IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 004762

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: Benjamin Albert APPELMAN

Delivered On:	1 June 2016
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing Dates:	14 May 2015
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr S. CASH of Counsel, instructed by Avant Law, appeared on behalf of Dr Tang and Dr Stiebel. Mr S. MORRISON of the Department of Health and Human Services appeared on behalf of Mr McCrone
Police Coronial Support Unit	Leading Senior Constable K. TAYLOR, assisting the Coroner

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of BENJAMIN ALBERT APPELMAN

and having held an inquest in relation to this death at Melbourne on 14 May 2015:

find that the identity of the deceased was BENJAMIN ALBERT APPELMAN

born on 30 September 1980

and that the death occurred on 14 December 2010

at Yarraman Creek near the southern side of Railway Parade, Dandenong, Victoria 3175

from:

I (a) MIXED DRUG TOXICITY (METHADONE, AMITRIPTYLINE, ALPRAZOLAM, DIAZEPAM, OXAZEPAM, NITRAZEPAM) IN A MAN WITH MITRAL VALVE DISEASE IN THE SETTING OF IMMERSION

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES[1]

1. Benjamin Appelman was the 30-year old son of Linda and John Appelman. As a teenager he ran away from home, ultimately living with a school teacher and attending high school in Sale. Around that time, at the age of 14 or 15 years, he reportedly started using cannabis and within a year or so was using heroin and coming to the attention of police.[2]

2. According to John Appelman, the 'pattern was set' for Mr Appelman by the time he was 18 years of age.[3] He would work casually as a brick layer, associate with older peers, use illicit drugs and alcohol, serve terms of imprisonment (on several occasions) for drug, dishonesty and driving offences and be relatively or actually drug-free on release from custody.[4]

3. Upon release from his last prison sentence in August 2009, Mr Appelman lived first at a "halfway house", then with a friend with whom he had been incarcerated. Towards the end of that year moved into a bungalow situated behind a rental home owned by his parents. John Appelman allowed his son to live there on condition that he not invite any drug-using friends to his home. However, he became aware that Mr Appelman had not always complied with this condition and also that he had been using heroin intermittently while being prescribed

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[1] This section is a summary of facts that were uncontentious, and provide a context for those circumstances that were contentious and will be discussed in some detail below.

[2] Coronial Brief of Evidence, Statement of John Appelman.

[3] Ibid.

[4] Ibid.

opiate replacement therapy [ORT][5] and taking 'anything' – any medications – he could obtain from a number of prescribers.[6]

Medical History, Medical Managers and Access to Prescription Medications

4. Between 2001 and 2010, Mr Appelman consulted at least 16 general practitioners at seven medical practices[7] and, in the month prior to his death, saw four doctors at different clinics.[8] His documented medical history included illicit drug use (heroin and cannabis),[9] opiate dependence,[10] depression,[11] generalised anxiety disorder[12] and positive Hepatitis B and C status.[13] He had been treated for opiate dependence with methadone, buprenorphine and suboxone, was prescribed a range of benzodiazepines to manage anxiety, acute insomnia and withdrawal from illicit substances at various times, as well as occasionally being prescribed the antidepressant, mirtazapine.

5. Information obtained from the Department of Human Services (as it then was) indicates that there was a permit to treat Mr Appelman with methadone[14] and/or buprenorphine at the time of his death. The permit was transferred to Dr Douglas Gee of Mediclinic in Clayton in

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[5] Mr Appelman had reportedly been prescribed both methadone and buprenorphine at different times as ORT.

[6] Coronial Brief of Evidence, Statement of John Appelman.

[7] See generally the Coronial Brief of Evidence, Statements of John Appelman, DSC David Sims, Dr Warnakulasuriya Fernando (South Gippsland Family Medicine, Wonthaggi), Dr Hla Wai (also of South Gippsland Family Medicine), Dr Peter Stiebel (Huntingdale Medical Centre), Dr Douglas Gee (Mediclinic) and the clinic's medical records, Dr Chi Lye Tang (Springvale South Medical Centre), and Wonthaggi Medical and Hanover Street Medical Centre patient records

[8] Coronial Brief of Evidence, Exhibit 2.

[9] Coronial Brief of Evidence, Statements of Dr Fernando, Dr Stiebel, Dr Gee, Dr Chi Lye Tang, and Wonthaggi Medical patient records. Some clinicians also referred to Mr Appelman's report of amphetamine use.

[10] Coronial Brief of Evidence, Statements of Dr Fernando, Dr Hla Wai, Dr Gee, Dr Tang – by implication, namely, a notation that methadone was prescribed to him by another clinician in 2006 (namely, Dr John O'Donoghue at South Gippsland Family Medicine).

[11] Coronial Brief of Evidence, Statements of Dr Fernando, Dr Wai, Dr Stiebel and Dr Tang.

[12] Coronial Brief of Evidence, Statements of Dr Stiebel, Hanover Street Medical Centre Medical records, and Wonthaggi Medical patient records.

[13] Coronial Brief of Evidence, Statements of Dr Tang and Dr Stiebel.

[14] Methadone is a synthetic narcotic analgesic available as a syrup for the treatment of opiate dependency (methadone maintenance programs). It is also available as Physeptone tablets for the treatment of severe pain. Recommended doses that can be tolerated depend on the degree of tolerance and the duration of use. Doses may vary from 20 to 100mg daily. Post-mortem femoral blood concentration following therapeutic use rant up to approximately 1mg/L. The terminal elimination half-life of methadone varies from about 15 to about 60 hours. Blood concentrations of methadone in patients receiving daily doses overlap considerably with blood concentrations in deceased apparently dying from methadone toxicity. Concurrent use of other central nervous system drugs such as benzodiazepines and alcohol may contribute to the toxicity of methadone.

December 2009, the ORT permit having previously been issued to Dr John O'Donoghue at South Gippsland Family Medicine [SGFM].[15] At his request, Mr Appelman was prescribed buprenorphine between December 2009 and June 2010[16] after which his ORT was changed to methadone syrup, with three takeaway doses each week but not more than two such doses on consecutive days.[17] He was last dosed with 45mg of methadone on 13 December 2010.[18]

6. Medicare records and a Pharmaceutical Benefit Scheme Patient Summary [PBS record] for the period 1 January 2009 to 14 December 2010[19] suggest that Mr Appelman engaged in "prescription shopping"[20] for multiple pharmaceutical drugs, most notably benzodiazepines. For example, in the 12 months immediately preceding his death, Mr Appelman attended at least seven doctors at six different medical clinics to obtain scripts for prescription-only drugs.[21] These included scripts for 1050 alprazolam[22] tablets from one prescriber,[23] 1540 diazepam[24] tablets from five prescribers at five medical practices,[25] 100 oxazepam[26] tablets

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[15] Coronial Brief of Evidence, Supplementary VIFM Toxicology Report and Statement of Dr Douglas Gee.

[16] Until Dr Gee was informed by police that Mr Appelman had diverted the medication at the pharmacy and had been caught allegedly seeling it on the street.

[17] Coronial Brief of Evidence, Statement of Dr Douglas Gee.

[18] Coronial Brief of Evidence, Supplementary VIFM Toxicology Report. I note that Dr Gee prescribed Mr Appelman an antidepressant (mirtazapine) and except for one prescription for 10 doses to be collected form the pharmacy daily to treat acute insomnia, he refused to co-prescribe benzodiazepines (see Dr Gee's statement).

[19] Coronial Brief of Evidence, Exhibit 2.

[20] The practice whereby a patient obtains more prescription medications than s/he medically requires, usually by consulting a number of medical practitioners and failing to disclose this fact and/or that similar prescriptions/medications have been provided and/or dispensed recently.

[21] I have limited my analysis to those drugs detected in Mr Appelman's post-mortem toxicology and which contributed to his death, namely, methadone, amitriptyline (which does not appear to have been prescribed to him), alprazolam, diazepam, oxazepam and nitrazepam.

[22] Alprazolam is a triazolobenzodiazepine derivative used as a short acting antidepressant and anxiolytic agent. It is also used to treat generalized anxiety, phobic and panic disorders. It is available commercially in Australia as Xanax, Alprax and Kalma (among other trade names). Daily doses range from 0.75mg to 9mg daily and therapeutic concentrations in serum range up to 0.1mg/L in patients given 9mg/day. The pharmakinetic half-life (time taken for the concentration to halve) of alprazolam is generally 10-12 hours. In 2010, alprazolam was a schedule 4 drug but has since, prior to the inquest in 2015, been re-scheduled as a Schedule 8 drug such that a permit is now required to be obtained by the clinician each times s/he intends to prescribe it.

[23] Dr Tang was Mr Appelman's only alprazolam prescriber (according to the PBS record) in the year prior to his death. I note Dr Tang's evidence [Transcript page 44] that he provided one private prescription for alprazolam in September 2010; this is not included in the "PBS totals". Dr Tang explained that he wrote the private script when, he *anticipated* that authority for an additional PBS script would be declined as it had been in March 2010 when he had sought to provide a PBS script ahead of schedule.

[24] Diazepam is a sedative/hypnotic of the benzodiazepine class. Proprietary medicines containing this drug include Valium, Amntenex and Valpam. Prescribed doses range up to approximately 40mg daily and blood concentrations of diazepam and its active metabolite nordiazepam following oral dosing of 30mg daily generally range from 0.7 to 1.5mg/L and 0.3 to 0.5mg/L, respectively. Diazepam has a plasma half-life of 20-40 hours, however, the half is extended among patients with liver disease, the elderly and neonates. Diazepam is a Schedule 4 drug.

from three prescribers in different clinics, and 75 nitrazepam[27] tablets from one prescriber.[28] These prescriptions were dispensed by 15 different pharmacies.[29]

7. Significantly, in the month before his death, Mr Appelman was dispensed 200 diazepam tablets, 150 alprazolam tablets, 50 oxazepam tablets and 25 nitrazepam tablets on scripts from three doctors at three clinics that were dispensed by seven different pharmacies.[30] PBS records, and indeed a diary used by Mr Appelman,[31] suggest that he was a strategic "prescription shopper". He exclusively sought alprazolam from Dr Tang of Springvale South Medical Centre after 31 December 2009 and, from January 2010, primarily obtained diazepam from Dr Stiebel at Huntingdale Medical Centre. Moreover, with few exceptions,[32] repeat prescriptions and prescriptions for the same drugs written by different doctors within days of each other were dispensed to Mr Appelman at different pharmacies.[33]

CIRCUMSTANCES PROXIMATE TO DEATH

8. In about the second week of December 2010, while his son was working with him, John Appelman noticed that Mr Appelman's physical condition had markedly deteriorated. He attributed the deterioration to 'using too many drugs' and expressed his disappointment to his son.[34] In the course of what became a heated exchange, John Appelman asked his son to

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[25] I note that only 240 (of 1540) diazepam tablets were *not* prescribed by Dr Stiebel in the 12 months prior to Mr Appelman's death according to the PBS record.

[26] Oxazepam is a sedative/hypnotic of the benzodiazepine class sold as Serepax, Murelax and Alepam in Australia. The maximum recommended dose is 15-30mg, 3-4 times daily. Following a single dose of oxazepam, serum concentrations average around 0.3mg/L. Oxazepam is a Schedule 4 drug.

[27] Nitrazepam is a sedative/hypnotic of the benzodiazepine class used to treat insomnia. It is sold as Mogadon and Alodorm in Australia. Recommended daily doses are between 2.5 and 10mg, to a maximum dose of 20mg. Nitrazepam is metabolised to 7-aminonitrazepam, which can be used as a marker of nitrazepam use. Ante-mortem blood concentrations of nitrazepam up to 0.2mg/L and its metabolite to a level of ~0.2mg/L may result from therapeutic use. Nitrazepam is a Schedule 4 drug.

[28] Dr Tang was Mr Appelman's only nitrazepam prescriber (according to the PBS record) in the year prior to his death.

[29] See generally Coronial Brief of Evidence, Exhibit 2 between 14 December 2009 and 14 December 2010.

[30] See Coronial Brief of Evidence, Exhibit 2 between 18 November 2010 and 14 December 2010.

[31] Coronial Brief of Evidence, Exhibit 5.

[32] See Coronial Brief of Evidence, Exhibit 2, for instance, which indicates that 150 diazepam tablets were dispensed in 15 days at the Fourway Pharmacy on scripts provided by Dr Stiebel in January-February 2010.

[33] See generally, Coronial Brief of Evidence, Exhibit 2 and also Exhibit E.

[34] Ibid.

move out of the bungalow.[35] Although initially resistant, Mr Appelman did vacate the bungalow and later resumed amicable relations with his father.

9. According to Mr Appelman's friend Tammy Lander, he was living at a boarding house in Hemmings Street, Dandenong, at the time of his death. Ms Lander saw Mr Appelman frequently in the last month of his life, noting that he was 'constantly out of it' and so 'drugged up' on prescription medications that 'you can't understand him'.[36] Indeed, on the evening of 13 December 2010, she physically helped him out of a chair and to her front door because, when she asked him to leave, he could not stand unaided due to his drug-affected state.[37]

10. Around 9.30am on 14 December 2010, Mr Appelman and his friend Lisa Yates caught a bus from her home in Railway Parade, Dandenong, to the shopping precinct so that Mr Appelman could report to his bank that his bankcards had recently been stolen along with his wallet.[38]

11. At about 10.30am, Mr Appelman and Ms Yates attended the New Life Pharmacy where 50 alprazolam tablets were dispensed to him and Endep (the antidepressant amitriptyline)[39] was dispensed to Ms Yates. They then went to a café and took their own medications as well as some of each other's.[40]

12. Around 2pm, Mr Appelman and Ms Yates went to Jane Butcher's home. They stayed a couple of hours during which time Mr Appelman was seen to take some Mogadon (the benzodiazepine nitrazepam) tablets.[41] Sometime after they left Ms Butcher's home, Mr Appelman and Ms Yates parted company.

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[35] Ibid.

[36] Coronial Brief of Evidence, Statement of Tammy Lander.

[37] Ibid.

[38] Coronial Brief of Evidence, Statement of Lisa Yates.

[39] Amitriptyline is used to treat depression and is sold in Australia under the trade name Endep. Recommended daily doses range from 50 to 300mg. Amitriptyline's active metabolite is nortriptyline. Therapeutic concentrations of amitriptyline in post-mortem blood range up to ~0.5mg/L and similar therapeutic concentrations apply to nortriptyline. Blood concentrations in fatalities associated with amitriptyline range from ~0.4mg/L. Amitriptyline has a long resident time in the body exceeding one day sand will, on repeated daily dosing accumulate in the body. The use of high doses or the use of higher than recommended doses may result in the development of toxicity as a result of accumulation. The presence of other drugs including alcohol may enhance the toxic effects of antidepressants.

[40] Coronial Brief of Evidence, Statement of Lisa Yates.

[41] Coronial Brief of Evidence, Statement of Jane Butcher.

13. Between 5pm and 6pm, Ms Lander saw Ms Yates at a bus stop. Ms Yates, who had been waiting for some time and appeared to be 'really out of it' said that she was waiting for Mr Appelman.[42] Ms Yates appears to have no recollection of this interaction.[43]

14. A little before 7pm on 14 December 2010, Steven Beck was walking his dog along Railway Parade in Dandenong where it crosses Yarraman Creek, about 400 metres from the train station. He observed what he believed was a body lying in the creek. He left his dog with a friend and went for a closer look. He observed a young man, later identified as Mr Appelman,[44] apparently deceased, face down in water a couple of inches deep. Emergency services were called.[45]

15. A number of police units attended the scene and commenced their investigations. Senior Constable Belinda Patten of the Victoria Police Forensic Services Centre examined the scene noting that Mr Appelman was found face down in a prone position with his right arm crossed under his body in a concreted-bedded, shallow section of Yarraman Creek which runs beneath the railway bridge south of Railway Parade.[46]

16. Mr Appelman was fully clothed and wearing shoes[47] and the face of his analogue wrist watch was damaged, the hands having stopped at "five-twenty".[48] A red cap, a pair of sunglasses, a red stubby holder, empty pre-mixed alcoholic drink cans and a soft drink bottle were found near Mr Appelman's body and a white card with handwritten numerals on it was found in the front pocket of his tracksuit pants.[49] Police observed no signs of a struggle.[50]

17. Forensic Pathologist Dr Melissa Baker, from the Victorian Institute of Forensic Medicine [VIFM], performed a post-mortem examination or autopsy of Mr Appelman's body. Dr Baker

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[42] Coronial Brief of Evidence, Statement of Tammy Lander.

[43] Coronial brief of Evidence, Statement of Lisa Yates.

[44] Mr Appelman's identity was established through visual identification by his father and fingerprint comparison conducted at the Fingerprint Branch of Victoria Police.

[45] Coronial Brief of Evidence, Statements of Steven Beck and Dixon Tauteka.

[46] Coronial Brief of Evidence, Statement of SC Belinda Patten.

[47] There is a discrepancy in the "description(s)" of Mr Appelman's clothing between the observations of SC Patten and the photographs taken by DSC David Sims. SC Patten's description suggests Mr Appelman was barefoot and the legs of his pants rolled up to his knees, however, the photographs indicate that this was not the case. The discrepancy was not further investigated as it appeared peripheral to the focus of my investigation.

[48] Statement of DSC David Sims.

[49] Coronial Brief of Evidence, Statement of SC Patten. Other items were also located and seized by police, including a red polo t-shirt found at a nearby toilet block.

[50] Coronial Brief of Evidence, Statement of DSC Sims.

reviewed the circumstances of Mr Appelman's death as reported by the police to the coroner and post-mortem CT scans of the whole body when preparing a written report of her findings.[51]

18. Among Dr Baker's anatomical findings were scattered bruises and abrasions to the face, left and right arms and both knees but no injuries that would have caused or contributed to death, mild myxoid thickening of mitral valve leaflets, hepatic steatosis and lymphocytic expansion of portal tracts consistent with chronic hepatitis, frothy fluid in the airways and possible water in the stomach. Post-mortem toxicology detected methadone, amitriptyline and diazepam and their metabolites, alprazolam, oxazepam, 7-aminonitrazapam (a metabolite of nitrazepam), and cannabinoids (indicative of cannabis use).[52]

19. Dr Baker opined that Mr Appelman's death was likely due to a combination of factors. She noted that several central nervous system-depressing drugs (methadone, alprazolam, diazepam, oxazepam and 7-aminonitrazepam) were detected and, though each was present at a level consistent with therapeutic use, their concurrent use enhanced the toxic effects of each. Dr Baker advised that the effects of these drugs were difficult to predict, due to the development of tolerance. Amitriptyline concentration was noted to be in excess of the therapeutic range but the drug's susceptibility to post-mortem redistribution potentially confounded the accuracy of extrapolating the likely level in the peri-mortem period.[53]

20. Dr Baker commented that myxomatous change of mitral valve leaflets can lead to mitral valve prolapse and sudden death due to a cardiac arrhythmia and so this possibility could not be eliminated as contributing to Mr Appelman's death.[54]

21. Although an autopsy diagnosis of drowning can be difficult due to the lack of specific and conclusive indicia, Dr Baker noted that hyperinflation of Mr Appelman's lungs, the frothy fluid within the airways and possible water in the stomach were anatomical findings consistent with drowning as a cause or contributor to death.[55]

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[51] Coronial Brief of Evidence, Medical Examination Report of Dr Melissa Baker.

[52] Coronial Brief of Evidence, Medical Examination Report of Dr Baker.

[53] Ibid.

[54] Ibid.

[55] Ibid.

22. Dr Baker concluded by formulating the cause of Mr Appelman's death as mixed drug toxicity (methadone, amitriptyline, alprazolam, diazepam, oxazepam, nitrazepam) in a man with mitral valve disease in the setting of immersion.[56]

INVESTIGATION – SOURCES OF EVIDENCE

23. This finding is based on the totality of the material the product of the coronial investigation of Mr Appelman's death. That is the brief of evidence compiled by Detective Senior Constable David Sims of Dandenong Police, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[57] 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

24. 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.[58] 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 death, and not merely all circumstances which might form part of a narrative culminating in death.[59]

25. The broader purpose of any coronial investigations 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.[60] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter

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[56] Ibid.

[57] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[58] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.

[59] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[60] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

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.[61] These are effectively the vehicles by which the prevention role may be advanced.[62]

26. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or maybe, guilty of an offence.[63] .[64]

FINDINGS AS TO UNCONTENTIOUS MATTERS

27. In relation to Mr Appelman's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity and the date and place of death were not at issue. I find, as a matter of formality, that Benjamin Albert Appelman born on 30 September 1980, aged 30, died at Yarraman Creek near the southern side of Railway Parade in Dandenong, Victoria, on 14 December 2010.

28. In light of Dr Baker's advice, I find that the cause of Mr Appelman's death is mixed drug toxicity involving methadone, amitriptyline, alprazolam, diazepam, oxazepam and nitrazepam in a man with mitral valve disease in the setting of immersion.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

29. In common with many other coronial investigations, the primary focus of the coronial investigation and inquest into Mr Appelman's death was on the circumstances in which he died. Of particular concern was the apparent ease with which Mr Appelman had accessed large quantities of prescription medications such as the benzodiazepines that contributed to his

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[61] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[62] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[63] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if the coroner believes an indictable offence may have been committed in connection with the death – see sections 69(2) and 49(1) of the Act.

[64] Sections 69 (2) and 49(1).

death. Accordingly, the investigation and inquest examined both specific and systemic issues relating to the prescription and supply of benzodiazepines to Mr Appelman, namely:

a. The adequacy of the clinical management provided by general practitioners Dr Stiebel and Dr Tang who were his primary prescribers; and
b. An update on progress towards implementation of a RTPM system in Victoria.

I shall outline the evidence in relation to each of these matters in turn.

ADEQUACY OF CLINICAL MANAGEMENT

30. Mr Appelman first consulted Dr Tang on 31 December 2009 and attended almost monthly thereafter.[65] He first consulted Dr Stiebel on 7 January 2010, returning twice each month and more often in January, March and October 2010.[66]

31. Both Drs Tang and Stiebel[67] noted the challenge they faced as general practitioners when consulted by a new patient requesting particular medications as did Mr Appelman. Although they both acknowledged that Mr Appelman's history of incarceration,[68] request for benzodiazepines[69] and new patient status[70] were each reasons to prescribe with caution, neither *admitted* having particular suspicions about him being drug dependent/drug seeking or a prescription shopper at any point during their therapeutic relationships.[71] Both described Mr Appelman as well-dressed and well-mannered, and stated that he presented appropriately during consultations.[72] Both doctors appeared willing to give Mr Appelman the benefit of any doubts they may have harboured.[73]

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[65] Medical records indicate that Mr Appelman was seen by Dr Tang once each month between December 2009 and December 2010 except in August 2010 when he attended twice, and in April, July and October 2010 when he did not attend at all.

[66] Medical Records for the dates of Mr Appelman's attendances at Huntingdale Medical Centre.

[67] Transcript pages 3-5.

[68] Transcripts pages 3 [Dr Stiebel] and 46 [Dr Tang, who reported being 'intimidated' by the knowledge that Mr Appelman had served a term of imprisonment].

[69] Transcript pages 3 [Dr Stiebel] and 37 [Dr Tang].

[70] Transcript page 3 [Dr Stiebel] and 37 [Dr Tang].

[71] Transcript page 7-8 [Dr Stiebel] and 59 [Dr Tang].

[72] Transcript page 6-7 [Dr Stiebel] and 36 [Dr Tang].

[73] See generally the tenor of both doctors' comments about Mr Appelman in the inquest transcript.

32. Mr Appelman attended Dr Tang reporting a history of anxiety, depression and previous intravenous drug use and requesting Xanax, Mogadon, Serepax and Avanza/mirtazapine[74] claiming these were his regular medications. He nominated Dr O'Donoghue of South Gippsland Family Medecine [SGFM] as his previous general practitioner [GP]. Dr Tang was 'uncomfortable' prescribing Xanax to a new patient without evidence that it had been previously/recently prescribed by his last GP and so prescribed the other three requested medications,[75] on the basis that these were less addictive and dangerous than Xanax[76] but would alleviate symptoms of anxiety and insomnia.[77] The PBS record shows that only the benzodiazepine prescriptions were dispensed.[78]

33. When Mr Appelman returned to see Dr Tang a fortnight later, he reported calling SGFM and being told to sign a medical release so that his records could be transferred. Dr Tang advised Mr Appelman that it was 'better to stick to one type of benzo' and if he came back another time without his 'old GP history' he would refuse Xanax.[79] He added a new script for 50 Xanax 2mg tablets to be taken b.d. [twice each day] as needed, with two repeats[80] and ceased Serapax and Mogadon while increasing the dosage of the antidepressant mirtazapine on a fresh script. According to PBS records, the mirtazapine prescription was never dispensed but 50 Xanax tablets were dispensed to Mr Appelman pursuant to Dr Tang's script, at three different pharmacies, on 13, 17 and 24 January 2010.[81]

34. On 15 January 2010, very limited information from SGFM – pathology results and information about ORT during a 2006 episode of care – was received by Dr Tang along with a

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[74] Mirtazepine (sold as Avanza in Australia) is an antidepressant.

[75] Dr Tang's medical records document that prescriptions for 25 tablets each of Serepax 30mg ½ daily p.r.n [as required], Mogadon 5mg 1-2 nocte [at night] p.r.n. and a script (with repeats) for large quantity of Mirtazapine 15mg 1 nocte were provided on 31 December 2010. The PBS record shows that only the benzodiazepine prescriptions were dispensed (and on the same day).

[76] Transcript 37.

[77] I note (in common with Dr Odell, Exhibit D) that generally Dr Tang's medical records contain few details of consultations with Mr Appelman such that the clinical basis for decision-making is difficult to divine. There are some references to Mr Appelman presenting as 'mildly anxious' in the medical records. The discrepancy between these sparse notes and the greater level of detail contained in a statement prepared by Dr Tang [Exhibit B] more than a year after his last consultation with Mr Appelman was the subject of cross-examination at inquest. Dr Tang's only explanation of the discrepancy was his independent recollection of the patient [Transcript page 36].

[78] Coronial Brief of Evidence, Exhibit 2.

[79] Dr Tang's medical records.

[80] Dr Tang obtained a telephone authority to write this script for the maximum allowable quantity of alprazolam available under the PBS system.

[81] Ibid.

half-page document purporting to contain a "Full Summary" of Mr Appelman's medical history "as at 13/01/2010" which listed alprazolam 2mg b.d. as the only "current medication".[82] I note that Mr Appelman's most recent SGFM attendance (and alprazolam prescription) had been nine months earlier[83] but that Dr Tang would not have been aware of this because he made no effort to verify the SGFM history.

35. Indeed, at inquest, Dr Tang conceded that he had no documentation in relation to Mr Appelman's medical history after 2006, that he was totally relying on information provided by Mr Appelman and had 'assumed' he was still taking the same medications four years later.[84] I note that Dr Tang did not assume Mr Appelman remained on ORT[85] though he was apparently prepared to assume that a highly addictive benzodiazepine had been prescribed for months or years. Dr Tang testified that he was 'more confident' in continuing with alprazolam after receiving documents from SGFM.[86]

36. Like Dr Tang, Dr Stiebel warned Mr Appelman that he needed his last GP's medical records to provide 'further' prescriptions when he presented providing a history of anxiety and insomnia[87] and needing prescriptions for diazepam and a non-benzodiazepine hypnotic Imovane since moving away from his last doctor in Gippsland.[88] Mr Appelman reported taking two-to-three 5mg diazepam tablets each day and intermittent use of Imovane and so Dr Stiebel provided scripts for both drugs; the diazepam script for 50 tablets, two-to-three tablets

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[82] Ibid. The date 13/01/2010 appears likely to be the date on which the "Full Summary" was generated by SGFM and given the time that had elapsed since Mr Appelman's last consultation, the information contained therein is rather misleading.

[83] SGFM medical records and Coronial Brief of Evidence, Statement of Dr Wai.

[84] Transcript page 40.

[85] Neither Dr Tang nor Dr Stiebel was aware that methadone was one of Mr Appelman's current medications (see Transcript pages 37 [Dr Tang] and 12 [Dr Stiebel]). While neither doctor appears to have probed this issue, I note the evidence of Dr Wai (see Dr Wai's statement) that Mr Appelman consistently denied being prescribed methadone when asked by that GP.

[86] Transcript page 58.

[87] Although Dr Stiebel's medical notes are slightly more detailed than those of Dr Tang, they are still rather sparse on clinical detail and vague, particularly in relation to the majority of consultations that involved anxiety, depression and medications. Dr Stiebel's statement [Exhibit A] is less detailed than his medical notes and at inquest [Transcript page 25] he remarked that the only time Mr Appelman had appeared 'really agitated' was during their final consultation in November 2010. Dr Stiebel presumed that Mr Appelman's anxiety was caused by his previous incarceration [Transcript page 13].

[88] Dr Stiebel's medical records.

to be taken per day as required. [89] The diazepam script was dispensed the same day but Imovane was never dispensed.[90]

37. Again, like Dr Tang, when Mr Appelman re-presented a fortnight later for another prescription and his previous GP's records had not been transferred, Dr Stiebel provided another script for 50 diazepam tablets.[91] *Seven* days later, Mr Appelman returned, his previous GP's records covering the period to April 2009 had arrived in the meantime, requesting a further diazepam script. Dr Stiebel's notes of this consultation indicate Mr Appelman reported using up to five diazepam tablets per day but that the doctor's compliance check suggested use of about seven tablets per day. Nonetheless, and apparently without demurrer, Dr Stiebel wrote a further script for 50 diazepam tablets that day, 28 January 2010.[92]

38. At inquest, Dr Tang and Dr Stiebel acknowledged that benzodiazepines are intended for short-term use – for four to six weeks only[93] – because they are highly addictive medications.[94] Dr Stiebel suggested that a patient could be weaned off such drugs, on average, within six and nine months.[95] Both GPs testified that their clinical management plan from the outset was to wean Mr Appelman off benzodiazepines gradually with an ultimate aim of ceasing to prescribe them.[96]

39. Dr Tang testified that the first time he prescribed Xanax he increased mirtazapine and ceased the other benzodiazepines as a 'long-term plan' to wean Mr Appelman off alprazolam by prescribing higher doses of the antidepressant.[97] His further efforts to wean Mr Appelman

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[89] Ibid.

[90] Coronial Brief of Evidence, Exhibit 2.

[91] Dr Stiebel's medical records and Coronial Brief of Evidence, Exhibit 2.

[92] Dr Stiebel's medical records.

[93] Transcript page 13.

[94] Transcript pages 10 and 27 [Dr Stiebel] and 40 [Dr Tang].

[95] Transcript page 9-10. The corollary of the "need to wean" is – obviously – presence of a chemical dependence, however, I note that Dr Stiebel, in particular and somewhat disingenuously, avoided conceding that Mr Appelman was "dependent" on benzodiazepines/diazepam [Transcript page 10-11].

[96] Transcript pages 9 [Dr Stiebel] and 45 [Dr Tang].

[97] Transcript page 45. Mirtazepine was prescribed on 31 December 2009 [30 tablets with five repeats which was a five-month supply if used as directed] and at the increased dose on 13 January 2010 in the same quantity as the earlier script. None of those prescriptions were dispensed. On 24 June 2010 Dr Tang notes, "off avanza" [mirtazapine] and on 18 November 2010, "discussed avanza/compliance".

were to tell him 'he should be back on mirtazepine',[98] advise him 'more than once'[99] to engage in psychological counselling and 'refer him'[100] to the South Eastern Alcohol and Drug Service [SEADS]. Dr Tang conceded that as a GP he had the power to refuse to prescribe alprazolam to Mr Appelman but failed to do so, until his last consultation.[101] He explained that he was a junior doctor in 2010 and was 'not good' at 'saying no'.[102]

40. I note that compliance with dosing instructions was noted as having been discussed during four of Dr Tang's twelve consultations with Mr Appelman.[103] Nonetheless, during their 11½-month therapeutic relationship, Dr Tang provided Mr Appelman with scripts for 1100 alprazolam tablets, inclusive of a private script for 50 tablets given when he reported being burgled and PBS authority for another script so soon after the last was declined. This is equivalent to an 18-month supply if taken as directed.[104]

41. Dr Stiebel's evidence about his efforts to wean Mr Appelman off diazepam was similar to that of Dr Tang regarding alprazolam.[105] In particular, he conducted a compliance check[106] of Mr Appelman's average daily use of diazepam at each consultation with a view to reducing use over time. The results would shape his management of his patient. There was 'chastising' if Mr Appelman had taken more than the prescribed dose, discussions about reasons for increased use (Mr Appelman reportedly always had an answer), the dangers of excessive use

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[98] Transcript page 46.

[99] Transcript page 46. I note that the medical records only contain one reference to a suggestion that Mr Appelman engage in psychological counselling, on 13 January 2010.

[100] Transcript page 46. The "referral" noted as "see SEADS" in the medical records on Dr Tang's last consultation with Mr Appelman (11 December 2010) occurred in the following context, noted in the records: "advised no more benzos from me after today! Come back if he wants antidepressants". I note that despite these comments, while no alprazolam script was provided on that day, Dr Tang wrote scripts for 25 nitrazepam and 50 diazepam tablets (both benzodiazepines) on that date and that the scripts were filled.

[101] Transcript page 46.

[102] Transcript page 46.

[103] Dr Tang's medical records. The content of the discussions was not noted.

[104] Dr Tang's medical records, Exhibit C and Coronial Brief of Evidence, Exhibit 2.

[105] Dr Stiebel conceded [Transcript page 5] that his notes did not reflect his suggestion that Mr Appelman engage with a psychologist (the patient was not keen to do so). Further, he did not seek to verify Mr Appelman's claim that he was seeking assistance from a drug counsellor in April 2010 [Transcript page 26]. He did not consider managing Mr Appelman as a "drug dependent" patient because the Dr Stiebel was 'attempt[ing] to wean him' [Transcript page 24], nor did he independently refer him for drug addiction counselling because the waiting lists are 'a mile long' [Transcript page 24].

[106] Software on the GP's computer calculates the average daily use since the last prescription.

were explained, and if compliance had been good Mr Appelman would be encouraged to continue in the same vein.[107]

42. Dr Stiebel testified that Mr Appelman 'did reduce his dosage, or I thought he [had]'.[108] In fact, of the 27 consultations between Dr Stiebel and Mr Appelman there are notations on only three dates indicating an average daily use of diazepam somewhat in accord with directions; two in April 2010 (average daily use 2.9 and 3.8 tablets) and once in June 2010 (when the supply was exhausted on the day of attendance).[109] All other notations refer to daily usage in excess of Dr Stiebel's directions and often significantly so. What Dr Stiebel did not know, was that in April and June 2010, Mr Appelman had supplemented his diazepam supply by obtaining 50 tablets from each of two other GPs.[110]

43. Despite Dr Stiebel's evidence that in his perception Mr Appelman's diazepam use was declining, his own records suggest otherwise.[111] "Reductions" in Mr Appelman's diazepam use – of which only three were noted – actually represent a closer correlation between actual use and the prescriber's dosing instructions. It is difficult to appreciate any sign that "weaning" occurred given that Dr Stiebel prescribed a 14-month supply of diazepam to Mr Appelman during their 11-month therapeutic relationship, even if one assumes the medication was used at the rate of the *maximum* dose directed.[112]

44. Both GPs conceded at inquest that there were elements of their management of Mr Appelman that could have been improved.[113] Moreover, the general tenor of their evidence was that they were not suspicious that Mr Appelman was a prescription shopper because they were each – independently – prescribing him exactly what he wanted in sufficiently large quantities to

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[107] Transcript page 20

[108] Transcript page 11.

[109] Dr Stiebel's medical records.

[110] Coronial Brief of Evidence, Exhibit 2.

[111] Dr Stiebel's medical records: see in particular notes of consultations on 28 January, 3 March, 8 June and 30 November 2010 all refer to Mr Appelman using excessive quantities of diazepam.

[112] Ibid. I note that Dr Stiebel did, once, "overwrite" a prescription so that half of the quantity of diazepam prescribed would not be dispensed by a pharmacy prior to a particular date [see Transcript page 21]. I note too that this occurred on 28 October 2010, a month in which Mr Appelman had already received three prescriptions from Dr Stiebel for 50 diazepam tablets – which had all been filled on the day they were written – on 1, 15, and 22 October 2010. Thus, in a 28-day period, Mr Appelman had received 200 diazepam tablets from Dr Stiebel [see PBD record].

[113] Transcript pages 24 [Dr Stiebel] and 51 [Dr Tang who went so far as to say (at 48 and 51) that he no longer prescribes benzodiazepines at all].

obviate the need to go elsewhere for benzodiazepines.[114] Both doctors enthusiastically agreed – somewhat missing the salient point – that a RTPM system would assist them in their clinical management of such patients.[115]

45. I have been greatly assisted by the independent expert evidence provided by general practitioner, Dr Cameron Loy, in his written report and testimony at inquest.[116] In addition to commenting on the riskiness of prescribing benzodiazepines,[117] indications and contraindications for their use, including "common" versus "evidence-based" use,[118] and good practice considerations when prescribing benzodiazepines in general, Dr Loy examined the prescribing practices of the clinicians involved in Mr Appelman's care.[119]

46. Dr Loy was critical of benzodiazepine prescription practices employed by Mr Appelman's doctors. He observed that there are few indications for the use of benzodiazepines for more than four weeks, after which dependence may be established and is difficult to treat, and that there is no compelling argument to co-prescribe multiple benzodiazepines.[120] As is clear from the evidence outlined above, Mr Appelman was prescribed a number of benzodiazepines for periods far in excess of four-to-six weeks and several prescribers at various times prescribed multiple benzodiazepines themselves, leaving aside their lack or enquiry and/or knowledge of other prescribers of these drugs.

47. In Dr Loy's opinion, benzodiazepines are high-risk medications, particularly for patients with clear signs and symptoms of addiction. He observed that both the statements and medical records prepared by Mr Appelman's prescribers, including Drs Tang and Stiebel, suggested that the GPs saw clinical indicators that Mr Appelman had substance addiction and misuse disorders.[121] As a result, all of the decisions about pharmacological interventions should have been made through this lens and overall management of Mr Appelman's presenting conditions

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[114] See the GPs' testimony generally and in particular pages 27 [Dr Stiebel] and 48 [Dr Tang].

[115] Transcript pages 18 [Dr Stiebel] and 52 [Dr Tang].

[116] Dr Loy's independent expert opinion is Exhibit E and his oral evidence appears in the Transcript on pages 73-94.

[117] Including the enhanced risk of prescribing benzodiazepines to patients long-term, co-prescribing multiple benzodiazepines and prescribing them to patients undertaking ORT and/or otherwise having drug addiction or misuse disorders [Exhibit E].

[118] Exhibit E. See Dr Tang's testimony page 40 for an example of the "common use" justification.

[119] Exhibit E.

[120] Ibid.

[121] Ibid.

should have included non-benzodiazepine pharmacological interventions and non-pharmacological interventions.[122]

48. Noting that prescribers must take responsibility – without deferral or dispersal[123] – for any medicine prescribed, Dr Loy opined that it was arguable that Mr Appelman's *prescriptions for benzodiazepines should have either been declined or entered into with a very clear strategy to engage the patient and, from the first prescription, start a one way purposeful wean.*[124] Moreover, once a decision to prescribe was reached, the prescribed dose should have been the *lowest effective dose, with regular reviews [to monitor for misuse] and regular genuine attempts at withdrawal.*[125] Dr Loy considered these to be key guidelines for safe prescribing of benzodiazepines,[126] departure from which could only be justified on compelling clinical grounds.[127] He commented that checks and balances to monitor for drug misuse were absent from Mr Appelman's management, as was the goal of actively reducing 'risky' benzodiazepine prescriptions, at least not in any meaningful sense.[128]

49. Although noting the sub-optimal prescribing practices of Mr Appelman's clinicians proximate to his death, Dr Loy observed that there was a compelling argument that were the prescribers and pharmacists able to see the PBS dispensing history, the chaos of Mr Appelman's pharmaceutical misuse may have been identified with a possible change in his outcome.[129] Nonetheless, the expert commented that it was not sufficient merely to have a RTPM system: the prescriber had to use it and that, in part, required prescribers to be educated about such a system and the benefits of its use.[130]

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[122] Ibid.

[123] Dr Loy referred specifically to the common practice among prescribers to continue prescriptions commenced by other clinicians especially if the originating prescriber is perceived to be more experienced or specialist in a field, which was exemplified in this case by Dr Tang's reassurance about providing alprazolam after receiving Mr Appelman's SGFM medical record. Dr Loy characterised this as a form of 'deferred responsibility' given that the properties of alprazolam as a 'high-risk prescription' remained unchanged. He observed that there is no compulsion or imperative that requires a clinician to continue the prescription of another. See Exhibit E.

[124] Exhibit E.

[125] Ibid.

[126] Ibid.

[127] Transcript page 75.

[128] Exhibit E.

[129] Exhibit E and Transcript page 76.

[130] Transcript page 77.

UPDATE ON IMPLEMENTATION OF RTPM IN VICTORIA

50. Matthew McCrone, Chief Officer of Drugs Poisons Regulation at the Department of Health and Human Services, gave oral evidence about the framework for RTPM and an update on the implementation of such a system in Victoria.[131] He acknowledged that there was broad agreement at state, territory and federal levels of government of the public policy benefits of, and the urgency of the need for, the establishment of a RTPM system, in part fostered by the consistent 'advocacy' of Victorian Coroners and their interstate counterparts.[132]

51. Nonetheless, since the Commonwealth developed a software package (based on the original model developed in Tasmania to "track" information about prescriptions) and made this available under licence to the states and territories, implementation of RTPM has been left to each individual jurisdiction.[133] A national system for the federation is not presently contemplated.[134]

52. As at the time of the inquest into Mr Appelman's death in May 2015, Mr McCrone stated that the Victorian Minister for Health had signed a licensing agreement to allow this state to access the Commonwealth's software package.[135] In addition, funds were allocated in the 2015-16 Victorian Budget to fund a RTPM implementation planning study to follow an in-house evaluation of the software itself.[136] Mr McCrone anticipated that the implementation planning study, once completed, would aid development of the financial resources and timetable for execution of RTPM in Victoria.[137]

53. In short, as at May 2015 – more than a decade after Victorian Coroners first recommended the establishment of a RTPM system – the state's Chief Officer for Drugs Poisons Regulation had no sense of when Victoria may have RTPM.[138]

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[131] Transcript pages 95-106.

[132] Transcript page 102.

[133] Transcript pages 103.

[134] Transcript page 105. A national system is not presently contemplated, though it does appear to be desired and desirable.

[135] Transcript page 99.

[136] Transcript page 99.

[137] Transcript page 102.

[138] Transcript page 100.

CONCLUSIONS

54. 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.[139] 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.

55. It is a truism that as Australia's health care system is presently organised, general practitioners are the "front line" providers of health care and management. I acknowledge that the GP's significant burden of responsibility is sometimes borne in the face of imperfect knowledge and that this must only exacerbate the challenge presented by the management of new patients, particularly those like Mr Appelman, seeking benzodiazepines and arguably having their own (incompatible) agenda.

56. That said, I accept and endorse the expert evidence provided by Dr Loy and find that Dr Tang and Dr Stiebel's clinical management of Mr Appelman, especially their benzodiazepine prescribing practices, were deficient. In particular, I am satisfied that:

    a. There is little information in the medical records maintained by Dr Tang and Dr Stiebel, or in their statements and oral evidence, to substantiate a clinical basis for prescribing benzodiazepines. While I cannot conclude on the materials before me that there was *no* clinical basis for providing prescriptions for benzodiazepines, I am not satisfied that either general practitioner applied an appropriate level of clinical rigor to *each of* their decisions to prescribe.

    b. Even accepting that it was clinically necessary to prescribe benzodiazepines to Mr Appelman, neither Dr Tang nor Dr Stiebel made any real effort to establish the lowest effective dose. To the contrary, their dosing decisions appear to be patient-led rather than based on clinical evidence. I note, in particular, the reliance each general practitioner placed on Mr Appelman's initial self report about dosing (and even as this changed over time in relation to diazepam) and that both doctors facilitated supply of benzodiazepines in excess of their dosing instructions over the course of the 11 months plus of their therapeutic relationships.

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[139] *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..."

c. Dr Tang and Dr Stiebel knew or *ought to have known* as a result of their therapeutic relationship that Mr Appelman was a drug dependent patient and that he was likely to be misusing his prescribed medications

d. Despite their oral evidence to the contrary, neither Dr Tang nor Dr Stiebel had a plan, realistic or otherwise, through which to engage Mr Appelman so as to wean him off benzodiazepines. I find that their efforts to engage Mr Appelman to this end, even if taken at their highest, were inadequate, particularly given the regularity and sufficiency of ongoing benzodiazepine prescriptions.

57. I find that the sub-optimal prescribing practices of Dr Tang and Dr Stiebel contributed to Mr Appelman's death.

COMMENTS

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

1. There is abundant evidence in this jurisdiction that simple strategies like those employed by Mr Appelman reduce the likelihood that over-prescription and over-supply of prescription-only medications will be detected in time to ameliorate or avoid harms and deaths.[140] This is particularly the case because in the Australian health care system nothing prevent patients from seeing multiple doctors and attending multiple pharmacies, there is no real-time prescription monitoring [RTPM] system for prescribers and dispensers, and those systems that are in place for notifying doctors about doctor shoppers or inappropriate prescribing[141] tend to be underutilised,[142] unreliable or ineffective.[143]

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[140] Prescription medications cause or contribute to the large and increasing number of over-dose deaths that occur in Victoria each year. For example, Victorian Health and Human Services data estimate deaths related to pharmaceutical medicines to have risen steadily from 266 in 2010 to 330 in 2015 (see RTPM Initiative Media Release April 2016). Numerous coronial investigations undertaken in the past decade document the myriad ways in which prescription drug seekers/doctor shoppers manipulate clinicians and the health care system to obtain medications in excess of clinical need. On at least 20 occasions since 2002, the findings of Victorian Coroners have been published with comments and recommendations advocating the implementation of a RTPM system to reduce the deaths and harm associated with prescription/doctor shopping.

[141] 'Prescription shopper' for the purpose of using these services is defined as a patient supplied at least one of: (i) pharmaceutical benefits prescribed by 6 or more different prescribers; (ii) a total of 25 or more target pharmaceutical benefits; or (iii) a total of 50 or more pharmaceutical benefits. If a patient 'qualifies' a prescriber/dispenser may be provided information about (i) the number of PBS medicines supplied in the previous three months (including repeat prescriptions filled on scripts issued within 12 months); the number (but not the identities of) individual prescribers of PBS medications supplied by pharmacies during the identified period. The services include: (a) Medicare Australia's

2. Mr Appelman's death was one of 266 in 2010 in which pharmaceutical medicines were implicated, and one of 169 in which benzodiazepines were implicated. Unfortunately, the frequency of deaths involving prescription medications in Victoria continues to rise and reached a total of 330 deaths in 2015, in 220 of which benzodiazepines were implicated. The number of Victorian deaths each year involving pharmaceutical drugs is higher than the number of deaths from illicit drug overdose (217 deaths in 2015) and higher than the annual road toll (252 deaths in 2015).[144]

3. In April 2016, the Victorian Government announced funding of $29.5 million over five years for the implementation of a RTPM computer software system that allows pharmacy dispensing records for certain medicines to be transmitted in real time to a centralised database, which can then be accessed by doctors during a consultation and pharmacists at the point of dispensing. While the announcement is very welcome and represents progress towards achievement of RTPM since Mr McCrone's advice at the inquest into Mr Appelman's death in May 2015, the restricted scope of drugs to be monitored is disappointing.

4. Currently, the drugs to be included in the scheme are Schedule 8 drugs of the Standard Uniform Scheduling of Medicines and Poisons such as opioid analgesics (like Endone, Oxycontin and methadone) and the recently rescheduled benzodiazepine, alprazolam. *Not* included are Schedule 4 benzodiazepines such as diazepam, oxazepam and nitrazepam, which contributed to Mr Appelman's death and for which he actively prescription shopped.

5. An analysis of Victorian coronial data for 2010-2015 undertaken by the Coroners Prevention Unit demonstrates that some Schedule 4 drugs are significantly implicated in overdose deaths each year. For example, diazepam contributed to 109 of 342 overdose deaths in

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Prescription Shopping Alert Service [PSAS] whereby computer algorithms analyse dispensing patterns of target drugs [drugs of dependence] to patients via the PBS, if a patient's dispensing history meets criteria deemed 'excessive' letters are sent to each of patient's prescribers to notify them; (b) Medicare's online doctor shopping health services at http://www.medicareaustralia.gov.au/provider/pbs/prescription-shopping/; and (c) Prescription Shopping Information Service [PSIS] is a 24 hour telephone services available everyday which is accessible to prescribers and dispensers which provides information about whether the patient meets the criteria of a 'prescription shopper' and is accurate up to the previous 24 hours.

[142] Both Drs Stiebel and Tang testified [Transcript pages 7, 15-17 & 19 and 49-50 & 52, respectively] to rare use of such services in their practices generally due to the user-unfriendliness of the services, delay in obtaining information or as a result of the limited utility of information available. Neither used any of the available services to support their management of Mr Appelman. Dr Loy, who provided independent expert evidence, also indicated the difficulties and delays associated with obtaining prescribing/dispensing information about patients under the current arrangements [Transcript page 76].

[143] Exhibit D and Transcript 62-71 [Dr Odell].

[144] Victorian Health and Human Services data, see above note 34.

2010; 124 of 362 overdose deaths in 2011; 132 of 368 overdose deaths in 2012; 164 of 379 deaths in 2013; 168 of 3884 overdose deaths in 2014 and 176 of 420 overdose deaths in 2015. Indeed, benzodiazepines as a class of drugs were implicated in more than 50% of all drug overdose deaths in Victoria each year between 2010 and 2015. *It follows that if RTPM is to assist in reducing the number of preventable overdose deaths, it needs to encompass those Schedule 4 drugs known to be implicated in overdose deaths.*

6. There is little doubt that a comprehensive RTPM system will be an important tool for prescribers and dispensers to identify prescription drug seekers and provide opportunities for timely preventative intervention to minimise harms and deaths. That said, implementation of RTPM appears to be some way off yet and so other measures similarly aimed at reducing harms must be utilised in the interim, particularly by prescribers.

7. The most obvious safety measure is that of responsible prescribing practices. I reiterate my comments in a previous investigation[145] commending the 2015 publication of information and guidelines by Drugs Poisons Regulation and the Royal Australasian College of General Practitioners, respectively, in relation to the prescription of medications including benzodiazepines to drug-dependent and non-drug-dependent patients.

8. While it is expected that general practitioners and other prescribers exercise independent clinical judgement when managing their patients, mindful of the risks of uncorroborated reliance on their patient's self-report or slavish accordance with the management strategy employed by another clinician, it is not unreasonable for them to expect that medical records maintained by other professionals and provided to them upon transfer of care are accurate and reasonable comprehensive.

9. While neither Dr Tang nor Dr Stiebel made any useful effort to verify the information contained in Mr Appelman's SGFM records, the records they were provided were on their face four years out of date and, in fact, misleading as to the currency of the list of "current" medications. Given the potential for subsequent medical managers to rely at least to a degree on information provided by previous clinicians - otherwise there would be no reason to obtain such records - minimum standards of accuracy and currency of information should be adopted.

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[145] Dean Wayne Wright COR 2011 000727.

10. Additionally, prescribers should be encouraged to use the tools available under the auspices of the Commonwealth Department of Human Services Prescription Shopping Programme, encompassing the Prescription Shopping Alert Service and the Prescription Shopping Information Services. I note the limitations of these services – particularly the limited definition of 'prescription shopper', the provision of only retrospective (not real time) information to prescribers and that they are, unfortunately, regarded as cumbersome to use.

RECOMMENDATIONS

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

1. I recommend that the Department of Health and Human Services' Real Time Prescription Monitoring Taskforce consider the inclusion of diazepam and other Schedule 4 drugs within the RTPM scheme.
2. I recommend that the Royal Australasian College of General Practitioners [RACGP] develop guidelines or otherwise inform its members as to minimum standards for ensuring effective transfer of care between general medical practitioners or practices. In particular, the RACGP include guidance as to what should be included in a patient's medical records to ensure accurate, comprehensive and current information accompanies a patient to a subsequent general practitioner upon a transfer of care.
3. I recommend that the Australian Health Practitioner Regulation Authority considers the circumstances in which Mr Appelman died, and takes whatever action it deems appropriate in relation to Dr Tang and Dr Stiebel.
4. For the purposes of Recommendation 3 above, I direct that the Principal Registrar provide a copy of this finding, the coronial brief and the inquest transcript to the Australian Health Practitioner Regulation Authority.

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

Mr Appelman's family

Dr Tang, Springvale South Medical Centre, c/- Avant Law

Dr Stiebel, Huntingdale Medical Centre, c/- Avant Law

Dr Loy, You Yangs Medical Clinic

Australian Health Practitioner Regulation Authority

The Secretary, Department of Health and Human Services

Department of Health and Human Services' Real Time Prescription Monitoring Taskforce

Mr Matthew McCrone, Chief Officer, Drugs and Poisons Regulation, Department of Health and Human Services

Royal Australasian College of General Practitioners

Royal Australasian College of Physicians

Signature:

PARESA ANTONIADIS SPANOS
Coroner
Date: 1 June 2016

Cc: Manager, Coroners Prevention Unit