IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2011 004797

FINDING INTO DEATH WITH INQUEST

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

Inquest into the death of Anne Christine BRAIN

Delivered On:	30 October 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank Victoria 3006
Hearing Date:	12 August 2014
Findings of:	Judge Ian L Gray, State Coroner
Police Coronial Support Unit:	Leading Senior Constable King Taylor

I, JUDGE IAN L GRAY, State Coroner, having investigated the death of ANNE CHRISTINE BRAIN

AND having held an inquest in relation to this death on 12 August 2014

at Melbourne

find that the identity of the deceased was ANNE CHRISTINE BRAIN

born on 3 August 1967

and the death occurred 24 December 2011

at 22 Nicholson Parade, Sunshine West, Victoria 3020

from:

I (a) INTOXICATION BY THE COMBINED EFFECTS OF TRAMADOL, METHADONE, DIAZEPAM, CODEINE, ALPRAZOLAM, RISPERIDONE, DOXEPIN AND METOCLOPRAMIDE.

in the following circumstances:

BACKGROUND

1. Ms Brain was a 44-year-old woman who lived with her daughter, Ms Vasinta Soldaini, at the above address. She was last seen alive by Ms Soldaini at approximately 0400 hours on 24 December 2011, sleeping on the couch and snoring. At approximately 1140 hours on the same day, Ms Soldaini attempted to wake her mother unsuccessfully. She called a neighbour for assistance who in turn contacted 000.

2. Police and MICA paramedics attended, but paramedics were unable to resuscitate Ms Brain and confirmed that she was deceased. Police found several prescription medications at the home in a kitchen cupboard. No illicit drugs were found.

3. Police spoke to Ms Brain's sister, Ms Rayleen Fagan, who told them that she had had an argument with Ms Brain via text message the previous night. She also said this was normal, and that Ms Brain had a psychiatric condition and was a heroin user.

4. Ms Brain is said to have had a complex mental health history, suffering from schizophrenia, anxiety and depression. Ms Brain was also dependant on prescription medication. She was treated for chronic pain; describing headaches, facial pain and lower back pain.

5. A search of her Medicare Australia Pharmaceutical Benefits Scheme (PBS) records indicate that in 2011, Ms Brain was repeatedly prescribed the same analgesic, anti-anxiety and antidepressant medications from seven different general practitioners (GPs).[1]

6. Ms Brain regularly attended GP Dr Iphigenia Chronas from May 2011 until December 2011, with her last visit being four days prior to her death. At the same time, she also attended GP Dr Dac Luu eleven times in 2011, GP Dr Neville Poynton until 27 September 2011 and GP Dr Kathryn Rainsford.

7. Dr Rainsford stated that Ms Brain attended her clinic between 2005 to 2007, and again between 2009 and 2011 for treatment of opiate dependence. Dr Rainsford prescribed methadone to Ms Brain from January 2009 to her last known prescription, being five takeaway doses, which was made on 2 August 2011 and expired on 6 September 2011.[2]

INVESTIGATION – SOURCES OF EVIDENCE

8. This finding is based on the totality of the material the product of the coronial investigation of Ms Brain's death. That is the brief of evidence compiled by Leading Senior Constable King Taylor of the Police Coronial Support Unit, and the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them. All of this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

9. The purpose of a coronial investigation of a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the

[1] The medications included analgesic codeine phosphate and paracetamol panadeine forte, anxiolytic medication oxazepam, antidepressant doxepin, anxiolytic medication alprazolam, narcotic-like pain reliever tramadol, non-steroidal anti-inflammatory meloxicam, oral narcotic analgesic oxycodone.

[2] Statement of Dr Rainsford, pages 27-8 of the summary inquest brief.

death, and not merely all circumstances which might form part of a narrative culminating in death.

10. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role. Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These are effectively the vehicles by which the prevention role may be advanced.

FINDINGS AS TO UNCONTENTIOUS MATTERS

11. In relation to Ms Brain's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. Her identity, the date, place and medical cause of her death were never at issue. Ms Brain was visually identified by her daughter, Ms Vasinta Soldaini, on 24 December 2011.

12. I find the deceased's identity to be Anne Christine Brain, born on 3 August 1967.

THE MEDICAL CAUSE OF DEATH

13. Nor was the medical cause of death controversial. On 30 December 2011, an autopsy was performed by Forensic Pathologist Dr Jacqueline Lee of the Victorian Institute of Forensic Medicine (VIFM). Dr Lee concluded that the cause of Ms Brain's death was *intoxication by the combined effects of tramadol, methadone, diazepam, codeine, alprazolam, risperidone, doxepin and metoclopramide.*

14. In her report, Dr Lee stated the autopsy findings and final diagnoses as follows:

    1. *Intoxication by the combined effects of tramadol, methadone, diazepam, codeine, alprazolam, risperidone, doxepin and metoclopramide.*

        a. *early bronchopneumonia*

        b. *pulmonary congestion and oedema*

        c. *hepatic congestion.*

    2. *Coronary Atherosclerosis, slight.*

3. *Pulmonary emphysema.*

15. The toxicologist noted Department of Health records which indicated that a valid permit was held to treat Ms Brain with methadone for opioid dependence, and that this permit was effective from 21 January 2009. The toxicologist report also noted that the concurrent use of depressant drugs such as benzodiazepines and other opioids may contribute to the toxicity of methadone.[3]

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

16. In common with many other coronial investigations, the primary focus of the coronial investigation and inquest into Ms Brain's death was on the circumstances in which she died. Specifically, the investigation and inquest examined the following issues:

- The current Medicare Australia Prescription Shopping Program alert system and the fact that it does not allow for real time monitoring of prescriptions.
- The value of real time prescription monitoring (RTPM), which seeks to link pharmacists and doctors electronically and its potential to prevent people from obtaining medications for non therapeutic use.
- The current state of affairs in respect of RTPM in Victoria and possible alternatives.

THE WITNESSES

17. The following witnesses gave evidence at the inquest:

- Dr Kathryn Rainsford
- Dr Iphigenia Chronas
- Dr Phillip Shepherd
- Mr David Freemantle
- Mr Mathew McCrone.

THE EVIDENCE

18. Dr Rainsford is a GP who has worked in the field of pharmacotherapy, prescribing methadone and buprenorphine for the treatment of opiate dependence, since mid-2006. She

[3] VIFM toxicology report dated 13 February 2012, page 3.

treated Ms Brain for opiate dependency at the Western Regional Health Centre, Footscray, during 2011 with methadone therapy.

19. In her statement,[4] Dr Rainsford stated that she was aware that Ms Brain had consulted other medical practitioners for prescription analgesics, anxiolytics and antidepressants. Dr Rainsford received a copy of Ms Brain's record of prescriptions via the Pharmaceutical Benefits Scheme (PBS) in February 2009, and stated that it revealed that she had received a large number of prescriptions from a several different doctors since 2005. These medications included olanzapine, oxazepam, codeine, doxepin, rabeprazole, quetiapine, diazepam and tramadol. Dr Rainsford stated that she was prohibited by Medicare from discussing her concerns about the variety of medications prescribed to Ms Brain with any of her other prescribing doctors.

20. Dr Rainsford stated that in 2010, she received a telephone call from Dr Poynton who had only just discovered that Ms Brain was receiving methadone therapy (he had been prescribing oxazepam and doxepin). Dr Rainsford and Dr Poynton discussed weaning Ms Brain off the oxazepam. Dr Rainsford stated that she did not consider referring Ms Brain to a pain clinic because her problem was not one of chronic pain, but of opiate dependence.

21. In her statement, Dr Rainsford made the following comments: *I believe it would be helpful for much more vigorous programs to be available to assist doctors in detecting people who are "doctor shopping" for prescription medications. The current privacy regulations from Medicare which prohibit doctors from sharing any information regarding an individuals [sic] PBS record, prevent communication of information regarding patient safety. The current system protects an individual's privacy and enables them to "doctor shop" with very limited capacity for detection. Prescription medication abuse is a huge problem and much needs to be done to reduce it and manage it.*

22. This commentary by Dr Rainsford crystallises the central issue in this case.

23. At inquest, Dr Rainsford testified that she understood clearly that it was 'standard' that she was not allowed to share the information in Ms Brain's PBS record, and did not challenge this. She testified that she found it to be frustrating, and stated that being able to readily access this information would allow her to better coordinate her care for Ms Brain. Dr

[4] Exhibit 1 – Statement of Dr Kathryn Rainsford dated 17 November 2012, pages 27-8 of the inquest brief.

Rainsford opined that it would *certainly, um, improve safety, and um, risk, issues of drug interactions and, um, toxicity.*[5]

24. Dr Rainsford conceded that she could call another treating doctor with the patient's consent, and dealt in detail with how this might have occurred in Ms Brain's case.[6] I infer from her evidence that Dr Rainsford did not explicitly seek Ms Brain's consent to telephone other doctors and possibly did not turn her mind to doing so. However, the fact remains that Ms Brain may have withheld that consent in any event. Whether Ms Brain would have consented or not may be a matter of speculation, but it could be stated that many other patients visiting their GPs in similar circumstances would be likely to withhold their consent so as not to limit their ability to access new or additional prescriptions.

25. Without the relevant information about a patient's access to prescription medications, with out without their consent, the relevant treating doctor is in the dark. Ultimately, the issue of patient consent is not the point, and consent is not the solution. This was made clear by Dr Rainsford in her evidence that there was no way for her to have Ms Brain's real-time history of prescriptions from other clinics readily available to her.[7]

26. At inquest, Dr Rainsford was asked how an ability to access real-time prescription information for a patient would benefit both her as treating practitioner and the patient. Dr Rainsford explained that the ability to become aware when a patient was being prescribed other restricted medications that might have adverse affects when consumed with their methadone therapy would be beneficial for their treatment, as it would allow the GP an ability to counsel the patient and consult with the other prescribing doctor.[8]

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[5] Inquest transcript pages 6-7.

[6] Inquest transcript pages 8 and following.

[7] Inquest transcript page 14:

You can bring up the Medicare record, and what that'll give you is these are the medications she has been prescribed - is that right?---Yes, um, well without getting the Medicare PBS record, um, I wouldn't know what she was getting elsewhere, but the Medicare PBS record, ah, lists the dates that, um, the prescription was written, the date that it was dispensed, ah, the doctor who prescribed it, and the pharmacy where it was dispensed at.

That's what that gave you?---Yes.

And that's what that - that's the routine - that's what it gives you when you get it?---Yes, but there's about a month delay in receiving that information.

I was about to ask you that, next (indistinct)?---M'mm.

So you don't through that system have real-time information, in other words what's happened in the most recent period - - - ?---No, not at all.

[8] Inquest transcript pages 12 and 13.

27. The other treating doctor to give evidence was Dr Iphigenia Chronas. She first met Ms Brain on 11 May 2011. In her statement, she said that Ms Brain mainly attended for anxiety, panic attacks and depression. Dr Chronas stated that Ms Brain had been prescribed antidepressants for a long time and reported previous drug abuse, but denied ongoing drug abuse.

28. Dr Chronas was not aware that Ms Brain was obtaining prescriptions from other doctors since seeing her. Dr Chronas never prescribed methadone to Ms Brain and did not hold a permit to do so. She stated that she was not aware that Ms Brain was using narcotic substances, nor that she was receiving methadone from any other treating practitioner.[9]

29. At inquest, Dr Chronas testified that she never suspected that Ms Brain was obtaining scripts from other doctors and was therefore not concerned about it. She trusted her patient and expected that Ms Brain would have told her about her methadone therapy.[10] Dr Chronas agreed that if she had been told this it would have "definitely" affected her treatment and prescribing for that patient and stated that *I would not be giving her medications such as the Valium I gave her on some occasions. I would not give her Panadeine Forte, and I would not give her...alprazolam, most importantly, because that's well known to interact.*[11]

30. When asked whether she would accept her patient's word on methadone or seek permission to contact the doctor prescribing the methadone, Dr Chronas stated that she would accept that her patient was receiving the therapy, and would make it clear to the patient that she would not be prescribing medications that were contraindicated.[12]

31. At inquest, Dr Chronas confirmed that she did not become aware of the fact that she was receiving methadone until after her death. When asked if the news surprised her, Dr Chronas said that it did as she believed that she had a good enough relationship with Ms Brain that she would have felt comfortable to disclose it.[13]

32. Dr Chronas gave evidence that there was nothing that had alerted her to the fact that Ms Brain may have been obtaining prescription medications from other GPs. She also supported a system which would allow prescribing doctors to be alerted when prescribing medication

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[9] Exhibit 2 – Report of Dr Iphigenia Chronas received 3 January 2012, pages 29-30 of the inquest brief.

[10] Inquest transcript pages 25-6.

[11] Inquest transcript page 26.

[12] Ibid.

[13] Ibid.

to a patient already receiving other medications, stating that this would be in the patient's best interests.[14]

33. Dr Chronas was asked about the Electronic Recording and Reporting on Controlled Drugs (ERRCD) system in Tasmania,[15] and was not aware of it, but was firmly of the view that it would be good to have a similar system available in Victoria that might alert her as a treating practitioner to any risk of prescribing medications to a particular patient.[16] Dr Chronas went on to say that if she had formed a belief that a patient was "perhaps doctor shopping,"[17] she preferred a quickly accessible system because "losing time or handing out a prescription and then finding out could prove to be late sometimes".[18]

34. Dr Chronas explained at inquest that she was prescribing alprazolam (under the trade name Xanax) and that this was the drug for which Ms Brain would "make appointments to come back one day or two before it was about to run out."[19] Dr Chronas was also prescribing Deptran as an antidepressant. She agreed that the principal concern with multiple drug prescriptions in Ms Brain's case was the combination of alprazolam and methadone – alprazolam being a benzodiazepine.[20] Dr Chronas stated that she would not have prescribed alprazolam if she had been aware that Ms Brain was receiving methadone, stating, "I would not prescribe it at all... The risk is too high."[21]

35. The clear conclusion to be drawn from Dr Chronas' evidence is that in the absence of real-time information about the prescriptions a patient is obtaining from other doctors, the prescriber must explicitly trust the patient regarding the issue of whether they are receiving prescriptions from other doctors. The treating practitioner is therefore often unable to identify and communicate with other prescribing doctors. Even if they did disbelieve their patient, they must seek the consent of the patient to communicate with another doctor and in

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[14] Inquest transcript page 27.

[15] Tasmania's real-time reporting system is known as the Drugs and Poisons Information System Online Remote Access (DORA), and is referred to by the Commonwealth Government as an Electronic Recording and Reporting on Controlled Drugs (ERRCD) system.

[16] Inquest transcript page 28.

[17] Inquest transcript page 29.

[18] Ibid.

[19] Ibid.

[20] Inquest transcript page 30.

[21] Ibid.

all probability would not obtain that consent. Doctors are then potentially prescribing in the dark.

RTPM IN AUSTRALIA

36. In their evidence at inquest, both Dr Chronas and Dr Rainsford clearly indicated that an RTPM system would have given them a more complete understanding of Ms Brain's presentation and drug seeking, and therefore would have enabled them to make more informed decisions about her health care.

37. In this respect, the evidence of the two doctors is consistent with the evidence Victorian coroners have heard repeatedly over the past 15 years; that RTPM is an essential tool medical practitioners need for clinical management of their patients. During this time, Victorian coroners have called for a Victorian RTPM system through their recommendations in at least 12 findings.

38. The most recent series of coronial recommendations calling for RTPM commenced with Coroner John Olle's February 2012 finding into the death of James.[22] Coroner Olle recommended that:

> *[t]he Victorian Department of Health implement a real-time prescription monitoring program within 12 months, in order to reduce deaths and harm associated with prescription shopping. The program should include the following functionality: (a) a primary focus on public health rather than law enforcement; (b) recording of all prescription medications that are prescribed and dispensed throughout Victoria without exception; (c) provision of real-time prescribing information via the internet to all prescribers and dispensers throughout Victoria without exception; (d) a focus on supporting rather than usurping prescribers' and dispensers' clinical decisions; and (e) facilitating the ability of the Victorian Department of Health to monitor prescribing and dispensing to identify behaviours of concern.*

39. The need for RTPM was reiterated in a subsequent recommendation made by Deputy State Coroner Iain West in his finding into the death of Rory Denman,[23] as well as Coroner Audrey Jamieson in the deaths of David Trengrove[24] and Kirk Ardern,[25] Coroner Jacqui

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[22] Finding with Inquest into the death of James, COR 2009 5181, delivered by Coroner Olle on 15 February 2012.

[23] Finding without Inquest into the death of Rory Denman, COR 2010 4232, delivered by Deputy State Coroner Iain West on 8 March 2012.

[24] Finding without Inquest into the death of David Trengrove, COR 2008 4042, delivered by Coroner Audrey Jamieson on 18 May 2012.

[25] Finding without Inquest into the death of Kirk Ardern, COR 2012 2254, delivered by Coroner Audrey Jamieson on 7 April 2014.

Hawkins in the death of Georgia Cheal,[26] and Coroner Jacinta Heffey in the death of Glen David Kingsun.[27] Deputy State Coroner West also commented on the urgent need for RTPM in his finding into the death of Simon John Millington.[28]

40. In responding to this series of recommendations, the Victorian Department of Health repeatedly indicated that it was engaging with the Commonwealth Department of Health through the ERRCD initiative to deliver RTPM to Victoria. However, when pressed as to when the mooted RTPM system would be delivered, the department has not been in a position to provide a concrete indication.

41. This situation was highlighted in Coroner Jamieson's finding in the death of Mr Ardern in April 2014, when Her Honour noted that almost two years after the Department of Health responded to the recommendations made by Coroner Olle indicating that it was engaging with the Commonwealth on its ERRCD initiative, Victoria was still without a RTPM system to assist in addressing the harms and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs. Coroner Jamieson expressed a view that *the current state of affairs is unchanged while the same problem remains.*[29] Her Honour recommended that:

> *the Victorian Department of Health explore options for implementing a Victorian-based real-time prescription monitoring system to prevent ongoing harms and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs.*[30]

42. Coroner Jamieson also stated that:

> *[a]s there is practically no discernable publically available information regarding the status of the ERRCD initiative and Victorian progress towards implementing real-time prescription monitoring, I* ***recommend*** *that within three months, the Victorian Department of Health should create a page on its website regarding real-time prescription monitoring, the ERRCD system and other related topics. The page should provide up-to-date information regarding the planning and implementation of this crucial public health initiative. Transparent, continuous disclosure of progress*

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[26] Finding with Inquest into the death of Georgia Cheal, COR 2006 4603, delivered by Coroner Jacqui Hawkins on 15 May 2014.

[27] Finding without Inquest into the death of Glen David Kingsun, COR 2007 2556, delivered by Coroner Jacinta Heffey on 28 July 2014.

[28] Finding without Inquest into the death of Simon Millington, COR 2010 0472, delivered by Deputy State Coroner West on 30 July 2014.

[29] Finding without Inquest into the death of Kirk Ardern, COR 2012 2254, delivered by Coroner Audrey Jamieson on 7 April 2014, page 34.

[30] Ibid.

would assist a broad range of stakeholders, including peak medical and pharmacy bodies, Coroners and the Victorian public."[31]

43. In responding to Coroner Jamieson's recommendations, the Secretary of the Department of Health said as follows:

> *The Department is very concerned to ensure the minimisation of deaths and other harms related to pharmaceutical drug use. Accordingly, during 2013 the Victorian Department of Health commissioned a business case to explore the options and present recommendations to the Minister regarding the possible establishment of a real-time prescription monitoring system (RTPM) in Victoria. The business case has presented its recommendations and these are currently under consideration.*
>
> *The establishment of an information page on the development and implementation of an RTPM may indeed by useful and interesting to a range of stakeholders in the community. However, at this stage, such an item is more likely to be useful after the necessary consideration of the business case for an RTPL has been completed.*[32]

44. To better understand the business case process currently underway within the Victorian Department of Health, the barriers (technical, legal and otherwise) that might be delaying the introduction of RTPM in Victoria, and potential pathways for delivering RTPM to save Victorian lives, I invited three further witnesses to give evidence before me at the inquest: Victorian Department of Health Chief Officer for Drugs and Poisons Regulation Mr Matthew McCrone; Fred IT Group General Manager Product Development Mr David Freemantle; and MediSecure Chief Executive Officer Mr Phillip Shepherd.

EVIDENCE OF MR MATTHEW MCCRONE

45. Mr McCrone gave highly informative and helpful evidence at the inquest into Ms Brain's death, commencing with an explanation of the Tasmanian DORA (Drugs and Poisons Information System - Online Remote Access) project that was rolled out in 2009 to deliver RTPM within Tasmania, and which is the genesis of the Commonwealth ERRCD initiative intended to deliver national RTPM.

46. Mr McCrone explained that the DORA system works through capturing information on Schedule 8 drugs dispensed in Tasmanian pharmacies, and transmitting it at the time of dispensing to a central storage location where others can see it. He described the Tasmanian DORA information technology as "*far and away the best thing that's available in Australia*" and emphasised that what the system brings to bear is that pharmacists are "*happily, but for*

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[31] Finding without Inquest into the death of Kirk Ardern, COR 2012 2254, delivered by Coroner Audrey Jamieson on 7 April 2014, page 35.

[32] Response to recommendations made in the finding into the death of Kirk Ardern by the Department of Health, 16 June 2014.

the first time, in a way, [playing] this gatekeeper role, where they're actually more and more aware of, OK, I've looked on DORA and I've seen that you just got this dispensed down the road yesterday, so I'm the one that's actually going to say no to you".[33]

47. Mr McCrone explained also that while the DORA system is rolled out to 100 per cent of pharmacists in Tasmania and is capturing all Schedule 8 drug dispensing information, enabling access to this information is an ongoing process. At present, less than half of Tasmanian general practitioners have direct access to the DORA data when treating patients, and the rest need to call the Tasmanian Department of Health and Human Services during business hours to make inquiries.[34]

48. Turning to the ERRCD, I asked Mr McCrone at inquest to provide a picture of where Victoria is at in developing and rolling out an RTPM system. Mr McCrone stated that the Commonwealth purchased the DORA software from Tasmania, modified it to create the ERRCD system as a basis to deliver national RTPM capacity, and then offered the ERRCD to the states through licence agreements. He noted however that the ERRCD software "*is nothing other than, if I can describe it as, the highway with which the cars can drive on*".[35] It is not an "*all-encompassing here's the thing, plug it in and you've got um, you've got everything you need*",[36] because actually implementing a RTPM system involves far more than just putting the software in place.

49. Mr McCrone explained that for Victoria, the starting point for introducing RTPM was Coroner Olle's finding in 2012, where explicit recommendations were made to the Department of Health to implement an RTPM similar to the model in Tasmania.[37] In August of that year, the department released a tender document for a service provider to develop a business case to implement RTPM in Victoria. The business case examined both the RTPM system itself, and the way the system was to interface with the department's internal Drugs and Poisons Information System (DAPIS). Three options were considered, including development of an entirely new system and integration of the ERRCD into the existing

[33] Inquest transcript pages 88-90.

[34] Inquest transcript pages 85-6.

[35] Inquest transcript pages 83.

[36] Inquest transcript pages 84.

[37] Inquest transcript pages 96-7.

DAPIS. The business case was finalised in January 2014, and recommended one of the proposed options.[38]

50. Mr McCrone explained that from here, the process still to unfold includes an implementation study to consider the recommended option, and case development including budgeting costs so that the option can be considered for funding through the budget process.[39] He noted that the Victorian Government's drug and alcohol strategy, Reducing the Toll, made "*specific reference to the implementation of a real-time prescription monitoring system*", so RTPM broadly fits within current government priorities and strategies.[40] He noted also that "*it's not an insignificant amount of money*" to implement RTPM,[41] so the budgetary process is important.

51. Together with his general evidence on the Victorian progress towards RTPM, Mr McCrone shared a number of insights that helped to illuminate specific issues surrounding RTPM implementation.

52. I found Mr McCrone's discussion regarding legal powers to implement RTPM in Victoria particularly illuminating. He noted that while many people raise privacy issues around monitoring and recording drugs prescribed to a person, privacy is not a difficult hurdle. In Victoria, under the *Health Records Act 2001*, the default position would be that a person's prescribing history "*is a person's private health record and it's for them*";[42] however Victoria has the statutory power to make exceptions to this, and to require under Drugs and Poisons legislation that certain records are made available:

> *We have already - under drugs and poisons legislation we can request the records, or we can, you know [...] demand the records. We would have to make regulation around obliging clinicians to look at those records, but there are regulatory powers already under the drugs and poisons legislation to allow those regulations to be made. [...] in terms of mandating under law that things be done, the powers are - exist under drugs and poisons legislation.*[43]

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[38] Inquest transcript pages 97-99. Mr McCrone could not elaborate further on the outcome of the tender process or the preferred option as it was still under consideration at the time of inquest.

[39] Inquest transcript page 99.

[40] Inquest transcript page 101-102.

[41] Inquest transcript page 102.

[42] Inquest transcript page 104.

[43] Inquest transcript page 106.

53. I understood from this evidence that the implementation of RTPM in Victoria could be effected through subordinate legislation and not an Act of Parliament.[44]

54. On the question of what it might cost to implement an RTPM system, Mr McCrone described the range of costs that would be incurred: implementing the software, teaching prescribers and dispensers how to use it, maintaining the underlying IT infrastructure, leasing or purchasing the computer servers that store the data, maintaining the software, sharing data and information between states, dealing with Schedule 8 permit applications, monitoring prescriber compliance with permit conditions, and acting upon the hugely increased amount of drug dispensing information suddenly available to the department.[45] Compared to these implementation and ongoing maintenance and human resource costs, he noted "*the fact that the Commonwealth is offering a piece of software [the ERRCD], free of charge, is not a big detail, in - in - in cost. It's not the big hurdle [...] in terms of cost*".[46]

55. On a related topic, Mr McCrone noted that Victoria has a population ten times larger than Tasmania, which means the implementation involves far more challenges than were faced in the Tasmanian DORA development, and will likely be far more expensive than it was in Tasmania.

56. Regarding the question of whether Victoria should introduce its own RTPM system or coordinate with other states on a national system, Mr McCrone indicated "*it's more than important, it's critical*" that a national standard for data collection on drug dispensing events is used, whereby "*the file contains exactly the same information, no matter where you are*" across the country.[47] However, when asked whether this meant Victoria should wait for national agreement on an RTPM system before it takes any action, he clarified:

> *I'm not saying don't move until there's national agreement, I'm just saying we should all be sure that the information is the same information, because otherwise there would be yet another hurdle to actually make it a national system that works.* [48]

57. He maintained that the best thing would be for the states to all 'share the load' of RTPM implementation together, however he conceded a system could be implemented stated by state if this was necessary.[49]

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[44] Inquest transcript page 106.

[45] Inquest transcript pages 108-109.

[46] Inquest transcript page 114.

[47] Inquest transcript page 119.

[48] Ibid.

58. In relation to the issue of support in other states for RTPM, Mr McCrone noted that it was an accepted proposition nationwide, and across health departments and health professionals nationwide.[50] He advised that in addition to Tasmania, the ACT has rolled out or is about to roll out an ERRCD-based RTPM system. He further advised the NSW position is that it is working through financial and practical implications of implementing ERRCD, and that a full rollout is likely to take three years. In Western Australia, technical and administrative work is being completed before software can be rolled out, and the Queensland government is considering modifications the technology system might require so that it can run in conjunction with its existing system for monitoring of drugs of dependence.[51]

59. Regarding what drugs should be covered in an RTPM system, Mr McCrone asserted that his preference would be for a system that monitors Schedule 8 drugs, because these are the drugs for which the department is already required and empowered to monitor dispensing under existing legislation:

> *[...] there is an argument - and I'm not one way or the other convinced - but our regulatory requirements are more for Schedule 8, so that is, you know, in terms of statutory powers, that's how we are able to get more information about those particular drugs. Um, that's not to say a real time system couldn't include more drugs, but the counter to that that you have to consider is you can overwhelm people with information, and you just - you do need to think which are the drugs that really, really matter, because if everything is there, it may be information overload, and some things may be missed.*[52]

60. Mr McCrone's reasoning, as I understood it, was that an RTPM system should only monitor drugs that are subject to misuse and diversion and cause harms. These drugs should be identified by the Therapeutic Goods Administration and listed under the appropriate schedule of the Standard for the Uniform Scheduling of Medicines and Poisons, being Schedule 8, to ensure their risks are properly managed. Where such a drug is not listed in Schedule 8, the appropriate response is to reschedule it:

> *It needs to be about here's the evidence, here's the evidence of these particular substances being subject to misuse, to diversion, so on that evidence let's reclassify those, and then go from there.*[53]

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[49] Inquest transcript pages 119-21.

[50] Inquest transcript page 123.

[51] Inquest transcript pages 114-5.

[52] Inquest transcript pages 125-6.

[53] Inquest transcript page 129.

61. This observation led to a discussion about how an RTPM system, if operating, would have enabled the relevant doctors to access real-time information on what other doctors had prescribed what medications to Ms Brain. Among the eight pharmaceutical drugs that contributed to her death, most were listed in Schedule 4, with only one (methadone) listed in Schedule 8 at the time, although another (alprazolam) was subsequently shifted to Schedule 8. Mr McCrone explained that if a doctor consulted the RTPM system and saw a Schedule 8 drug had been prescribed, a doctor could then reason:

> *Hang on, this Schedule 4 that I'm about to prescribe, that information there that they're on morphine or something makes me think twice about prescribing this benzo or this other Schedule 4.*[54]

62. When I asked Mr McCrone directly whether it might not be better to show both the Schedule 8 and Schedule 4 drugs dispensed, so doctors could gain a better appreciation of drugs and interactions, he responded: "*I think it's best to start somewhere, and Schedule 8s is the best place to start*".[55]

63. Finally and critically, as to whether such a system would 'save lives', Mr McCrone's evidence was that it would be fair to say that the implementation of a RTPM system in Victoria would be highly likely to save lives.[56] He additionally made the observation that "*everyone*"[57] supports the need for RTPM.

EVIDENCE OF MR PHILLIP SHEPHERD AND MR DAVID FREEMANTLE

64. Over the past three years, the Victorian Department of Health has repeatedly indicated in response to Victorian coroners' recommendations that it is committed to engaging with the Commonwealth to deliver RTPM through the ERRCD initiative. I note that during this period, media articles have cast doubt on the ERRCD initiative's ability to deliver RTPM to Victoria or any other state in the near future.[58] Additionally, organisations and individuals have from time to time contacted the Court to provide information about alternatives to the ERRCD that might deliver RTPM more quickly, efficiently and cheaply.

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[54] Inquest transcript page 129.

[55] Ibid.

[56] Inquest transcript page 130.

[57] Inquest transcript page 90

[58] See for example McDonald K, "Regulations and rail gauge problems holding up ERRCD roll-out", *Pulse+IT*, 20 March 2014; Lord E, "Opioid tracking delayed for years: expert", *Australian Doctor*, 26 March 2013.

65. Therefore, as part of the inquest into Anne Brain's death, I sought to explore alternatives to the ERRCD by inviting Fred IT Group General Manager Product Development Mr David Freemantle and MediSecure Chief Executive Officer Mr Phillip Shepherd to give evidence. Fred IT Group and MediSecure are two private sector companies that specialise in health information technology, particularly script exchange software.

66. Briefly, script exchange software works as follows. A patient attends a medical practitioner, and the medical practitioner produces a pharmaceutical drug prescription using any commercially available prescription software package. The prescription exchange software interfaces with the prescription writing software, encrypts the prescription information and sends it to a secure electronic storage centre. A paper copy of the prescription with a barcode is produced for the patient. The patient then presents the prescription at the pharmacy, where the barcode is scanned and the prescription information is retrieved from the secure electronic storage centre and loaded into whatever dispensing software the pharmacy uses. The medication is dispensed, and the dispensing event is stored in the secure electronic storage centre.

67. In both conceptual and practical terms, the script exchange process is very closely aligned with the RTPM process. The main difference is that for RTPM, an interface is needed to let doctors and pharmacists and the Department of Health access the vault to view prescribing and dispensing information for a particular patient.

68. Fred IT Group and MediSecure are developers and vendors of script exchange software. Although commercial competitors, their products are interoperable with one another and are compatible with every major prescribing and dispensing platform used in Australia. I was keen to learn at inquest whether their products could be modified as described above to deliver RTPM capacity as an alternative to the ERRCD.

69. I heard first from Mr Shepherd, who provided a detailed statement to the Court (marked Exhibit 3) in advance of his evidence. Mr Shepherd indicated in his statement, and confirmed in his testimony, that the MediSecure system can be modified to become an RTPM system. He added that MediSecure already provides limited RTPM capacity to participating doctors, who can view all medicines of concern prescribed to a particular patient through MediSecure over the preceding 90 days.[59]

[59] Inquest transcript page 39.

70. When asked about the practical impediments to rolling out the MediSecure system as an RTPM system, Mr Shepherd identified privacy as his central concern:

> *[...] look, there is a - there's an inherent conflict between the Privacy Act and the... social value of reliable Real-Time Prescription Monitoring. We've spent a lot of money over two separate exercises getting legal opinions from some of the ah, you know, most expensive silks in town, about how you address this. We've got an opinion from Minter Ellison recently following our work with the AMA to look at the implications of providing this data to the clinician at the point of care. The essence of the opinion is that there is no change in the liability, the medico-legal liability for the doctor, and also there's no conflict with the Privacy Act, provided that the practice implements good practice around how they deal with the whole electronic health issue, and in particular electronic prescriptions.*[60]

71. Mr Shepherd proposed that to overcome any privacy issue, medical practices could introduce processes whereby all patients are informed that their prescribing information will be recorded and may be accessed, and are asked to sign an acknowledgement and consent form to this effect.[61]

72. Mr Shepherd was asked about what drug dispensing could be monitored through the MediSecure system, and confirmed that any prescribed drug - not just drugs listed in Schedule 8 - could be monitored. He also explained that the interface was designed such that it seamlessly integrated with the doctor's established work flow, "*because all our experience with general practice says if you change the workflow it's too difficult.*"[62] When asked about costs, he explained that the costs of the MediSecure software itself were marginal in the overall scheme of implementing RTPM:

> *The real costs associated with this are providing the GPs with the toolsets and the training and the protocols to deal with the highly unexpected thing, which is, oh, that patient's actually a doctor shopper. Now, we've heard, you know, the - the more you talk to the real experienced, practiced managers, they are very surprised when they find out that Mr Smith's a doctor shopper, because, you know, they describe them as the model patient. Now, the issue for the GP is how do I deal with this, what's the process that I go through, how do I raise it, where do I refer them to, what - what steps. That sort of training, and putting those protocols in place, costs money. There needs to be an investment in that. And the second component where the money is, is in the report. So that data ought to go somewhere, and we've got a part of the Department of Health here that looks after those sort of reportable medicines, and it would seem logical that they get some sort of information about what the extent of*

[60] Inquest transcript page 42.

[61] Inquest transcript page 44.

[62] Inquest transcript page 48.

the problem is, how it's being managed, um, those sort of elements. So there's some costs associated with that.[63]

73. When asked if he could indicate the range within which these costs might fall, Mr Shepherd indicated he had engaged in talks with the Australian Medical Association, which had put a proposal forward to the Victorian Government about managing the RTPM process for approximately $9 million per year.[64] Finally, Mr Shepherd confirmed that if the MediSecure system was available for RTPM in the lead-up to Anne Brain's death, all drugs prescribed by all treating practitioners would have been accessible via the system and the practitioners could have acted on it.

74. Mr Freemantle appeared after Mr Shepherd to give evidence regarding the eRx script exchange service produced by Fred IT. His statement provided in advance of his appearance is Exhibit 4.

75. Mr Freemantle explained that at present the eRx system does not deliver RTPM capacity, however it could be adapted easily to provide this. He noted that Fred IT has extensive experience in this area, as in addition to the eRx it built a component of the Patient Controlled Electronic Health Record (PCEHR) system to store information on the medication history of patients, and also ran a trial of software to store medication history for all patients in the Barwon Health service region called the 'MedView' project:

> *[...] through the - the - the MedView system that we built as a - a government trial around - literally around consolidating medications histories was the purpose, um, so that - that has actually been integrated into GP desktops, ah, in the Barwon region, and - and three other Medicare locals, including Tasmania. So it could actually pull back complete medication histories, um, ah, for a patient, so that would include the sort of - the - the drug classes and particular drugs and ah, we're talking about here.*[65]

76. Mr Freemantle identified that the central issue with the MedView system, as well as other existing electronic patient record systems such as the Patient Controlled Electronic Health Record (PCEHR) system, was that "*it's an opt in system. Ah, if you're ah, you know, I - I - I would argue that the patients who most need an electronic health record are probably the*

[63] Inquest transcript pages 48-49.

[64] Inquest transcript page 53.

[65] Inquest transcript pages 58.

ones who deliberately choose not to have one."[66] RTPM must to be compulsory in order to be effective.

77. Finally, Mr Freemantle was asked whether, if an RTPM system based on the eRx was in existence when Ms Brain was being treated by multiple doctors, it would have alerted the doctors as to the drugs she was being prescribed and dispensed. Mr Freemantle responded to my questions as follows:

> *Now, to go to the point I was asking you about earlier, if your system was operating, and any doctor prescribing her any of those particular medications wanted to know whether she was on any other of those medications, your system would enable that doctor to know that in the - within the clinical practice?---Yes.*
>
> *Within five to 10 seconds?---It - it - it - - -*
>
> *Once the doctor goes into the case note?---It would give the doctor a list of all the prescriptions of reportable medicines, plus benzos - - -*
>
> *Yes?--- - - - that the patient had over the past 90 days.*[67]

78. Mr Freemantle confirmed that any doctor using the eRx in an RTPM implementation would have been able to bring up the history of drugs dispensed to Ms Brain going back up to two years, and use this history to make appropriate clinical decisions about her treatment.

EVIDENCE OF OTHER FAMILIES

79. The Court also received written and oral submissions from families of deceased persons in whose findings coroners made comments and recommendations regarding RTPM. Families of other deceased persons also attended court or otherwise maintained interest and participation in the discussion of RTPM.

80. The families supported a national model for RTPM, especially for patients who lived close to state borders.[68] The families were also in favour of a RTPM that included *all* prescribed medications, and not just Schedule 8 medicines.[69]

81. I am grateful for the families' attendance at inquest and their efforts in sharing their experiences and concerns regarding pharmaceutical drug misuse. Their appearance at inquest to assist with the investigation into the death of another person highlights the ongoing community interest in having this issue resolved as quickly as possible.

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[66] Inquest transcript pages 61-62.

[67] Inquest transcript pages 75.

[68] Inquest transcript page 133.

[69] Letter to the State Coroner from Mr and Mrs Cheal dated 13 August 2014.

CONCLUSION

82. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[70] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

83. I make no adverse finding against any of the individual clinicians who treated and prescribed medications to Ms Brain, as the weight of the available evidence does not support a finding that they departed from the prevailing standards of their respective professions. Rather, the circumstances surrounding Ms Brain's death necessitated examination of systemic issues regarding prescription monitoring in Victoria.

COMMENTS

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

1. The first key question for examination at inquest was whether a RTPM system could have prevented Ms Brain's death if one had been operating successfully at the time she sought treatment from the relevant clinicians. I am satisfied that the evidence at inquest was that if an appropriate RTPM system was in place, it would have enabled all clinicians involved in Ms Brain's care to learn about one another and about all drugs prescribed to her. This in turn would have enabled the clinicians to make better-informed decisions about her care. Whilst it cannot be determined with certainty that this would have saved her life, the potential for a different outcome remains.

2. The second question was whether and when an RTPM system would be implemented in Victoria. On this question, I am grateful to Mr McCrone for his evidence regarding the ERRCD, the development of the Department of Health business case for RTPM, and his explanation of the issues that need to be addressed and the costs that must be met before Victoria is in a position to introduce RTPM. In addition, I am grateful to Mr Freemantle and Mr Shepherd, who provided evidence regarding other existing information technology

[70] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."

solutions that are able - either now or in the very near future - to deliver RTPM capacity in Victoria and Australia.

3. I am satisfied from Matthew McCrone's evidence that the Department of Health is genuinely engaged in the process of introducing an RTPM system to Victoria. However, given the critical need for RTPM and the amount of time that has passed since the delivery of Coroner Olle's finding in 2012 with still no indication as to when a system will be implemented, I feel compelled to make another recommendation to the Department of Health that RTPM be implemented in Victoria.

4. The third question, which emerged in examining the first two questions, related to the scope of drugs that should be monitored through RTPM. Mr McCrone's view was that in the first instance, only Schedule 8 drugs should be subject to RTPM. He maintained this position in part because the legislative power already exists to monitor these drugs, and also as I understood, because he believed the appropriate mechanism for regulating drug access is the scheduling system; whereby if a drug presents sufficient danger of misuse and harm to warrant being monitored through RTPM, it should also be listed in Schedule 8. Both Mr Freemantle and Mr Shepherd confirmed that the technology existed to monitor drugs outside Schedule 8, therefore I understand the question regarding the scope of drugs to be monitored is not a question of what can be monitored, but what *should* be monitored.

5. The evidence before me at inquest clearly indicated that an effective RTPM system should not be limited to Schedule 8 drugs only. Most of the drugs that contributed to Ms Brain's death were listed in Schedule 4, so a Schedule 8 only RTPM system would not have provided Ms Brain's clinicians with sufficient information to inform decisions about appropriate treatment and coordination of treatment. Further to this point, I note that data produced by the Coroners Prevention Unit (CPU)[71] and annexed to Coroner Jamieson's finding in the death of Mr Ardern clearly shows that several of the most frequent contributing drugs in recent Victorian overdose deaths – including diazepam (the most frequent contributor), codeine, quetiapine, mirtazapine, nitrazepam, amitriptyline, citalopram, doxylamine, venlafaxine and clonazepam – fall outside Schedule 8.[72]

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[71] The Coroners Prevention Unit (CPU) is a specialist service comprising a team of investigators and health clinicians. The CPU assists coroners fulfil their prevention role and contribute to a reduction in preventable deaths.

[72] Finding without Inquest into the death of Kirk Ardern, COR 2012 2254, delivered by Coroner Audrey Jamieson on 7 April 2014, Appendix 1.

6. The need to for an effective RTPM system to monitor all pharmaceutical drugs – not just Schedule 8 drugs – was recognised by Coroner Olle in 2012 when he made his recommendation in the death of James, specifying that "all prescription medications that are prescribed and dispensed throughout Victoria without exception". In the Victorian Department of Health response to this recommendation, then Acting Secretary Lance Wallace disagreed with the requirement that all prescription medications be monitored, because this would be onerous and resource-intensive and unnecessary. He stated:

> *The nature of prescription shopping is such that different drugs may be sought after at different times. The current Tasmanian system tracks all instances of supply of Schedule 8 poisons and alprazolam. More importantly; it can be readily adjusted to capture any other medication that may require monitoring. The department supports the implementation of a national system such as this, which is adaptable to changing trends in what drugs might be targeted by prescription shoppers, rather than one that tracks all prescription medications which may risk overwhelming those accessing the system with information.*

7. I note Mr Wallace's indication that the Tasmanian system can be adjusted to capture drug prescribing outside Schedule 8. My hope would be that a Victorian system has similar flexibility. I do not agree that tracking all prescription medications would risk overwhelming those accessing the system with information. Given the expertise and experience within the Australian health information technology sector, a solution could be developed whereby practitioners can filter the information they view in an RTPM system to focus only on the types of drugs that concern them.

8. In reaching this conclusion, I also gave consideration to Mr McCrone's position that drug scheduling is the appropriate mechanism through which drugs of concern are identified and access to them is regulated. In response to this, I note the Court has had experience with the drug rescheduling process, most recently through Coroner Jamieson's application (which I wrote in support of) to the Therapeutic Goods Administration to reschedule all benzodiazepines to Schedule 8. Moving a drug from one schedule to another is a time-consuming process, and commercial considerations can override public health considerations in the process of decision-making by the Therapeutic Goods Administration. Rescheduling is not a reliable mechanism for bringing drugs of concern into the scope of a RTPM program that monitors only Schedule 8 drugs.

9. I also gave consideration to Mr McCrone's evidence regarding the legislative basis underpinning the Department of Health's power to gather information about drug dispensing events. I found this evidence to be highly cogent in how it informs the practicalities of

implementing RTPM in Victoria. There is a desperate need in Victoria for an RTPM system to assist doctors in coordinating their care for patients, thus reducing the harms and deaths associated with pharmaceutical drugs. If at present, the legislation only permits information to be gathered on Schedule 8 drugs, and legislative change is required to expand the program to drugs outside Schedule 8, I fear this could be yet another hurdle – in addition to other hurdles already identified and discussed at this inquest – further delaying the delivery of this crucial public health tool.

10. Balancing the need for broad drug monitoring against the continuing harms from the lack of any drug monitoring (even a limited Schedule 8 system), is a very difficult equation. I have made a recommendation that attempts to strike such a balance.

11. Finally, I accept the evidence of Mr Freemantle and Mr Shepherd that technology solutions are available right now to deliver RTPM capacity to clinicians and pharmacists, and that these solutions can be incorporated into current commercially available software being used within the health system. As Fred IT and MediSecure are private organisations, it is not appropriate for me to make any recommendation directly supporting their commercial activities. However, it appears from the evidence that there might be in general terms a place for the private sector in delivering RTPM capacity, particularly given that nearly three years have now passed since Coroner Olle's recommendation in the death of James and the much-vaunted ERRCD initiative is yet to be given an implementation date in Victoria.

RECOMMENDATIONS

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

1. I recommend that the Victorian Department of Health progress the implementation of a Victorian-based real-time prescription monitoring system as a matter of urgency to prevent ongoing harms and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs.

2. I recommend that while the Victorian Department of Health continues with its efforts to implement a real-time prescription monitoring program for Schedule 8 drug dispensing, it also identifies the legislative and regulatory barriers that might prevent drugs listed in other schedules (particularly Schedule 4) from being monitored within the scope of the program. If any such barriers are identified, I recommend that the department then considers what reforms are necessary so that in due course its real-time prescription monitoring program

can be expanded beyond Schedule 8 drugs. This will enhance clinicians' ability to make appropriate clinical decisions about patients.

3. I recommend that the Victorian Department of Health consider meeting with private health information technology developers and vendors to discuss and, if appropriate, address the legislative and regulatory barriers that might prevent private companies providing real-time prescription monitoring capacity through their products and services.

I convey my sincere condolences to the family of Ms Brain.

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

Ms Vasinta Soldani

Ms Rayleen Fagan

Dr Pradeep Philip, Secretary, Department of Health

Mr Matthew McCrone, Department of Health

The Hon David Davis MLC, Victorian Minister for Health

The Hon Peter Dutton MP, Commonwealth Minister for Health

Mr Martin Bowles PSM, Secretary, Commonwealth Department of Health

Mr Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association

Mr Wayne Flower, Herald Sun

LSC King Taylor, Police Coronial Support Unit

Manager, Coroners Prevention Unit.

Signature:

JUDGE IAN L GRAY
STATE CORONER
Date: **30 October 2014**