IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 000727

**FINDING INTO DEATH WITHOUT INQUEST**

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

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of DEAN WAYNE WRIGHT
without holding an inquest:
find that the identity of the deceased was DEAN WAYNE WRIGHT
born on 7 March 1980
and that the death occurred on 25 February 2011
at Rear Bungalow of 4 Anna Street, St Albans, Victoria 3021
**from:**

I (a) MIXED DRUG TOXICITY (CODEINE, TRAMADOL, OXAZEPAM, DIAZEPAM)

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

1. Mr Wright was a 30-year old single unemployed man who lived in a rear bungalow of a house in St Albans. He had a medical history that included bipolar affective disorder, schizophrenia, anxiety, depression, back pain secondary to spinal injuries sustained in traffic accidents, previous opiate and benzodiazepine dependence, excessive alcohol use, absent right kidney and previous heroin encephalopathy (2003).[1]

2. Mr Wright's regular prescribed medications included quetiapine (an antipsychotic, brand name "Seroquel"), oxazepam and diazepam (benzodiazepine sedative/hypnotics), tramadol (a narcotic analgesic marketed as "Tramadol", "Zydol" among others) and a combination of paracetamol and codeine (analgesics marketed as "Prodeine Forte").

3. On 24 February 2011, after consulting a general practitioner, Dr Robert Young, at the Melton Medical Clinic[2] and collecting prescription medications, Mr Wright telephoned his mother, Ms Bayliss, and invited her to spend the day with him and a friend. Ms Bayliss agreed. Mr Wright was in a brighter

[1] Mr Wright's Melton Medical Clinic Medical Records.

[2] Ibid.

than usual frame of mind and cooked a meal for everyone that evening although he ate little himself. Afterwards, he and Ms Bayliss watched three films together.[3]

4. When the third film ended, at about 2am on 25 February 2011, Mr Wright wanted to watch another but Ms Bayliss declined as she was tired and so prepared to sleep on the couch. Mr Wright decided to retire for the night also and asked Ms Bayliss to wake him later in the morning. Ms Bayliss was aware that her son took some time to settle. She heard him walk back and forth to the bathroom several times and heard a rustling sound that she assumed was him taking his nightly medication.[4]

5. At about 10am on 25 February 2011, Ms Bayliss attempted to wake her son but found he was unresponsive. She sought assistance from an occupant of the adjacent building, contacted emergency services and attempted cardio-pulmonary resuscitation as directed by the operator.[5] On arrival, paramedics confirmed that Mr Wright was deceased.[6]

**Coronial Investigation**

6. A coronial investigation into Mr Wright's death was initiated by Senior Constable Renee Hulls formerly of Sunshine Police Station. S/C Hulls photographed Mr Wright's bungalow and observed several packets of prescription medications, most with tablets missing, on a chair. Among the medications found at the scene were benzodiazepines (Temaze, Alodorm, Alepam, Antenex), opioid analgesics (Codapane and Panadeine Forte), antipsychotics (Seroquel and Risperdal), antidepressants, anti-emetics, anti-hypertensives and antibiotics. S/C Hulls later compiled a brief of evidence and this finding is based on the witness statements contained therein, and additional statements and other materials obtained subsequently at my direction.

7. Forensic Pathologist, Dr Heinrich Bouwer, of the Victorian Institute of Forensic Medicine reviewed the circumstances of Mr Wright's death as reported by police to the Coroner, Dr Young's medical notes, post-mortem computerised tomography [CT] scans of the whole body and performed an autopsy. Among Dr Bouwer's anatomical findings were remote inferior temporal cortical injury, focal chronic inflammation in the posterior wall of the left ventricle, heavy congested lungs and pigmented alveolar macrophages, commonly referred to as "smoker's macrophages".[7]

8. Routine toxicological analysis of post-mortem samples detected codeine, free (0.5mg/L), tramadol (1.9mg/L), oxazepam (1.7mg/L) Diazepam (0.3mg/L) and its metabolite, nordiazepam (0.2mg/L), paracetamol (11mg/L) and quetiapine (0.5mg/L).[8] Dr Bouwer noted that codeine is a narcotic

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[3] Coronial Brief of Evidence, Statement of Sandra Bayliss.

[4] Ibid.

[5] Ibid.

[6] Ambulance Victoria Electronic Patient Care Report #10348 dated 25 February 2011.

[7] Medical Examination Report of Dr Heinrich Bouwer dated 30 August 2011.

[8] Toxicology Report of Melinda Hargreaves dated 4 April 2011.

analgesic closely related to morphine and that free blood concentrations of more than 0.4mg/L may be sufficient to cause death due to respiratory failure. Benzodiazepines, like oxazepam and diazepam, are central nervous system [CNS] depressants, the effects of which are enhanced in the presence of other CNS depressants such as opioids.[9]

9. Dr Bouwer concluded that the cause of Mr Wright's death is mixed drug toxicity involving codeine, tramadol, oxazepam, diazepam and nordiazepam.[10]

10. In correspondence with the Court dated 18 September 2013, Ms Bayliss requested an inquest into her son's death because she believed that further investigation should be conducted in relation to the medication prescribed to Mr Wright prior to his death.

11. Medicare records and a Pharmaceutical Benefit Scheme [PBS] Patient Summary were obtained for the period 25 February 2010 to 25 February 2011. Both records suggest that Mr Wright engaged in 'prescription shopping' for multiple pharmaceutical drugs, including those drugs found to have contributed to his death.

12. For example, in the six months prior to his death, 25 August 2010 until 25 February 2011, Mr Wright attended at least 21 doctors practicing from seven different medical clinics to obtain scripts for prescription-only drugs. These included scripts for 800 tramadol tablets from 13 doctors at six clinics; scripts for 500 codeine tablets from nine doctors at five different clinics; scripts for 1,768 diazepam tablets[11] from eight doctors at four clinics and scripts for 375 oxazepam tablets from four doctors at two different clinics. These prescriptions were dispensed by nine different pharmacies.[12]

13. At my request, the Coroners Prevention Unit [CPU][13] provided advice about avenues for further investigation of issues that may have underpinned Mr Wright's ability to access the pharmaceutical drugs that caused his death. The CPU advised:

    a. Information gleaned, particularly from Medicare and PBS records, clearly demonstrated that Mr Wright had engaged in 'prescription shopping' involving multiple medications, prescribing doctors, medical practices and pharmacies.

    b. There is evidence of doctors prescribing benzodiazepines for extended periods of time, co-prescribing multiple benzodiazepines, co-prescribing multiple opioids, and providing repeat prescriptions for large quantities of drugs that are addictive and frequently misused.

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[9] Medical Examination Report of Dr Heinrich Bouwer dated 30 August 2011.

[10] Ibid.

[11] This total is inclusive of all repeats prescribed; as they were non-PBS it was not possible to determine whether each repeat had been dispensed at the time of Mr Wright's death.

[12] See generally, Mr Wright's Medicare and PBS records 25 February 2010 to 25 February 2011.

[13] The Coroners Prevention Unit was established in 2008 to assist coronial investigations and the formulation of coronial recommendations and comments aimed at prevention. The CPU is staffed by independent, highly skilled and experienced clinical medical, mental health and allied health care professionals.

However, without further information from the relevant clinicians it is not possible to determine whether clinically sub-optimal prescribing practices may have facilitated Mr Wright's ability to obtain pharmaceutical drugs.

c. Among the medical records provided by Melton Medical Clinic is a copy of a letter from Medicare Australia's Prescription Shopping Program alerting Dr Young that between 1 September 2010 and 30 November 2010 Mr Wright was dispensed 72 target drugs[14] on prescriptions from 16 different prescribers.[15] The other 15 prescribers would have received similar correspondence. However, the available information does not clarify who received this alert, when it was received and what action, if any, was taken in response to it.

d. Victorian medical practitioners are required, pursuant to section 33 of the *Drugs Poisons and Controlled Substances Act* 1981 [DPCS Act], to notify Drugs Poisons Regulation [DPR] if they have reason to believe that a patient is drug-dependent and the patient requests or is supplied a drug of dependence.[16] The available evidence does not clarify whether any doctors (other than Dr Young) who knew that Mr Wright was drug-dependent, contacted DPR to notify of his/her intent to supply a drug of dependence.

14. In light of the CPU's advice, I asked Mr Wright's primary prescribers and dispensing pharmacists to provide statements. The information in those statements is encapsulated below.

**Melton Medical Clinic**

15. Mr Wright was a patient of Melton Medical Clinic from 2001. He reportedly attended sporadically and saw a number of general practitioners there until May 2010, when, with the exception of one consultation, he only saw Dr Young.[17]

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[14] "Target drugs" include most drugs of dependence.

[15] Medicare Australia's Prescription Shopping Alert Programme involves using computer algorithms to analyse patters of target drug dispensing to patients via the PBS. If a patient's dispensing history meets criteria for being deemed excessive, Medicare Australia's compliance pharmacists analyse the information to determine what action should be taken. Usually, a letter is sent to all doctors who prescribed target drugs to the patient.

[16] Drugs of Dependence are listed in Schedule 11 to the Act and include tramadol, codeine, diazepam and oxazepam. The benefit for medical practitioners who contact DPR is not only compliance with legal requirements to report concerns about potential drug-seekers, but that they can learn more about the patient such as whether any other doctor holds a permit to treat the patient with Schedule 8 poisons (such as opioid replacement therapies), details of any aliases used by the patient when drug-seeking, and whether there are any reports of the patient using forged or fraudulent prescriptions or of obtaining drugs of dependence by false representation.

[17] Statement of Dr R. Young dated 14 March 2014.

16. . Dr Young confirmed that Mr Wright suffered from significant psychiatric uses (extreme anxiety, bipolar disorder and schizophrenia), was admitted to psychiatric hospitals on several occasions and was under the care of NorthWest Mental Health [NWMH] and psychiatrist, Dr Don Senadipathy. In correspondence dated December 2010, NWMH confirmed that his treatment regime of Seroquel (1300mg at night), Pristiq[18] (100mg per day) and diazepam (15mg per day) was appropriate and should continue. In Dr Young's opinion, there were sound clinical reasons for prescribing these medications.[19]

17. Dr Young confirmed prescribing tramadol and Panadeine Forte (from March 2010) for cervical and thoracic spinal pain management. He noted that these drugs were often prescribed in combination and in doses the same as that prescribed to Mr Wright.[20]

18. Dr Young was aware of the risk of dependence associated with the long-term use of benzodiazepines and was concerned that Mr Wright was dependent upon them. He was not aware of his obligation under the DPCS Act to report his concerns and intent to prescribe drugs of dependence to the DPR, and so had made no report.[21]

19. However, by early 2011, Dr Young was concerned that Mr Wright may be attending clinicians outside his practice to obtain medications and so applied, in early 2011, for a record of his prescriptions. On or about 14 February 2011, he received a letter from Medicare Australia's Prescription Shopping Alert Programme detailing Mr Wright's dispensing history between September and November 2010.[22] Dr Young reportedly discussed the alert letter with Mr Wright who denied ongoing 'prescription shopping' during their final consultation on 24 February 2011.[23]

20. Dr Young stated that he endeavoured to manage Mr Wright's drug dependence, while addressing his clinical need for benzodiazepines, by obtaining further information from the Prescription Shopping Alert Programme and intended to involve him in a detoxification program. However, Mr Wright advised Dr Young that he would soon re-locate for work in Queensland and so the plan for detoxification was abandoned.[24]

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[18] Venlafaxine, an antidepressant.

[19] Statement of Dr R. Young dated 5 June 2015.

[20] Ibid.

[21] Statements of Dr R. Young dated 5 June 2015.

[22] Statement of Dr R. Young dated 5 June 2015.

[23] I note that Dr Young's note of his discussion with Mr Wright about the alert letter appears on 25 February 2011 – after he has learned of Mr Wright's death – as follows: "Had discussed with him letter from Dr Shopping Project – denies still doing this" (Mr Wright's Melton Medical Clinic medical records).

[24] Statement of Dr R. Young dated 5 June 2015. I note that despite noting, on 4/11/2010 "Wean off Tramal [tramadol]", Dr Young continued to prescribe this drug, at the same dosage, at the two subsequent consultations on 31/1/2011 and 24/2/2011. I note also that Mr Wright attended with arguably spurious stories about "lost Valium" (15/7/2010) and that he had lost "all" his medications (on 21/10/2010 when he saw Dr Lee); on the first occasion a fresh script for Valium

**Cairnlea Superclinic**

21. Mr Wright was a patient of the Cairnlea Superclinic [Cairnlea] between 15 March and 26 November 2010, and initially consulted Dr Andre. Dr Andre received correspondence[25] from a NWMH Case Manager referring Mr Wright for ongoing mental health management following his disengagement from community-based voluntary psychiatric treatment.[26]

22. The referral confirmed that Mr Wright's episode of care commenced in February 2010 following a psychiatric inpatient admission precipitated by a suicide attempt by antidepressant overdose. Mr Wright's compliance with treatment in the community was reportedly poor, and he usually only attended appointments when in need of diazepam. NWMH had referred him to detoxification for benzodiazepine dependence, and reduced his dosage of diazepam with a view to weaning him off it. Mr Wright was reportedly not happy with this plan and so stopped attending NWMH's clinic. NWMH also informed DPR of Mr Wright's 'benzodiazepine shopping'.[27]

23. On nine occasions between June and September 2010, Mr Wright consulted Dr Rahman at Cairnlea.[28] On the first occasion, despite being diagnosed with an upper respiratory tract infection for which antibiotics were prescribed, Mr Wright requested – but was not prescribed – oxazepam.[29] Subsequently, Dr Rahman regularly prescribed tramadol for chronic neck pain and provided one prescription each for small quantities of Panadeine Forte for acute physical pain[30] and diazepam for acute anxiety.[31]

24. Dr Rahman confirmed that having read the NWHS correspondence on Mr Wright's file, he was aware of his patient's drug dependence. However, as Tramadol is not a Schedule 8 drug, he did not consider contacting DPR before prescribing it to Mr Wright and made no comment about his one-off prescription of diazepam.[32]

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was provided and on the second – noted as "drug seeking behaviour" – a script for oxazepam (but not requested Panadeine Forte) was provided. (Mr Wright's Melton Medical Clinic medical records).

[25] NWMH correspondence dated 9 July 2010 (appended to the Statement of Dr Rahman dated 12 May 2015).

[26] NWMH correspondence dated 9 July 2010, Mr Wright's Cairnlea Superclinic medical records. I note that the same correspondence records Dr John Lee of Melton Medical Centre as Mr Wright's general practitioner.

[27] NWMH correspondence dated 9 July 2010, Mr Wright's Cairnlea Superclinic medical records.

[28] Statement of Dr M. Rahman dated 12 May 2015.

[29] Mr Wright's Cairnlea Superclinic medical records.

[30] Mr Wright reported pain following a traffic incident on 6/7/2010 (he also attended Melton Medical Clinic the same week with this history and obtained prescriptions for Tramadol and Valium).

[31] Mr Wright reported acute anxiety following the death of his father on 13/7/10. I note that Mr Wright reported acute anxiety as his father's recent death in October 2010 at WestGroup medical and obtained scripts for Diazepam and Tramadol; he also reported depressive symptoms at a Cairnlea consultation in November 2010 and obtained an antidepressant (as well as Tramadol). I note too that at Melton Medical Clinic in February 2011, Mr Wright deflected Dr Young's referral for benzodiazepine detoxification on the grounds he was to move to Townsville to work with his father as a concreter. (See generally Mr Wright's medical records).

[32] Statement of Dr M. Rahman dated 12 May 2015.

25. None of Dr Rahman's colleagues at Cairnlea were prescribing the same medications as him simultaneously. He asserts that he was not aware that Mr Wright was attending other clinics while consulting him;[33] he learned this after receiving an alert letter in February 2011 from the Prescription Shopping Alert Programme.[34]

26. Nonetheless, Dr Rahman observed that he had tried to reduce Mr Wright's tramadol dose but failed.[35] He noted that Mr Wright twice presented claiming to have lost prescriptions for tramadol and was given a fresh prescription each time. However, on the second occasion, Dr Rahman warned Mr Wright that he would not write any further tramadol prescriptions until the supply from the preceding one would be exhausted if taken as directed.[36] Dr Rahman made the following progress note on 20 September 2010, "Other doctor[s] not to prescribe any tramadol to him".[37] Mr Wright did not consult Dr Rahman after that date.[38]

27. Mr Wright consulted Dr Gredina, once, on 26 September 2010 requesting tramadol for chronic back injuries.[39] He was provided a prescription for tramadol, six days after Dr Rahman provided a script for 20 tablets, with instructions that doubled Mr Wright's dose from one tablet per day as directed by Dr Rahman to one tablet twice per day as directed.[40]

28. In his statement, which was prepared almost five years after his consultation with Mr Wright using clinical records, Dr Gredina stated that he recalled no warnings or concerns on file from his Cairnlea colleagues about prescriptions.[41] He considered it "the regular prescriber's" duty to inform colleagues of such issues.[42] Dr Gredina stated that at the time he saw Mr Wright, he was not aware of his drug dependence, he was not exhibiting "abnormal drug-seeking behaviour" and he was not aware (until February 2011) of his 'prescription shopping'.[43] For these reasons, and because tramadol "is not a Schedule 8 drug", he did not consider reporting his script to DPR.[44]

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[33] I note that the NWMH's July 2010 correspondence reference to a Mr Wright's Melton Medical Clinic general practitioner ought to have made Dr Rahman alive to the possibility that his patient may be consulting another practitioner.

[34] Statement of Dr M. Rahman dated 12 May 2015 (enclosing correspondence from the Prescription Shopping Program dated 14 February 2011).

[35] Statement of Dr M. Rahman dated 12 May 2015.

[36] Statement of Dr M. Rahman dated 12 May 2015 and Mr Wright's Cairnlea Superclinic medical records.

[37] Mr Wright's Cairnlea Superclinic medical records.

[38] Statement of Dr M. Rahman dated 12 May 2015.

[39] Statement of Dr C. Gredina dated 23 June 2015.

[40] Ibid.

[41] Ibid. Dr Rahman's last clinical note (20/9/2010), which presumably immediately preceded the note made by Dr Gredina, contains a clear warning to colleagues about prescribing tramadol to Mr Wright.

[42] Statement of Dr C. Gredina dated 23 June 2015.

[43] Ibid.

[44] Ibid.

29. On 13 October 2010, Mr Wright consulted Dr Greene at Cairnlea complaining of pain secondary to a reported fall and requesting Panadeine Forte. Dr Greene was aware that opiate medication had been prescribed on multiple occasions in the previous six months and benzodiazepines on a few occasions. He refused to prescribe Panadeine Forte because he was concerned that Mr Wright may develop an opiate dependency if such drugs continued to be prescribed. He counselled Mr Wright about the risk of opiate dependency suggesting these medications be avoided in future and made notations to this effect in progress notes to ensure his colleagues would be aware of his concerns. Dr Greene prescribed an anti-inflammatory medication to manage the presenting problem.[45]

30. Mr Wright consulted Dr Vivares at Cairnlea on four occasions between 23 October and 20 November 2010.[46] During Mr Wright's first presentation for a Panadeine Forte script for relief of back pain, Dr Vivares reported being "suspicious" that he was a multidrug user.[47] Nonetheless, satisfied that there was a clinical basis for prescribing Panadeine Forte and observing that no other Cairnlea clinician had recently prescribed this medication, Dr Vivares provided a script for 20 Panadeine Forte tablets. Mr Wright reportedly re-presented within thirty minutes requesting a prescription for diazepam which was refused.[48]

31. On 28 October 2010, Dr Vivares was again consulted by Mr Wright for pain relief. Mr Wright was "persistent and aggressive".[49] Initially, the general practitioner prepared prescriptions for Panadeine Forte, tramadol and Oxycontin but before providing them to Mr Wright, called the Prescription Shopping Information Service and was informed that Mr Wright was obtaining multiple medications from practitioners at other clinics. Dr Vivares informed his patient that he would not prescribe tramadol or Oxycontin and only 20 Panadeine Forte tablets; Mr Wright reacted aggressively.[50]

32. After the consultation had concluded, Dr Vivares received a fax from the Prescription Shopping Information Service confirming the information provided earlier by telephone, and it was duly placed in Mr Wright's clinical file. A meeting was convened between Dr Vivares, Dr Terris and the Practice Manager to discuss how to manage Mr Wright should he re-present at Cairnlea.[51] The outcome of this meeting is unclear from the available information,[52] however, Dr Vivares noted that he "refused to prescribe any Schedule 8 medications or benzodiazepines" to Mr Wright.[53]

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[45] Statement of Dr D. Greene dated 12 May 2015.

[46] Statement of Dr E. Vivares dated 16 July 2015.

[47] Ibid.

[48] Ibid.

[49] Ibid.

[50] Ibid.

[51] Ibid.

[52] I note that Dr Terris' statement, dated 14 May 2015, is short and was provided on the basis of Mr Wright's clinical notes rather than independent recollection. Dr Terris failed to specify when he saw Mr Wright on 'three separate occasions' (though he prescribed antipsychotic medications in September 2010) and refused to prescribe analgesia other

33. Mr Wright re-presented to Dr Vivares on 12 November 2010 and was prescribed an antidepressant for management of depressive symptoms and 20 tramadol tablets for chronic back pain. On 20 November 2010 Dr Vivares provided scripts for 20 tablets each of tramadol and Panadeine Forte to manage "lower" back pain to allow Mr Wright to recommence work in a few days' time. That was Mr Wright's final attendance at Cairnlea.[54]

**WestGroup Medical**

34. Between 10 April and 24 November 2010, Mr Wright consulted Drs Gebrehiwot (five times), Chavali (three times), Sheppard (twice) and Li (once) at WestGroup Medical. There are two references in the clinical notes, made by Dr Gebrehiwot in April and October 2010, to Mr Wright having a regular general practitioner at a practice in Melton.[55]

35. Mr Wright's first attendance was explicitly for prescriptions of tramadol, oxazepam and diazepam of which he claimed to have run out. Dr Gebrehiwot provided scripts for 10, 25 and 20 tablets of these medications respectively to "tide him over" until he could see his usual doctor.[56]

36. In September 2010, Dr Li diagnosed a soft tissue injury secondary to Mr Wright's report of neck pain after a fall. He prescribed 20 tramadol tablets for short term management of the acute injury and 20 diazepam tablets for anxiety, reducing the dose of the latter medication by two thirds of that prescribed by Dr Gebrehiwot five months earlier.[57] Dr Li was not aware that Mr Wright had a drug dependence or that he was attending other clinics "for drugs of dependence," though he was aware his usual general practitioner was in Melton.[58] Dr Li observed, among other factors, that tramadol and diazepam are "Schedule 4" drugs and so did not consider contacting DPR about his prescriptions.[59]

37. Dr Chavali saw Mr Wright three times in October 2010. During the first consultation on 4 October 2010, Dr Chavali diagnosed soft tissue injury of the thoracic spine secondary to Mr Wright's report of sustaining an injury while weight-bearing at work. Scripts for 20 tramadol tablets and an anti-inflammatory medication were provided.[60]

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than paracetamol. His statement suggests that he had no recollection of the practice meeting in October 2010 (suggesting that the meeting was not adequately documented in the progress notes) and intimates that notification of concerns to the DPR was the province of a patient's regular prescribing clinician (and he did not consider himself Mr Wright's regular prescriber).

[53] Statement of Dr E. Vivares dated 16 July 2015.

[54] Statement of Dr E. Vivares dated 16 July 2015.

[55] Mr Wright's WestGroup Medical records.

[56] Statement of Dr H. Gebrehiwot dated 11 August 2015.

[57] Statement of Dr J. Li dated 5 August 2015.

[58] Ibid.

[59] Ibid.

[60] Statement of Dr S. Chavali dated August 2015.

38. Eight days later, Mr Wright returned complaining of insomnia following the death of his father and declining Dr Chavali's offer of a non-benzodiazepine tranquilizer on the grounds his previous use of the medication provided no relief. He also complained of ongoing back pain. Dr Chavali provided prescriptions for 25 temazepam to assist with sleep and a prescription for Panadeine Forte, considering it reasonable to do so upon Mr Wright's report of ongoing back pain after a soft tissue injury which had not resolved with tramadol.[61]

39. Mr Wright again consulted Dr Chavali on 18 October 2010, claiming that he had lost his Panadeine Forte prescription and seeking another one. Dr Chavali was suspicious of the genuineness of Mr Wright's request. He reviewed the clinical notes and observed that since his own prescription for Panadeine Forte was written six days earlier, Mr Wright had been provided with a further script for this medication by Dr Gebrehiwot who had noted, "claimed he has lost his panadein[e] forte tabs".[62]

40. Dr Chavali refused to provide another prescription and endeavoured to highlight his concerns about Mr Wright's possible misuse of Panadeine Forte by making a clinical note to this effect.[63] He also instructed reception staff to place a note in Mr Wright's electronic record so that a warning, "Consistent Panadeine Forte Requests," would pop up in the warnings section of clinical notes accessed by other clinicians at WestGroup Medical.[64] Dr Chavali did not contact DPR about his supply of analgesics to Mr Wright because he only intended to supply them "for a very limited period of time as clinically required".[65]

41. On Saturday, 23 October 2010, Mr Wright saw Dr Gebrehiwot, claiming that he had "lost his Valium medication [and ...] will see his GP on Monday".[66] Dr Gebrehiwot prescribed 10 Valium tablets to "tide him over".[67]

42. Mr Wright re-presented to Dr Gebrehiwot on 29 October and 3 November 2010.[68] While there are no notes to elucidate Dr Gebrehiwot's clinical rationale, he provided prescriptions for tramadol on each occasion and a script for Panadeine Forte at the leter consultation, notwithstanding Dr Chavali's alerts.[69]

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[61] Statement of Dr S. Chavali dated August 2015.

[62] Mr Wright's WestGroup Medical records, entry by Dr H. Gebrehiwot dated 13 October 2010.

[63] Statement of Dr S. Chavali dated August 2015.

[64] This alert was created the same day (18 October 2010) and appears in Mr Wright's WestGroup Medical records.

[65] Statement of Dr S. Chavali dated August 2015.

[66] Mr Wright's WestGroup Medical records, entry by Dr H. Gebrehiwot dated 23 October 2010.

[67] Statement of Dr H. Gebrehiwot dated 11 August 2015.

[68] See Mr Wright's WestGroup Medical records for these dates.

[69] Ibid.

43. Dr Gebrehiwot stated that he believed Mr Wright was using his medications appropriately and had a regular general practitioner in Melton whom the patient was encouraged to see about prescriptions. In his opinion, as Mr Wright did not attend WestGroup Medical frequently, Dr Gebrehiwot did not believe there was any need for him to co-ordinate his prescriptions with those of his colleagues. While he was not aware that Mr Wright had a pharmaceutical drug dependence, he did not consider contacting the DPR because he only saw him on a few occasions.[70]

44. Dr Sheppard saw Mr Wright on 24 November and 3 December 2010 when he complained of ongoing back pain and requested tramadol and Panadeine Forte.[71] Dr Sheppard reviewed the clinical notes, observing that Mr Wright had been diagnosed with back injuries in September and October and that he was last prescribed opioid analgesia on 3 November 2010. He considered that previous medications would have been finished if taken as directed and so provided scripts for tramadol and Panadeine Forte in November and a further script for Panadeine Forte in December 2010.[72]

45. Dr Sheppard did not refer in his statement to the impact, if any, of Dr Chavali's alerts on his prescribing practices. He reportedly was not aware that Mr Wright had a pharmaceutical drug dependence and, as both analgesics he prescribed are "Schedule 4" medications, did not consider contacting DPR.[73]

46. WestGroup Medical was advised in correspondence from the Prescription Shopping Program dated 14 February 2011 of concerns about the amount of PBS medications prescribed to Mr Wright.[74]

**East Esplanade Health Centre**

47. Mr Wright attended the East Esplanade Health Centre in St Albans [Esplanade], a two-doctor bulk-billing clinic, between 27 April 2010 and 17 January 2011.[75] Both general practitioners considered Dr Irani to be Mr Wright's primary clinician, Dr Prakash only seeing him twice, when Dr Irani was unavailable.[76]

48. Mr Wright informed Dr Irani that he had previously consulted Dr Young in Melton but had moved to St Albans and so would prefer to consult him. He provided a history of chronic back and neck pain from injuries sustained in two traffic accidents, and anxiety. Dr Irani considered that treatment with

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[70] Statement of Dr H. Gebrehiwot dated 11 August 2015.

[71] Statement of Dr L. Sheppard dated 24 July 2015. Mr Wright also sought a prescription to manage symptoms of reflux on 24 November 2010.

[72] Ibid.

[73] Ibid.

[74] See Mr Wright's WestGroup Medical records.

[75] Statement of Dr R. Irani undated.

[76] Ibid and Statement of Dr S. Prakash dated 21 May 2015.

multiple benzodiazepines and opioids in combination was clinically indicated and so wrote regular prescriptions for tramadol, oxazepam, diazepam and Panadeine Forte. He advised Mr Wright that fresh prescriptions for these drugs would not be provided before the previous supply had been used as directed.[77]

49. Dr Irani considered it safe to prescribe benzodiazepines and opioids for an extended period because limited quantities were provided, supervision occurred regularly every two-to-three weeks and because Mr Wright did not show any signs of drug dependence or engage in drug-seeking behaviours. Dr Irani did not suspect that Mr Wright had a benzodiazepine or opioid dependence[78] or that he was consulting other clinicians at other clinics.[79]

50. Dr Prakash saw Mr Wright in October 2010, when he claimed to have lost the tramadol and diazepam prescriptions provided by Dr Irani,[80] and for his last Esplanade appointment in January 2011.[81] On both occasions, prescriptions were provided in circumstances were Dr Prakash considered tramadol, diazepam and oxazepam clinically indicated and supplied in quantities that were safe for concurrent use.[82]

51. The Esplanade clinicians were reportedly shocked to receive correspondence from the Prescription Shopping Alert Programme in February 2011 indicating Mr Wright was a 'prescription shopper'.[83]

**Dispensing Pharmacies**

52. Mr Wright's various prescriptions were dispensed at a number of pharmacies. However, his PBS Patient Summary suggests that Mr Wright's use of pharmacies was systematic. That is, prescriptions written by Dr Young, with only four exceptions, were dispensed primarily at Melton ChemMart Pharmacy Superstore while he used Chemist Warehouse St Albans exclusively to fill Dr Irani's scripts. It appears that pharmacists were not concerned about Mr Wright's medication use when presented with prescriptions from a single prescriber for "not excessive" quantities of medications.[84]

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[77] Statement of Dr R. Irani undated.

[78] I note Dr Irani's comment that his 'long term plan' was to 'reduce the dosage of [Mr Wright's] medication' [see his undated statement]. It is unclear which medication Dr Irani is referencing, and indeed, why dosage reduction would form part of his long term management given his other statements about clinical need, safe prescribing levels, regular supervision and absence of a concern about drug dependence.

[79] Statement of Dr R. Irani undated. I note Dr Iran's indication that at some point during Mr Wright's episode of care he disclosed that an antidepressant was being prescribed by a clinician in Cairnlea. Dr Irani advised Mr Wright to continue to see that clinician in relation to prescriptions for antidepressants.

[80] Both Drs Irani and Prakesh concede that they gave Mr Wright the 'benefit of the doubt' when replacing prescriptions he claimed to have lost.

[81] Statement of Dr S. Prakash dated 21 May 2015.

[82] Ibid.

[83] Statement of Dr R. Irani undated.

[84] Statement of Anthony Cox undated.

53. Meanwhile, a third pharmacy, Priceline Pharmacy Cairnlea, dispensed Mr Wright's scripts from different prescribers every month, sometimes twice per month, between March and November 2010.[85] Thereafter, Mr Wright employed a similar tactic when presenting scripts from a range of prescribers, in sequence, at Your Chemist in St Albans.[86]

**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.[87] 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. I find that Dean Wright, late of 4 Anna Street, St Albans, died at home on 25 February 2011, and that the cause of his death was mixed drug toxicity involving codeine, tramadol, oxazepam and diazepam.

56. The evidence supports a finding that for at least six months prior to his death Mr Wright engaged in 'prescription shopping' for multiple pharmaceutical drugs, including those drugs that contributed to his death.

57. Although Mr Wright was identified as a 'prescription shopper' no later than 30 November 2010 for the purposes of Medicare's Prescription Shopping Program and was likely, on the basis of Dr Vivares' evidence, to have been aware that Mr Wright had received excessive amounts of PBS medication a month earlier, there was a delay of at least two-and-a-half months in notifying Mr Wright's prescribing practitioners accordingly. This delay undermined the ability of the various medical practitioners to respond optimally to Mr Wright's presentation and requests for further prescriptions of opiate and benzodiazepine drugs, and his access to excessive quantities of these drugs.

58. The available evidence does not support an adverse finding against or comments about any one of Mr Wright's prescribing clinicians or dispensing pharmacists. With limited exceptions, the medical practitioners consulted by Mr Wright at Melton Medical Clinic, Cairnlea, WestGroup Medical and Esplanade proximate to his death provided clinically justifiable prescriptions given the information available to them at the time. For similar reasons, I am satisfied that Mr Wright's dispensing pharmacists' supply of prescribed medications was reasonable in the circumstances.

59. It is axiomatic that 'prescription shoppers' like Mr Wright exploit gaps in their prescribers' and dispensers' knowledge to access inappropriate quantities of prescription medication. The prescription

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[85] Statement of T. Nguyen and T. Goulopoulos dated 5 June 2015.

[86] See generally Mr Wright's PBS Patient Summary.

[87] *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..."

shopper's pursuit of his/her objective is unlikely to be thwarted efficiently or effectively by even the commendable, but ultimately piecemeal and disparate, efforts of individual clinicians in possession of only some of the available clinically relevant information.

60. Numerous coronial investigations conducted over the last decade attest to the fact that curtailing 'prescription shopping' requires a comprehensive, systematic and real-time solution to the information deficit that impedes coordination of medical care.[88]

61. That said, the weight of the evidence supports a finding that, with the exception of East Esplanade Health Centre, at least one general practitioner at each of the clinics consulted by Mr Wright was concerned that he had a pharmaceutical drug dependence and/or was misusing benzodiazepines or opioid analgesics. It is to their credit that when the risk of Mr Wright's drug dependence or medication misuse was appreciated, these clinicians responded appropriately, if not exhaustively, to address the situation: by counselling Mr Wright about the dangers of misuse of prescription medication; warning him that they would not continue to prescribe such medications; documenting their concerns in clinical notes; alerting their colleagues to their concerns; and seeking further information from the Prescription Shopping Information Service.

62. Nonetheless, it is apparent that better and more timely flow of pertinent information between general practitioners, medical practices, pharmacists, DPR and the Prescription Shopping Alert Service would have optimised clinical decision-making and prescribing and dispensing practices, and may have changed the outcome in this case.

COMMENTS

1. I note that for more than a decade Victorian Coroners have recommended the development and implementation of a real-time prescription monitoring system to prevent ongoing harm and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs. Mr Wright's death again highlights the benefits such a scheme could have in saving lives.

2. I am aware of the work already undertaken by the Commonwealth and States towards the realisation of a real-time prescription monitoring system, the complexity of the task and that its implementation will result in significant changes to clinical practice in Australia. Nonetheless, preventable deaths, like Mr Wright's, continue to occur.

3. In the interim, therefore, it is essential that those tools and strategies already available to facilitate detection of 'prescription shopping' and support safe prescribing practices are widely disseminated and understood, particularly among prescribers.

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4. The investigation into Mr Wright's death suggests that general practitioners may generally have a poor understanding of their obligations under section 33 of the DPCS Act. Even those of Mr Wright's clinicians who were aware of the existence of these obligations failed to appreciate their extent; namely, that the obligation to notify the Secretary/DPR of a drug-dependent person is not limited to requests for or an intent to prescribe only Schedule 8 medications.

5. Similarly, the obligation is not vitiated by an intent to treat with a specified medication 'for a short time' or if the prescriber is not (or does not consider themselves) the patient's 'primary' medical practitioner. If clinicians do not comply with their obligations under section 33 of the DPCS Act, the important preventative purpose sought to be achieved by it – to enable DPR to assist prescribers who might seek advice or apply for a permit to treat the person and identify and address concurrent prescribing – cannot be achieved.

6. While several of Mr Wright's prescribing doctors took steps to address concerns about their patient's drug-dependence, prescription misuse or 'prescription shopping,' this response was not uniform across all of the clinicians Mr Wright consulted, was often minimalist and reactive and, in multiple practitioner clinics particularly, appeared to have little appreciable impact on other clinicians' prescribing practices. These clinical behavioural trends, particularly if replicated across Victoria, are alarming.

7. In light of the foregoing, I commend the 2015 publication of information and guidelines by DPR and the Royal Australasian College of General Practitioners, respectively, in relation to the prescription of medications (including benzodiazepines)[89] to drug-dependent and non-drug-dependent patients.

8. The Commonwealth Department of Human Services [CDHS] administers the Prescription Shopping Programme on behalf of the Commonwealth Department of Health, in accordance with the relevant legislation and policy. Relevantly, this encompasses the Prescription Shopping Alert Service [PSAS] and the Prescription Shopping Information Service [PSIS].

9. The PSAS provides retrospective information to prescribers that a patient may have been sourcing PBS[90] medicines in excess of their medical need based on an examination of data over a three month period. According to the CDHS, in 2010, there was a lag between a prescription shopping event and notification to prescriber due to the PSAS accessing data only after it had been reconciled and closed in the PBS system, which could take up to six weeks. That data would then be extracted and analysed to decide the appropriate intervention, if any. Since 2010, the CDHS has streamlined system processing and assessment by pharmaceutical advisers which has led to a reduction in time lags for prescriber notification.

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[89] I note that RACOGP anticipates completing a guideline in relation to the prescription of opioids in general practice later in 2016.

[90] Drugs and medicines subsidised by the Commonwealth under the Pharmaceutical Benefits Scheme.

10. The PSIS is an optional telephone service for prescribers which operates on a 24/7 basis, providing information which is current to 24 hours prior to the enquiry. The CDHS advised that according to their records, five calls were made to the PSIS in 2009 and 2010 regarding Mr Wright. A Patient Summary Report was sent to Dr Vivares[91] on request as Mr Wright met the programme's criteria only once, in October 2010. The report provides the prescriber with details of the PBS items dispensed to the patient in a three month period, including dosage and quantity.

11. In June 2015, the CDHS updated scripts for operators working on the PSIS. Prescribers whose patients do not meet the programme's criteria are now advised that if they continue to have concerns about their patient, there are other options available to them, including contacting their state or territory health department for more information on any statutory reporting requirements or relevant programmes.

RECOMMENDATIONS

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

1. In line with recent recommendations published by State Coroner Ian Gray in the Finding into the death of Anne Brain [COR 2011 4794], 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 harm and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs.

2. While the Victorian Department of Health continues with its efforts to implement a real-time prescription monitoring program for Schedule 8 drug dispensing, I recommend that 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. And, if any such barriers are identified, I recommend that the department considered what reforms are necessary so that in due course its real-time prescription monitoring program can be expanded beyond Schedule 8 drugs.

3. I note that the Department of Health and Human Services has responded to recommendations one and two made in the Anne Brain Finding (and one and two above), and to similar recommendations made by Coroner John Olle in his Finding into the death of James Dougan [COR 2010 4459] and Finding into the death of Jamie Apap [COR 2010 3678]. The responses indicate that issues are under consideration and in the May 2015 Budget $300,000 was allocated to evaluate and plan for the implementation of a real-time prescription monitoring system but that no commitment to action has yet been made. Therefore, I reiterate the above-mentioned recommendations.

4. That the Royal Australasian College of General Practitioners consider including and/or enhancing a section in its *Standards for General Practices* to inform and advise general practitioners about their

[91] See paragraph 36 above.

legal obligations when prescribing medications, especially those arising from section 33 of the DPCS Act and to provide opportunities for professional development relating to the safe prescription of 'drugs of dependence' to drug-dependent and non-drug-dependent patients.

5. Pending implementation of a real-time prescription monitoring system, I recommend that the Royal Australasian College of General Practitioners reminds its members about the PSIS and encourages them to use it whenever they have concerns that a patient may be abusing prescription medications, as it provides the most up to date information current to up to 24 hours of any enquiry they make.

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

Ms Bayliss

Dr Young c/o Melton Medical Clinic

Dr Chavali c/o MDA National

Drs Gebrehiwot, Sheppard, and Li c/o WestGroup Medical

Dr Vivares c/o TressCox Lawyers

Drs Rahman, Gredina, Greene c/o Cairnlea Superclinic

Dr Terris c/o Ti-Tree Family Doctors

Drs Irani and Prakash, East Esplanade Health Centre

Thomas Goulopoulos, Priceline Pharmacy Cairnlea

Anthony Cox, Melton ChemMart Pharmacy Superstore

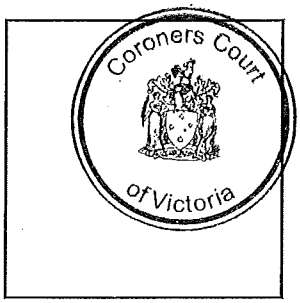
Victorian Department of Health and Humans Services

Drugs Poisons Regulation

Royal Australasian College of General Practitioners

Mr Barry Sandison, Deputy Secretary, Health & Information Group, (Commonwealth) Department of Human Services

Commonwealth Department of Health




Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 18 January 2016