IN THE CORONERS COURT
OF VICTORIA
AT [*COURT LOCATION*]

Court Reference: 2010 / 1624

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: HELEN MAREE STAGOLL

Delivered On:	29 October 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne 3000 and via video link to Bendigo Coroners Court
Hearing Dates:	24 June 2013 to 27 June 2013 – Bendigo Coroners Court 1 July 2013 – Melbourne Coroners Court
Findings of:	JACINTA HEFFEY, CORONER
Representation:	MS P. MURPHY appeared on behalf of relatives of the Deceased. MR P. HALLEY appeared on behalf of St Luke's Anglicare. MS E. GARDNER appeared on behalf of the Department of Human Services.
Counsel Assisting the Coroner	MS R. SHARP was present to assist the Coroner.

I, JACINTA HEFFEY, Coroner having investigated the death of HELEN MAREE STAGOLL

AND having held an inquest in relation to this death on [*date*]
at BENDIGO
find that the identity of the deceased was HELEN MAREE STAGOLL
born on 4 October 1993
and the death occurred on 2 May 2010
at Bendigo Hospital, 62 Lucan Street, Bendigo 3550
from:

1 (a) COMBINED DRUG TOXICITY (METHADONE, ALPRAZOLAM AND CABBABIS)

in the following circumstances:

1. Helen Stagoll was aged 16 years at the time of her death having been born on the 4th October 1993. She was a client of the Department of Human Services being subject to a Custody to the Secretary Order (since 25 February 2008) pursuant to which she was required to reside at St Luke's Church Street Residential Unit in Kangaroo Flat. Over the preceding 12 months, she had spent more time away from the unit than she actually stayed there[1].

   She went missing on the 2nd February 2010 and was not found until the 14th April when picked up by police. She had been in Queensland with her then boyfriend. Upon her apprehension, she was placed in Secure Welfare. The original plan was for her to stay there for 21 days- the maximum time in the absence of exceptional circumstances-however, the Department of Human Services approved her request to exit Secure Welfare detailing reasons in a letter to Helen dated 22nd April 2010.[2] She spent the following nights, the 22nd and 23rd April, at the St Luke's unit, but thereafter failed to return home to sleep. She did call into the unit periodically during the days of the 26th April, (observed to be in a "pleasant mood"), on the 27th April, (observed to be "heavily substance affected"), on the 28th April ("seemed in good spirit"), twice on the 30th April (during the first of which, arrangements were made for her to go shopping with her worker the following Monday after Helen had

[1] Steven Bruce, Social Worker at St Luke's told the court that in the preceding 12 months Helen had "probably only stayed approximately 20 nights at the unit". (Statement of Steven Bruce – P. 85 Inquest Brief.)

[2] See Letter addressed to Helen and signed by Sue Jamieson DHS dated 22 April, 2010 at P.269 of Inquest Brief. She stated (inter alia) that she had been impressed by how well she looked, how positive and clear she had been about her plans and noted "a big difference in you from our last meeting".

expressed a desire to do this). St Luke's had notified the Department of Human Services on two occasions during this period of her overnight absences. From a review of the case notes, it seems that Helen would tell them if she was not returning home and was encouraged to contact the unit if she needed any help, transport etc.

It is now known, that she had been spending her nights with her new boyfriend James Croft, then aged 24 years, a boarder at the home of Stacey Doyle, then aged 39 years, in 29 Short Street, Kangaroo Flat. Both Mr Croft and Ms Doyle had drug histories and were on the methadone programme.

2. Helen was an extremely vulnerable young woman. The Case Overview (See Exhibit 12- p.283 of Inquest Brief) outlines her life history and a childhood punctuated with violent physical abuse at the hands of her mother, occasioned by drugs and alcohol, homelessness, numerous changes of placement within the family, both maternal and paternal. She had a mild to moderate intellectual disability and was barely literate. At the time of her death, she had had at least 14 admissions to Secure Welfare and had engaged in various types of criminal conduct. It was suspected, that she also had provided sexual services for money and/or drugs. It was also believed that she had been the victim of sexual assaults.

3. As best as can be pieced together, the last day of her life was spent obtaining and using various drugs. The exact chronology was difficult to determine due to the quality of the evidence of her companions on that day. Her erstwhile boyfriend James Croft told the court that he was very intoxicated.

4. What was able to be established was the following: that on the morning of the 1st May, Helen asked Croft if she could have some of his take-away methadone. He refused. He had take-away doses each for that Saturday, Sunday and Monday and had already used two of them on the Saturday.

Helen then announced that she was going to go to the "King Street Flats" to see one Nicholls Hall in order to get some cannabis. She was driven there by Stacey Doyle's daughter, Shannon Zimmer, accompanied by Shannon's boyfriend, Dustin Wells and Croft. Only Helen entered the flat and soon exited with the cannabis. They returned home and commenced to smoke it.

Helen then announced that she was going to go back to see Nicholls Hall as he was going to purchase some Xanax from her for $20. Again, she was driven by Shannon Zimmer and the same passengers accompanied her. This time, she was in the flat for considerably longer.

Shannon went to get her twice and on the second occasion, Helen was coming out.[3] Dustin Wells in his statement said that she seemed drug- affected and was breathing heavily.[4] Back at the house, Zimmer noticed a bottle of methadone in the pocket of Helen's jacket.

At some stage during the afternoon, Helen was seen to trip over and later she went to lie down. At some point between 6.30 pm and 8 pm (the evidence was conflictual), she was observed to be unrouseable. She was cold and breathing slowly, intermittently and heavily. A discussion ensued between Zimmer, Doyle and Croft about calling an ambulance. Croft opposed it, saying that she had been awake all night the night before that he had seen her like this before and she had snapped out of it. In evidence he told the court: *"...because I was that off my head that I didn't realise that she was in that bad a trouble at the time"* and he did not know why the others did not call an ambulance. He said he had had a double dose of methadone, cannabis, xanax and six cans of Red Bear Vodka. All he could remember was that Helen was then propped up in the bed and left there. Mr Croft was aware that Helen had taken xanax and when asked why he had not warned her of the dangers he said in evidence *"I was going to keep an eye on her but, you know, I had just gotten with her, I'm not going to push her away by bloody being a control freak. But now I regret it".* [5]

At 3.30 am on the 2nd May, an ambulance was called after Croft woke up beside Helen who had vomited. She was unconscious and unrouseable. Cardiopulmonary resuscitation (CPR) was administered prior to the arrival of the ambulance on the instructions of the 000 operator. Details such as who called 000 and who administered the CPR are not at all clear and the evidence is again conflictual. Suffice to say that upon arrival, the paramedics were handed by Croft an empty bottle of methadone. Despite administration of adrenaline and use of defibrillation pads, Helen could not be revived and was delivered to the Bendigo Hospital where life was pronounced extinct.

5. Police attended 29 Short Street, Kangaroo Flat later that day. Four empty methadone bottles were seized from Mr Croft's bedroom. Two were in the name of Mr Croft, one in the name of Stacey Doyle and the fourth bottle had had the label partly torn off. This was subsequently established to have belonged to one Sarah Castelton. The last letters of her surname were visible and she conceded it must have been her bottle.

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[3] It is to be noted, that Nicholls Hall in evidence denied there was any second visit to his flat that day.

[4] See Inquest Brief Statement of Dustin Wells P.39.

[5] Transcript P.99

6. Ms Castleton gave evidence (with the protection of a Section 57 Certificate)[6] that she had regularly, over the preceding year, attended at the flat occupied by Nicholls Hall on Friday evenings after she had collected her take-away doses of 70 mg of methadone from the Helms Street Clinic. She would trade one bottle of her weekend supply with Mr Hall in exchange for 3 grams of cannabis. When he did not drink her methadone in front of her, she "presumed he was going to drink it later".[7] She told the court she had no idea that he was selling or exchanging it.

7. Mr Hall's evidence that he was "topping up" with Ms Castelton's methadone as he was trying to reduce his own significant dose made no "pharmacological sense" according to the independent Addiction Specialist called to give evidence at the inquest, Dr Matthew Frei. He said that with the high dose Mr Hall was on, he would not get any effect from taking somebody else's lower dose methadone once a week.[8]

8. Police searched Mr Hall's flat on the 4th May, 2010 and recovered several empty methadone bottles some with labels partially removed, others in the name of Nicholls Hall. One bottle recovered from the rubbish bin had its label intact in the name of Sarah Castleton and was for 70 mg. When asked if he could think of any explanation for removal of labels, Dr Frei said that the obvious one was that the bottle was intended for diversion.[9]

9. An autopsy was performed on Helen's body by Dr Vince Murdolo and toxicological examination revealed the presence in her system of methadone, cannabis, midazolam (a benzodiazepine[10]) and alpraxolam (Xanax).

10. That Helen had been frequently using methadone during the 12 months before her death was reasonably clear from all the evidence. Youth Worker Kathryn Turner [11] had offered her a great deal of support over recent years and frequently attended at the King Street flats to collect Helen after being phoned to be picked up. She would knock on the door of Mr Hall, and go and wait in the car and Helen would later come out. Helen admitted to her that she was using methadone and that she was getting it from the King Street flats. She was also

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[6] A Certificate issued pursuant to Section 57 (5) Coroners Act 2008.

[7] Transcript P 200

[8] Transcript p. 608.

[9] Transcript P. 641.

[10] This drug is likely to have been administered in course of attempted resuscitation.

[11] Inquest Brief P 92

using Xanax. She told Ms Turner that she had overdosed on methadone at the flats and been revived by ambulance crew but had given a false name and birth date. Ms Turner could think of no other person in the King Street flats that could have been supplying it and Helen always came out of the same flat when she went to pick her up. Helen always refused to tell her the source of the drug saying it was better for her not to know. Ms Turner was aware that another resident of St Lukes had previously attended Mr Hall's flat to get drugs in exchange for sex. Helen had often accompanied her. When the other girl stopped going, Helen continued to go alone. Ms Turner believed that Helen was obtaining methadone by offering sex to Mr Hall.

11. Mr Hall gave evidence at the inquest. He was not represented. That he could seek to object to giving evidence was explained to him by Counsel Assisting and the solicitor assisting her prior to his entering the courtroom. I additionally advised him of the provisions of Section 57 Coroners Act as soon as he was sworn in. He indicated that he understood this but stated that he had no objection to giving evidence. I invited him to apply to me if at any time he felt uncomfortable about giving an answer, to which he replied "I won't feel uncomfortable".[12]

Mr Hall's evidence differed from the evidence of Shannon Zimmer and Dustin Wells in that he maintained strongly that Helen had only been to his flat on one occasion on the 1st May and that was to get cannabis and to give him 6 Xanax tablets. He had some difficulty explaining under cross examination how this was transacted. He said that Helen had given him $80 for the cannabis and he had separately given her $20 for the Xanax.[13] He denied that he supplied Helen with Sarah Castleton's methadone. He said at page 264 that he "did not have any of Sarah's to give her".[14]

I prefer the evidence that there were two trips to Mr Hall's flat during the Saturday on the 1st May, 2010. I accept the evidence of Sarah Castelton that on occasions she left bottles of methadone at Nicholls Hall's flat on Friday nights.[15] Given the evidence of Shannon Zimmer, which I accept, that she observed a bottle of methadone in the pocket of Helen's

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[12] Transcript P. 211.

[13] Transcript P. 240. At p. 241 he responded to Ms Murphy (for Mr Stagoll and Mrs Robertson- paternal grandmother) " No, she didn't come back a second time...Get this second time out of your head, mate. She wasn't there two times".

[14] Transcript P.264.

[15] Ms Castleton had previously denied this to the police but of her own volition returned to provide a further statement admitting to have traded her methadone for cannabis on a regular basis with Nicholls Hall. Mr Hall did not deny this but maintained that he always drank the methadone supplied on the spot.

jacket after they returned from the second trip to the flat, I consider the evidence to be very strong indeed that Nicholls Hall supplied Sarah Castleton's take away methadone dose to Helen Stagoll on Saturday the 1st May, 2010. An alternative possibility might be that Helen had seen Ms Castleton's methadone in Mr Hall's flat and stolen it. However, Mr Hall did not raise this possibility and indeed maintained that he did not have any methadone belonging to Ms Castleton at the time of Helen's visit.

THE ROLE OF DEPARTMENT OF HUMAN SERVICES

12. Owing to the status of Helen being a person who, immediately before her death, was a person placed in care, an inquest into her death is mandatory.[16]

I have reviewed the material placed before the Court on behalf of the Department of Human Services including the four statements provided and its file in relation to Helen. I heard evidence Kristy Farrell, the Intensive Case Manager who was employed by St Luke's (who had a supervisory role in addition to the DHS Case Manager Therese Edwards).

It was clear from all the evidence that Helen was a difficult client to manage. Her father and paternal grandmother had been unable to manage her behaviour and Youth Worker Kathryn Turner also had had to relinquish her care of her. She was a chronic absconder. Numerous warrants had been issued to bring her back to the residential unit. She was nearly 17 years old. From my reading of the material, the way she was managed under the Order was to continue to engage with her and to encourage her to keep in touch, offering her assistance in terms of transport, mobile phone etc. She refused to avail herself of Disability Client Services with which she had been registered; historically she had refused to attend school. She was a difficult client to plan for. The overall plan was to work towards independent living as this was what Helen really wanted to do.

Her request for early release from Secure Welfare was granted by the DHS. I read the Statement of Susan Jamieson, Manager, Child Youth and Families for the Loddon-Mallee region of DHS.[17] Helen was originally to stay in Secure Welfare until 29th April, 2010. [18] On the 20th April, she lodged an appeal. Ms Jamieson consulted with senior staff at Secure

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[16] Section 52 (2) (b) Coroners Act 2008.

[17] Inquest Brief Pp 66-70.

[18] Under the Children, Youth and Families Act 2005 Section 173 (2) (b), the Secretary of the D of HS is limited to placing a child in Secure Welfare for no more than 21 days, and in exceptional circumstances a further period of not more than 21 days.

Welfare who expressed surprise at the "positive changes that they had noticed in Helen's behaviour since her last admission"; these changes included that she was "sleeping well, describing positive plans for her future, participating in cooking, engaging with other residents, appearing to be in good physical health and displaying maturity..."[19]

She also spoke to Secure Welfare Take 2 Clinician, Eamonn McCarthy, who had undertaken a consultation with Helen the day before. He told Ms Jamieson that he had no immediate concerns for Helen's safety and no hesitation in recommending that she exit Secure Welfare.

Ms Jamieson's observations of Helen echoed these. In her statement she describes Helen as presenting very positively, talking in a clear way about her hopes and plans for the future. She looked well, skin and eyes clear, with clean hair.

> *"She had certainly matured"....She was able to articulate what changes she needed to make and what skills she needed to develop...This was a vastly different presentation... from my meeting with her in February 2009."*

In all the circumstances, I am satisfied that the DHS and St Lukes managed Helen as well as possible, including the decision to allow her earlier exit from Secure Welfare. The very fact that there was a plan to take her shopping at her request after her pending court case in the Criminal Division of the Children's Court (appointed for the Monday after her death), is an indication of the effort being made to engage with Helen and keep her "in the fold" until she was able to transit to independent living. Unfortunately, they could not keep an eye on her 24 hours a day after she exited Secure Welfare and had to be satisfied with her regular habit of returning to the unit during the day and advising of her immediate plans.

Under the circumstances, I make no adverse comment or finding in relation to the management of Helen under the CTSO.

DIVERSION OF METHADONE

13. One of the purposes of The Coroners Act is to contribute to the reduction of deaths through findings and the making of recommendations.[20] Dr Jeremy Dwyer of the Coroners Protection Unit was asked by me to write a report in relation to deaths investigated by the Victorian Coroners Court of persons due to methadone use. In particular, he was asked to research the data relating to deaths of persons not registered on the methadone programme

[19] Statement of Susan Jamieson at Inquest Brief P.67.

[20] Section 1 Coroners Act 2008.

who have died as a result of the unauthorised use of the methadone prescribed and allowed to be "taken away" by persons who are registered on the programme. This practice is known as "dose diversion".

Apart from one minor amendment at Page 7 that Report was accepted into evidence as Exhibit L and is attached as an addendum to this Finding.[21] Dr Dwyer produced a second report containing extracts and attachments in support of the first report including references to Commonwealth and various State agencies. This was admitted into evidence as Exhibit L1 and is also attached as an addendum to this Finding.[22]

14. The court also heard from Dr Matthew Frei, an Addiction Medicine Specialist, who had been asked to comment on Dr Dwyer's reports. Dr Frei's report (Exhibit H) is attached to this Finding as Addendum 3.

THE LEGAL FRAMEWORK IN RELATION TO THE METHADONE PROGRAMME

15. Each jurisdiction (state and territory) is responsible for the detailed application in practice of the policies and guidelines outlined by the Commonwealth government in various policy documents. Page 2 of Exhibit L sets out in summary form the maximum take-away doses allowed in states other than Victoria and the period of "stability" required prior to the client being regarded as suitable to receive the maximum take-away dose of methadone. The annexures provide the details. Whilst the variations from state to state are curious (ranging from Tasmania - maximum of two take-away doses only after at least six months of stability to the ACT where there is no limit on the number of take-away doses with a stability minimum of only three months), the relevance of this material to this inquest lies in the way in which the stability factor is established and how it is monitored and whether the risk of dose diversion is adequately assessed and quantified.

Consistent with the over-arching policy guiding the programme which is to shift opioid-dependent people onto a less dangerous replacement drug regime with the hopeful consequence that there will be less deaths from heroin overdose, less HIV infection from injections and less criminal activity in the community, the emphasis in all the official documentation, policies and guidelines is on encouraging continued participation in the programme by the people for whom it has been designed.

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[21] Addendum 1 - Report of Dr Jeremy Dwyer dated 5th June 2013.

[22] Addendum 2 – Supplementary Report of Dr Jeremy Dwyer dated 27th June 2013.

This inquest, however, was concerned to investigate how it came about that a sixteen year old girl, not on the programme, was able to access a take-away dose of methadone that had been provided to another person. The thrust of the enquiry, therefore, was to examine whether the present programme in Victoria adequately protects somebody in the position of Helen Stagoll. This necessarily involves an analysis of the guidelines in Victoria and the reality "on the ground" in terms of actual practice insofar as it relates to and discourages dose diversion.

Whilst not strictly valid in research terms, it was nevertheless revealing to hear evidence from four of the witnesses at the inquest about their experience in the methadone programme, all of them having been in receipt of take-away doses for many years. Their evidence related (inter alia) to frequency of review by prescribing doctors (ranged from three to six monthly)[23]; adherence to the requirement to secure the methadone safely (none of them had a locked container or safe storage arrangements); eligibility for take-away doses rather than supervised doses (all said that it was automatic after about a month if you can establish trust- rather than establishing a particular need for takeaway doses- such as work or travel commitments); Ms Castelton said that she lived not far from the clinic, had a car and did not work. She had never discussed with her doctor or dispenser her need for take-away doses. *"No, they will try and give you more take-away doses than take your take-away doses away from you...they will try to give you more so you are at the clinic less.."*[24]; awareness of "black market" or trading in methadone (Stacey Doyle said that "everybody knew that"[25] Sarah Castleton told the court she was aware of the "black market" in methadone and agreed that others were aware of it.[26] James Croft told the court that he tried not to let many people know he was on it (methadone)...in case he was "stood over" for it.[27]

Whilst the "harm minimization" philosophy that underpins the methadone programme is laudable, the question with which this inquest was concerned was whether the benefits of enabling clients to "take their doses away" from a supervised environment outweighed the

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[23] See Evidence of Dr Matthew Frei P.517-8 Transcript in which he states that monthly reviews are recommended and more frequent if patient is unstable.

[24] Transcript P. 186.

[25] Transcript P 28.

[26] Transcript P 201-2.

[27] Transcript P 146.

risks posed to other people in the community, particularly vulnerable people like Helen Stagoll to whom the drug might be diverted.

The starting point is the Commonwealth Government National Policy on Methadone Treatment 1997, its Clinical Guidelines and Procedures for the use of Methadone in the Maintenance treatment of Opioid Dependence 2003 (designed to complement the aforementioned Policy) and the National Pharmacotherapy Policy for people dependent on Opioids 2007.

The original National Policy in 1997 stated that "*supervised* (my emphasis) dosing is an essential component of methadone treatment and, in general, methadone should be consumed each day under direct supervision at a location approved by the jurisdictional authority responsible for the control of methadone". The "significant risks associated with providing takeaway doses included "methadone diversion and involvement in drug trafficking" and "accidental overdose/death of ..a third person". "The client should be advised that to avoid risk of consumption by children or other unauthorised people, takeaway doses should be stored in a place that is not easily accessible by people other than the client."

In Victoria, the Department of Health is responsible for formulating policy for this State and has had two policy statements issued in 2006 and 2013.

The Department of Health is also responsible for regulating the methadone programme.

The Drugs and Poisons Regulation Department of Health *Policy for Maintenance Pharmacotherapy for Opioid Dependence* sets out three levels of supervised dosing and the maximum number of takeaway doses available at each level: (1) High intensity, no takeaway doses permitted; (2) medium intensity, up to two takeway doses weekly permitted (3) low intensity, up to five takeaway doses per week permitted. The period of stability required to be demonstrated before being allowed up to two takeaway doses per week has reduced from two months (under the 2006 policy) to one month (under the 2013 policy).

The relevant legislation is contained in the Drugs Poisons and Controlled Substances Act 1981.

LITERATURE ON SUBJECT OF TAKEAWAY DOSING

16. That the takeaway programme is more attractive to opioid dependent people than supervised dosing is borne out by the literature. (See Exhibit L pp. 13 -15.) The accepted wisdom is

that by being able to access methadone in this way, patients are able to be more integrated into the community in terms of being able to work and travel. None of the witnesses in this case was working. Their access to takeaway dosing was simply something that they were entitled to after establishing trust with the GP after a month. There is no data available to support the contention that takeaway dosing has enabled particular clients to engage in employment or other activities that rendered attending for supervised dosing more difficult.

17. One reason often advanced to support takeaway dosing is the stigma attached to attending at pharmacies to drink the methadone on a supervised basis. One of the reasons reported by clients in surveys is that supervised dosing creates a greater chance of being recognised at the dosing point. There was evidence, however, in this inquest, that at the Helm Street Clinic some Fridays there are seven or eight people waiting to collect their takeaway doses.[28] As reported above, James Croft did not want people to know he was on the takeaway methadone programme for fear of being "stood over". Dr Dwyer opined (at page 489 of Transcript) that the literature in this respect was based on responses given by clients on the programme and they were unlikely to volunteer that they preferred takeaway doses because they were easier to divert. "So to that extent the research does not reflect the reality..." At page 490, Dr Dwyer commented that one of the pre-requisites for continued eligibility on the programme is that the client is not supposed to divert the methadone. Satisfying this requirement is totally reliant on self-reporting by the client. It goes without saying, that a client is not likely to confess to this.

In a submission received yesterday from Harm Reduction Victoria the following comment appears:

> *"...we believe that it is only a small minority of methadone clients who abuse their access to TADs (Takeaway doses) and the vast majority of methadone consumers use and store their methadone TADs in a safe and responsible manner. As far as we are aware, the majority of clients value their TADs enormously and are unlikely to jeopardise them in any way."* Again, no objective basis is provided for these assertions.

[28] See Evidence of Sarah Castleton Transcript P. 192

Dr Matthew Frei was engaged by the Coroners Court to write an expert opinion and review of Dr Dwyer's report.[29] He referred to the comment in Dr Dwyer's report as to the weakness of the Victorian policy in respect of risk assessment and the fact that this "must effectively rely on client self-report"[30] and Dr Frei went on to say in his own report at page 4, that there are objective measures available and instanced signs of intoxication, physical examination of injection sites and urine drug screening.

The specific examples instanced by Dr Dwyer, however, were the requirement for stable accommodation, secure storage arrangements and *the risk of diversion*. However useful the aforementioned *objective* measures may be in assessing *clinical eligibility* for the commencement of or continuation of takeaway dosing in a particular patient, they do not go towards learning whether the patient is engaging in *diversion*. A patient may satisfy all the criteria clinically and objectively to be eligible but still be diverting methadone in exchange for other drugs or money. Self-confessed diverter Sarah Castleton, a client on the takeaway programme for many years and a witness in this case, is one such example.

Reference was made in Dr Dwyer's report to Victoria having a contingent, as opposed to non-contingent, programme in terms of takeaway dosing in that there are pre-requisites to entitlement.[31]However, some of the contingencies are not, in practice, objectively satisfiable and there is no data on how often failure to satisfy these particular requirements results in ineligibility to start of continue in the programme.

Dr Dwyer articulated very succinctly the short-comings of the literature studies. *"A weakness of the existing literature is that each study only examines a subset of the interrelated benefits and harms attached to opioid replacement therapy."* He cites a study in the BMJ linking an increase in supervised dosing to a decrease in methadone-related deaths. *"The authors did not consider how reducing access to takeaway methadone impacted on heroin deaths, on HIV and hepatitis C transmission, on client retention in treatment and so on".* I would add that this study also does not distinguish between methadone related deaths of third parties and those on the programme, which is the focus of this inquest.

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[29] Dr Matthew Frei is an Addiction Secialist and Clinical Director of Turning Point Alcohol and Drug Centre Eastern Health. He was a member of the expert advisory group for the 2013 Victorian Department of Health policy referred to above.

[30] Page 34 Exhibit L

[31] See Footnote 27 on page 15 of Exhibit "L".

RESEARCH ON DOSE DIVERSION BASED ON CORONIAL DATA BASE

18. However, an attempt has been made to research deaths in Victoria over a 24 month period in which diverted methadone has played a role.[32] At page 22 of Exhibit L, a chart records and analyses 124 deaths in Victoria between 2010 and 2011 due to methadone toxicity. Of these, in 68 deaths, the methadone source could be positively identified and of these, in 61 cases methadone had been prescribed for opioid replacement therapy (as opposed to analgesia). Of these, 50 cases involved takeaway doses of which 29 involved the death of the client who was on the programme. The remaining 21 died as a result of taking a dose *diverted* from a client on the methadone programme

Of the aforementioned 124 deaths, 56 deaths were deaths for which the methadone source could not be positively identified. Of these, there were 42 cases in which there was no current permit for the deceased. Some of these may be methadone patients "between permits" in the sense of changing prescribers and others may have been prescribed methadone as analgesia (no permit required for 8 weeks). The evidence was mute on this issue. Dr Frei, however, suspected that a number of these deaths were as a result of diverted doses.[33] Indeed, he agreed with the suggestion that it was "quite possible" that the entire number of 42 cases were diverted doses.[34] If this were the case, that would mean that in a two year period, 63 people potentially died from diverted methadone, more than two deaths per month.

Dr Dwyer was of the belief that there is no data collected in Victoria in terms of how many clients at any given time are on takeaway doses (and if so, frequency of doses) and how many have to have their doses supervised by a pharmacist. In other words, there is no on-going or regular analysis of the client population in terms of how many pass/fail the eligibility test within a month (since 2013 changes), how many are removed from eligibility at some stage, how many never advance to takeaway doses. This was confirmed by Dr Frei. Amongst the data gaps he instanced were *"numbers of patients receiving takeaway doses, dose ranges of methadone prescribed, treatment drop outs, data on patients prescribed*

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[32] In 85.1% of methadone deaths between 2000 and 2012 multiple drugs were involved. 14.9% involved methadone alone. In all there were 537 methadone related deaths during this period steadily increasing from 2006 onwards. See chart on page 20 of Exhibit L.

[33] Transcript P.586.

[34] Transcript P. 625.

methadone and other drugs of dependence such as benzodiazepines and links with utilization of emergency and acute services (police, ambulance, hospitals). [35]

Dr Frei told the court that that

> *"the only data the Department (of Health) holds is on initial application for a permit....the name and details of the patient, the dose they're going to start them on and the date that dose is going to start; whether they are taking over from someone else or starting anew and the dispensing point. So that's the sum of the details."*[36]

COMBINED EFFECT WITH OTHER DRUGS

19. Dr Frei, in evidence, said that the euphoric effect of heroin is not present in methadone after it has been taken for a while. For this reason it is frequently combined by users with benzodiazepines or alcohol to get a stronger effect. For only occasional users or one off users to whom the drug is diverted, the euphoric effect is much greater and therefore more attractive. [37]

It is this combined toxicity that caused the death of Helen Stagoll. She died from the combined effects of Alprazolam (Xanax), methadone and cannabis. Trading in prescription drugs is a practice of long-standing. Mr Hall admitted to purchasing 6 Xanax tablets from her. Just where she got the Xanax from is not clear. Mr Croft is prescribed Xanax but he told the court that the ones he saw in Helen's possession were a different colour from his. Currently there is no way for a doctor to know whether a patient has previously approached other doctors for the same prescription. Dr Frei instanced the not unrealistic possibility that a patient could obtain five different scripts and then approach five different pharmacies. Were there a real-time prescription monitoring scheme (such as the court heard exists in Tasmania) a doctor could run a check before issuing a script. Dr Frei said that the main objection to such a scheme seems to be issues of privacy and that it is unacceptable to patients. He added that he thought "*there has been enough concern about community harm from prescription drugs that we've gone past that now.*"

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[35] See p. 5 Report of Dr Matthew Frei Exhibit M

[36] See Transcript P 522 Lines 13-20.

[37] Transcript P.527

ALTERNATIVE OPIOID REPLACEMENT THERAPY (ORT)

20. The 2013 Victorian *'Policy for Maintenance of Pharmacotherapy for Opioid Dependenc'* enables any treating medical practitioner to commence a patient on buprenorphine/naloxone for opioid replacement therapy if there is an immediate need. A general practitioner is able to prescribe buprenorphine for up to five patients without having to do specific training.

Buprenorphine carries less risk in that there is less potential for respiratory depression (when combined with benzodiazepines) as there is with methadone. Dr Frei told the court that combining Xanax with buprenorphine is not nearly as respiratorily depressing as mixing Xanax with methadone.[38]

Notwithstanding this, people stay longer in treatment when on the methadone programme, largely because it is more addictive *"and if you don't take your methadone, you get really sick".*[39] Whilst on the face of it this seems to be an extraordinary reason for preferring methadone to buprenorphine, it is in line with harm minimisation principles. If patients cease buprenorphine they are more likely to revert to heroin use. Addiction on the other hand equals greater chance of retention on replacement therapy.

A major attractive feature of Buprenorphine is the fact that it is now combined with naloxone. Since September 2011, this has been available in the shape of a "film" which adheres to the sublingual mucosa within a few seconds and it delivers the drug rapidly across the mucosa. Due to its speed of delivery it is difficult to divert and, if supervised, requires less supervision time. It formerly came in the form of a tablet. This could be crushed up and injected. The availability of the drug in this form was to have ceased in September 2013. I assume that this occurred, although my researches could not confirm this.

Matthew Frei told the court that long-term use of methadone[40] causes dry mouth leading to dental problems, possibly osteoporosis, appetite and weight problems, and as it is a sedating drug it might slow down cognition.

COMMUNITY BASED OR PUBLIC SECTOR DELIVERY

21. The seeming lack of regulation in this area of public health arises from fact that the decision making involved is in the main made by private practitioners and private pharmacies.

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[38] See Transcript P. 553.

[39] See Transcript P.554

[40] See Transcript P 600.

Decisions are made by clinicians using their professional judgement. However, as previously stated, a significant number of pre-requisites to eligibility for takeaway dosing rely on self-reporting by the patient. Dr Frei expressed the view that given that the protection of the public is one that is the role of *government*, there should be more regulation and there should be larger *public sector involvement* in the treatment of people with substance abuse disorders.[41]

"The Victorian pharmacotherapy system differs from all other states and territories which to varying degrees rely on public clinic service provision".[42] One consequence of this system is that there can be little enquiry into what transpires between doctor and patient. There is no regulation in terms of prescribed entries in databases or other means of scrutinising the progress of patients on the programme. Apart from the need to obtain a permit to register the patient on the methadone programme and associated paper-work, there are no other statutory requirements. Information provided by the Department of Health is advisory only, in recognition of the professional relationship between doctor and patient. It is clear that additional paperwork and regulatory oversight would discourage medical practitioners from becoming involved in becoming authorised prescribers of methadone. One wonders how often doctors complete the detailed pro forma assessment tools contained in the 2013 Policy.

Dr Frei also stated that "you can make a living out of prescribing buprenorphine and methadone, but only if it is something you can do on a large scale...and where you do it on a large scale you don't necessarily have the opportunity to do the holistic medicine, the general health". [43] He went on to say that when GPs list the reasons why they do not want to do this work, remuneration figures high. Other reasons include lack of specialist support, resistance by other partners in the clinic to having methadone patients in the waiting room. Some such patients "are often behaviourally complex and challenging". The workload is very high and a survey of permits showed that some doctors have 1500 permits between one

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[41] Victorian Auditor General Report 2011 "Pharmacotherapy in Victoria is provided through a 'community based' model. This means that clients access services in the community rather than through an institution. Nearly all pharmacotherapy clients (92 per cent) see a prescribing general practitioner. and community pharmacy which dispenses the pharmacotherapy medications. The aim of community based pharmacotherapy is to 'normalise' and 'de-stigmatise' the treatment and to improve client access to this form of treatment."

[42] "Enhancing the Victorian Community based Pharmacotherapy System" Directions Paper issued by Victorian Department of Health January 2013.

[43] Transcript P. 558.

and a half doctors. Dr Frei agreed that they cannot be seeing their patients once a month, as recommended, with those numbers. Accordingly he went on *"when one (doctor in a region) retires or ..gets sick and can't work, it's quite a crisis for the region"*. [44]

An audit conducted by the Victorian Auditor-General released in March 2011 showed that the number of people receiving methadone had risen by 15 % to more than 13,000 in the preceding four years. [45] If a sizeable number of these participants are receiving takeaway doses, as seems likely, it follows that there is a large amount of methadone available in the community to divert.

In country regions, access to prescribing pharmacists can be a problem, often necessitating travel with the associated cost of petrol etc. Some towns do not have prescribing pharmacies open 7 days per week and, in those cases, takeaway dosing is almost essential and *" that goes to the flexibility around guidelines.....In some cases, from day one, prescribers sometimes have to bend the guidelines because there's not a pharmacy close by that is open every day of the week so they have to, from day one, give that person take-home doses for a Sunday."* [46]

Given time constraints, particularly for GPs dealing with large numbers of participants, it is likely that insufficient attention is devoted to trying to wean patients of their dependence. This requires a holistic approach, which, in turn, requires time and specialist expertise in areas such as mental health, counselling and advice about employment, resolution of family conflict etc.

The 2013 Policy enabling GPs to prescribe buprenorphine/naloxone for up to five patients without the requirement to undergo training or assessment to become an approved prescriber would seem to be a welcome addition to the replacement therapy model. If taken up in reasonable numbers it may go some way towards addressing the strain on GPs participating in the methadone programme allowing them more time to get to know their patients and assess any risk of diversion.

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[44] Transcript P.561.

[45] The Directions Paper "Enhancing the Victorian Community Based Pharmacotherapy System" issued by the Victorian Department of Health in January 2013 states that there were 14,085 clients as at October 2012 with significant increases in client numbers in rural areas.

[46] Dr Matthew Frei-Transcript P.563.

Whether the future direction of the Opioid Replacement Therapy (ORT) system in Victoria lies in continued community based prescribing complemented by area-based pharmacotherapy networks or in a model closer to the NSW public system of delivery is not within the scope of this inquest.

It is to be hoped, however, that addressing the risks to third parties affected by the possibility of diversion is part of any plan designed to render ORT more accessible to opioid dependent clients.

FINDINGS AND CONCLUSIONS

I repeat my formal finding that 16 year old, Helen Maree Stagoll died on the 2nd May, 2010 at Bendigo from combined drug toxicity.

Amongst the drugs present and contributing to her death were methadone and alprazolam (better known by its trade name, Xanax). The effect of both these drugs was to cause respiratory depression leading to cardiac arrest. Helen was not on the opioid replacement therapy programme. She had not been prescribed methadone. It follows that the methadone that she ingested was diverted to her by another person who had access to takeaway methadone.

The issue with which this Inquest was concerned was not the continuation or cessation of the opioid replacement therapy programme or the continuation or cessation of takeaway dosing. Whilst there are gaps in the literature and the data, it is common sense that a programme that limits the risk posed by opioid addicts to the community and to themselves by placing them on an alternative drug such as methadone must have merit.[47]

The takeaway dose option is considered a further incentive to encourage opioid abusers to go on and, importantly, to stay on the methadone programme.[48]

The complete lack of data in terms of participation rates renders it impossible to qualitatively assess the success or otherwise of this option. The witnesses in this inquest who were on the programme,

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[47] In evidence, Dr Frei compared methadone with heroin. "...the difference is that it's much cheaper, it's taken under the direction of a doctor and a pharmacist, a treatment team. It's used only once a day under supervision,..whether it's take-home doses and supervision, or completely supervised, it's not injected...the purity is known, it's not a street drug. It allows people to engage in other forms of treatment. So while they're seeing their doctor about methadone, they are more likely to get their general health checked." Transcript P. 541. However at Page 557, Dr Frei appears to contradict himself saying that his understanding is that methadone prescribers refer general health matters to other GPs. "So people have their GP for methadone or buprenorphine and another GP for everything else".

[48] From the evidence of Dr Frei, and, contrary perhaps to general perceptions in the community, the main focus of the therapy is not so much the gradual reduction of dependence but rather the transfer of dependence onto an alternative drug that is safer. I imagine it is for this reason that it is called a "maintenance programme".

considered takeaway dosing eligibility as a rite of passage after establishing trust with the prescribing doctor. It was conceded by Dr Frei that the expectation that one would be so eligible after a month is "the genie that has got out of the bottle in Victoria" and requires a significant culture change in both prescribers and patients that it is not a rite of passage but a clinical decision.[49] However, as has been stated above, the appropriateness for eligibility in many respects is dependent on self-reporting and is not just a clinical decision. In particular, assessing the risk that the patient might be diverting the methadone must rely, by definition, on self –reporting. Unless doctors were prepared to visit the patient's home, the condition of safe storage of the takeaway dose must rely on self-reporting.

Given the statistics compiled by Dr Dwyer, and detailed above, it is surely time to re-visit the takeaway dosing component of the methadone programme as applied to opioid abusers.[50]

These statistics are alarming to say the least. It could persuasively be argued that the pendulum has swung too far in favour of minimizing harm to participating clients, taking short cuts to attract them into and retain them in the programme and to respond to their particular needs. This approach has created an expectation in the minds of the participants that they should be entitled to takeaway doses within a very short time of being accepted into the programme. As a result of this process, third parties have been able to access a dangerous drug which, in too many cases, has ended in their deaths. Nor is it not known how many near-misses there have been. Such data that has been able to be found as being collected from emergency departments of hospitals does not distinguish between overdoses by clients on the programme and persons to whom methadone has been diverted. [51] Helen Stagoll had had at least one "near-miss" in which she was revived by ambulance paramedics. She had given a false name and date of birth. As far as I was able to determine, there are no records kept in a data base relating to "near-miss" episodes in which patients are resuscitated by ambulance paramedics following methadone overdoses.

Should the patient arrive in hospital, emergency department staff can telephone a number to ascertain whether a patient is on the program but this is only staffed during office hours. There is no requirement to make such a call, no requirement to note anywhere the information so obtained. The ability to collect data in the context of methadone overdoses, at all hours, to ascertain whether the patient is on the methadone programme or using diverted methadone, Dr Frei agreed, would be

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[49] Transcript P 522 Lines 3-9.

[50] As distinct from patients who have takeaway doses for analgesic purposes.

[51] See Attachment J to Exhibit L1.

"invaluable" but did not know how receptive ED physicians would be "to filling out another form...". It is hard to see how a valid risk/benefit analysis can be complete without this data in terms of opioid replacement therapy programs in general and takeaway dosing in particular.

RECOMMENDATIONS

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

This case has brought to light significant gaps in a system designed primarily to respond to the health risks posed to opioid addicts. The number of deaths of third parties occasioned by the abuse of the system by the people for whom it was designed is shameful and deserves a robust re-thinking.

Significant data instanced in this Inquest derived from the Victorian Coronial Data base from which it is clear that *at a minimum* 21 "third persons" died in the 24 months of 2010-2011. Of the 56 deaths for which the methadone source could not be positively identified, 42 did not have a current Schedule 8 permit. It is reasonable, as stated by Dr Frei, to conjecture, that a significant number of those additional 42 deaths were of persons to whom methadone had been diverted.

The difficulty with making recommendations in this area, that are balanced and responsive, that can practicably be implemented and subsequently evaluated is the alarming dearth of data collected during the operation of the scheme. It is difficult to imagine how policy planning can be informed in any effective way without access to such basic data.

Accordingly, the first and most significant recommendation relates to adequate collection of future data. The other recommendations have been drafted taking into account the literature available, the observations of the system as related by Dr Frei and the experience and operation of the system as related by witnesses in this inquest.

A. That the Victorian Department of Health urgently review its policy with respect to the takeaway dosing component of the Opioid Replacement Therapy programme, taking into account the number of deaths that have occurred due to the widespread availability of methadone in the community and the lack of any real safeguards to protect vulnerable third parties from the risks associated therewith.

   At Page 21 of the 2013 Policy it is stated:

   "*Pharmacotherapy in Victoria is based on the principle of supervised dosing*".

However, in response to a recommendation made by Coroner Kim Parkinson in the matter of Damien Perceval Coroners Case 2063 of 2009 in which she recommended that supervised dosing only be implemented and takeaway dosing be prohibited, the Department of Health stated:

> *"The overall long-term success of maintenance therapy and patient retention in treatment is contingent on providing patients the opportunity to normalise their lives through the provision of takeaway dose. Takeaway doses facilitate a patient's re-integration into the community and enable stable patients to meet work and family commitments with minimal disruption."* [52]

On the face of it, this response seems to be at odds with the principal policy position that clearly states that *supervised dosing* should be the norm.

I am not advocating that takeaway dosing cease to be available. However, the statistics that have come to light in the course of this investigation in my view warrant an urgent re-thinking of the way in which the ORT programme is operating in practice, the way in which eligibility for takeaway doses is assessed. The apparent expectation in the minds of ORT clients that they will automatically be entitled to takeaway doses seems to be contrary to the overriding policy as set out above. Given the reliance of prescribers on self-reporting by the patients in a number of areas that relate primarily to the safety of third parties, unless the safety of other members of the public can be objectively ascertained in some way (and I accept that this is difficult in a practical sense) and/or the other recommendations listed below are implemented, it is certain that there will be more tragic deaths like this one.

B. That the Victorian Department of Health initiate a process whereby data is required to be generated in the following areas:
   (a) The number of patients on takeaway dosing;
   (b) Period of time between initial presentation to GP and commencement on takeaway dosing;
   (c) The weekly number of takeaway doses allowed those patients;
   (d) The dosage ranges of those takeaway doses;
   (e) Any reductions in numbers of takeaway doses due to suspicion of diversion;
   (f) Any reasons provided in support of permission to take away doses.

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[52] See Exhibit "L" pages 31-32.

The abovementioned data relate to quantifying risks of *diversion* only. Other items that were listed by Dr Frei as desirable relate to the methadone programme generally (as opposed to takeaway doses) and do not fall within the scope of this inquest.

C. That the Department of Health make ORT permit information accessible to hospital emergency departments 24 hours per day.

D. That the Victorian Department of Health require all hospital emergency departments to record all admissions of patients suffering from methadone toxicity who are not on the ORT programme as evidenced by a search of the data base referred to in C above and forward such documentation to the Department of Health.

E. That the Victorian Department of Health require ambulance paramedics to record attendances on all patients presenting with methadone overdose and forward such information to the Department who can then establish and record in a data base whether the patient is or is not currently registered on the ORT programme.

(In cases D and E, this will require some effort on the part of personnel to satisfy themselves as to the true identity of the patient, if necessary asking for proof of identity-name and date of birth. In the event that no satisfactory proof is supplied, this fact should also be recorded and the reasons why. Whilst privacy arguments may be advanced in opposition to this Recommendation, it is arguable that, given the number of deaths due to diverted dosing and the greater public health concerns, patients enrolled in the programme should be prepared to sacrifice some privacy for the greater good.)

F. That the Victorian Department of Health embark on an investigation to determine the extent of trading in takeaway methadone such as, for example, requesting ORT programme clients to complete an anonymous survey in which they are asked about their knowledge of the practice.

G. That the Secretary to the Commonwealth Department of Health amend the current Poisons Standard to require that containers of methadone dispensed as takeaway doses for opioid pharmacotherapy are adequately labelled with the caution: *"Never leave a person who has taken methadone to sleep it off. Call an ambulance immediately. Dial OOO".*

H. That the Victorian Department of Health investigate the viability and safety of doctors supplying Narcan in injectable form or, should it become available, as a nasal spray to all clients on the ORT who are eligible for takeaway doses. The idea would be that the general practitioner strongly encourage, in the event of an overdose of a third person, the

calling of an ambulance as a first response but, failing that, the administration of the Narcan, with appropriate demonstration of how to administer the drug. The shelf life of Narcan is two years. Some form of alert system could be instituted to warn the patient of the need to replace the supply after that time has elapsed. Whilst it is appreciated that the half life of Narcan is short, it may save a life in time and enable transfer to hospital for further treatment.

I. That General Practice Victoria include in its pharmacotherapy GP Training Program a component in which prescribing doctors are trained to teach patients on the ORT programme who are eligible for takeaway doses and their families and friends how to recognise signs of opioid overdose in the event that a third person accesses the takeaway dose.[53] (I am concerned that the "targeted methadone consumer safety education campaign" outlined in the submission of Harm Reduction Victoria, whilst laudable in its intention, nevertheless suffers from the subtle difficulty that in providing so much information publicly and generally about how to respond to a third person suffering effects from ingesting a takeaway dose, it may tend to suggest to ORT clients that diversion is a recognised, even if unacceptable, practice. For this reason, I limit my recommendations in this regard to doctors providing this information on a private doctor/patient basis to the patient and his/her family).

J. That the Victorian Department of Health consider requiring patients on the ORT programme to return their bottles with labels intact when attending to obtain takeaway doses. Whilst it is appreciated that there may be health concerns in relation to the adequate cleansing of the used bottles for future use, the pros and cons of such a requirement should be part of the risk-benefit evaluation process in relation to the current takeaway programme policy.

The following recommendations relate to **new patients** entering the ORT programme.

K. That the Victorian Department of Health policy should recommend that when a patient expresses the desire to commence opioid replacement therapy that the doctor encourage the patient to commence on the buprenorphine/naloxone (Suboxone) course of therapy,

[53] It is noted that a program called Community Overdose Prevention and Education was recently announced by the Victorian Minister for Mental Health. It is to be hoped that doctors prescribing methadone will participate in this programme and that family and friends of participants on the ORT programme shall be encouraged to attend information sessions.

which, after an initial trial period of two weeks could, if appropriate, become automatically a takeaway option gradually increasing the number of takeaway doses to 6 per week. This may represent an incentive to select this programme rather than methadone, particularly if entitlement to takeaway doses in the latter programme is restricted

J. That the Department of Health policy recommend that *methadone* therapy be offered only as dosage *under supervision*-unless compelling reasons (which are officially recorded) warrant a takeaway dose. Such takeaway doses should be limited to the number necessary to address the "compelling reasons" provided by the patient and be reviewed from time to time to determine whether those reasons still exist. This is in line with the general policy situation as outlined in the Victorian Policy of 2013 at Page 21: "Pharmacotherapy in Victoria is based on the principle of supervised dosing".

L. That the Department of Health policy recommend that as a condition of accepting a patient into either programme, the doctor require the patient to participate in drug counselling and such other therapy as may be appropriate to address the underlying reasons for their addiction problems. This should be monitored by the doctor from time to time and the patient encouraged to persevere with it.

M. That the Department of Health require doctors to maintain and, if necessary, furnish to the Department of Health, a ledger listing all new patients on ORT, stipulating which programme they are on and, in the case of patients assigned to the methadone programme and allowed takeaway doses, a summary of the "compelling reasons" on the basis of which such doses were allowed.

N. That the Department of Health require that if a doctor identifies that a patient is exchanging, trading and/or selling methadone to a third person, this should result in automatic ineligibility for continued *takeaway doses,* and patients, both new and current, should be told this at the commencement of their participation in the program and also the fact that diversion is a criminal offence under the Drugs Poisons and Controlled Substances Act.

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

The Secretary of the Victorian Department of Health.

The Secretary of the Commonwealth Department of Health.

General Practice Victoria.

Harm Reduction Victoria Inc, PO Box 12720, A'Beckett Street, Melbourne 8006

Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association, 211 Victoria Parade, Collingwood 3066

John Ryan, Chief Executive Officer, ANEX, 95 Drummond Street, Carlton 3053

Dr Matthew Frei, Head of Clinical Services, Turning Point Alcohol & Drug Centre, 54-62 Gertrude Street, Fitzroy 3065

Manager, Barwon South West Region Pharmacotherapy Network, Great South Coast Medicare Local, PO Box 63, Warrnambool 3280

Manager, Grampians and Loddon Mallee Region Pharmacotherapy Network, Ballarat Community Health, PO Box 1156, Bakery Hill 3354

Manager, North West Metropolitan Region Pharmacotherapy Network, Western Region Health Centre, 81-83 Paisley Street, Footscray 3011

Manager, Hume and Gippsland Region Pharmacotherapy Network, Latrobe Community Health Service, PO Box 960, Morwell 3840

Signature:

JACINTA HEFFEY
CORONER
Date: 29 October 2013