CITATION: *Inquest into the death of Richard Mark Kiel* [2007] NTMC 061

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FINDING OF:	Mr Greg Cavanagh SM

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Death from drug overdose, prescribed drugs, medical treatment of known drug addict.

REPRESENTATION:

Counsel:

Assisting:	Mr Richard Bruxner
Dr Goodhand	Mr Michael Grant QC

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

No. D0160/2005

In the matter of an Inquest into the death of

RICHARD MARK KIEL
ON 10 SEPTEMBER 2005
AT 23/4 SHIER STREET, THE NARROWS

FINDINGS

(13 November 2007)

Mr Greg Cavanagh SM:

Introductory

1. Mr Richard Mark Kiel was found dead on the 10th of September 2005 at unit 23, 4 Shiers St The Narrows.

2. The deceased was born in New Zealand on 30 January 1969 but spent most of his life in Australia. He is survived by his mother, who resides in Victoria. He was not married and did not have a partner at the time of his death. In the mid 1990s he was in a defacto relationship with Raylene Pool. He maintained contact with Ms Pool after their separation. He had one child with her; a son Byrson (now 10). He had two daughters (both now in their late teens) from an earlier defacto relationship but had not seen them since they were very young.

3. Mr Kiel's death was investigated by Coroner's Constable Peter Bound and an Inquest hearing was held by me as a matter of discretion. The hearing commenced on 11 and 12 October 2006 and continued on 12 to 14 February 2007. Mr Bruxner appeared as counsel assisting me. Mr Grant QC appeared with my leave on behalf of Dr Gerald Goodhand. No other interested person was represented at the hearing, although Mr Alderman of counsel was

present in the Court when his client Ian Marshall (a pharmacist) gave evidence.

4. A comprehensive brief was prepared by Constable Bound and tendered at the hearing. Dr Goodhand's records maintained in respect of Mr Kiel were also tendered, as well as records maintained in respect of Mr Kiel by the Royal Darwin Hospital (RDH) and the Alcohol and Drug Clinic and a number of expert reports concerning Dr Goodhand's management of Mr Kiel. A report of a Pharmacist, Michael Broadbent, concerning issues confronting pharmacists in dealing with customers such as Mr Kiel was also tendered.

5. The following gave evidence at the hearing:

- Constable Bound;
- Michael Vincent - with whom Mr Kiel was staying at the time of his death;
- Raylene Pool - Mr Kiel's former de-facto partner;
- Dr Terence Sinton - a forensic pathologist who conducted an autopsy of Mr Kiel's body;
- Deborah Halliwell - an employee of the Day and Night Pharmacy at Casuarina;
- Ian Marshall - a pharmacist, and the owner and manager of the Day and Night Pharmacy at Casuarina;
- Senior Constable Tim Sandry, who examined and photographed the death scene;
- Dr Tarun Weeramanthri - the Chief Helath Officer of the Northern Territory;

- Dr Michael McDonough - a specialist in Clinical Toxicology and Addiction Medicine;
- Dr Paul Gray - a specialist in Pain Medicine and Anaesthesia; and
- Dr Gerald Goodhand - Mr Kiel's general practitioner between March 2001 and the time of his death.

6. Pursuant to section 34 of the *Coroners Act*, I am required to find, if possible:

(1) A coroner investigating –

(a) a death shall, if possible, find –

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*; and

(v) any relevant circumstances concerning the death; or

7. The coronial brief also included statements from a number of other people who encountered Mr Kiel in the days before his death, as well as several police officers who attended at the death scene.

Formal Findings

8. The deceased person was Richard Mark Kiel

9. The date and place of death was between 7pm on 9 September 2005 and 8 am on 10 September 2005 at Unit 23/4 Shiers St, The Narrows, Northern Territory.

10. The cause of death was acute heart failure caused by multiple drug toxicity.

11. Particulars required to register the death:

    i. The deceased was male and 37 years old. He was born on 30 January 1969.

    ii. The deceased was a New Zealand national.

    iii. The cause of death was established or confirmed by a post mortem examination and reported to me.

    iv. No injury contributed to the death.

    v. The body was viewed after death by a pathologist Dr Terence John Sinton.

    vi. The deceased's mother was Diane Kiel

    vii. The deceased was unemployed.

Relevant Circumstances

12. At the time of his death Mr Kiel had temporarily been staying at a unit occupied by Michael Vincent at Shiers St in The Narrows.

13. When he returned home between 6 and 7pm on the evening of 9 September 2005 Mr Vincent saw Mr Kiel lying in the location where he was found the next day. Mr Vincent assumed Mr Kiel was sleeping. Mr Vincent recalls that he at one stage observed that Mr Kiel was snoring.

14. Mr Kiel was found dead at about 8am on 10 September 2005 by Mr Vincent and some associates of Mr Kiel who had come to see him.

15. The findings by Mr Sinton on autopsy were that Mr Kiel's death is likely to have resulted from the presence in his blood of lethally high levels of the drugs methadone and alprazolam (Xanax). This, according to Mr Sinton,

likely caused acute heart failure. He also observed that the lethal effect of the drugs was likely to have been compounded by the fact that Mr Kiel was in extremely poor health - with longstanding coronary artery, heart, lung, and liver damage. I accept Dr Sinton's findings.

16. Mr Kiel had been for several years before his death taking the medication Methadone. For several years it had been prescribed to him by his GP Dr Gerry Goodhand as treatment for Mr Kiel's chronic lower back pain. Dr Goodhand also prescribed a number of other drugs (including benzodiazepines) to treat Mr Kiel for anxiety and many other ailments.

17. There is very little evidence regarding Mr Kiel's movements and activities on 9 September 2005. He was seen early that day at Shiers St by Mr Vincent and in Parap by Mr Thomas Baird.

18. More is known about some relevant events in the week before Mr Kiel died. On 2 September 2005 Mr Kiel visited Dr Goodhand at the Farrar Medical clinic and obtained his monthly methadone prescription. The prescription was for 100 tablets (with two repeats) at a daily dosage of 10 tablets. The prescription specified "5 day pick up" meaning that only 50 tablets were to be made available to Mr Kiel at a time. That day Dr Goodhand also prescribed Xanax (1 tablet per day) and Hypnodorm (6 per night). Those medications were also subject to a 5 day pick up regime.

19. Later on 2 September Mr Kiel presented the prescription at the Trower Rd Day and Night Pharmacy and was supplied with the first allocations of medication.

20. Six days later, at about 3pm on 8 September 2005 Police attended at the residence of a Mr Jason Drommel also at 4 Shiers St (unit 32). Mr Kiel had been staying with Mr Drommel and had outstayed his welcome. Mr Drommel apparently requested police presence to keep the eviction uneventful (which it was).

21. Later that day, 8 September 2005, Mr Kiel again visited Dr Goodhand. He told Dr Goodhand that he needed all his medications because he had been 'kicked out' of his residence and was moving to a residence at Bynoe Harbour. Dr Goodhand told Mr Kiel that he should ask the pharmacist to phone Dr Goodhand for approval to make the medication available.

22. On the evening of 8 September 2005 Mr Kiel attended at the Day and Night Pharmacy and requested the balance of methadone tablets from the 2 September prescription – namely 250 methadone tablets - as well as the remainder of the Xanax and Hypnodorm. While Mr Kiel was there, the pharmacist on duty contacted Dr Goodhand and obtained Dr Goodhand's authorisation for the early supply. At the inquest I heard from Deborah Halliwell who was working that night at the pharmacy. She gave evidence that Mr Kiel was in a belligerent and intimidatory mood.

23. On the morning of 10 September 2005 a police search of Mr Kiel's body and possessions and the Shier St premises located only 10 tablets of any description. This was despite the fact that he'd had 250 methadone tablets (as well as over 100 Hypnodorm and over 20 Xanax tablets) in his possession a day and a half earlier.

24. Having regard to the events of 8 September and the autopsy findings it can reasonably be inferred, and I find, that at some time on the 9th of September 2005 Mr Kiel consumed a very substantial quantity of methadone and xanax tablets.

25. For all of his adult life Mr Kiel was an abuser of drugs, particularly opiates and benzodiazepines. According to Michael Vincent "Ricky was the type who lived to get smashed off his face and would take copious amounts of medication." His former defacto partner Ms Pool says in her statement that Mr Kiel was a heroin user when she first met him in Perth in 1995. In the mid to late 1990s Mr Kiel was a heavy user of MS Contin (morphine) and various benzodiazepine drugs.

26. Mr Kiel was once a client of the Northern Territory Alcohol and Other Drugs Services Clinic ("ADS" clinic). That was between 1996 and March 2001. He was first treated with MS Contin and, later, Methadone syrup. His relationship with the clinic, as evidenced by its file in respect of Mr Kiel, was "on again off again" and characterised by repeated breaches of agreed treatment regimes.

27. At the time he was a client of the ADS clinic Mr Kiel was also a patient of the RDH Pain Clinic for about two years (seeing Dr Martin Carter for most of that time). Dr Carter experienced difficulty in managing Mr Kiel, who was plainly considered a difficult patient by most if not all of the many medical professionals he encountered.

28. Dr Carter performed a lower back facet block procedure in late 1997 to no apparent effect. In a letter to the ADS clinic following that procedure he wrote:

> "Ricky came to see me for review following his facet joint injections which he says did not benefit him at all. He walks with an exaggerated forward posture, however, he has dispensed with the walking stick that he came in with for his facet joint injections.
>
> He is pushing for me to take over his medication, a fact that I am not desperately keen on. However, I am prepared to look at co-analgesics to deal with his pain problem but I am not going to attempt to deal with his drug problem. To that end in view of the spasm that he is complaining of I am starting him on Baclofen 10 mg tds. I am sure that he will come back to me in two weeks time telling me how useless they are. However, there are many forms of co-analgesics that can be tried in this gentleman whilst maintaining his opiate levels at 300 mg MS Contin daily."

29. Perhaps unsurprisingly Mr Kiel was no stranger to the Courts.

30. In a pre-sentencing report provided to Magistrate Lowndes in early 2000, Dr Elizabeth Moore had this to say:

> "Mr Kiel was this clinic's first client. I had known Mr Kiel prior to this. He had seen me once in Palmerston general practice requesting

prescription psychotropic drugs, which I declined to give. I saw him frequently thereafter however as he visited my colleagues there. He was often intoxicated, or agitated and loudly abusive about having to wait. He had been banned from appearing at numerous other surgeries, and is permanently banned from visiting Palmerston shopping centres, presumably for intoxicated and disinhibited behaviour. He attempted to remove a foot cushion from the surgery waiting room in full view of our receptionist. It was returned immediately. This has been typical of the chaotic and disinhibited behaviour he has when intoxicated on benzodiazepine drugs. He steals on impulse, apparently believing these acts are 'invisible'.

Through 1999 I watched his general appearance deteriorate. He then began to lose the function of his hands from temazepam injection. This oily substance blocks blood vessels, and causes inflammatory sores near injection sites. He has now lost access to all veins in the arms and feet. In February2000 he was admitted to RDH with ischaemic ulcers to both arms and hands due to arterial injection of temazepam. The function of his hands is now permanently impaired. He is unable to cook meals, his diet is poor, consisting of takeaway food. He lives separately from the mother of his son, she has a restraining order, and has no-one to help him care for himself. He cares about his son, and would like to be a father to him. He does have friends who visit and transport him to clinics etc. He has been depressed for some years, and doctors have prescribed anti-depressants for him on & off. He tends not to abuse these.

While in hospital in February, Dr Paul Williamson, visiting specialist from Warinilla, commenced him on methadone, and a reducing regime of benzodiazepines. Just prior to commencement of this treatment, he had been using up to 6 tablets per day of 100 mg MS Contin (morphine), orally because of inability to inject it. He also took ten 20 mg temazepam capsules per day, and up to fifteeen 5 mg valium tablets per day on occasions. Occasionally also he would smoke marijuana, and take amphetamine. Much of the morphine and benzodiazpines were prescribed, some bought illegally.

Mr Kiel has a long history of drug use. He is of Maori origin, and his father was a heavy drinker, and abusive. Mr Kiel started drinking but had problems controlling his violent behaviour. He finds this is less of a problem with narcotics and benzos. He first began using temazepam aged 15 years. He first started using narcotics in his early 20's. He smoked opium tar while living in Tasmania; his mother arranged treatment for him at a methadone clinic. He has had several attempts at withdrawal through detox clinics. In December 1999 he had a near fatal episode with pneumonia following overdose. He has

> acquired hepatitis C following unsafe injecting practices. He has only been drug free for a significant amount of time while in gaol for 18 months."

31. Dr Moore concluded her report with this (sadly prescient) observation:

> "... I think there is some hope for Mr Kiel if he continues treatment, and stays away from benzodiazepines. However, the prognosis for rehabilitation to normal family and working life is poor. I expect he will relapse to a chaotic drug seeking lifestyle as soon as treatment is terminated, until he is either gaoled, or dies from complications of drug use."

32. Mr Kiel became a patient of Dr Goodhand, who was then based at the Darwin Private Hospital, in March 2001. By that time there was no longer a pain clinic at RDH. That remained the case until after Mr Kiel's death. After contact with Dr Carter and his own investigations and examinations Dr Goodhand formed the view that Mr Kiel was suffering from chronic back pain. He also formed the view that Mr Kiel had an addiction problem. Indeed Mr Kiel had told Dr Goodhand that he was a drug abuser.

33. Dr Goodhand started Mr Kiel on methadone tablets - 10 x 10mg methadone tablets per day - to manage his back pain. He initially established a medication regime that meant that Mr Kiel was able to access only two days' dosage at a time. Later, as Mr Kiel adjusted to the new medication and was generally compliant with the medication regime Dr Goodhand moved him onto a regime of monthly prescriptions and 5 or 7 day pick ups.

34. Dr Goodhand also prescribed daily doses of Hypnodorm. This was to address Mr Kiel's chronic sleeping difficulties as well as to help him manage anxiety. At times when Mr Kiel's anxiety levels were higher than normal Dr Goodhand would also prescribe Xanax or more rarely Oxazepam. Mr Kiel's access to the Hypnodorm and Xanax was subject to the same (or a similar) pick up regime as for Methadone.

35. Dr Goodhand would also from time to time prescribe medication to deal with Mr Kiel's raft of other health problems. Basically, however, the combination of methadone and hypnodorm, occasionally supplemented by Xanax was the main medication regime for the 4.5 years that Mr Kiel was in Dr Goodhand's care.

36. For the bulk of the time a 5 or 7 day pick up regime was in place; however, there were occasions when that was departed from. In February - March 2004, for example, Dr Goodhand reduced Mr Kiel's dose to 80mg (ie 8 Tablets per day) . This was after Mr Kiel had been hospitalised for an infection apparently resulting from intravenous drug use (return shortly). Dr Goodhand also temporarily reinstated two day pick ups at this time. The two day restriction was again implemented in July 2005 following a hospital admission for an apparent overdose.

37. On other occasions Dr Goodhand would permit Mr Kiel to pick up larger quantities of medication - for example if Mr Kiel told him he was travelling interstate, or if there was a special reason for making more than the weekly dose available. This could happen in two ways.

38. Occasionally Dr Goodhand would provide Mr Kiel with scripts that were not subject to a limited pick up regime - that is allowing the whole monthly script to be made available at once. More often, Dr Goodhand would provide authorisation to the Trower Road Day and Night Pharmacy to allow Mr Kiel early pick up - as indeed happened on 8 September 2005.

39. The available records suggest that on most of the occasions of early pick up there was communication between the Pharmacy and Dr Goodhand in which authorisation was provided.

40. There is no suggestion, nor do I find, that the pharmacy ever supplied medication early without appropriate approval from Dr Goodhand. I add that having considered the evidence of Mr Marshall, and the report of Mr

Broadbent, I consider there is no basis for criticism of the Day and Night Pharmacy in respect of its dealings with Mr Kiel or Dr Goodhand.

41. Mr Kiel was generally unwell. He suffered from hepatitis C. He regularly fell victim to pneumonia and breathing difficulties. He had limited use of his fingers as a result of damage sustained from injecting into them. In the years prior to his death Mr Kiel was admitted several times to RDH for emergency treatment.

42. The most noteworthy occasions closest to his death were as follows:

- he was twice admitted in August 2003 with skin sepsis and pneumonia - the two admissions were a few days apart. On the first occasion he discharged himself against advice only to be readmitted 36 hours later.

- on 15 January 2004 he was admitted with cellulitis of the left leg. The discharge summary noted that a month earlier he had shot up morphine and methadone and that his injection site was exacerbated. Along with the principal diagnosis of cellulitis there were additional diagnoses of hepatitis C, a staph infection and intravenous drug use.

- on 18 March 2004 Mr Kiel arrived by ambulance at RDH Emergency Dept and was admitted. He discharged himself, again against advice, the following day. The diagnosis was again left leg cellulitis. The additional diagnoses included "Narcotic seeking behaviour". During the course of that admission he left the ward and presented at Dr Goodhand's rooms at the private hospital where he appears to have had a scheduled appointment.

- on 7 July 2005 Mr Kiel arrived at the Emergency Dept by ambulance following an overdose. He had earlier been found unconscious. At the time of his admission he stated that he had taken "lots of Xanax". The following day he discharged himself from the high dependency

unit - once again against advice. I will examine this particular episode and its aftermath in more detail later in these reasons.

43. The hospital records for these and earlier admissions show that Mr Kiel was frequently uncooperative and aggressive in his dealings with hospital staff.

44. Dr Goodhand was generally aware of Mr Kiel admissions, although sometimes he did not find out until some time later. As already mentioned, he made temporary adjustments to Mr Kiel's medication regime following the incidents in 2004 and 2005.

45. A focus of the Inquest was upon Dr Goodhand's management of Mr Kiel over the four and a half years of their association.

46. Fundamentally Mr Kiel died because he was a serious serial drug abuser. He killed himself. Whether he meant to do so is uncertain but unlikely. Despite ample evidence of his self destructive behaviour there is no evidence that he displayed suicidal tendencies. Dr Gray agreed that it was just speculation on his part that Mr Kiel may have been trying to put his affairs in order a day or so before his death.

47. To his associates and to his ex wife Mr Kiel was known as a drug addict who often over dosed. To the staff at the Day & Night Pharmacy at Casuarina where he collected his medication he was known to regularly exhibit aggressive, abusive and impatient behaviour when collecting his drugs the chemist Mr Ian Marshall, stated in evidence (transcript p.39-40):

> "What was your assessment of Mr Kiel?---Well he - he was all of the thing that are mentioned in paragraph 5, though he wasn't - he never ever exhibited any violent - you know violent - there was never any violence as such. If you knew how to handle him you could get over these things, but to someone who didn't know him or was unfamiliar with him as such, he could appear all these things, but he never – you know instigate any acts of violence in the pharmacy or anything like that.

> And you were confident that you knew how to handle him?---Well I mean - yeah I could, I could handle him I didn't enjoy it but I could handle him.
>
> And how did you generally do that?---Well just had to be firm with him, you know just had to hold the line because he - he was an urger, and a harasser, he was manipulative, so you just had to keep saying no, no. Eventually on a lot of occasions I virtually just had to leave him standing in the middle of the shop. I'd just say I'm not talking to you any more Ricky, go and then I'd just turn on my heel and go back into the dispensary.

48. Mr Kiel was a frequent visitor to the Royal Darwin Hospital. His over-indulgence in drugs led to a number of emergency admissions by ambulance. His indiscretions sometimes continued within the ward. The evidence before me of Mr Kiel's excesses is extensive; however, it is important to emphasise that much of that evidence did not come to Dr Goodhand's attention whilst he was treating Mr Kiel.

49. Dr Goodhand knew Mr Kiel was an opiate addict. He also believed that Mr Kiel had a chronic back pain condition that could only effectively be managed by the use of opioid medication, specifically methadone.

50. That created an obvious, and difficult, dilemma for Dr Goodhand. The dilemma was exacerbated by the fact that Mr Kiel had a raft of other health problems, including anxiety and sleeping problems. These he chose to treat with benzodiazepines. However a difficulty that that presented was that benzodiazepines were known to interact dangerously and unpredictably with methadone.

51. Mr Kiel was resistant to trying any other medications. He was unprepared to be referred to the Drug and Alcohol clinic or for psychiatric assessment.

52. Dr Goodhand's evidence is that he diagnosed Mr Kiel's addiction problems as secondary to the primary diagnosis of Chronic back pain. That was a diagnosis arrived at in March 2001 and did not change. Dr Goodhand's goal

was to treat the pain in a manner in which the addiction was managed as well as possible.

53. One of the specialists, Dr Gray, whose brief included significantly more material regarding Mr Kiel's history than appears to have been accessed by Dr Goodhand, and who of course had the benefit of hindsight, believed that Mr Kiel was primarily an addict and that the complaints of chronic pain were secondary to the addiction.

54. There were, throughout the period Dr Goodhand treated Mr Kiel, a number of episodes in which Mr Kiel's behaviour was that of a serious and out of control drug abuser - termed ‘red flag’ events.

55. The most profound of these were instances of apparent overdose two years apart (August 2003 and July 2005). There was also an occasion in late 2003 when Mr Kiel appears to have shot up whilst incarcerated and another in March 2004 when he absconded from the RDH, with a central line in situ, to make an appointment with Dr Goodhand to collect his methadone script.

56. In my view, there were also a number of instances that, if not quite red flags, should have raised suspicion in Dr Goodhand - most notably claims by Mr Kiel that his medication had been stolen or lost. There were also occasions, recorded in Dr Goodhand's notes, where Mr Kiel presented with infected fingers caused by attempts to inject medications. It should in fairness be pointed out that Dr Goodhand was heavily dependent upon what Mr Kiel told him at their regular consultations - he did not have the benefit, as we do, of being able to pore over Mr Kiel's hospital records. However that is not a complete answer, particularly when dealing with a patient such as Mr Kiel.

57. Mr Kiel proved himself time and again to be untrustworthy. That should have come as no surprise to Dr Goodhand. Perhaps he should have been more vigilant at the outset when dealing with a patient who was a known

opiate addict. He says he was - and yet time and again there were matters that came to his attention (via Mr Kiel and via other sources) that he did not appear to adequately follow up. Moreover he showed himself willing time and again to give Mr Kiel the benefit of the doubt when Mr Kiel simply did not deserve his trust.

58. Mr Kiel's hospital admission of July 2005 and Dr Goodhand's management of Mr Kiel in the ensuing months warrant particular attention in this context. This is not just because it was the closest major episode to his death, but because it was the last of a series of similar episodes.

59. The starting point was a scheduled appointment on 4 July 2005. Mr Kiel told Dr Goodhand that he needed to travel to Melbourne to visit his sick mother and that he therefore required his entire monthly supply of medication (which included including 300 methadone tablets). Dr Goodhand acceded to the request and gave Mr Kiel a script authorising immediate dispensing. Dr Goodhand's evidence, which I accept, is that he asked for and obtained from Mr Kiel some proof of his travel plans. Dr Goodhand also testified, and again I accept, that it would have been extremely difficult to arrange for Mr Kiel to secure a supply of his medication from an interstate source.

60. On 8 July 2005 Dr Goodhand again saw Mr Kiel. He said his medication had been stolen. He gave a vague report to Dr Goodhand of having been hospitalised for pneumonia. According to Dr Goodhand, Mr Kiel produced a record from the police showing that he had reported the theft of his medication. I am prepared to accept that the record was provided, although I note that such a record was hardly proof of the theft.

61. Dr Goodhand thinks he queried Mr Kiel about why he had not travelled to Melbourne but cannot recall what was said. He says he was suspicious about Mr Kiel's report of stolen medication but he accepted it and provided

him with a new script. Because he was suspicious he changed Mr Kiel's prescription regime to one involving daily pick up of his medication.

62. Some time between 8 July 2005 and when he next saw Mr Kiel on 4 August 2005 Dr Goodhand received from the Royal Darwin Hospital a notice that Mr Kiel had been admitted to the hospital on 7 July 2005 with a "working diagnosis" of a suspected drug overdose and aspiration pneumonia.

63. At the 4 August 2005 consultation, Dr Goodhand restored Mr Kiel's 5-daily pick up regime. He did not discuss with Mr Kiel the report from the hospital. Despite the reference to a suspected overdose he did not challenge Mr Kiel about the claim of stolen medication. His evidence instead was that when he saw the letter from the hospital he discounted it, because he thought the working diagnoses must have been inaccurate. It did not occur to him, when he received the letter, to get Mr Kiel in and discuss it with him - this was despite the fact that Mr Kiel was attending his rooms every second day to pick up his scripts.

64. As I have mentioned, this was the last of a series of episodes with similar characteristics. In each case Dr Goodhand gave Mr Kiel the benefit of the doubt.

65. Two experts prepared reports and gave oral evidence concerning Dr Goodhand's management of Mr Kiel: Dr McDonough and Dr Gray. A Dr Williamson also prepared two reports; however, he was not cross examined at the inquest and I therefore attach very little weight to his evidence.

66. I found Doctors Gray and McDonough to be impressive witnesses. They were eminently qualified to comment upon Dr Goodhand's management of Mr Kiel.

67. Mr Grant QC asked that in considering the experts' criticisms of Dr Goodhand I take into account the fact that both practice in a context that in terms of expertise and resources is a long way from the 'coal face'. He also

asked that I take into account that Dr Goodhand was confronted by an extremely complicated and difficult patient in Mr Kiel. I have taken these matters into account; however I am generally persuaded that the criticisms by Doctors Gray and McDonough are valid.

68. Although Dr Gray was less inclined than Dr McDonough to be overtly critical of Dr Goodhand's management of Mr Kiel, there was not much difference between their expert assessments. Each considered that Dr Goodhand's management of Mr Kiel fell short of good practice in key respects. Dr McDonough was especially critical of the lack of a documented treatment management plan - something he regarded as all the more critical in dealing with a complex patient such as Mr Kiel.

69. Both thought that Dr Goodhand's records maintained in respect of Mr Kiel were substandard. Dr McDonough pointed out the importance of comprehensive notes in terms both of mapping out future treatment but also understanding the treatment history. He made the important observation, which I accept, that the notes belong to the patient - in the sense that a patient who changes doctors is entitled to have the content of the notes passed on to their new Doctor.

70. Dr Goodhand did not seek to contend that the records he maintained of his dealings with Mr Kiel were adequate - nor could he have, they were in my view clearly inadequate. To his credit, Dr Goodhand conceded this.

71. Dr Goodhand was not prepared to concede that his treatment plan for Mr Kiel was inadequate. He did not appear to accept the criticisms of his management of Mr Kiel by Doctors Gray and McDonough (nor of Dr Williamson). In terms of what was known to Drs Gray and McDonough of Dr Goodhand's treatment plan, neither thought it adequate.

72. At one stage in his evidence in chief Dr Goodhand appeared to concede that it was premature for him to have restored Mr Kiel to 5-daily pickups on 4

August 2005 and that he erred again on 8 September 2005 when he permitted Mr Kiel to pick up 25 days worth of medication in one go. Although I give Dr Goodhand some credit for these concessions, they were firmly couched in the language of hindsight and his evidence when cross examined about the events of July and August 2005 left me doubting that he in fact believes that he fell into error.

73. Having regard to all the evidence I find that to the extent Dr Goodhand had a treatment plan for Mr Kiel it was inadequate because it was not documented.

74. I find also that Dr Goodhand's ability to effectively and properly manage Mr Kiel throughout the period of their association was impaired by his continued willingness to give Mr Kiel the benefit of the doubt when confronted by a mounting series episodes that strongly suggested that Mr Kiel's addiction to opiates was not under control. His willingness to do so meant that he overlooked or gave insufficient weight to important "red flag" evidence. That Dr Goodhand was prepared to discount the advice from the hospital regarding Mr Kiel 's admission on 7 July 2005 for a suspected overdose was a remarkable example of this tendency and its effect on his management of Mr Kiel. So too was his willingness to authorise the early release of a large quantity of medication to Mr Kiel only two months later.

75. In my view, Dr Goodhand’s unwillingness to acknowledge the substantial criticisms made of him by the expert witnesses is reflective of a lack of insight.

76. I accept that Dr Goodhand believed in his diagnosis of Mr Kiel throughout the time of their association and that he managed him accordingly. When Dr Goodhand was asked whether he was surprised to learn of Mr Kiel's death his answer, which I accept, was that he was both shocked and surprised. I strongly doubt, however, that many others who had frequent contact with Mr

Kiel in the several years before his death would have shared Dr Goodhand's shock and surprise.

77. I hasten to add that despite the above findings there is no question in my mind that Dr Goodhand is a caring and dedicated practitioner who at all times sought to act in Mr Kiel's best interests.

Recommendations

78. It is common ground that Dr Goodhand's management of Mr Kiel is already the subject of a complaint to the Medical Board. The Board has deferred consideration of the complaint pending the outcome of this inquest . It will no doubt consider my findings regarding Dr Goodhand in the context of the future consideration of the complaint.

79. In the circumstances I do not need to consider making recommendations by which this matter might otherwise be brought to the Board's attention.

80. I do however direct that a copy of these findings be delivered to the Chairman of the Medical Board, and that officers of the board have access to the various expert reports exhibited during the Inquest together with the transcript of evidence.

Dated this 13th day of November 2007.

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GREG CAVANAGH
TERRITORY CORONER