IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 6155

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Coroner
Deceased:	
Date of birth:	18 October 1983
Date of death:	5 December 2015
Cause of death:	I(a) Multidrug overdose
Place of death:	19 Gamble Road, Carrum Downs, Victoria

BACKGROUND

1. [redacted] was a 32-year-old man who lived in Carrum Downs at the time of his death.

2. [redacted] suffered chronic pain and had a history of mental health issues including diagnoses of polysubstance abuse, schizoaffective disorder and antisocial personality disorder.

3. On 5 December 2015 [redacted] was discovered at home unconscious and was unable to be resuscitated.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. [redacted] death was reported to the Coroner as it appeared to be unexpected and unnatural and so fell within the definition of a reportable death in the *Coroners Act 2008.*

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family members, the forensic pathologist who examined [redacted] treating clinicians and investigating officers.

7. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established to the standard of proof of the balance of probabilities.[1]

IDENTIFICATION OF THE DECEASED

8. On 5 December 2015, [redacted] visually identified [redacted] body as being that of his housemate [redacted]

9. Identity is not in dispute and requires no further investigation.

[1] This is subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

10. began to have difficulties with substance abuse before the age of 20. At around that age, he became abusive towards his family who have attributed his behaviour to his drug use.[2] He moved out of home and received support from the Melbourne City Mission.

11. came into contact with mental health services and eventually received diagnoses of polysubstance abuse, schizoaffective disorder and schizophrenia. He had a number of inpatient admissions for mental health treatment in the following years.

12. After leaving home, commenced a relationship with and the two later had a daughter . had become a heroin user, but after became pregnant with he entered a methadone program.

13. In December 2011 suffered a broken leg in an assault and was hospitalised. Upon his discharge from hospital he was given opioid painkillers for chronic pain from his leg. His mother stated '*I think that was when things went really downhill for him again. He was going really well and being put back on morphine was a major setback*'.[3]

14. and initially lived with family after his discharge but later moved out together, eventually being placed in a housing commission unit in Frankston. and relationship had difficulties and he would often be kicked out of their house and live with others for periods of time.

15. On 29 November 2013, attended the Frankston Hospital Emergency Department after presenting following an apparent attempt at self-strangulation. He was discharged on the following day for review by a general practitioner.

16. On 20 December 2013, again presented to the Frankston Hospital Emergency Department with psychiatric symptoms, but abruptly left and ran in front of a moving vehicle, suffering injuries. He later stated that he left as he was upset that Emergency Department Staff believed had had taken an overdose of oxycodone.[4]

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[2] Statement of dated 11 March 2016, Coronial Brief.
[3] Ibid.
[4] Peninsula Health Psychiatric Service Discharge Summary dated 8 January 2014, Humphries Road Medical Centre Medical Records.

17. was subsequently admitted as an inpatient to the Adult Acute Inpatient Mental Health Unit at Frankston Hospital Ward '2 West' and was discharged on 8 January 2014.

18. His drug use continued, and on 12 January 2015 was admitted to the Frankston Hospital Emergency Department following an overdose on fentanyl after dissolving fentanyl patches in vinegar and injecting the resulting liquid.

19. Toward the end of his life and his mother had discussed residential drug treatment programs, but no arrangements were made prior to his death. He also began a course at TAFE, but was unable to continue due to financial issues.

20. On 25 September 2015, presented to the Frankston Hospital Emergency Department with psychiatric symptoms following an argument with and being asked to leave their house. He was admitted to ward '2 West' until being discharged on 28 September 2015.

21. was offered support by the Peninsula Health Drug and Alcohol Services, but declined at the time.

22. After his discharge, moved to live with in Carrum Downs. reports that his house was convenient as it was still close to and and that continued to see them often along with his mother.[5]

23. On 16 October 2015 made phone contact with the local Drug and Alcohol Services and attended for an assessment on 30 November 2015.

Prescription drug abuse

24. was a user of prescription medications and illicit substances including marijuana and methamphetamine. reports that toward the end of his life also used prescribed fentanyl, clonazepam and diazepam and that '*always had prescription medication*'.[6] He was additionally prescribed the antipsychotic olanzapine for his mental health issues.

25. had been treated with opioids including oxycodone and fentanyl pursuant to permits from the Department of Health and Human Services, and had received assessment

[5] Statement of dated 22 February 2016, Coronial Brief.
[6] Ibid.

and treatment from Frankston Pain Management in relation to pain resulting from his leg injury in December 2011.

26. [redacted] had received prescriptions for a number of drugs from multiple general practitioners (GPs). Several GPs had recognised [redacted] drug seeking behaviour and had refused to provide further prescriptions.

27. Dr Christopher Hughes ceased providing fentanyl after 24 August 2015 upon discovering that [redacted] was receiving fentanyl from other GPs,[7] and Dr Andrew Taylor ceased providing [redacted] with diazepam after September 2015 when he had identified him as a '*chaotic poly substance using male with little insight into how dangerous his behaviour was*'.[8]

28. Dr Taylor had cancelled his permit to prescribe Schedule 8 opioids to [redacted] on 25 August 2015. His medical records note:

> '*It is my belief that he has a sore knee which can never justify the use of long term opioids in a 31 yo male. I suspect he has both past and present narcotic dependence and should be treated appropriately.*'[9]

29. Dr Emad Tadros had refused to provide diazepam to [redacted] in August 2015 after becoming aware that [redacted] was also sourcing diazepam from Dr Taylor.[10]

30. Nevertheless, [redacted] continued seeing new practitioners, and as late as 27 November 2015 obtained prescriptions from Dr Peter Shea for clonazepam and fentanyl.

31. Dr Shea had requested that the supplying pharmacist for [redacted] fentanyl prescriptions notify him if [redacted] were receiving fentanyl from other doctors,[11] and a pharmacist had previously contacted one of [redacted] doctors to notify him that [redacted] had multiple prescribing doctors.[12]

32. However, in addition to having multiple prescribing doctors, [redacted] also had his prescriptions supplied at a number of different chemists.

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[7] Progress note of Dr Christopher Hughes dated 24 August 2015, Mornington Coast Medical Centre Medical Records.
[8] Statement of Dr Andrew Taylor dated 1 March 2016, Coronial Brief.
[9] Progress note of Dr Andrew Taylor dated 25 August 2015, Frankston HealthCare Medical Records, Coronial Brief.
[10] Progress note of Dr Emad Tadros dated 31 August 2015, Frankston HealthCare Medical Records, Coronial Brief.
[11] Statement of Dr Peter Shea dated 27 June 2016.
[12] Progress note of Dr Christopher Hughes dated 24 August 2015, Mornington Coast Medical Centre Medical Records.

Events proximate to death

33. On the morning of 5 December 2015 several friends had visited and and had reportedly arranged to work as a concreter with one of them.[13]

34. At some point that afternoon, left the house with two acquaintances while stayed behind. recalls seeing *"have some pills"* at this time.[14]

35. returned home at around 5.30pm. He discovered unconscious in the bathroom of the house. After attempting to rouse unsuccessfully, instructed one of his acquaintances to contact emergency services.

36. then spoke to the emergency services operator and moved into the kitchen of the house in order to have space to perform CPR. began vomiting at this time, and attempted to clear his mouth.

37. commenced CPR in accordance with instructions from the emergency services operator and continued until Ambulance attended. Ambulance paramedics took over CPR but were unable to resuscitate

38. Ambulance paramedics verified that was deceased at 6.05pm on 5 December 2015.

CAUSE OF DEATH

39. On 8 December 2015, Dr Paul Bedford, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon body and provided a written report, dated 22 December 2015. In that report, Dr Bedford concluded that a reasonable cause of death was '*1(a) Multidrug overdose*'.

40. Toxicological analysis of the post mortem samples taken from identified the presence of methadone, EDDP (a metabolite of methadone), fentanyl, methylamphetamine, amphetamine, 7-aminoclonazepam, nordiazepam, the antipsychotic olanzapine and paracetamol.

[13] Statement of dated 22 February 2016, Coronial Brief.
[14] Ibid.

Intent

41. There is no evidence to suggest that [redacted] intended to take his own life.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

42. [redacted] fatally overdosed using pharmaceutical drugs sourced from multiple clinicians. These drugs included both the opioid fentanyl and the benzodiazepines clonazepam and diazepam. Victoria's coroners frequently investigate overdose deaths that have occurred in similar circumstances, and have long advocated for implementation of a real-time prescription monitoring (RTPM) system to reduce the risk of these deaths occurring.

43. The central anticipated benefit of an RTPM system is that it will enable a clinician to access timely information on what drugs a patient has been prescribed and by whom, and use this information to make informed decisions on how to treat that patient. Additionally, a RTPM system is hoped to improve dramatically the ability of clinicians to coordination the care they provide to a patient, including their prescribing to the patient.

44. With access to accurate prescribing information about a patient, clinicians should be able to identify and respond to issues such as over-consumption of prescribed drugs, access to inappropriate combinations of prescribed drugs, and pharmaceutical drug dependence.

45. On 25 April 2016 the Victorian Government announced funding for the implementation of a Victorian RTPM system. On 28 July 2017 the Victorian Government re-iterated this commitment, stating that '*it is expected the system will be rolled out next year*'.[15] On the same day, the Victorian Department of Health and Human Services publicly released a research paper titled 'Evidence to inform the inclusion of Schedule 4 prescription medications on a real-time prescription monitoring system',[16] which was prepared to inform the planning for RTPM implementation.

46. The existence of a RTPM system could have reduced the ability of [redacted] to access the drugs that contributed to his death. Given the developments outlined above there is no need for me to make any further recommendation at present regarding the implementation of a RTPM system in Victoria.

[15] The Hon Jill Hennessy MP, 'More prescription pills to be monitored to save Victorian lives', media release dated 28 July 2017.
[16] David Liew et al, Department of Clinical Pharmacology and Therapeutics and Pharmacy Department Austin Health, 'Evidence to inform the inclusion of Schedule 4 prescription medications on a real-time prescription monitoring system' (March 2017).

47. I direct that this finding be provided for information only via the Secretary, Department of Health and Human Services, to the Real-Time Prescription Monitoring Taskforce, in case the circumstances of the death are useful to inform the further planning and implementation of the system already underway.

FINDINGS AND CONCLUSION

48. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that [redacted] born 18 October 1983, died on 5 December 2015 at Carrum Downs, Victoria, from a multidrug overdose in the circumstances described above.

49. Pursuant to section 73(1A) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

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

[redacted] senior next of kin.

Peninsula Health.

Office of the Chief Psychiatrist.

Real-Time Prescription Monitoring Taskforce, via the Secretary, Department of Health and Human Services

Detective Senior Constable Tamara Gilbert, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH

CORONER

Date: 16 August 2017