management in late 2016 by his local GP. Mr Eckersley's original prescription was for 50mg of immediate release tramadol up to three time daily (as needed) until 27 October 2017. From 10 November 2017, he was prescribed 50-100mg up to three times daily (as needed), this dose remained unchanged until the fatal incident.

THE CORONIAL INVESTIGATION

9. Ms Harris's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

10. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

11. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

12. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Harris's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

13. This finding draws on the totality of the coronial investigation into the death of Amanda Jane Harris including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[5]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

14. In the weeks lead up to the fatal incident, Mr Eckersley's friends and family noticed a distinct change in his mood and demeanour. On 1 July 2018, Ms Harris rang her grandmother and told her that Mr Eckersley was very agitated and that she needed help in Victoria.[6]

15. A few days later on 4 July 2018, Ms Harris called her sister and indicated that Mr Eckersley was having a breakdown and very bad depression. On this same date, Ms Harris took Mr Eckersley to see his local GP. Mr Eckersley's GP recorded him as struggling with depression due to a loss of income and employment, and that he had been self-medicating with alcohol and cannabis but had stopped consuming these substances.[7] Mr Eckersley's GP further recorded that he may be experiencing an adjustment disorder with anxiety and depression. A mental health treatment plan was drawn up and Mr Eckersley was referred to a psychologist. Mr Eckersley was prescribed desvenlafaxine (an anti-depressant medication) on this day.[8]

16. On 5 July 2018, Mr Eckersley visited a friend in Berwick and was reported to be acting erratically, stating that someone had poisoned him. Mr Eckersley was observed as upset and crying and later on Ms Harris came over to pick up Mr Eckersley and they were both reportedly crying and hugging each other.[9]

17. On 7 July 2018, Mr Eckersley's mental state continued to deteriorate and he allegedly cleared out the kitchen cabinets and fridge of food and cleaning products. At approximately 10.00am, neighbours heard a loud argument between Mr Eckersley and Ms Harris. At some point after the loud argument, Mr Eckersley punched Ms Harris and then kicked her when she fell to the ground. This attack occurred in the kitchen close to the dining area. Mr Eckersley grabbed a

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[5] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[6] *Coronial Brief*, Statement of Beryl Currie dated 17 July 2018, 136

[7] Medical records provided by Officer Medical Centre dated 26 May 2020, 2

[8] Ibid.

[9] The Queen v Eckersley [2020] VSC 22, 3-4

kitchen knife and stabbed Ms Harris multiple times whilst two of their older children tried to intervene and stop Mr Eckersley.[10]

18. Mr Eckersley set fire to a fabric couch located in the dining area and took all of the children in the family car and drove off. A neighbour who was an off-duty firefighter came over to the burning house and found Ms Harris lying face down with blood over the floor.[11] He checked for signs of life but she had no pulse. Ambulance and firefighters arrived around 11.00am and pronounced Ms Harris deceased.[12]

19. Mr Eckersley was arrested later that afternoon at approximately 3.50pm at an associate's house where he had taken the children. He was assessed by a forensic medical officer and taken to Casey Hospital for assessment.[13]

20. Two consultant forensic psychiatrists later assessed Mr Eckersley for the purpose of criminal proceedings and both opined that at the time of the offence Mr Eckersley was psychotic, most likely induced by tramadol and possibly exacerbated by desvenlafaxine.[14] Both reports agreed that the symptoms had an abrupt onset around a week before the fatal incident and rapid resolution after approximately one week in custody without any sustained treatment.

21. Both psychiatric reports also noted the potential impact of ceasing heavy alcohol and cannabis use, however this was thought to be a less likely explanation for Mr Eckersley's psychosis.[15] In addition, Dr Sullivan stated that Mr Eckersley would have satisfied a diagnosis of polysubstance abuse and dependence including opiates, stimulants, benzodiazepines, cannabis and alcohol.[16]

22. On 30 January 2020, in the Supreme Court of Victoria, Mr Eckersley was convicted of the murder of Ms Harris and sentenced to 18 years' imprisonment with a non-parole period of 14 years.[17]

Identity of the deceased

23. On 7 July 2018, Amanda Jane Harris, born 23 September 1981, was visually identified by her neighbour.

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[10] Ibid, 3
[11] *Coronial Brief*, Statement of Rodney Zealley dated 23 July 2018, 268
[12] Ibid, 3
[13] *Coronial Brief*, Statement of Ambulance Paramedic dated 17 July 2018, 284-285
[14] Psychiatric Report of Dr Danny Sullivan dated 8 April 2019, 9; Psychiatric Report of Dr Andrew Carroll dated
[15] Ibid
[16] Psychiatric Report of Dr Danny Sullivan dated 8 April 2019, 9-10
[17] *R v Eckersley* [2020] VSC 22

24. Identity is not in dispute and requires no further investigation.

Medical cause of death

25. Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 8 July 2018 and provided a written report of his findings dated 25 October 2018.

26. The post-mortem examination revealed the following:

    a) The stab injury was directed from the front to back, acutely right to left, and upwards.

    b) There were three additional stab injuries to the chest. These stab injuries did not enter the chest cavity.

    c) There was evidence of body changes in keeping with close proximity to a fire/heat source.

27. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

28. Dr Burke provided an opinion that the medical cause of death was 1 (a) Stab injury to the right chest.

29. I accept Dr Burke's opinion.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

30. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by an intimate partner is particularly shocking, given that all persons have a right to safety, respect and trust in their most intimate relationships.

31. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr Eckersley and Ms Harris was one that fell within the definition of '*de facto partner'*[18] under that Act. Moreover, Mr Eckersley's actions in fatally assaulting Ms Harris constitutes '*family violence'*.[19]

[18] Family Violence Protection Act 2008, section 9
[19] Family Violence Protection Act 2008, section 8(1)(a)

32. In light of this death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[20] examine the circumstances of Ms Harris' death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[21] As Mr Eckersley was also being treated for a mental health condition and there may be issues with the prescription of tramadol and desvenlafaxine in proximate period leading to the fatal incident, I have requested that the CPU Mental Health team also conduct a review of services. The CPU Mental Health team reviewed aspects of the mental health treatment provided by Mr Eckersley's GP and sought an expert report regarding the prescribing of tramadol and desvenlafaxine to Mr Eckersley.

Family violence history between Ms Harris and Mr Eckersley

33. Ms Harris and Mr Eckersley commenced their relationship in approximately 2001.[22] Statements provided by family members of Ms Harris suggest that Mr Eckersley was very controlling of Ms Harris and deliberately isolated her from her family.[23] Family members advised that Ms Harris would very rarely see them, and that when she did, Mr Eckersley would call her repeatedly asking her when she was coming home.[24] Ms Harris's mother stated that Mr Eckersley would only let her go out to do the shopping.[25]

34. Both Ms Harris's mother and sister, reported being suspicious that Mr Eckersley was emotionally abusive towards Ms Harris.[26] However, none of the witnesses reported ever seeing Mr Eckersley be physically abusive towards Ms Harris or their children.[27] Ms Flynn reported witnessing bruises on Ms Harris, although when questioned Ms Harris made up '*excuses for how she got them*.'[28]

35. Mr Eckersley was purportedly aggressive to Ms Harris's family members and was described as being argumentative or aggressive when he attended family functions.[29] Ms Harris's brother

[20] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[21] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community
[22] Coronial brief, Statement of B Currie, 135.
[23] Coronial brief, Statement of C Harris, 130-131; Statement of B Currie, 136; Statement of L Flynn, 142; Statement of M Harris, 154.
[24] Coronial brief, Statement of C Harris, 130-131; Statement of B Currie, 136; Statement of L Flynn, 142.
[25] Coronial brief, Statement of C Harris, 131.
[26] Coronial brief, Statement of C Harris, 132; Statement of L Flynn, 143.
[27] Coronial brief, Statement of L Flynn, 143; Statement of M Harris, 155.
[28] Coronial brief, Statement of L Flynn, 143.
[29] Coronial brief, Statement of C Harris, 130.

relayed an incident where Mr Eckersley was threatening towards him at a family function and stated that on a subsequent occasion Mr Eckersley threatened to cut his throat and stab him.[30]

36. Victoria Police records indicate that there were no recorded incidents of family violence between Ms Harris and Mr Eckersley prior to the homicide, although police did have contact with Mr Eckersley in relation to other violent offences.

37. In August 2009 there was a family violence incident between Mr Eckersley and Ms Harris's mother's partner.[31] During this incident Mr Eckersley damaged the walls and furniture at the house where he lived with Ms Harris and her mother, Christine. During the incident, Mr Eckersley assaulted Ms Harris's mother's partner and threatened him with a knife. Christine called the police and Mr Eckersley was subsequently convicted of criminal damage and intentionally causing serious injury for which he was placed on a Community Based Order (**CBO**) for 12 months. As part of the conditions of this order Mr Eckersley was to engage in mental health treatment, anger management, drug and alcohol treatment and community work.[32]

38. In May 2010, Mr Eckersley was convicted of possessing a controlled weapon without excuse, possessing a dangerous article in a public place, possessing and using cannabis and failure to comply with his CBO. This occurred after Mr Eckersley attended a gym with a knife and sledgehammer, purportedly looking for some people who had assaulted him there previously. He was sentenced to four months imprisonment in relation to these offences.[33] There was no further contact with Victoria Police in relation to family violence between Ms Harris and Mr Eckersley.

39. The fatal incident appears to have occurred in circumstances where Mr Eckersley had a decline in his mental health, for which he sought treatment from his general practitioner,[34] and a reported increase in paranoid thoughts which caused him to believe incorrectly that Ms Harris was poisoning him and the children. This mental health decline appears to have been due to Mr Eckersley's cessation of alcohol and cannabis use approximately one month prior to the fatal incident, and a resultant increase in his consumption of Tramadol around this time.[35]

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[30] Coronial brief, Statement of M Harris, 153.
[31] Victoria Police records, volume 1, 31.
[32] Victoria Police records, volume 1.
[33] Victoria Police records, volume 2; Coronial brief, 896-897.
[34] Coronial brief, 564; Supplementary material, volume 2, Statement of W Van Rheede, 2, 10-11.
[35] *R v Eckersley* [2020] VSC 22; Psychiatric assessment of Daniel Eckersley by Dr Sullivan, 3-4; Psychiatric Assessment of Professor Carroll, 17-18.

History of prescribing Tramadol in Mr Eckersley's treatment by his GP

40. On 23 May 2018, Mr Eckersley attended his GP Dr Wil Van Rheede and reported that he was seeing a surgeon the following week, had a court date coming up[36], was coping with domestic tasks and had some suitable work with limited hours and shifts planned. Mr Eckersley was given prescriptions for long acting and immediate release tramadol. This was the final prescription provided for long acting tramadol, with the dose documented to be 100mg twice daily. PBS records indicated that five repeats were provided and it was dispensed on 27 May 2018 and 24 June 2018.

41. On 12 June 2018, Mr Eckersley saw Dr Van Rheede to request a repeat prescription for tramadol and a modified Centrelink certificate to say that he could do some work if sedentary and no lifting above 15kg.

42. From around mid-June 2018 (three weeks prior to the fatal incident), Mr Eckersley ceased alcohol and cannabis use and increased tramadol use to 700-800mg per day, sometimes obtaining tramadol from friends.[37] He occasionally used prescription opiate oxycodone which he obtained from friends, but this made him angrier, so he stopped.

43. On 20 and 27 June 2018, Mr Eckersley saw Dr Van Rheede. The first of these appointments was for follow-up after removal of a benign mole and the second was for review of an inclusion cyst on the outside of his eye. At the second appointment he was provided with an ophthalmology referral letter, a repeat prescription for immediate release tramadol and a Workcover letter. This was the final prescription provided for immediate release tramadol prior to the fatal incident, with the documented dose being 1-2 x 50mg tablets three times daily as needed.

44. On 4 July 2018, Mr Eckersley and Ms Harris attended an appointment with Dr Van Rheede. Dr Van Rheede stated that Ms Harris did most of the talking and they were both tearful. Mr Eckersley reported feeling depressed due to loss of income and employment. He reported using alcohol and cannabis to cope, had stopped this by the time of the review but needed help. Dr Van Rheede documented "*affect appropriate and reactive, thoughts normal amplitude and volume, no suicidality or homicidal ideation, no previous attempts, no psychotic features, no*

[36] It was not specified what the court date was for but was presumably regarding his Workcover claim.
[37] He was prescribed 200mg slow release and 300mg immediate release daily.

delusions". He diagnosed adjustment disorder with anxiety and depression[38], commenced 50mg desvenlafaxine and completed a GP Mental Health Care Plan[39].

45. Following his arrest, Mr Eckersley told the forensic medical officer that he had not taken desvenlafaxine for two days prior to the fatal incident (i.e. 6 and 7 July 2018) and he later told the two forensic psychiatrists that he took 100mg or 150mg on the first day hoping that a higher dose would "*do something*", followed by 50mg each day thereafter. After reading the product information warning of potential interactions between desvenlafaxine and tramadol, he formed a belief that Ms Harris was trying to poison him with the tablets.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Appropriateness of prescribing Tramadol in Mr Eckersley's pain treatment

46. Due to the rarity of medication induced psychosis related to tramadol and desvenlafaxine, I sought an expert opinion from a psychiatrist, Dr Enrico Cementon, Fellow of Royal Australasian College of Physicians Chapter of Addiction Medicine and Victorian Director of Addiction Psychiatry Training in the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**).

47. Dr Cementon confirmed that tramadol-induced psychosis is a very rare complication of tramadol use, with very few reports of the syndrome. The tramadol prescribing information lists hallucinations and confusion as rare adverse events[40] associated with tramadol use, however not delusions, paranoia or psychosis. Hallucinations and other central nervous system (**CNS**) symptoms such as confusion, delusions and paranoia are documented to have "*very rarely been seen with tramadol discontinuation*".[41]

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[38] An adjustment disorder is a time limited diagnosis characterised by the presence of emotional or behavioural symptoms in response to an identifiable stressor, with the symptoms occurring within three months of the onset of the stressor. The type of adjustment disorder relates to its specific symptoms, giving the diagnosis of adjustment disorder with: depressed mood, anxiety, mixed depressed mood and anxiety, disturbance of conduct, mixed disturbance of emotions and conduct, or unspecified.

[39] Medicare records did not show a consultation with a psychologist after this date. Medicare records do not record consultations in which the patient had paid the full fee without claiming a Medicare rebate, however the purpose of a GP Mental Health Care Plan is to allow the patient to obtain a Medicare rebate for psychology sessions.

[40] Rare adverse events are characterised as greater than or equal to 1/10,000 but less than 1/1000 (i.e. more than or equal to 0.01% but less than 0.1%).

[41] MIMS Online. APO-Tramadol, <https://www.mimsonline.com.au.acs.hcn.com.au/Search/AbbrPI.aspx?ModuleName=Product%20Info&searchKey

48. Dr Cementon noted that he found three cases of tramadol-related psychosis that occurred in the context of tramadol withdrawal in the medical literature. Each of the three case reports referred to the onset of psychosis in the context of tramadol withdrawal as "*atypical*" and in each case the person was reported to be taking doses above 400-600mg daily and for prolonged periods. There was evidence that Mr Eckersley was taking 700-800mg tramadol daily for an unknown period prior to the fatal event with a recent increase in use. There were no reports that he had abruptly ceased use, however Dr Cementon noted this possibility, given Mr Eckersley said to forensic medical officer "*she got my tramadol*" and "*I read the information on the tramadol… it said you can't be on antidepressants"*, thereby raising the possibility that his intake of tramadol had been reduced following the commencement of desvenlafaxine three days earlier.

49. Dr Cementon also noted that Mr Eckersley was diagnosed with a psychotic disorder retrospectively, several months after the incident and therefore he considers the diagnosis to be provisional in the absence of contemporaneous observation and assessment. He opined that if tramadol-related psychosis were the correct diagnosis, it was more likely a tramadol-withdrawal psychosis as this is previously reported in the literature. Dr Cementon stated that possible recent abrupt cessation of tramadol use, high-dose use, prolonged use, recent cessation of heavy cannabis and alcohol use, the addition of desvenlafaxine and significant social stress may have been risk factors to Mr Eckersley developing psychosis.

50. The available evidence suggests that immediate release tramadol had been prescribed around twice monthly since the beginning of the medical records provided.[42] It was unclear whether it had been prescribed prior to this. Mr Eckersley was prescribed 50mg immediate release tramadol up to three times daily PRN (as needed) until 27 October 2017. At the next consultation on 10 November 2017 this was increased to 50-100mg up to three times daily PRN, however the reason was unclear as the documentation stated only *"Needs renewal cert of capacity, employment has stopped*"[43]. This dose remained unchanged until the fatal incident eight months later. Mr Eckersley was prescribed buprenorphine and oxycodone-with-naloxone[44] until December 2017 when Dr Van Rheede ceased these medications and commenced long acting tramadol (in combination with the previously prescribed immediate

word=tramadol&PreviousPage=~/Search/QuickSearch.aspx&SearchType=&ID=88180001_2>, accessed 17 December 2020.

[42] No consultation were documented between November 2016 to May 2017, however the medical record, Medicare and PBS records contain evidence of consultations and prescriptions from Dr Van Rheede and it is therefore likely that these consultations were missing from the copy of the medical record provided to the Court.

[43] Coronial brief page 569.

[44] Oxycodone-with-naloxone was last dispensed in September 2017 and buprenorphine was last dispensed in July 2017. Other prescription analgesics had been prescribed in 2016.

release tramadol). From this time onwards, tramadol was the only pain relief prescribed. From time of commencing long acting tramadol in December 2017 until the fatal incident seven months later, Mr Eckersley was prescribed 100mg long acting tramadol twice daily. It was not clear from the medical record why buprenorphine and oxycodone-with-naloxone were ceased at this time and long acting tramadol commenced, with medical records saying only "*date to see surgeon has been postponed to new year*"[45].

51. In light of the above prescribing history, Mr Eckersley had been prescribed tramadol for at least 22 months, with his dose being stable at a maximum of 200mg long acting and 300mg immediate release tramadol for seven months prior to the fatal incident. For moderate pain in adults and children over 12 years, the recommended dose of immediate release tramadol is 50-100mg 8-12 hourly. For severe pain in adults and children over 12 years, the recommended dose is 50-100mg 4-6 hourly. The recommended maximum dose of immediate release tramadol is 400mg per day for people aged 75 years and under[46]. For adults and children over 12 years, the recommended dose of slow release tramadol is 100-200mg twice daily with a maximum recommended dose of 400mg daily[47].

52. While Mr Eckersley was prescribed doses within the recommended range for both immediate and slow release tramadol, in combination he was prescribed a high dose. Dr Cementon stated that this was *"a high level of tramadol prescribing*" and "*frequent and high dosage prescribing of tramadol*". Prescribing high doses may be appropriate in circumstances where this is clinically indicated, specialist advice has been sought and appropriate monitoring of efficacy and abuse/dependence occurs.

53. Mr Eckersley reported overusing his prescribed tramadol and getting additional tramadol from friends in the weeks prior to the fatal incident. He reported taking up to 3 x 100mg slow release tablets and up to 8 x 50mg immediate release tablets daily. There was no evidence that Dr Van Rheede was aware of this.

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45 Coronial brief page 568.

46 MIMS Online. APO-Tramadol, <https://www.mimsonline.com.au.acs.hcn.com.au/Search/AbbrPI.aspx?ModuleName=Product%20Info&searchKeyword=tramadol&PreviousPage=~/Search/QuickSearch.aspx&SearchType=&ID=88180001_2>, accessed 17 December 2020.

47 MIMS Online. Tramadol Sandoz SR, <https://www.mimsonline.com.au.acs.hcn.com.au/Search/AbbrPI.aspx?ModuleName=Product%20Info&searchKeyword=tramadol&PreviousPage=~/Search/QuickSearch.aspx&SearchType=&ID=88460001_2>, accessed 17 December 2020.

54. According to PBS records and GP medical records, Mr Eckersley's tramadol was not prescribed or dispensed more frequently than would be expected. Long acting tramadol was dispensed in packs of 60 tablets and at two tablets per day, this should have lasted 30 days per prescription. Some packets were dispensed earlier than expected (i.e. 9 and 15 days) while others were dispensed later than expected (i.e. 44 and 46 days), however when averaged over the dispensing period, prescriptions lasted an average of 28.5 days. Immediate release tramadol was dispensed in packs of 20 tablets and at a maximum six tablets per day, each packet would last at least 3.3 days. PBS records show that prescriptions were dispensed every 5-9 days in the weeks leading up to the fatal incident. Prescriptions for both slow and long acting tramadol were not dispensed more frequently leading up to the fatal incident. Conversely, dispensing of immediate acting tramadol became gradually less frequent in the 12 months prior to the fatal incident, despite the prescribed dose increasing 8.5 months prior to the fatal incident[48]. Prior to the dose increase, Mr Eckersley was prescribed 50mg up to three times daily and therefore a packet of 20 tablets should have lasted 6.66 days at that time, however was being dispensed approximately every four days. The frequency of prescription requests therefore would not have alerted Dr Van Rheede to Mr Eckersley's abuse of tramadol, nor would Safescript if it had been in place at the time.

55. Mr Eckersley was prescribed tramadol for at least 22 months, with no changes in the dose for seven months prior to the fatal incident. Tramadol prescribing information advises that there are no available studies investigating the safety and efficacy of tramadol treatment beyond six months[49]. The tramadol treatment information also indicates that when tramadol is required long-term, careful and regular monitoring should be carried out to establish whether, and to what extent, ongoing treatment is necessary[50]. There was evidence that Mr Eckersley was seeing an orthopaedic surgeon periodically, which was appropriate. However given the long-term and high dose tramadol prescribing, referral to a pain management specialist may have also been appropriate in the circumstances.

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[48] Prescriptions for 20 x 50mg immediate release tramadol lasted an average of 5.82 days in the three month period prior to the fatal incident. For each three month period prior, these prescriptions lasted 5.62 days, 4.74 days (the dose was increased during this period) and 4.23 days respectively.

[49] Tramadol has been studied in controlled clinical trials for periods of up to three months, and one small uncontrolled study of patients with cancer pain who received 150mg tramadol daily for up to six months.

[50] MIMS Online. APO-Tramadol, <https://www.mimsonline.com.au.acs.hcn.com.au/Search/FullPI.aspx?ModuleName=Product%20Info&searchKeyword=tramadol&PreviousPage=~/Search/QuickSearch.aspx&SearchType=&ID=88180001_2#Interactions8611>, accessed 17 December 2020.

56. Additionally, while cases of dependence and abuse of tramadol have been reported rarely, in patients with a tendency for drug abuse or dependence treatment with tramadol should only be carried out for short periods and under strict medical supervision[51]. It was unclear whether Dr Van Rheede formally assessed Mr Eckersley's history of substance abuse at any time during treatment and if so, whether Mr Eckersley disclosed his history of substance abuse. There was no evidence in the 22-month history of medical records provided that a formal substance abuse assessment occurred. Regular assessments for substance abuse would be reasonable when prescribing medications with the potential for abuse including tramadol and other opiate medications that Mr Eckersley had been prescribed in the years prior to his death. There was no evidence available to Dr Van Rheede that Mr Eckersley was using increasing amounts or more than the prescribed amount of tramadol, however regular reviews of substance abuse in a patient who is prescribed medications with the potential for abuse, especially over a prolonged period and in high doses, should not be predicated on current evidence of misuse of that particular medication.

57. Dr Cementon stated that it would have been reasonable for Dr Van Rheede to refer Mr Eckersley to alcohol and other drug (AOD) services if there was an assessment of his long-term use of tramadol in the context of chronic pain, his past history of drug addiction and the recent disclosure of alcohol and cannabis use. Dr Cementon stated that this represented a complex case of chronic pain, addiction, mental health and social issues that required referral to specialist services. I note that it is unlikely that any significant treatment would have been implemented in the three days between Mr Eckersley's disclosure of alcohol and cannabis abuse and the fatal incident, however had appropriate substance abuse assessments occurred throughout treatment, a referral for treatment of substance abuse may have occurred much earlier.

58. Although Dr Van Rheede maintained that he regularly observed Mr Eckersley during each attendance at the clinic, there are no recorded clinical notes of conducting any substance abuse assessments. More assertive assessment and monitoring of substance abuse was required given Mr Eckersley was prescribed high doses of multiple medications with the potential for abuse over a long period (22 months) of time.

59. Dr Cementon's report noted that it would have been reasonable for Dr Van Rheede to refer Mr Eckersley to a psychiatrist during the period of his care, as it was probable that a man with long-

[51] MIMS Online. APO-Tramadol, <https://www.mimsonline.com.au.acs.hcn.com.au/Search/FullPI.aspx?ModuleName=Product%20Info&searchKeyword=tramadol&PreviousPage=~/Search/QuickSearch.aspx&SearchType=&ID=88180001_2#Interactions8611>, accessed 17 December 2020.

standing musculoskeletal pain necessitating long-term analgesic treatment and associated social problems would also have mental health issues. Dr Cementon stated that had Mr Eckersley's substance abuse been adequately assessed, this would have been another reason to refer him to a psychiatrist or to an AOD service.

60. The available evidence is clear that Dr Van Rheede prescribed tramadol to Mr Eckersley for at least 22 months in high doses. There are no available studies investigating the safety and efficacy of tramadol treatment beyond six months. While it is accepted that long-term prescribing may be clinically indicated in some cases, this should only be done with careful and regular monitoring including monitoring of efficacy, the need for ongoing treatment and emergence of tramadol abuse or abuse of other substances to manage pain.

61. The circumstances in this case suggest that referrals should have been made to specialist clinicians such as a pain management specialist and/or psychiatrist would be a reasonable inclusion in the treatment plan when a patient is prescribed long-term tramadol. The level of monitoring that occurred for Mr Eckersley was suboptimal in circumstances where he was prescribed multiple medications with potential for abuse in the years prior to the fatal incident. Tramadol was prescribed in high doses and over a long period. There was no evidence of a substance abuse assessment documented in the 22 months leading up to the fatal incident and it was unclear whether a substance abuse assessment had been completed prior to this. Had Mr Eckersley been assessed for the presence of substance abuse during this period, it may have become apparent that he was abusing cannabis and alcohol for some time prior to the fatal incident and later abusing tramadol, which would have presented the opportunity to refer him for substance abuse treatment.[52]

FINDINGS AND CONCLUSION

62. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Amanda Jane Harris, born 23 September 1981;

    b) the death occurred on 7 July 2018 at 5 Maria Court, Cranbourne North, Victoria, 3977, from a stab injury to the right chest; and

[52] RACGP Guidelines for screening patients with alcohol and drug addiction - https://www.racgp.org.au/alcohol-and-other-drugs/aod-screening?utm_source=AOD&utm_medium=AOD&utm_campaign=AOD+homepage+tiles&utm_id=tile+click+AOD+screening

c) the death occurred in the circumstances described above.

63. I convey my sincere condolences to Amanda's family for their loss.

64. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Christine Harris, Senior Next of Kin

Detective Senior Sergeant Benjamin Gordon, Coroner's Investigator

Dr Wil Van Rheede

John Arranga, Director, Ball and Partners

Professor Tony Lawler, Deputy Secretary, Therapeutic Goods Administration

Dr Neil Coventry, Chief Psychiatrist, Office of the Chief Psychiatrist

Signature:

Judge John Cain
STATE CORONER
Date : 12 October 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.