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REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act*

In the matter of the Coroner's Findings and recommendation(s) regarding the death of Ms Heather Fotiades

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Pursuant to section 46B of the *Coroners Act*, I provide this Report on the findings and recommendations of the Territory Coroner, Local Court Judge Greg Cavanagh, dated 5 May 2017, regarding the death of Ms Heather Fotiades (the Deceased) (refer Attachment A).

The Report includes the response to the recommendations from the Chief Executive Officer (CEO) of the Department of Health (refer Attachment B).

The Deceased, a 33 year old Caucasian female, died between midnight on 19 July 2015 and 1:00 pm on 20 July 2015 at 12 Minorelli Court, Gray. The cause of death was acute multiple toxicity on a background of chronic pain and morbid obesity.

Recommendations of the Coroner

Pursuant to section 35(1) and (2) of the *Coroners Act*, the Coroner made the following recommendations in regards to the death of the Deceased:

'117. I **recommend** that the Northern Territory Government implement real time monitoring of Schedule 8 drugs as soon as possible.

118. I **recommend** that the Northern Territory Government give consideration to maximum prescribing levels for opioids.

119. I **recommend** that the Department of Health and the Health Service Boards consider implementing restrictions on the provision of unnecessary opioids to patients being discharged from hospital.

120. I **recommend** that the Health Service Boards do all such things as are reasonable to ensure collaboration between Pain Specialists and Addiction Medicine Specialists with the view to ensuring safe use of addictive medications used for the control of pain.'

NORTHERN TERRITORY GOVERNMENT

Response to Coroner's recommendations

A copy of the Coronial Findings was provided to the Department of Health on 29 May 2017, in accordance with section 46A(1) of the *Coroners Act*.

A written response was received from the CEO of the Department of Health dated 10 September 2017, as required by section 46B(1) of the *Coroners Act*, advising as follows:

- In response to the recommendation at paragraph 117, the Department of Health acknowledges that the way in which records are currently provided to the Northern Territory's Drug Monitoring System can result in a lag time of two to three weeks in displaying prescription activity.

  The Council of Australian Governments Health Council has agreed to work on a national system to allow near real-time monitoring of prescription data related to Schedule 8 drugs.

  Work is underway to develop a national governance arrangement for the system and the NT participates in this work. It is anticipated that the new system will replace the present NT Drug Monitoring System.

- In response to the recommendation at paragraph 118, the present NT Code of Practice regarding Schedule 8 substances lists maximum daily doses and requires that the Chief Health Officer be notified if they are exceeded. This is monitored by the Substances Clinical Advisory Committee.

  The Code is presently under review.

- In response to the recommendation at paragraph 119, a working group was convened to consider the recommendations and actions to be taken in response. The working group has recommended limiting maximum amounts of opioids to be prescribed on discharge.

  The Central Australian Health Service has placed further restrictions on the provision of unnecessary discharge scripts for opioids.

  The Pharmacy section has performed audits to determine the level of discharge prescriptions and the Chief Pharmacist is working to set mandatory end dates and decision support advice for opioid prescriptions in the NT Health electronic prescription system.

  The Top End Health Service is providing education and is reinforcing the prescribing guidelines available on the NT Health policy site.

  The Drug and Therapeutics Committee is also undertaking audits to assess the scope of the discharge prescription issue.

- In response to the recommendation at paragraph 120, the Alice Springs Hospital has strengthened its addiction medicine speciality, the availability of pain specialists and the coordination between the two over recent years. Supervised opioid replacement therapy is available in the Alice Springs Hospital.

  Meetings have been held with key stakeholders in pain and addiction medicine to consider the recommendations and the pain specialist is drafting a coordination model for implementation.

I am satisfied that the Department of Health has considered the recommendations of the Coroner and is taking necessary steps with respect to those recommendations.

DATE: 9 OCT 2017

NATASHA FYLES

CITATION: *Inquest into the death of Heather Fotiades* [2017] NTLC 012

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0111/2015
DELIVERED ON:	5 May 2017
DELIVERED AT:	Darwin
HEARING DATE(s):	10, 11 April 2017
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Medical practitioners prescribing high dose opioids for chronic non-cancer pain, addiction, failure of system to identify prescription shopping, failure to taper high doses to safer levels, failure of pain specialist to reduce dose despite unsafe levels and knowledge drugs ineffective in relieving pain, possibly increasing pain**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie

Judgment category classification:	B
Judgement ID number:	[2017] NTLC 012
Number of paragraphs:	120
Number of pages:	24

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0111/2015

In the matter of an Inquest into the death of

HEATHER FOTIADES
ON 20 JULY 2015
AT 12 MINORELLI COURT, GRAY

FINDINGS

Judge Greg Cavanagh

Introduction

1. Heather Fotiades (the deceased) was involved in a motor vehicle crash when 17 years of age. She had many operations and a great deal of pain. Her doctors prescribed her significant levels of opioids for her pain in an era when the full difficulties of long term and high doses of opioids were not fully appreciated. She became addicted.

2. Those high doses were ineffective in controlling her pain but resulted in her losing functionality and mobility. She became obese, could no longer assist around the home and her family relationships became strained.

3. Tapering (or reducing) the high dose opioid regime was always going to be complex and demanding. To be successful there needed to be a written and understood plan, guidance and leadership from pain and addiction specialists, a drug management system that ensured she only received the reducing amount of prescription opioids, and coordination between the hospital and her general practitioners. However, those conditions were not met and the tapering of opioids was unsuccessful.

4. As the medical profession became more aware of the harm from opioids, her prescription levels were sought to be reduced. However, she maintained her dosage due to a number of factors including receiving prescriptions from

two doctors at the same time. That went undetected by her doctors and the Drug Management System overseen by the Department of Health.

5. She went into hospital in January 2015 for a total right hip replacement to try and solve some of her pain issues. She was prescribed even more opioids than before and was released on an increased dose that included "take as required" opioids.

6. Her general practitioner was most concerned and sought clarification from the specialist about reducing the opioids. However no reduction was made.

7. She died on 20 July 2015 of an unintentional overdose of her prescription medication. She was 43 years of age.

Background

8. Heather was born 12 June 1972 in the United Kingdom to Brenda and Mike Martin. She had one older sister, Vanessa and two younger siblings, Samantha and Sean.

9. The family migrated to Australia in 1974 and after stays in Sydney and Adelaide relocated to Darwin in 1980. Heather showed an aptitude for motor vehicles and obtained a motor mechanics apprenticeship with Bridge Autos. While there she thrived.

10. At the age of seventeen years, she was involved in a motor vehicle crash (her vehicle was hit from behind and pushed into another vehicle). Her injuries were severe. She suffered a fracture dislocation of the right hip, a crush injury of the left foot, a de-gloving injury to the left forefoot and injury to her right knee. She was taken to the Royal Darwin Hospital for medical treatment.

11. Heather had further operations in the years that followed, paid for by the insurer. In 1992 she was admitted to the Darwin Private Hospital on two occasions:

"a. On 12 February 1992, she had an operation performed by Dr Schmidt to remove two screws from her right hip, arthroscopic surgery to her right knee and the release of mortons neuroma in her left foot (tissue forming a lump on the ball of her foot).

b. On 10 December 1992 Dr Wardill performed an operation to remove a foreign body from her left foot. He made a longitudinal incision. A small stone fragment was located deep in the foot and was removed."

12. She continued thereafter to have operations, most attempting to limit her pain.

13. In 1993 Heather gave birth to her daughter, Kira. In 1995 she met Evan Fotiades. In 1998 they had a son, Jaidyn. They were formally married in 2001.

14. She continued to exhibit high levels of pain and over the years her medication (particularly her opioid medication was increased). Often that was in response to further operations or injuries suffered.

15. By 2012 Heather had been on high dose opioid medication for approximately seven years. Her prescribed medication was:

a. "OxyContin[1] 80mg four times a day;
b. Gabapentin[2] 300mg capsule four times a day;
c. Endep[3] 25mg x3 at night;
d. Stilnox[4] 10mg x3 tablets at night;
e. Naramig[5] 2.5mg 1 tablet a day if needed (for migraine)."

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[1] OxyContin is a trade name for a drug called 'Oxycodone Hydrochloride' which is a semi-synthetic opioid medication. It is prescribed for moderate to severe pain and is a slow release form of Oxycodone.
[2] Gabapentin (generally to treat seizures) is used to relieve nerve pain.
[3] Endep belongs to a class of medications called tricyclic antidepressants.
[4] Stilnox is a sedative used for insomnia.
[5] Naramig is prescribed for migraine

16. On 12 November 2012 Consultant Physician, Dr Peter Stevenson, undertook a medical assessment on behalf of the insurer and provided a report. In relation to the prescription opioids (OxyContin) he stated:

> "The widespread use of opioids in non-cancer pain was a compassionate initiative popular in the early 1990's but has failed; long term studies are indicating that the effects are not only unhelpful but counterproductive ... She is taking a dose of opioid equivalent to 480mg of morphine. This is the level of opiate well proven to engender paradoxical pain and central sensitisation ... The opiate should be dramatically reduced. Central sensitisation and paradoxical pain is less of a problem with methadone and it can be useful medication in the transition ...Patients actually feel better and experience less pain when the mechanism of paradoxical pain is realised and opioids ceased. Methadone should be low dose and temporary."[6]

17. Dr Stephenson also stated that the Gabapentin can be beneficial for true neuropathic pain of objective nerve injury but not in non-specific pain and it could be eliminated without loss. Similarly, Stilnox was only useful short term and Endep is often ineffective after six months. He thought the migraines were probably due to analgesic excess and would improve if the opioids were ceased.

Reduction (Tapering) of Opioids

18. Following receipt of that letter, Heather's General Practitioner, Dr Elizabeth Moore at the Palmerston GP Super Clinic, ceased the Gabapentin and started a 10% reduction per month of the OxyContin.

19. The reduction continued until 4 July 2013. At that stage Dr Moore was prescribing OxyContin 80mg twice daily and 20mg in the middle of the day. Dr Moore wrote in the notes that Chronic Pain Management Guidelines state that 40mg of OxyContin twice daily should be the maximum dose. She then left the Palmerston GP Super Clinic.

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[6] Pages 7 & 8

20. There was no management plan for the treatment of Heather at that time, or at any time thereafter.

21. Those remaining at the Palmerston GP Super Clinic continued to provide to Heather OxyContin 80mg twice daily and 20mg at lunch time (total 170mg daily). The prescriptions were provided on 29 July 2013, 21August 2013, 18 September 2013 and 10 October 2013.

Prescription Shopping

22. Records of prescribing of all Schedule 8 drugs are recorded by the Department of Health in the "Drug Monitoring System". All OxyContin prescribed to Heather was recorded in that system along with the contracts entered into between Heather and the doctors.

23. However, the Drug Monitoring System (DMS) is somewhat limited. It is not "real-time". It takes about 14 days for information from pharmacies to be entered into the system. I was told that the DMS generates "alerts" to highlight occurrences of prescription shopping. However it is clear from what follows that the system did not detect the multiple prescribers in this case or the fact that two contracts were in existence at the same time.

24. The DMS is also not set up to evaluate whether or not a prescriber is prescribing unsafe doses. That is despite the system requiring notification from doctors of doses over a pre-set level. In this case the pre-set level was 80mg per day.

25. The limitations of the DMS or the course of prescribing to Heather seemed not to be well understood. Those that oversaw the DMS provided the following analysis in a statement provided to my Office:

> "From the regulator point of view, prescribing to Mrs Heather Fotiades appeared to be well managed as:
>
> - The patient obtained prescriptions from one medical practice;

- The patient had been placed on contract by the prescriber so she was required to stay with one practice and pharmacy;

- The patient had a recent pain specialist review (February 2015 with Dr Chin at RDH) so the GPs had recent advice to follow.

Mrs Fotiades remained with a particular practice/prescriber for a long period of time and did not visit other surgeries for prescriptions."

26. The last of the prescriptions from the Palmerston GP Super Clinic noted above (at paragraph 21) was on 10 October 2013. Four days later, on 14 October 2013, Heather saw Dr Moore at her new place of work and was prescribed 56 tablets of OxyContin 80mg (total 160mg daily). At that time she also entered into a "Contract for Patients Prescribed Opiate Pharmacotherapy". That was for a period of one year and indicated that Heather agreed to see only Dr Moore in relation to her treatment. That contract was forwarded via facsimile to the Department of Health at 10.41am on that day from the Arafura Medical Clinic at Casuarina.

27. From that date, Dr Moore continued to reduce the opioids each month. On 20 November 2013 she prescribed a dosage totalling 140mg per day (80mg x 28, 40mg x 28 and 20mg x 28). On 9 December 2013 the dosage prescribed totalled 130mg per day (80mg x 28, 40mg x 28 and 10mg x 28). On 2 January 2014 she provided a prescription to Heather totalling 120mg per day (80mg x 28, 40mg x 28).

28. Also on 2 January 2014, Heather attended the Palmerston GP Super Clinic. She did not tell the doctor she was receiving opiates from Dr Moore. The doctor recorded in his notes:

> "Terrible, pain in hip, knees and ankle, not had any pain relief for a few days. Tearful ++ Definitely has serious dependency and feels totally disempowered. Probably needs careful rehab with a pain control element. Physical therapies."

He prescribed OxyContin 80mg x 56 and 20mg x 28 (170mg per day).

29. On 31 January 2014 Heather returned to the Palmerston GP Super Clinic. She was provided with the same prescription for OxyContin (total of 170mg per day).

30. On 24 February 2014 she attended on Dr Moore who prescribed OxyContin 40mg x 56 and 30mg x 28 (total 110mg per day).

31. Four days later on 28 February 2014 Heather attended the Palmerston GP Super Clinic where she was again prescribed OxyContin 80mg x 56 and 20mg x 28 (170mg per day).

32. From that point Heather continued to obtain the OxyContin from the Palmerston GP Super Clinic.

33. On 19 May 2014 Heather entered into another "Contract for Patients Prescribed Opiate Pharmacotherapy". On this occasion, with Dr Heard at the Palmerston GP Super Clinic. That contract was sent via facsimile to the Department of Health at 12.24pm that same day. It should be noted that the contract with Dr Moore still had five months until it expired. That did not raise an alert and Dr Heard was not told there was already a contract in existence for Heather.

34. On 11 June 2014 Heather told Dr Heard that she needed to go down south to stay with her very ill mother. She said she would be there until the end of September. She asked for prescriptions to last for 16 weeks. On 11, 12, 13 and 16 June 2014 Dr Heard wrote monthly prescriptions for OxyContin 80mg x 56 and 20mg x 28 (170mg per day). He wrote in the notes:

> "No further medication UNTIL 30th SEPT 2014. Discussed need to be careful."

35. On Monday, 15 September 2014 she attended on Dr Heard. He wrote the following notes of that visit:

> "Says has had major burglary on Friday. Took tablets, and lots of other goods. Tachycardia and sweating – clearly withdrawing.

> Possible abuse of tablets – upset that I recorded this. Denies having ever taken extra tablets."

36. Dr Heard provided a further prescription of OxyContin 80mg twice a day and 20mg once a day. He reduced the Stilnox from 3 to 2 in the evening. He wrote "Very upset that I reduced tablets – Stilnox". He asked Heather to provide a Police report relating to the theft.

37. Three weeks later on Tuesday, 7 October 2014, Heather saw Dr Eccles at the Palmerston GP Super Clinic. Dr Heard was away that week. Heather told Dr Eccles that she only had enough OxyContin to last until Saturday. She said she was going to Melbourne to see her daughter who was studying there and had a car accident. She had not seen her for two years. She wanted tablets to cover from Saturday for a week.

38. Dr Eccles recorded: "Quite agitated when I suggested she should see Sam to get supply for whilst away. Wanted me to give them all to her today."

39. Dr Eccles gave her enough to cover from Saturday until Monday when she was to see Dr Heard.

40. On Monday 13 October 2014 Heather saw Dr Heard. He recorded:

> "Came in with stat declaration about her theft ... Very upset that I did not believe her about the theft. Tearful, very upset that I did not trust her at the time ... Stressed important not to use her pain killers (This upset her a great deal).

41. Twenty-six days later, on Saturday 8 November 2014, Heather saw Dr Heard again. She presented with pain to her left index finger. He recorded, "Furious that I have brought up that this is a little early". He provided her the OxyContin prescription and made an appointment to see Heather the following Wednesday for a full assessment.

42. On that date, 12 November 2014, there is recorded in the GP notes that Heather had raised with the surgery manager that she felt distressed that her

doctor was not trusting her appropriately. The manager suggested Dr Heard use a chaperone. Heather kept saying to Dr Heard, "after my operation I'll cut down and I've already cut down one medication".

43. Thereafter, the prescription of OxyContin remained at 80mg twice daily and 20mg at lunchtime. Heather also continued on the same prescription for Endep and Stilnox.

44. Due to obtaining opioids from two different prescribers, over the 18 months leading up to her hospital admission on 29 January 2015, Heather had available to her between 220mg and 230 mg of OxyContin per day (equivalent to 330mg and 345mg of morphine each day).

Concerns of her GP

45. Dr Heard was most concerned about Heather's opioid intake and her increasing weight. He told me however, that Heather was not willing to consider his suggestions of a reduction. She was only interested in what the specialists were considering at the hospital. He said in evidence, "the feeling of control of her life from the hospital was very strong ... just always thinking the solution was getting closer."[7] The effect was that her general practitioners had little influence over Heather.

46. On 20 August 2014 Dr Heard wrote to Dr Matthew Sharland in an attempt to forge a mutual management strategy with the surgeon:

> "Thank you for seeing Heather Fotiades who has ongoing issues with pain and debility following a MVA. She has now been assessed by a third party orthopaedic specialist who concurs with your opinion that the R hip is significantly arthritic and that hip replacement is likely to be helpful.
>
> I have a number of concerns:
>
> 1. Heather's R knee continues to cause as much trouble as her hip

[7] Transcript p53

2. She is still on 100mg of Oxycontin twice daily as well as other medications of dubious benefit such as stilnox.

3. She has chronic pain problems that are likely to work against her recovery from surgery.

I would like to propose that we set some criteria for going ahead with surgery:

1. That her weight is reduced to 90kg (10% reduction)

2. That her Oxycodone be reduced slowly in the lead up to the operation reducing 10mg/day/month aiming for 40mg daily prior to the operation.

3. That she cease stilnox prior to the operation.

I am motivated to achieve these changes so that she has some reserve to accommodate the pain of the operation and can mobilise quickly. To assist her in this I propose that we seek support for her to attend aqua-aerobics with some physio support."

47. Dr Heard received no response to that letter. On 28 January 2015 he called the Orthopaedic Surgeon to agree on a plan to manage her pain following surgery.

48. On 29 January 2015 Heather was admitted to Darwin Private Hospital for an elective total right hip replacement. She stayed in the Hospital until 18 February 2015.

49. During that time her pain management was undertaken by Dr Gavin Chin, a Consultant in Rehabilitation and Pain Medicine. He took the opportunity to transition Heather from OxyContin to Methadone while in hospital.

50. On 30 January 2015 Dr Chin prescribed Methadone 10mg twice a day. That was increased to 20mg twice a day on 2 February. On 7 February it was increased to 30mg twice a day and on 17 February it was increased to 40mg twice a day.

51. The conversion of Methadone to morphine equivalence is not as straight forward as with other opioids. Dr Chin calculated the equivalence by using the formula of "roughly 3 times the potency of Morphine"[8] and equating to 240mg of Morphine per day. Other conversion tables suggest the formula should be at least 4 times the potency. Dr Heard was of the opinion from his research that the equivalence was more likely to be about 8 times the potency.[9]

52. In any event, even taking the formula suggested by Dr Chin, the Methadone was only 30mg less than the OxyContin Heather was thought to be taking prior to her admission.

53. In addition to the Methadone, Heather had access to "as required" (prn) opioids while in hospital. Those included Ketamine through the patient controlled analgesia, Endone[10] in tablet form (up to 80mg daily) and intramuscular injections of Morphine (up to 120mg daily).

54. On 18 February 2015 Heather was released from the Private Hospital on a prescription of Methadone 40mg twice daily and Endone 5mg as required, up to 16 tablets a day (a total of 80mg per day).

55. That was in addition to her other medications; Lyrica 150mg twice a day (total 300mg per day), Endep 75mg (at night), Stilnox 30mg (at night) and a Ventolin Inhaler.

56. On 26 February 2015 Heather saw Dr Susan Chambers at the Palmerston GP Super Clinic. She said she had fallen and jarred her right knee. The prescription regime provided on her release from hospital was continued.

57. On 26 March 2015 Heather described being in a lot of pain. She said she was getting migraines and nausea. She told Dr Chambers she used to have

[8] Transcript p76
[9] Transcript p55
[10] Fast release Oxycodone

morphine injections for the migraines. Her Endep was increased to 100mg at night and the Lyrica was increased to 225mg twice daily (total 450mg per day).

58. On 9 April 2015 the GP notes record that Heather was "bitterly complaining of swelling of right leg, the skin was sore and stretched and red near the ankle". She said she had been having migraines and vomiting. She said she knew it was not from medication over-use. She said she had another fall when her right knee gave way.

59. On 23 April 2015 the GP notes written by Dr Chambers state:

> "Review due by Dr Chin. On 12 Endone a day, has 4 mane (morning), 2x2 in day then 4 at night, possibly some in night depending on what she has done in day, like physio. Had another fall, so more pain as hit hip, knee gave way again.
>
> Distressed – says daughter won't have anything to do with her, says lazy as housework not getting done. Husband "fed-up" with her, partly as unable to do things at home, partly around drug use – he does not understand."

60. On that same day Dr Chambers wrote to Dr Chin. The reason for her referral was stated as:

> "I wondered about the plan for reduction of her Endone – she has had some setbacks with a couple of falls and continuing back pain, but she is now 8 weeks postop. I have increased her Lyrica. She is having physio."

Dr Chambers did not receive a response from Dr Chin until 11 June 2015.

61. On 21 May 2015 Dr Chambers recorded:

> "Has had migraine for 4 days, only left house when needed food. Pain behind eyes, light sensitive, nausea, no visual aura. Naramig not helped ... Even with 100mg Endep not slept more than 2 hours. Has increased Endone to 16 a day again as back hurts ... 6 metres increasing shortness of breath on exertion and dizzy-faint and sweating ... due Dr Chin next week. No period for two years ...

> Shortness of breath on exertion predates op tho' is getting worse. Increase preventer inhaler (was using son's). Increase endep for migraine and pain, separately increase Lyrica up to max 300mg bd. I wonder if Lyrica is causing some oedema?

The Endep prescription was changed to 125mg at night and the Lyrica to 600mg per day.

62. On 4 June 2015 Heather saw Dr Chambers. The notes state:

> Pain in spine and hip bad so has gone up to 14 Endone a day ... I wondered if leg swelling is due increase in Lyrica, she thinks not.

63. In a letter to the Clinical psychologist on 4 June 2015, Dr Chambers wrote:

> "She manages pain by taking Endone, which she takes at the same level and is having difficulties reducing. She is awaiting follow-up appointment with Dr Gavin Chin, methadone was started in hospital postop I assume with a plan to substitute it for the Endone."

64. On 10 June 2015, Dr Gavin Chin saw Heather. In his report to Dr Chambers the following day he wrote:

> "This lady had chronic pain with opiate dependency and obesity. She needs to lose weight and I have referred her to a dietician. With regard to her pain management I have increased the Endep to 150mg at night and also the Lyrica to 225mg BD. The only other option would be to look at increasing the Methadone but she would definitely need to reduce her dose of Endone ... she may need to be assessed for sleep apnoea."

65. On 18 June 2015 Dr Chambers saw Heather and wrote:

> "Has seen Dr Chin, he increased endep to 6 at night, happy with increase in Lyrica but did not change endone/methadone."

66. On 19 July 2015 Heather, Evan and Jaidyn spent the evening together at their home. Heather went to bed after midnight.

67. Jaidyn found her after midday the next day, 20 July 2015, slumped face down across the foot of the bed. She was unresponsive and paramedics declared her deceased.

68. In her room were found the following prescription medications:

- "24 boxes of 20 tables of Endone 5mg (Oxycodone), and
- 9 boxes of 20 tablets of Physeptone 10mg (Methodone),
- 7 boxes of 30 tablets of Brufen 400mg (ibuprofen, an anti-inflammatory)
- 5 boxes of 14 tablets of Stilnox 10mg (Zolpidem for sedation)
- 1 box 56 capsules of Lyrica 300mg (neurological pain)
- 1 box 56 capsules of Lyrica 150mg (neurological pain)
- 3 boxes of two tables of Naramig 2.5mg (Naratriptan for migraine)
- 1 box 50 tablets of Endep 25mg (Amitriptyline for depression)
- 1 box of 50 tablets Endep 50mg (Amitriptyline for depression)
- Asmol inhaler x2 (Asthma)
- Panamax 2 strips (Paracetamol)"

69. An autopsy was performed and blood sent for testing. The toxicological analysis found in her blood:

1. "0.77mg methadone/L
2. 0.65mg amitriptyline/L
3. 0.49mg nortriptyline/L
4. 0.04mg oxycodone/L (consistent with therapeutic concentrations)
5. 2mg ibuprofen/l (consistent with therapeutic concentrations)
6. Zolpidem (consistent with therapeutic concentrations)
7. Naratriptan"

70. The methadone, amitriptyline and nortriptyline (major metabolite) were above therapeutic concentrations. One study reported the therapeutic range for methadone up to 0.75mg/L. Another reported fatal concentrations ranging from 0.084mg/L to 2.7mg/L.

71. The therapeutic range for amitriptyline and nortriptyline is said generally to be between 0.1 and 0.2mg/L but has been documented as high as 0.16mg/L. Fatal ranges have been noted to be 0.43mg/L to 8.3mg/L.

72. It is quite possible that each of the drugs alone at that dosage would not have been fatal. However the combination was.

73. Dr Chin told me during the inquest, "people do – can die from the combination of drugs she was on"."[11]

Issues

74. The findings of the Penington Institute published *Australia's Annual Overdose Report 2016* included:

> "Over the period 2008-2014 there was an 87 per cent increase in prescription opioid deaths in Australia, with the greatest increase occurring in rural/regional Australia which saw a 148 per cent increase."

75. More people are dying from prescription drugs than from car accidents and from illicit drugs.

76. The Director of the US Food and Drug Administration is quoted as saying about opioids:

> "We know of no other medication that's routinely used for a nonfatal condition that kills patients so frequently".

77. On 2 March 2017, "Medicine Today" had a "Prescription Opioid Supplement". In the Paper titled, *"The rise and rise of prescription opioid use in Australia"* the following was said:

> "Long-term opioid use had been associated with increased risk of overdose, extra-medical use, falls and fractures, myocardial infarction, depression, hyperalgesia and hormonal and sexual problems. Chronic use can also have negative effects on day to day functioning, quality of life, mood, physical activity and pain

[11] Transcript p80

severity. Interestingly, tapering or withdrawing high-dose opioid treatment had been associated with improvement in these markers." [12]

78. On 29 April 2017 a consultant in pain medicine in Bristol, United Kingdom was quoted in The Times saying that although opioids work for short term pain they do little for people suffering from long term pain that is not caused by tissue damage. She said:

> "We see a lot of patients take these drugs to cope ...we need a real public message that if these drugs don't do anything, just come off."

Recognition of problem

79. On 15 February 2012 Dr Tim Semple a Visiting Pain Specialist wrote to Heather's General Practitioner stating:

> "The dose of Oxycontin 320mg per day (roughly equivalent to 480mg of oral Morphine per day) is at a level that rotation options are limited. I would suspect that either Methadone tablets or Fentanyl patches may be the best options. The best approach would be done in an inpatient setting although I recognise that access to such services is relatively limited here in Darwin. I will discuss with Dr Gavin Chin whether it was feasible to try to achieve an inpatient rotation or whether a community approach would be needed."

80. Seven months later on 24 September 2012 Heather's General Practitioner wrote to Dr Gavin Chin stating:

> "I am writing as a follow up after Dr Tim Semple's last visit with Heather. He made a plan to admit her to hospital, withdraw her from narcotics, establish her narcotic requirement with morphine and rationalise her treatment ...We have had no further communication, so I called Dr Semple's rooms in Adelaide, and he does not expect to return here any time soon. He asked that I follow up this plan with you."

However there was no further response or involvement of Dr Chin until 2015 and on that occasion the opioid medication was increased.

[12] Page 6

81. On 21 November 2012 the following was written in Dr Moore's GP notes:

> "Heather reports her family has had a conference with her – husband and children. Family are fed up with her inactivity, medication use etc and want her behaviour to change. ... Heather is tearful today and says she can't do a dose reduction, I explained again the nociceptive effect of high dose narcotic, and in her best interest I am giving her no choice now."

82. As the expert witness, Associate Professor Michael McDonough, pointed out, despite a recognition that Heather was drug dependent the focus of her treatment continued to be her chronic pain symptoms. He said:

> "However ... the medical condition carrying the greatest risk to her health and safety (i.e. having greatest morbidity and mortality risk) was her Drug Dependence status".

83. Over the next three years, however, very little changed and when it did it was not for the better. Why that was so, given the specialist indications that opioids should be reduced, the clear loss by Heather of her functionality, the recognition of her drug dependence and the understanding that the level of her dosage may be sensitising her to some of the chronic pain she suffered was the subject of questioning during the inquest.

Dealing with Addiction

84. The challenges of dealing with Heather's addiction particularly after such a sustained period on high doses of opioids should not be underestimated. Dr Heard said:

> "There are many clients ... that are very much in the addiction space, or going down that pathway. I think it's fair to say that Heather absolutely rejected that pathway. Absolutely, with all her heart and soul did not see herself as an addict."

85. That did not stop the successive GPs from attempting to reduce her dose. However, those attempts ultimately failed. The attempts of Dr Moore were thwarted by the limitations of the Drug Management System. The attempts

of Dr Heard and Dr Chambers were thwarted by the lack of engagement of the specialists.

86. But there was not the necessary focus on the addiction:

a. There was no written plan to treat her addiction. There was reference in the evidence of the churn of GPs in the Northern Territory. That led to Heather seeing six different doctors at the Palmerston GP Super Clinic. It would seem in that situation there should be more priority given to having a clear and written management and treatment plan.

b. There were from time to time contracts with Heather specifying that she was to use only one GP and one pharmacist. There wasn't however a contingency plan for emergencies or exceptional circumstances. For instance, there were no clear instructions on what should happen or who Heather should see if her primary prescriber was unavailable.[13] That clearly exacerbated the relationship with Heather and increased the frustrations of all involved. I encourage the Department of Health to make provision for a secondary provider in the pro forma contract.

c. The opinion of a specialist in Addiction Medicine was not sought as to substitution pharmacotherapy. Having said that, the evidence was that in the Top End of the Territory there is not at this time such a specialist (although I was assured there is a Senior Registrar fulfilling that role).

d. Dr Semple said that in South Australia the Pain Specialists and Addiction specialists work closely together. It is evident that did not happen in this case. The Chief Health Officer provided the opinion that

[13] The Department of Health "Contract for Patients Prescribed Opiate Pharmacotherapy" does not include provision for a secondary prescriber.

there should be more collaboration between the pain management service and the clinicians who practice in addiction medicine.[14]

87. That lack of focus was in circumstances where there were clearly significant risks to Heather:

a. She was obese and putting on weight rapidly. She was 100kg in August 2014, 108kg when having the hip operation in January/February 2015, 132kg when seen by Dr Chin in June 2015 and 137kg when she died.

b. Associate Professor McDonough described the increased risks caused by obesity:

> "People with obesity have a much higher vulnerability to opioid toxicity. In short, opioids manifest toxicity principally through disturbance of our respiratory drive, our drive to breathe ...People with obesity tend to breathe more shallowly because the weight on the diaphragm which reduces their airflow [and affects] their ability ... to oxygenate and they fatigue more easily ... with opioids on board this is a significant contributing factor ... reducing the drive to breathe."[15]

c. Heather had other important respiratory risk factors. She had previous surgery involving her upper airway, asthma, recurrent bouts of chest infections, suppurative sinusitis, otitis media and possibly sleep apnoea.[16]

d. For the last four months of her life she was prescribed more than one opioid at the same time. The Methadone and Endone both depress the respiratory drive. I was told by Associate Professor McDonough that prescribing more than one opioid at a time is not recommended in the clinical guidelines.[17]

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[14] Transcript p65
[15] Transcript p18
[16] Dr Chin's letter to GP dated 11 June 2015; Report of Dr McDonough p9
[17] Report of Dr McDonough p9

e. More than that however was the prescribing of the Endone on a "take as required" basis. Heather had been identified as drug dependent and demanding opioids from the doctors. Both of those aspects raised the risk of excessive use of opioids. [18]

f. Added to those risks were the sedating drugs; Endep (Amitriptyline), Lyrica (Pregabalin) and Stilnox (Zolpidem). Those sedating drugs increased the risk of medication error, adverse interaction, toxicity and overdose.[19]

g. Heather also had noted changes to her liver function. Abnormalities were noted in her liver function tests from 2011 and I was told those changes were likely to have contributed to her obesity. Those changes increased the risk of altered drug distribution, metabolism and excretion.[20]

Leadership

88. The issues appeared to be understood by most, if not all, of the medical practitioners involved in the care and treatment of Heather and yet there was no coordinated effort to make the necessary changes.

89. The General Practitioners were looking to the specialists to provide advice and direction to change the prescription regime and reduce the risks. They did not and their lack of engagement clearly frustrated the General Practitioners.

90. Dr Heard went as far as to say that he hasn't referred patients to the pain clinic in the Darwin Hospital because in his experience the doses of opioids are increased whenever anybody goes there.[21]

[18] Report of Dr McDonough p11
[19] Report of Dr McDonough pp9 & 11
[20] Report of Dr McDonough p11
[21] Transcript p50

91. Dr Evan Ackermann, the Chair of the Royal Australian College of General Practitioners echoed that sentiment, saying, "GPs sometimes find their patients returned simply on higher opioid doses".[22]

92 Dr Heard gave evidence that often people leaving hospital are provided with opioids just in case they experience pain. He said:

> "I really hope that the court will get in a position to maybe even look at some regulation around dosing of opiates for non–cancer and even, you know, some of the suppliers of this medication in the community have been patients with cancer very long, slow cancers where pain hasn't been a feature. Also, during home visits here in Alice Springs, in Aboriginal families, we see packets of Endone. Women have a Caesarean section, packets of Endone lying there, not used. What's going to happen with that? Why are we sending people home from hospital on strong narcotic medication? How are they here? It never used to happen. What's going on? It's just seeding this supply. Why would you take Codeine Forte for a headache? Bad idea. You don't need to. You need to go and lie down and take a Panadol. There's so much overuse of narcotics in the hospital environment that's leaking out into the community all the time and I think we just have to do something about it."

93. The Chief Health Officer agreed saying that patients being discharged from hospital can be prescribed Oxycodone when they don't actually have pain but just in case they get pain.[23]

94. Dr Heard attempted to avoid Heather being discharged on a higher dose by engaging with Heather's surgeon on that very issue. However that was unsuccessful.

95. When Dr Gavin Chin gave evidence he told me that he did advise for the opiates to be reduced when he saw Heather on 10 June 2015. He accepted that he was seeing Heather on a referral to see whether her Endone should be reduced.[24]

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[22] Letter from Dr Ackermann to Coroner dated 15 March 2017
[23] Transcript p59
[24] Transcript p79

96. The following question was asked and answer given:

> "Q. However, after you saw her you increased a couple of her other medications but didn't taper the Endone and didn't suggest tapering the Endone?
>
> A. No, that's not correct. I recommended that she should definitely need to reduce her dose of Endone."

97. That was not however the case. The passage in the letter of 11 June 2015 Dr Chin relied upon in holding that belief read:

> "With regard to her pain management I have increased the Endep to 150mg at night and also the Lyrica to 225mg BD. The only other option would be to look at increasing the Methadone but she would definitely need to reduce her dose of Endone."

98. The import of those sentences is clear. There was no plan to reduce her opioid intake. There was no recognition that Heather should be on less drugs. There was no recognition that her high levels of pain may have been due to the high doses of opioids. There was no plan to taper her opioids.

99. The only plans were to increase the non-opioid drugs with the option of increasing her Methadone. For the latter she would need to reduce the Endone. The plan suggested by Dr Stephenson in 2012 of transferring Heather to Methadone and then reducing her dose with a view to ceasing opioids altogether was not evident in the advice of Dr Chin.

Regulatory System

100. Regulatory systems allowed the provision of long term high doses of opioids for chronic non-cancer pain in an era when it was not fully recognised that after a few months the drugs were largely ineffective due to a build-up of tolerance, were addictive and placed patients at significant risk.

101. Now those aspects are recognised the regulatory system has been slow to ensure that practices change and the risks are appropriately mitigated.

102. Dr Heard is of the opinion that there should be a maximum dose of opioids able to be prescribed for a patient with non-cancer pain.[25] I found Dr Heard to be a most engaging, knowledgeable and impressive witness.

103. The Code of Practice for issuing prescriptions for Schedule 8 substances requires the prescriber to notify the Chief Health Officer of the prescription in certain circumstances. One of those relates to the daily dose prescribed. Notification must be provided of a daily dose in excess of 40mg of methadone tablets and 80mg of oral oxycodone. If a combination is supplied, the total must not exceed the dose equivalents.[26]

104. However, there was no indication that the Department of Health looked at that information or considered there was anything that should be done with it. The Chief Health Officer provided evidence that he was of the opinion that such information should be analysed to see whether the prescribing was appropriate.[27] I agree entirely.

Formal Findings

105. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased was Heather Fotiades born on 12 June 1972 in the United Kingdom.

(ii) The time of death was between midnight on 19 July 2015 and 1.00pm on 20 July 2015. The place of death was her home at 12 Minorelli Court, Gray in the Northern Territory.

(iii) The cause of death was acute multiple drug toxicity on a background of chronic pain and morbid obesity.

(iv) The particulars required to register the death:

1. The deceased was Heather Fotiades.

2. The deceased was of Caucasian descent.

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[25] Transcript p49
[26] Code of Practice 1.4 (3) and (4)
[27] Transcript p64

3. The deceased was not employed at the time of her death.
4. The death was reported to the coroner by the Police.
5. The cause of death was confirmed after autopsy by Forensic Pathologist, Dr Terence Sinton.
6. The deceased's mother is Brenda Martin and her father is Mike Martin.

Comment

106. Section 34(2) of the *Act* operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

107. This was a preventable death. Heather should not have been on such high doses of the drugs. It was known that the high doses were a risk to her life. It was known that the high doses of opioids were largely ineffective. It was also known that keeping Heather on such high doses was affecting her functionality and quality of life. It was known that she was addicted.

108. Coroner Stephen Carey in Tasmania, on 25 May 2016, referred to the ever increasing evidence that some prescription medication used to treat chronic non-cancer pain was not only ineffective but harmful to the patient and known to be so. He said that such deaths should not be called "accidental" because that suggested they were unavoidable. [28]

109. I entirely agree. The death of Heather was foreseeable and should have been foreseen by her medical practitioners. She should not have been on such high doses and the drugs should have been tapered to safer levels years before.

110. Most of Heather's treatment was undertaken by the private sector paid for by the insurer after the injuries incurred in the motor vehicle crash in 1990.

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[28] Coronial Findings (without Inquest) into the death of Deearne Joan Barnes

The contributions of the specialists were therefore provided in their private practices.

111. Meaningful coordination or collaboration between those specialists and the General Practitioners in the last three years of Heather's life was non-existent. I encourage doctors to consider their obligations to their patients and how that might be improved by their ready and willing engagement. Recourse should also be had to the Code of Conduct for medical practitioners:

> **"4.2 Respect for medical colleagues and other healthcare professionals**
>
> Good patient care is enhanced when there is mutual respect and clear communication between all healthcare professionals involved in the care of the patient. Good medical practice involves:
>
> Communicating clearly, effectively, respectfully and promptly with other doctors and healthcare professionals caring for the patient.
>
> Acknowledging and respecting the contribution of all healthcare professionals involved in the care of the patient.
>
> Behaving professionally and courteously to colleagues and other practitioners including when using social media."

112. It is also apparent that more could be done through the regulatory system. I was being told about real time prescribing databases over 15 years ago in other prescription overdose cases. I understand that no other State or Territory (other than Tasmania) has to date made significant improvements to their systems.

113. However it is time that the Drug Management System is improved to a real time system.

114. It is also evident that the already available data should be properly analysed so that high risk and inappropriate prescribing is detected and acted upon.

115. It is also difficult to find an argument against having maximum levels for prescription opioids. The past practices of prescribing high doses of opioids for long periods for chronic non-cancer pain need to stop and those that are already on such high doses need to be tapered to safer levels.

116. The seeming overly liberal provision of opioids on discharge from hospitals must also be better controlled.

Recommendations

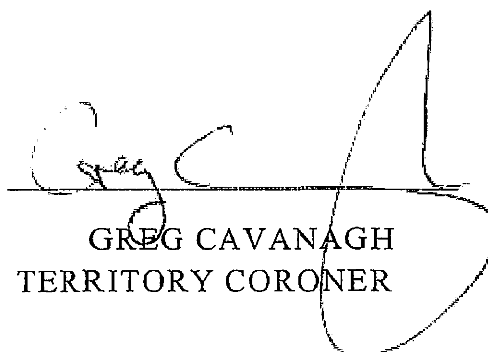
117. I **recommend** that the Northern Territory Government implement real time monitoring of Schedule 8 drugs as soon as possible.

118. I **recommend** that the Northern Territory Government give consideration to maximum prescribing levels for opioids.

119. I **recommend** that the Department of Health and the Health Service Boards consider implementing restrictions on the provision of unnecessary opioids to patients being discharged from hospital.

120. I **recommend** that the Health Service Boards do all such things as are reasonable to ensure collaboration between the Pain Specialists and Addiction Medicine Specialists with the view to ensuring safe use of addictive medications used for the control of pain.

Dated this 5th day of May 2017.



GREG CAVANAGH
TERRITORY CORONER

NORTHERN TERRITORY GOVERNMENT

2017\2603-NKF
RECEIVED
14 SEP 2017
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File Ref: DD2017/6359

The Hon Natasha Fyles MLA
Attorney-General
Minister for Justice
GPO Box 3146
DARWIN NT 0801

Dear Attorney-General

Re: Coronial Findings – Heather Fotiades [2017] NTLC 12

Section 46B (3) of the *Coroner's Act* requires the Department of Health to provide a written response to the Coroner's recommendations to enable the Attorney-General to table a report in the Legislative Assembly.

I provide you the following statement of action taken by Northern Territory (NT) Health in the relation to the findings in this matter.

117. The Northern Territory Government implement real time monitoring of Schedule 8 drugs as soon as possible.

Currently in the NT, Schedule 8 (S8) medicines supplies from pharmacies are uploaded into a database called the Drug Monitoring System (DMS). Community pharmacies report all S8 prescription activity every seven days. Records received from community pharmacies are electronically uploaded but manual checks are required to ensure data integrity. This can result in a lag-time of two to three weeks.

The COAG Health Council has recently agreed to work on introducing a national system allowing near real-time monitoring of S8 prescription data by prescribers and pharmacists. The proposed system is the Electronic Recording and Reporting of Controlled Drugs (ERRCD). Work is underway by state and territory jurisdictions on developing a national governance arrangement for ERCCD. The NT participates in this work as a jurisdictional representative, and anticipated that when fully implemented, the ERRCD will replace the NT DMS.

118. The Northern Territory Government give consideration to maximum prescribing levels for opioids.

NT Health supports maximum prescribing levels for opioids.

The NT Code of Practice S8 Substances (S8 Code) lists maximum daily doses for unrestricted S8 substances which if exceeded require the prescriber to notify the Chief Health Officer by completing a notification form and lodging with Medicines and Poisons Control. This is monitored by the Scheduled Substances Clinical Advisory Committee (CLAC). The Code is currently under review.

119. The Department of Health and the Health Service Boards consider implementing restrictions on the provision of unnecessary opioids to patients being discharged from hospital.

The Executive Director Medical Services, Central Australia Health Service convened a working group with the addiction medicine specialist, chronic pain coordinator, chief pharmacist and quality manager to consider the recommendations and actions to be undertaken.

The Central Australia Health Service has taken action to place further restrictions on the provision of unnecessary discharge scripts for opioids. The working group has recommended generally limiting maximum amounts. The Pharmacy Department has performed audits to determine the scope of the discharge prescribing issue. The Chief Pharmacist is working on the findings which include setting mandatory end dates and decision support advice for opioid prescriptions within the NT Health electronic prescribing system.

Top End Health Service has commenced prescriber education and reinforcement of prescribing guidelines currently available on the NT Health policy site. The Drug and Therapeutics Committee is undertaking audits to confirm the scope of the discharge prescribing issue.

120. The Health Service Boards do all such things as are reasonable to ensure collaboration between the Pain Specialists and Addiction Medicine Specialists with the view to ensuring safe use of addictive medications used for the control of pain.

Within Central Australia Health Service, Alice Springs Hospital (ASH) has strengthened the addiction medicine speciality, the availability of pain specialists and the coordination between pain specialists and addiction medicine specialists over recent years. Addiction medicine and drug and alcohol services are managed within the same management cluster. Supervised opioid replacement therapy is available in ASH.

The Executive Director Medical Services, Top End Health Service has met with the pain specialist, Top End Mental Health and Alcohol and Other Drugs Services, medicine management, an addiction medicines specialist and emergency department representatives to consider the recommendations. The pain specialist is drafting a proposed coordination model for implementation.

Yours sincerely

Professor Catherine Stoddart
10 September 2017

Copy to: **Mr Greg Shanahan, CEO, Department of Attorney-General and Justice**