IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2012/4064

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of MARGARET HELEN MCCALL

without holding an inquest:

find that the identity of the deceased was MARGARET HELEN MCCALL

born 3 April 1952

and the death occurred between 26 and 27 Sept ember 2012

at 2/583 Esplanade, Mount Martha, 3934

from:

1 (a) HANGING[1]

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Ms Margaret Helen McCall was a 60-year-old retired School Teacher who lived alone in Mount Martha after her divorce in 2006. She had two children, Sarah and Jamie McCall whom she maintained a relationship with. Ms McCall's medical history included a history of acoustic neuroma (2008),[2] gastric reflux, diverticulosis, hypercholesterolemia and myoclonus seizures.[3] In addition, Ms McCall had a diagnosed complex regional pain syndrome (CRPS).[4]

[1] Mechanisms of death in hanging include compression of large airways, compression of large arteries and veins supplying and draining the head and neck, pressure on the carotid sinuses or a combination of these mechanisms.

[2] An acoustic neuroma is a benign, slow-growing tumour that originates in the canal connecting the brain to the inner ear. Symptoms of advanced acoustic neuroma can include headache, pain in the face, facial numbness and twitches, visual disturbances, such as double vision, difficulties swallowing and eventual death as the functioning of the brain stem is impaired. Margaret McCall had annual imaging (last 2012) which showed a stable tumour.

2. Ms McCall's CRPS developed in 2001 after she fractured her left patella and aggravated the injury in 2011. Ms McCall had been prescribed opiates for the CRPS (that she had developed a dependency on, especially fentanyl)[5] and had been treated with ketamine in 2012 to reduce her pain and associated opiate use. Ketamine is a recognised treatment option for CRPS.[6]

3. Ms McCall's psychiatric history includes a fifteen year history of panic attacks, anxiety, low mood and a dysfunctional coping style when feeling stressed. She reported childhood sexual abuse and had found it difficult to deal with the death of her brother. According to the documentation available, Ms McCall had consulted with various Psychologists and Psychiatrists since at least 2007.[7] Ms McCall reported an exacerbation of her anxiety symptoms within the year after her divorce (in 2006) when she perceived she had been abandoned and found it difficult to adjust to the change in life style, including the financial aspects.

4. Ms McCall consulted with several specialists and she consulted with her then regular General Practitioner (GP) Dr Richard Duff from as early as July 2000. She consulted with him at least monthly up until April 2012. Medical records show she was prescribed an antidepressant since 2001, had evidence of insomnia and started reporting knee pain since exacerbating her injury in 2006. This was extensively investigated and she was referred to appropriate specialists.

5. On 23 January 2012, Ms McCall's long-standing Physician Dr Blombery referred her to Frankston Pain Management Clinic because she found it difficult to travel to Melbourne from Mt Martha. In Dr Blombery's referral, he listed fentanyl as a current medication. In the forms completed by Ms McCall, she wrote that socially, she had a partner, worked in her garden, owned a dog and that her pain had worsened. On 31 January 2012, Dr John Monagle of Frankston Pain Management assessed Ms McCall and encouraged her to attend physiotherapy,

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[3] Myoclonic – brief, shock-like jerks of a muscle or a group of muscles, usually involving the upper body.

[4] Complex regional pain syndrome (CRPS) is a painful condition of a person's arm, hand, leg or foot which occurs after an injury, such as a fracture. Symptoms can range from mild to severe, and may last months or years. The cause of CRPS is unknown but treatment aims to relieve symptoms and restore limb function (movement and activity). Most people recover fully but the condition can recur and for a small group of people with CRPS, symptoms may be severe and have significant pain and disability that persists for years. Females are three times more likely to be affected than males.

[5] Fentanyl (Actiq, Fenpatch, Durogesic) is an opioids analgesic indicated for the treatment and severe acute and chronic pain available in lozenge, an injectable and intranasal forms and in a patch. Like all opioids analgesic analgesics, it carries a high risk of dependency with continued use.

[6] O'Connell NE, Wand BM, McAuley J, Marston L, Moseley GL 2013. Interventions for treating pain and disability in adults with complex regional pain syndrome – an overview of systematic reviews. Cochrane Database of Systematic Reviews 2013, Issue 4.

[7] Medical record of Tanti Creek General Practice.

to increase her activity and provided scripts for fentanyl and oxycodone.[8] Dr Monagle noted her reluctance to change any of her medications, becoming anxious when he discussed reducing the opioids. He also sent a referral for physiotherapy in Mt Martha. Ms McCall regularly completed the Pain Inventory Scale, rating her pain as high, with its interference with her day-to-day activities and mental state as considerable. Dr Monagle discussed the option of ketamine infusions with her.

6. On 3 February 2012, Dr Monagle injected the nerves on Ms McCall's knee and although she was anxious, the procedure resulted in improvement. He organised for an inpatient ketamine infusion at Peninsula Oncology Unit. Ms McCall provided her consent to the procedure.

7. On 16 February 2012, General Practitioner Dr Richard Duff completed a referral to Frankston Pain Management.

8. On 9 March 2012, Ms McCall had had a day admission for a ketamine infusion at Peninsula Oncology Centre, at which time she had no adverse effects and stated her pain was much better (scored at one out of 10).

9. On 18 April 2012, General Practitioner Dr Ayo Omidiora referred Ms McCall to Frankston Pain Management as he had recently taken over her care after she left Dr Duff. According to Dr Omidiora's referral letter, Ms McCall was currently prescribed fentanyl patches. Dr Monagle's letter to Dr Omidiora stated Ms McCall's pain had decreased to two out of 10 and they had completed the paperwork for an "as needed" ketamine infusion. Dr Omidiora was asked to contact the Department of Health (as it then was) for the purposes of listing himself as the schedule 8 prescriber (for fentanyl).

10. On 14 June 2012, Ms McCall had a day admission for a ketamine infusion at the Peninsula Oncology Centre and self-rated her pain as reduced from seven to two out of 10. She experienced hallucinations, which resolved.

11. On 21 June 2012, Ms McCall saw Dr Monagle and reported her pain had worsened since the infusion. She expressed sadness about her 2006 divorce, her dog's ill health and her relationship with her daughter, which she was trying to repair. Dr Monagle suggested a hospital stay for a five-day infusion, however Ms McCall was worried about how she would get to and from the hospital and who would care for her dog.

[8] Oxycodone – schedule 8 analgesic indicated for the treatment of moderate-to-severe acute or chronic pain.

12. On 22 June 2012, Ms McCall had a day admission for a ketamine infusion at the Peninsula Oncology Centre, with her pain rated as unchanged. She experienced nausea, which resolved.

13. On 29 June 2012, Dr Monagle wrote to Dr Omidiora explaining the last ketamine infusion had not been effective and they were planning an admission to Beleura Private Hospital for an infusion over five days. Ms McCall was apparently upset at this stage because her relationship had ended. Dr Monagle told Ms McCall that the mainstay of ongoing treatment was therapy with a Psychologist, however Ms McCall was reluctant to engage with one.

14. Ms McCall was admitted to the Beleura Private Hospital on 9 July 2012. She had listed her son who lives in South Australia as her next of kin.[9]

15. On 9 July 2012, Dr Murray Taverner of Frankston Pain Management referred Ms McCall to Consultant Psychiatrist Dr Jeremy Stone during the admission because he was concerned at her increased anxiety and the hallucinations she experienced during the infusion. Dr Stone assessed Ms McCall on 10, 11, 12 and 16 July 2012. He considered she had general anxiety that may or may not have increased during the ketamine infusion. He did not see any further need for his involvement or in changing any of her medications. He did not consider a longer admission would be beneficial.[10] Ms McCall was discharged home in a taxi on 17 July 2012.

16. On 30 July 2012, Ms McCall consulted with GP Dr Alisdair Barnes of the Tanti Creek General Practice for the first time. She presented with knee pain and explained she was "not aware that this [ketamine] was aimed at bringing her off addictive analgesics."[11] Ms McCall was not taking any addictive analgesics at that time. Dr Barnes provided advice, made a follow-up appointment and requested her files from the involved specialists.

17. On 7 August 2012, Ms McCall told Dr Barnes that she was in pain, was isolated and had what she perceived to be a dysfunctional relationship with her daughter. Dr Barnes encouraged her to exercise and increase her general activity.

18. On 13 August 2012, Ms McCall told Dr Barnes that she would never have ketamine again. Dr Barnes completed a GP plan and referred Ms McCall to the PACE Exercise Physiologist for

[9] Beleura Private Hospital health records Patient Registration form.
[10] Frankston Pain Management health records, letter to Dr Taverner dated 19 July 2012.
[11] Medical record of Tanti Creek General Practice, dated 30 July 2012.

free sessions. Ms McCall was to wean off the antidepressant duloxetine and commence the antidepressant mirtazapine.

19. On 17 August 2012, Ms McCall rang the GP clinic and said she was not coping due to her pain levels, but refused an earlier appointment.

20. On 22 August 2012, Ms McCall told Dr Barnes she was in pain. Dr Barnes rang Dr Monagle, who approved the pain management plan, which included exercise physiology and psychology.

21. On 23 August 2012, Ms McCall was transported by ambulance to the Frankston Hospital Emergency Department (ED) after she had expressed an intention to self-harm to her house cleaner. She was found to have scratches on her stomach but repeatedly denied any suicidal thoughts or intent to staff. She complained of abdominal pain, of being unable to self-care and experiencing increased anxiety. Ms McCall also told staff she was withdrawing from fentanyl and clonazepam and specified that her son, listed as next of kin, was not to be contacted. Ms McCall provided no other contact details. She also told staff she had thoughts of self-harm after her GP (unknown which GP she was referring to) refused to prescribe her ketamine (which is not a drug that is prescribed outside of a hospital setting). Ms McCall discharged herself against medical advice because she did not want to wait in the ED.

22. On 24 August 2012, Ms McCall called an ambulance and was taken to the Frankston Hospital ED but left without being seen by the Psychiatric service CLIPS. CLIPS unsuccessfully attempted to contact her after she left. CLIPS made contact the following day when Ms McCall stated she was going to go to another GP, that she had slept well and had no more thoughts of self-harm. She was consequently discharged from CLIPS.

23. On 28 August 2012, Ms McCall consulted with Dr Aram Isaac at Ti Tree Family Doctors for the first time. She told Dr Isaac that she had been in the ED, had knee pain, ketamine infusions and had a colonoscopy the day prior. Dr Isaac agreed with the plan (by Dr Barnes) for her to wean off the duloxetine and to commence mirtazapine. Dr Isaac arranged for her previous medical records be obtained.

24. On 31 August 2012, Ti Tree Family Doctors notified the Tanti Creek General Practice that Ms McCall was now a patient of their clinic and requested a copy of her health record.

25. On 3 September 2012, Ms McCall was transferred by ambulance to the Frankston Hospital ED after she had taken an overdose of clonazepam[12] (which she claimed was not to kill herself but for the purpose of pain relief), cut both wrists (one required stitches) and her neck. She expressed being unhappy with the hypnotherapy treatment provided by Psychologist Geoff Woods, which she reported was not helping her to manage her pain. The mental state examination (MSE) found Ms McCall to have some impaired judgement, but was otherwise considered normal. Ms McCall denied any suicidal ideation, plans or intent. She was discharged with advice to the Ti Tree Medical Centre to source an alternative Psychologist.

26. On 4 September 2012, after Dr Ann Michael of the Ti Tree Medical Centre requested a medical and psychiatric assessment, Ms McCall returned to the ED. She told staff her marriage had been abusive, that she believed she was estranged from both children, and listed her parents as next of kin. She denied the neck scratches were indicative of self-harm, and denied any suicidal thoughts or intent. She expressed her major problem was pain and its daily impact. She was admitted to the medical ward for review of her pain management.

27. During the 10-day admission to Frankston Hospital, Ms McCall had extensive medical, physical and psychiatric assessments and treatments, including an MRI scan. She was referred to and assessed by occupational therapy, including a functional assessment, physiotherapy, social work, speech pathology and neurology. There was frequent consultation with the other practitioners involved in her care, including pain management specialists Drs Monagle and Tavener, and GPs Drs Barnes and Ann Michael. There is also documented liaison with her nominated next of kin/contacts, including her parents and neighbour. Ms McCall requested opiate analgesic, particularly fentanyl but in consultation with Dr Monagle, she was prescribed tramadol[13] and later pregabalin[14] to which she reported a decrease in her knee pain. The antidepressant mirtazapine was weaned and she commenced venlafaxine.

28. Reassessment by CLIPS was frequent throughout Ms McCall's admission. CLIPS clearly documented their involvement in the clinical notes so the medical team and other involved staff had access to their assessment. Ms McCall reported no suicidal or self-harm ideation after a few days in the medical ward. She was reviewed again immediately prior to discharge and

[12] Clonazepam – long acting benzodiazepine used as a preventative to individuals diagnosed with epilepsy and in palliative care. In addition, it is used for its sedating effects in patient with anxiety that has not responded to other treatments.
[13] Tramadol (Tramadol) – opioid analgesic for moderate-to-severe acute or chronic pain.
[14] Pregabalin (Lyrica) is indicated to treat fibromyalgia, diabetic nerve pain, spinal cord injury nerve pain, and pain after shingles; also indicated to treat partial onset seizures in adults with epilepsy who take one or more drugs for seizures.

her mental state and risks were assessed. Ms McCall was visited regularly by a friend (unnamed) and her neighbour and spoke with her parents.

29. On 7 September 2012, Sarah McCall visited her mother in hospital and as reported by Ms McCall,[15] a nurse had contacted Sarah without Margaret's permission. Ms McCall told staff she was upset her daughter knew she was there, however, ongoing communication between staff and Sarah McCall ensued, including a meeting between Sarah McCall, the social worker and medical team on 13 September 2012, when the discharge plan was explained and provided to Sarah McCall. The discharge plan was developed after consultation with the involved practitioners and with Margaret McCall.

30. The discharge plan included a referrals to the HARP (hospital admission risk program), and to the Royal District Nursing Service, Physiotherapy, council run meals and shopping assistance, domestic occupational therapist assessment, and continuance of her private cleaning service and referral to the dual diagnosis service once settled. There was clear communication of this plan to the services involved and to GP Dr Barnes, including an appointment with Dr Monagle for review of pain management on 21 September 2012. Ms McCall was discharged home in the company of her daughter on 14 September 2012, which she agreed to only after the hospital transport service did not meet with her schedule.

31. There is limited information about what took place over 15 and 16 September 2012 other than Sarah McCall stating she observed her mother to be tearful, manipulative, and threatening to harm herself, and that she improved with the return of her son Jamie from South Australia, to the point of being able to get ready to go to lunch and drive her car. At some time following this period and prior to 23 September 2012, according to Sarah McCall, her mother ceased communicating with her children and turned to her cousins and parents for support. Sarah McCall states this was not normal.

32. On 18 September 2012, Ms McCall again saw Dr Barnes. Dr Barnes noted she did not want to see Dr Monagle again and did not want her daughter involved. She was taking the pregabalin, was weaning off tramadol and continued the venlafaxine.

33. On 17 September 2012, CLIPS received a call from Ms McCall's father expressing his concerns. Ms McCall was telephoned. She stated that she was in constant pain, denied

[15] Medical record of Tanti Creek General Practice.

suicidality and was remorseful about her previous actions, was concerned about her weight loss and had a planned appointment with Dr Barnes. She was unaware why her father had contacted CLIPS.

34. On 18 September 2012, CLIPS contacted the Tanti Creek General Practice to confirm Ms McCall had attended the planned appointment and Dr Barnes saw no further role for CLIPS.

35. On 19 September 2012, HARP clinician nurse Ms Susan Mills received a referral to see Ms McCall and arranged an appointment for 24 September 2012.

36. On 21 September 2012, Ms McCall returned to Dr Barnes and stated she could not cope, was unhappy with the HARP and other service involvements, but she could not articulate other reasons that Dr Barnes thought contributed to her acopia. After a discussion of options, Dr Barnes thought Ms McCall was willing to engage with services that were trying to support her.[16] There is no evidence that Ms McCall attended the prearranged appointment with Dr Monagle.

37. On 24 September 2012, Nurse Susan Mills completed a home visit with Ms McCall and while there, Nurse Mills attended to and dressed a wound. Ms McCall stated she had an appointment with GP Dr Duff arranged by her daughter that she did not want to attend. At Ms McCall's request, Nurse Mills rang Sarah McCall and explained her mother did not want to attend. Nurse Mills explained that she did not have permission to discuss anything else about her mother, but did explain HARP's role. Ms McCall's cousin contacted CLIPS expressing concern because Ms McCall's mood appeared labile, however she had no suicidal ideation or intent. During a second call soon after, her cousin stated that Ms McCall was in good condition, had her children with her and did not need CLIPS.

38. On 26 September 2012, Dr Barnes received a letter from Sarah McCall in which she recorded her concerns for her mother, including her observed change since the ketamine infusion in July. Dr Barnes arranged an appointment to see Ms McCall the following day in the company of Jamie McCall.

39. Nurse Mills at the HARP received two messages from Ms McCall both regarding her not wishing HARP to speak with Susan McCall, but rather with her parents.[17] In addition, Ms

[16] Coronial brief page 17.
[17] Coronial brief page 27.

McCall's case was reviewed with the HARP multidisciplinary team and the plan of care made, including attending appointments with her and encouraging her to permit HARP to speak with her family to better coordinate her care.

40. On 27 September 2012, Nurse Mills went to Dr Barnes' rooms to attend the appointment with Ms McCall but on arrival, she was told the appointment was two hours prior to what Ms McCall had stated and that Ms McCall had not attended. Jamie McCall telephoned Dr Barnes from his mother's home because he could not locate her and was worried. Dr Barnes recommended he contact the police, which he did. Victoria Police entered the home and located Ms McCall deceased and hanging in the garage. Nurse Mills attended the home and met with the police and family, including Ms McCall's ex-husband, Lindsay McCall.

INVESTIGATIONS

41. Dr Melissa Baker, Forensic Pathologist of the Victorian Institute of Forensic Medicine (VIFM) performed an external examination on the body of Ms McCall, reviewed a post mortem CT scan and the Police Report of Death, Form 83. Toxicological analysis of post mortem blood samples identified the prescribed medications, antidepressant venlafaxine, analgesic tramadol and anti-seizure medication levetiracetam at therapeutic levels. Dr Baker ascribed the cause of Ms McCall's death to hanging.

Coroners Prevention Unit

42. The Coroners Prevention Unit (CPU)[18] reviewed the circumstances of Ms McCall's death on my behalf, specifically the role and benefit/s of ketamine infusions, the prescription of antidepressant medication to Ms McCall, her apparent consultation with multiple GPs over a short time period, and the association, if any, between chronic pain and suicide.

43. I note that a review of the medical records does not support Ms McCall as being incompetent or that she at anytime complied with the *Mental Health Act 1986* (Vic) (as it then was) that would have supported practitioners to ignore what were her clear directions not to contact her children. Ms McCall listed her parents as her next of kin.

[18] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

a. Ketamine

44. According to Sarah McCall, Dr Barnes and Dr Duff, Ms McCall had ketamine infusions to treat the CRPS related to her knee.[19]

45. Ketamine is a current treatment for CRPS[20] with known physical and psychiatric adverse effects such as hallucinations, agitation and confusion (known as emergent reactions), nausea, vomiting and headache, which are noted to occur frequently with ketamine infusions but are short lived, occurring during and resolving shortly after the infusions cease.[21] There have been cases of re-emergent reactions that have occurred days or weeks after the infusion,[22] however there is no evidence that Ms McCall reported any hallucinations after the infusion. Ms McCall did report anxiety however, she had a long history of anxiety.

i. Ketamine infusion

46. The Therapeutic Goods Administration[23] information relating to ketamine does not list low dose administration for pain relief as an indication for its use, however I accept that this is a long-standing accepted clinical practise. A ketamine infusion is a procedure whereby the patient is administered a very low continuous dose of the pharmaceutical drug ketamine, usually via intravenous drip. For patients who suffer chronic pain, ketamine produces a strong analgesic effect by blocking ascending pain signal transmission from the spine to the brain; it might also enhance the transmission of pain-blocking signals from the brain to the spine and peripheral nervous system.[24] In addition, some studies have found that ketamine infusion is effective at suppressing symptoms of opioid withdrawal and reducing the amount of opioids a patient requires to achieve analgesic relief.[25]

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[19] 24/02/2012, 13/03/2012, 20/04/2012, 14/06/2012, 22/06/2012 and 10-16 July 2012.

[20] Rasmussen, K 2014. Psychiatric side effects of ketamine in hospitalized medical patients administered subanaesthetic doses for pain control. Neuropsychiatricia, Vol 26(4), Aug, 2014. Pages 230-233.

[21] O'Connell, NE, Wand, BM, McAuley et al, 2013, Interventions for treating pain and disability in adults with complex regional pain syndrome – an overview of systemic reviews (Review). *Cochrane Database of Systematic Reviews* 2013, Issue 4. Art. No.: CD001496. DOI: 10.1002/14651858.CD009416.pub2. pages 2, 32-33.

[22] Australian Medicines Handbook 2013, *Australian Medicines Handbook* Pty Ltd; Adelaide, page 12-13.

[23] Therapeutic Goods Administration. "Ketamine is recommended:1. As the sole anaesthetic agent for diagnostic and surgical procedures that do not require skeletal muscle relaxation. Ketamine is best suited for short procedures and it can be used with additional doses, for longer procedures; 2. For the induction of anaesthesia prior to the administration of other general anaesthetic agents; 3. To supplement low-potency agents, such as nitrous oxide." Accessed on 9 February 2015 at: <https://www.ebs.tga.gov.au/servlet/xmlmillr6?dbid=ebs/PublicHTML/pdfStore.nsf&docid=219039&agid=%28PrintDetailsPublic%29&actionid=1>

[24] See for example Niesters M, Martini C, Dahan A, "Ketamine for chronic pain: risks and benefits", *British Journal of Clinical Pharmacology*, vol 77, no 2, 2013, pp.358-359.

[25] See for example Jovaisa T, et al, "Effects of ketamine on precipitated opiate withdrawal", *Medicina (Kaunas)*, vol 42, no 8, 2006, p.625; Quinlan J, "The Use of a Subanesthetic Infusion of Intravenous Ketamine to Allow Withdrawal of

47. As these beneficial effects can last for some time (up to a period of months) after the ketamine infusion has been administered, it is sometimes used in patients who suffer chronic pain and are treated with high-dose opioids, to assist in their withdrawal from opioids and to "reset" their opioid use, recommencing them on lower and thereby safer doses.

48. An important feature of using ketamine infusion for analgesia is that its effects are only temporary. As noted in a 2013 comprehensive review of evidence on ketamine infusion that was published in the *British Journal of Clinical Pharmacology*, the initial analgesic effects experienced in the first four weeks after infusion are very significant. However:

> *While these effect sizes are relatively large, indicating that the effect of ketamine treatment persists for at least 4 weeks, they show a rapid decline in effect, an indication that retreatment is required within 4–6 weeks following the initial treatment period. This then requires another admission to hospital that is costly and an additional burden to the patient. [...] A final remark on these long term ketamine treatment studies is that while pain relief was present during the weeks following ketamine treatment little or no improvement in functionality was observed.*[26]

49. During her admission to Beleura Private Hospital for the ketamine infusions, Ms McCall's prescribed fentanyl patches had been ceased and she was discharged home with Panadol Oesto[27] to be taken three times a day as the analgesic. Her last ketamine infusion was on 16 July 2012.

50. According to the health records and self-reports by Ms McCall, she appears to have had some pain relief from the ketamine infusion (her pain score decreased from nine to five out of 10) however, the health records clearly record Ms McCall as presenting less than five weeks after the last ketamine infusion with increased pain.

b. Antidepressant

51. According to the medical records, Ms McCall was prescribed antidepressants, which was changed from duloxetine to mirtazapine on 13 August 2012, and from mirtazapine to venlafaxine on 10 September 2012. I consider that Ms McCall was not on either mirtazapine or venlafaxine long enough to reach a reliable therapeutic level. I accept however that there were

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Medically Prescribed Opioids in People with Chronic Pain, Opioid Tolerance and Hyperalgesia: Outcome at 6 Months", *Pain Medicine*, vol 13, 2012. p.1524.

[26] Niesters M, Martini C, Dahan A, "Ketamine for chronic pain: risks and benefits", *British Journal of Clinical Pharmacology*, vol 77, no 2, 2013, p.360.

[27] Paracetamol is an analgesic indicated for the treatment of mild-moderate pain and Panadol Oesto is a slow-release version marketed for bone related pain.

no issues identified with the prescribing or changeover of the antidepressants, as Ms McCall had complained about adverse effects of the medication, especially mirtazapine.

c. Multiple general practitioners

52. It appears that Ms McCall changed her doctors in search of improved pain relief. Based on all medical records from the involved services; she requested fentanyl and at times ketamine. She appears to not have engaged well with exercise, physiotherapy and psychology treatments. I consider there to be risks associated with seeing multiple doctors over the short term. Assessments are completed, treatments are put in place and the evaluation of the effectiveness of the treatment does not have the opportunity to occur. I consider the benefits of a doctor's familiarity with their patient, their patient's history and responsiveness to various treatments are significant.

d. Chronic pain and suicide

53. The review of the health records shows Ms McCall was involved with her choice of treatments and did not hesitate to change doctors if she did not feel she was getting what she wanted or perceived she needed, including prescribed fentanyl.

54. Ms McCall had been prescribed fentanyl for many years and at the last ketamine infusion, the fentanyl was ceased. There is little evidence that Ms McCall sought scripts for fentanyl until her admission to the Frankston Health medical ward. The notes written to her treating practitioners and the forms completed by her reflect her major concerns regarding the pain was her inability to function and self-care.

55. According to Suicide Prevention Australia, chronic pain is defined as daily pain for three months or more in a six-month period. It affects approximately one in five people at one stage throughout their lifetime. Physical symptoms include reduced and degenerative mobility and functioning, sleep disturbance and pain sensations. There is an associated high risk of depression, anxiety and social isolation. There is some evidence of people with chronic pain experiencing high levels of suicidal ideation, plans and attempts regardless of the presence of a co-morbid mental disorder. The Suicide Prevention Australia position statement on chronic illness, chronic Pain and suicide prevention states:

> *There is a two-way relationship between pain and psychological factors: psychological factors influence a person's experience of pain, and reciprocally, pain has an impact on psychological wellbeing. Chronic pain which lasts for a prolonged*

period can influence emotional, interpersonal and physical functioning, having significant impacts on wellbeing.[28]

56. Ms McCall experienced chronic pain that was temporarily decreased by the use of low-dose ketamine infusion, however her pain was reported to increase some weeks after the last infusion.

COMMENTS

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

1. I consider the comprehensiveness of assessment, gathering of collateral information and previous history, engagement with Ms McCall and communication with other practitioners by GPs Dr Barnes and Dr Michael was of a very high quality.

2. I have not identified any issues with the assessment and follow-up provided by Frankston Health including the CLIPS and HARP services, however I am unable to say with a comfortable degree of satisfaction that Frankston Hospital specifically took into account Ms McCall's potential withdrawal from opioids sufficiently in the context of her aberrant behaviour.

3. I note that some studies have found that ketamine infusion is effective at suppressing symptoms of opioid withdrawal and reducing the amount of opioids a patient requires to achieve analgesic relief.[29] Of significance to the death of Ms McCall, the opioid fentanyl was ceased at the same time she had the ketamine infusion in July 2012, when the evidence supports the pain relieving properties of low-dose ketamine infusion is not permanent. Some five weeks after the last ketamine infusion, Ms McCall experienced increase pain and appears to have had no access to effective analgesia. Her GPs are aware of her prior history of apparent opioid dependency and appropriately were reluctant to prescribe them again. Whilst in Frankston Hospital, Ms McCall was prescribed tramadol[30] and pregabalin, with short term

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[28] Suicide Prevention Australia. 2012. Position Statement. Chronic Illness, Chronic Pain and Suicide Prevention Position Statement. April 2012. Accessed on 9 February 2015 at: < http://suicidepreventionaust.org/wp-content/uploads/2012/05/SPA-PositionStatement-_April_2012_Final-V4.pdf>

[29] See for example Jovaisa T, et al, "Effects of ketamine on precipitated opiate withdrawal", *Medicina (Kaunas)*, vol 42, no 8, 2006, p.625; Quinlan J, "The Use of a Subanesthetic Infusion of Intravenous Ketamine to Allow Withdrawal of Medically Prescribed Opioids in People with Chronic Pain, Opioid Tolerance and Hyperalgesia: Outcome at 6 Months", *Pain Medicine*, vol 13, 2012. p.1524.

[30] Tramadol is effective for moderate pain and useful in neuropathic pain, but not in severe pain.

effect. Ms McCall had a depressive illness and sustained anxiety since her divorce in 2006, and her recent relationship had failed. She lived alone with her dog and reported a perceived dysfunctional relationship with her children, and received some support from her parents. She repeatedly identified her decreased functional capacity and insomnia as the major effects of her pain. I note that approximately 65 percent of people with chronic pain report interference with daily activities including sleep, sex, work, exercise and routine self-care, which can have a negative effect on personal relationships, social interactions and lifestyle.[31]

4. There is nothing documented in the records reviewed to suggest that Ms McCall understood the possibility of increased pain after a number of weeks following the infusion. There is similarly nothing documented to indicate there was communication of this to her treating GPs, possibly permitting a plan of approach should it occur. On 18 September 2012, Dr Barnes rang Dr Monagle and discussed the plan of approach to Ms McCall's pain, to which he reportedly agreed; however I note Dr Monagle had not reviewed Ms McCall since the ketamine infusion.

5. Based on the available information, I consider it was reasonable to be prepared for the possibility of pain increase within three months following a low-dose ketamine infusion. In the context of Suicide Prevention Australia's information on the link between of chronic pain and people "experiencing high levels of suicide ideation, plans and attempts regardless of the presence of a co-morbid mental disorder",[32] I consider that pre-infusion preparation should include a management plan for an exacerbation or return of pain that involves the patient and the GP. There is an absence of evidence-based clinical guidelines regarding the preparation, administration and follow-up for low-dose ketamine infusions to guide practitioners, including the prescribing pain specialists, GPs and patients and their families in the safety of all aspects of low-dose ketamine administered for pain management.

RECOMMENDATIONS

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

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[31] Pain Australia. Accessed 9 February 2015 at: http://www.painaustralia.org.au/consumers/what-is-pain.html>

[32] Suicide Prevention Australia. 2012. Position Statement. Chronic Illness, Chronic Pain and Suicide Prevention Position Statement. April 2012, page 7. Accessed on 9 February 2015 at: < http://suicidepreventionaust.org/wp-content/uploads/2012/05/SPA-PositionStatement-_April_2012_Final-V4.pdf>

The Coroners Court of Victoria has reviewed two other suicide deaths[33] where the circumstances included long-term treatment of chronic pain with opioids that had a re-emergent or increase in pain four to five weeks following a low-dose ketamine infusion, with concomitant cessation of prescribed opioids. There are no evidence based guidelines or consensus for the safe administration of low dose ketamine that provide quality practice regarding the assessment, administration and management of ketamine administration, including care in the months after the infusion. There is an absence of understanding of the implications for patients, their families and the treating General Practitioners of the likelihood of re-emergence of pain within weeks of treatment. I consider that this likelihood requires proactive management and a response that is safe, balancing adequate patient pain relief and avoiding iatrogenic dependency.

I therefore **recommend**:

> To increase the safety of patients who receive a low-dose ketamine infusion, the Australian and New Zealand College of Anaesthetists Faculty of Pain Medicine develop evidence based information regarding best practice in low-dose ketamine infusion for pain management. This information should specifically include the appropriate assessment, follow-up care, response to the likelihood of re-emerging pain and communication with primary practitioners.

FINDINGS

The investigation identified a number of precipitating factors that may have influenced Ms McCall's decision to adopt the course of action she ultimately chose, including a long history of chronic pain, mental illness, attempts at self-harm, possible opioid withdrawal, and personal and familial relationship issues.

I accept and adopt the medical cause of death as identified by Dr Melissa Baker and find that Ms Margaret Helen McCall died from hanging in circumstances where I am satisfied that she intended to take her own life.

I acknowledge the extensive research and synthesis of material completed by the Coroners Prevention Unit.

I direct that this Finding be published on the internet

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

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[33] COR 2011 3033 and COR 2011 4646).

Ms Sarah McCall

Ms Mia Janssen on behalf of Peninsula Health

Ms Rebecca Stracke, Health Information Manager on behalf of Beleura Private Hospital

Mr Julian Walter on behalf of MDA National

Frankston Pain Management

Dr Alisdair Barnes, Tanti Creek General Practice

Dr Aram Isaac and Dr Ann Michael, Ti Tree Family Doctors

Dr Ayo Omidiora

Dr Richard Duff

Australian and New Zealand College of Anaesthetists Faculty of Pain Medicine

Senior Constable N Prosser

Signature:

AUDREY JAMIESON
CORONER
Date: **15 July 2015**