IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 4459

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008 (Vic)

I, JOHN OLLE, Coroner having investigated the death of JAMES STEWART DOUGAN without holding an inquest:
find that the identity of the deceased was JAMES STEWART DOUGAN
born on 1 May 1978
and the death occurred on 19 November 2010
at 5 Moonah Street, Frankston VIC 3199

from:

1(a) MIXED DRUG TOXICITY (CODEINE, METHADONE, ALPRAZOLAM, DIAZEPAM) IN A MAN WITH CORONARY ARTERY ATHEROSCLEROSIS

Pursuant to Section 67(2) of the *Coroners Act 2008* (Vic), I make these findings with respect to the following circumstances:

1. James Dougan was born on 1 May 1978 and was 32 years old at the time of his death. He resided with his partner Jenna Ireland at Narre Warren.

2. A coronial brief was provided by Victoria Police to this Court, comprising statements obtained from family, witnesses, treating clinicians and investigating officers. I have drawn on all of this material as to the factual matters in this finding.

BACKGROUND AND CIRCUMSTANCES

3. Mr Dougan had a longstanding history of illicit and prescription drug and alcohol abuse. His partner Jenna Ireland reported to police, 'ever since I met [Mr Dougan] he was always taking drugs. Heroin was his drug of preference but he would take anything'. Ms Ireland did not tolerate Mr Dougan's drug and alcohol abuse and the couple frequently fought as a result.[1]

[1] Statement of Jenna Ireland, dated 21 November 2010, Coronial brief 8.

4. In approximately June 2010, Ms Ireland discovered she was pregnant and reported that Mr Dougan was very excited about becoming a father, stating to her that it was 'going to be the best thing in the world'.[2] Mr Dougan attempted to seek employment in order to financially support his family, however Ms Ireland reported that 'the drugs controlled him and made it very hard'.[3]

5. On 15 November 2010 Ms Ireland drove Mr Dougan to a local bus stop in order for him to travel to a general practitioner at Bentleigh to obtain alprazolam[4]. After arriving at the bus stop, Mr Dougan met friend Natalie Hayes at Frankston Train Station and they travelled to Bentleigh together. Mr Dougan attended upon general practitioner Dr Elizabeth Orbach and obtained prescriptions for alprazolam, temazepam and a paracetamol and Panadeine Forte.[5] Mr Dougan presented the scripts at a local pharmacy and received the medications as per Dr Orbach's prescription, then returned to Frankston Train Station with Ms Hayes to sell a portion of the alprazolam he had received. [6]

6. Mr Dougan spent the following four days residing with Ms Hayes. During this time, she observed him 'popp[ing] pills constantly'. In the mornings she observed Mr Dougan swallow four alprazolam tablets, stating that this was his daily dose. In addition to alprazolam, she observed him taking methadone and his prescribed painkillers 'every few hours'.[7]

7. On approximately 16 November 2010 Mr Dougan met Ms Ireland at Frankston Train Station and they attended a store in Karingal. Ms Ireland observed Mr Dougan allegedly shoplifting several items and confronted him about his behaviour. They fought for some time and Ms Ireland drove Mr Dougan to Frankston. Mr Dougan did not return home following this argument and in the subsequent days Ms Ireland made several unsuccessful attempts to contact him.[8]

8. On 18 November 2010 Mr Dougan spent the day with Ms Hayes and she observed him to be extremely drug affected. Ms Hayes reported to police that Mr Dougan passed out several times

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[2] Ibid.

[3] Statement of Jenna Ireland, above n 1.

[4] Ibid.

[5] Medical Records of Jasper Medical Centre, appendix to Coronial brief, p 5 of records.

[6] Statement of Natalie Hayes, dated 19 November 2010, Coronial brief 1.

[7] Ibid; Statement of Senior Constable Amber Hull, dated 13 December 2010, Coronial brief 17.

[8] Statement of Jenna Ireland, above n 1, 9.

during the evening. At approximately 2.30am she roused him and stated that she was going to bed. Mr Dougan entered Ms Hayes' bedroom and sat down on the edge of her bed while eating cereal. They maintained a brief conversation after which Ms Hayes fell asleep. Ms Hayes observed Mr Dougan sitting on the bed and eating when she fell asleep[9]

9. On 19 November 201 at approximately 8.30am Ms Hayes woke up and observed Mr Dougan lying in bed beside her. She shook Mr Dougan in an attempt to wake him but observed him to be unresponsive. Ms Hayes reported that Mr Dougan was a heavy sleeper and that it was common for him to remain unresponsive despite her attempts to wake him. At this time Ms Hayes dressed and left the residence to attend an appointment.

10. At approximately 1.00pm Ms Hayes returned to the premises and observed Mr Dougan lying in bed. She tried to rouse him but observed that his lips were blue, he was unresponsive and had no pulse. Ms Hayes contacted emergency services and paramedics and police arrived a short time afterwards.[10] Paramedics attended to Mr Dougan and confirmed that he was deceased. Police located a bottle of alprazolam on the bedside table next to Mr Dougan, which contained various unknown white and orange tablets.

MR DOUGAN'S DRUG SEEKING BEHAVIOUR

11. At my request, the Coroners Prevention Unit[11] reviewed the medical management of Mr Dougan in respect to his drug seeking behaviour. I have used this information to assist my finding.

12. Mr Dougan's drug addiction saw him attend numerous doctors with the aim of obtaining the benzodiazepine alprazolam.[12]

13. General practitioner Dr Ronald Korman reported to police that Mr Dougan had attended his practice several times over a four-year period, since July 2006, seeking prescription medications. In particular, Mr Dougan 'complained of anxiety, stress and panic attacks and sought benzodiazepines including diazepam and alprazolam which he said he was buying on

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[9] Statement of Natalie Hayes, above n 6, 2.

[10] Ibid.

[11] A specialist service for coroners created to strengthen their prevention role and provide them with expert assistance. Hereafter referred to as 'CPU'.

[12] Statement of Jenna Ireland, above n 1; the medical records of Mr Dougan.

the street and required in order to be able to function and work'.[13] Dr Korman provided Mr Dougan with diazepam on an ongoing basis for at least six months and then commenced him on a methadone treatment program to address his heroin addiction. In August 2010 Mr Dougan attended a consultation with Dr Korman and 'begged for some diazepam although he denied benzodiazepine use in general'. Dr Korman prescribed diazepam and referred Mr Dougan to a withdrawal counsellor.[14]

14. General practitioner Dr David Christiansen provided a history of Mr Dougan's attendances at his clinic between August 2007 and April 2010. Dr Christiansen prescribed alprazolam to him on numerous occasions to treat panic disorder. In relation to his clinical reasoning for prescribing alprazolam to Mr Dougan, Dr Christiansen stated '[I] would only have ordered it if I believed that my patient would get on something worse if it were not prescribed'.[15] Dr Christiansen continued to prescribe alprazolam to Mr Dougan. In a clinical note on 22 March 2010, Dr Christiansen expressed concerns about Mr Dougan's drug seeking behaviour however provided prescriptions for alprazolam, diazepam and temazepam in subsequent consultations.[16] A fellow practitioner at the clinic, Dr Danny Leber, issued a letter to Mr Dougan on 17 June 2008 refusing to issue any further prescriptions for benzodiazepines due to Mr Dougan's drug seeking behaviour.

15. General practitioner Dr Joe Cacek provided a history of Mr Dougan's attendances at his clinic between April 2010 and November 2010. Dr Cacek prescribed diazepam to him several times over this period to treat alcohol dependence. Dr Cacek also prescribed temazepam to treat sleeping issues.[17]

16. In a statement dated 16 February 2011, general practitioner Dr Elizabeth Orbach noted that James Dougan attended her practice monthly between August and November 2010. She stated:

> He was suffering a panic disorder which required Xanax 2mg three times daily. I offered him monthly prescription of 150 tablets. He was also dispensed Panadeine Forte and Normison for

[13] Statement of Dr Ronald Korman, dated 4 January 2011, Coronial brief 11.

[14] Ibid 11-12.

[15] Letter from Dr David Christiansen, dated 26 November 2013, Supplement to Coronial brief p 4.

[16] Medical Records of Cheltenham Medical Centre, Supplement to Coronial brief.

[17] Statement of Dr Joe Cacek, dated 30 November 2010, Coronial brief 13-14.

sleeping. On 29/10/11 he presented claiming his Xanax medication was left on the train. His permit was not yet due and I prescribed Xanax 50 tablets on a private script.[18]

17. Dr Orbach reported contacting the Pharmaceutical Benefits Scheme (PBS) Authority during several consultations to obtain authority to prescribe alprazolam. Dr Orbach's accompanying clinical notes list the prescriptions issued to Mr Dougan during consultations. Of note, the medical record identifies four prescriptions for alprazolam, as well as prescriptions for diazepam and temazepam, issued between 27 October 2010 and 15 November 2010, immediately proximate to Mr Dougan's death.[19] In the five months leading up to his death, Dr Elizabeth Orbach wrote him scripts for 900 tablets of 2mg alprazolam.

18. General practitioner Dr Tooraj Chamacham provided a history of Mr Dougan's attendances at his clinic between July 2009 and May 2010. Dr Chamacham prescribed diazepam to him several times over this period to treat anxiety and stress. Dr Chamacham also prescribed temazepam to treat insomnia.[20]

19. A further four doctors, Dr John Pragastis, Dr Martin Hill, Dr Xiao Wang and Dr Deepa Nappally, provided medical records in relation to prescribing benzodiazepines to Mr Dougan in the 12 months leading up to his death.[21]

20. Mr Dougan's medical history indicates that for a significant period of time leading up to his death he was engaged in 'prescription shopping' by attending multiple doctors to obtain pharmaceutical drugs of dependence in excess of his therapeutic need.[22] His medical records reveal numerous instances where he obtained diazepam, alprazolam, temazepam and/or codeine phosphate concurrently from different doctors. He obtained benzodiazepines from at least nine different doctors in the 12 months leading up to his death. Because Mr Dougan was

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[18] Statement of Dr Elizabeth Orbach, dated 16 February 2011, Coronial brief 16.

[19] Medical Records of Jasper Medical Centre, above n 5.

[20] Letter from Dr Tooraj Chamacham, dated 11 June 2014, Supplement to Coronial brief.

[21] Progress Notes of Dr John Pragastis, Supplement to Coronial brief; Patient Health Summary of Stud Road Medical Centre, dated 10 July 2012, Supplement to Coronial brief.

[22] Prescription shopping is defined as follows:

> [Prescription shopping] involves patients attending several doctors in order to obtain several prescriptions for controlled drugs so as to get a quantity of drugs greater than their therapeutic needs, which are then used for personal consumption or sold on the street market. This phenomenon is not limited to patients seeking drugs from general practitioners, as patients also attend accident and emergency departments of hospitals seeking drugs. There is also a smaller but nonetheless significant problem associated with people seeking to illegitimately obtain prescription drugs from dentists and other allied health professionals.

Drugs and Crime Prevention Committee, Parliament of Victoria, *Inquiry into the Misuse/Abuse of Benzodiazepines and Other Forms of Pharmaceutical Drugs in Victoria: Final Report*, December 2007, p.108.

also being prescribed and dispensed medications privately that did not appear on his PBS Patient Summary,[23] it is possible that his prescription shopping was more extreme than his PBS medical records show.

21. Despite his drug seeking behaviour, Mr Dougan was never identified as a prescription shopper under the Medicare Australia Prescription Shopping Program, which monitors the nature and quantity of medicines dispensed to individuals through the PBS. The current threshold for defining prescription shopping is very high[24] and Mr Dougan did not meet this criteria based on the medications dispensed to him under the PBS.

22. It is notable that between July 2005 and July 2008, Medicare Australia's Prescription Shopping Information Service received five calls regarding Mr Dougan. One of the main purposes of the Prescription Shopping Information Service is to inform doctors as to whether or not a particular patient has been identified as a prescription shopper under the Prescription Shopping Program.[25] The caller was advised on each occasion that Mr Dougan had not been identified as a prescription shopper at the time of the call.

23. Medicare Australia's history of medications dispensed to Mr Dougan under the PBS for the two years leading up to his death contained material that suggested Mr Dougan was prescription shopping. In the two weeks before his death, he was prescribed temazepam by two different doctors. Mr Dougan's medical history records numerous examples of him obtaining diazepam, alprazolam, temazepam and/or codeine phosphate from multiple doctors concurrently. He obtained benzodiazepines from at least nine different doctors in the 12 months leading up to his death. It is known that Mr Dougan was also prescribed and dispensed medications that did not appear on the PBS Patient Summary because they did not attract a PBS co-contribution. Specifically, on 29 October 2010 Dr Elizabeth Orbach prescribed alprazolam to him on a private script.

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[23] For instance, Dr Elizabeth Orbach's reference on 29 October 2010 to a private script for alprazolam.

[24] The criteria for identification are that within a three-month period the individual has been dispensed either (a) PBS items from six or more different prescribers, or (b) a total of 25 or more target PBS items, or (c) a total of 50 or more of any PBS items.

[25] See Medicare Australia, "Prescription Shopping Program", 13 January 2011, <http://www.medicareaustralia.gov.au/provider/pbs/prescription-shopping/index.jsp>, accessed 14 January 2011.

POST-MORTEM EXAMINATION AND REPORT

24. A post-mortem examination and report was undertaken by Dr Melissa Baker, Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Baker reported that post mortem examination revealed significant natural disease affecting the cardiovascular system with severe single vessel coronary artery atherosclerosis. The left anterior descending coronary artery showed up to 90% stenosis. This degree of stenosis is associated with sudden death due to reduced blood flow to the myocardium (myocardial ischaemia) precipitating a cardiac arrhythmia.

25. Dr Baker reported that risk factors for atherosclerosis include smoking, hypertension, hypercholesterolaemia, diabetes mellitus and family history. A post mortem cholesterol level was found to be within the normal range at 3.5mmol/L.

26. Toxicological analysis of Mr Dougan's blood revealed the presence of multiple central nervous system depressant drugs including methadone (~0.5mg/L) and its metabolite EDDP (~0.04mg/L), diazepam (~0.4mg/L) and its metabolite nordiazepam (~0.4mg/L), codeine (0.14mg/L), alprazolam (~0.08mg/L) and temazepam (~0.1mg/L). Morphine was detected in urine (7.9mg/L) but not in blood. Dr Baker reported that the presence of multiple central nervous system depressant drugs potentiates the effects of each and the combined effects may cause death even if the level of each individual drug is present at therapeutic level.

27. According to information obtained from the Department of Human Services, there was no permit for methadone prescription for the deceased.

28. Dr Baker reported that it is conceivable that hypoxaemia (low blood oxygen levels) in the setting of an altered conscious state due to the effects of drugs may lead to reduced blood flow to the myocardium in an area which is already compromised by severe coronary artery atherosclerosis and precipitate a cardiac arrhythmia. As such the cause of death is most appropriately ascribed to the combined effects of mixed drug toxicity and natural disease.

29. Dr Baker determined that the cause of death is mixed drug toxicity (codeine, methadone, alprazolam, diazepam) in a man with coronary artery atherosclerosis.

COMMENTS

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

Victorian deaths from benzodiazepine toxicity, 2010 - 2013

31. Mr Dougan's ability to obtain benzodiazepines from various doctors is of concern in the context of the contributory role benzodiazepine medications play in Victorian overdose deaths. Of 1457 Victorian overdose deaths between 2010 and 2013 benzodiazepines played a contributory role in over half of the deaths.[26] The annual frequency of fatal overdose involving benzodiazepines rose steadily over the period examined. In 2013 benzodiazepines contributed to 56.7% of overdose deaths, up on 53.4% in 2012, 49.0% in 2011 and 48.1% in 2010.[27] The benzodiazepine diazepam was the most frequent contributing drug in Victorian overdose deaths between 2010 and 2013, contributing to 36.2% of deaths examined.[28]

Benzodiazepine guidelines

32. As discussed above (paragraphs 12-19), benzodiazepine prescribing to Mr Dougan was characterised by a number of suboptimal practices. Multiple general practitioners co-prescribed benzodiazepines, prescribed alprazolam and diazepam on an ongoing basis without other interventions in place, and treated Mr Dougan for alcohol dependence with diazepam without ongoing review.

33. Several other recent Victorian coronial investigations have highlighted suboptimal benzodiazepine prescribing practices contributing to overdose death. Among them I particularly note the finding of my colleague Coroner Audrey Jamieson in the death of David Trengrove (COR 2008 4042, published 19 May 2012). Coroner Jamieson noted therein that systemic factors contributed to sub-optimal benzodiazepine prescribing, including a lack of strong Australian benzodiazepine prescribing guidelines. Her Honour recommended that the Royal Australian College of General Practitioners (RACGP) update its benzodiazepine

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[26] n = 756, 51.9%

[27] For the detailed data see Appendix 1 to Jamieson A, finding without inquest into death of Kirk Steven Ardern, Coroners Court of Victoria, Court Reference 2012/2254, delivered on 7 April 2014.

[28] Again an upward trend is noted in diazepam related deaths. In 2013 diazepam contributed to 43.9% (n = 164) of drug related deaths in Victoria, compared to 35.7% (n = 131) in 2012, 33.8% (n = 124) in 2011 and 31.2% (n = 109) in 2010.

guidelines to reflect current evidence and good clinical practice; the RACGP endorsed and accepted this recommendation in its response.

34. In July 2014 the RACGP disseminated for comment the consultation draft of its new Good Practice Guide: Drugs of Dependence in General Practice, which included (as Part B to the Guide) its Benzodiazepine Guidelines. This consultation draft offered clear and evidence-based advice on safe benzodiazepine prescribing, both generally and to treat specific conditions such as anxiety, insomnia and alcohol withdrawal. The Guidelines repeatedly highlighted the importance of exercising care when prescribing benzodiazepines and the unambiguous advice included:

> Benzodiazepines should not be prescribed where there is a history of drug and alcohol addiction or abuse.
>
> The very strong recommendation would be to not initiate prescription of benzodiazepines to polydrug users in general practice.
>
> The very strong recommendation would be to reduce and cease prescription of benzodiazepines to polydrug users in a supervised manner.
>
> The use of benzodiazepine should be avoided for treatment of patients with a comorbid serious mental health disorder due to the high risk of addiction/abuse.[29]

35. In July 2015, the RACGP provided the Coroner's Court with the RACGP's *Prescribing drugs of dependence in general practice, Part B – Benzodiazepines*. It provides guidance on prescribing benzodiazepines in general practice which includes, but is not limited to, the subsection of the population with a history of co-morbid substance abuse or misuse. It also addresses broader issues such as governance and patient management and their impact on drugs of dependence and problematic prescription use. I have reviewed the document and I am impressed by its scope, detail and practical advice for how to minimise the risk of harms when prescribing benzodiazepines. I hope this guidance document is a positive step forward in encouraging clinically appropriate benzodiazepine prescribing, and that it will be embraced by general practitioners. I have asked the Coroners Prevention Unit to continue monitoring benzodiazepine involvement in Victorian overdose deaths, to measure whether the guidance document has an impact on this.

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[29] Royal Ausstralian College of General Practitioners, *Good practice guide to drugs of dependence: Benzodiazepines Consultation Draft*, July 2014, 3.

Real time prescription monitoring

36. Victorian coroners have advocated the need for a functioning real-time prescription monitoring (RTPM) system in Victoria to assist medical practitioners in coordinating their care for patients and reduce the harms and deaths associated with pharmaceutical drugs.[30] Such a system can be of significant benefit to medical practitioners involved in the care of patients such as Mr Dougan as it can alert them to each other's existence and to the fact that the patient has been prescribed and dispensed quantities of benzodiazepines well above therapeutic need.

37. In response to the recommendations set out by Victorian coroners, the Victorian Department of Health has consistently indicated that it has been engaging with the Commonwealth Department of Health through their national Electronic Reporting and Recording of Controlled Drugs (ERRCD) initiative to deliver RTPM to Victoria. However as State Coroner Ian Gray noted in his finding in the matter Finding with Inquest into the death of Anne Brain (COR 2011 4797), 'when pressed as to when the mooted RTPM system would be delivered, the department has not been in a position to provide a concrete indication'.[31]

38. The ongoing harms associated with inappropriate prescribing and dispensing of pharmaceutical drugs and the increasing contributory role diazepam in particular plays in Victorian drug related deaths strongly suggests that the implementation of a Victorian-based real-time prescription monitoring system should proceed as a matter of urgency. On 16 February 2015 The Coroners Court received the Department of Health and Human Services ('DHHS') response (signed by Secretary Dr Pradeep Philip and dated 6 February 2015) to State Coroner Judge Ian Gray's recommendations in the death of Anne Brain (COR 2011 4797). The DHHS stated:

> With the recent change of Government, the Department is providing advice to the Minister for Health on the issue of prescription drug misuse and the need to reduce the harms and deaths related to prescription shopping. The Department is also advising the Minister on all issues relating to real-time prescription monitoring implementation. These matters are currently being considered by the Government.

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[30] See for example Finding with Inquest into the death of James, COR 2009 5181, delivered by Coroner Olle on 15 February 2012; Finding without Inquest into the death of David Trengrove, COR 2008 4042, delivered by Coroner Audrey Jamieson on 18 May 2012, and Finding without Inquest into the death of Kirk Ardern, COR 2012 2254, delivered by Coroner Audrey Jamieson on 7 April 2014; Finding with Inquest into the death of Anne Brain, COR 2011 4797, delivered by State Coroner West on 30 October 2014.

[31] Finding with Inquest into the death of Anne Brain, COR 2011 4797, delivered by State Coroner West on 30 October 2014.

39. Another key issue with the ERRCD initiative that several of my fellow Coroners have highlighted and explored is the scope of drugs it must capture. At present, it appears that the ERRCD is intended only to capture the dispensing of Schedule 8 drugs. The contributory effect of Schedule 4 benzodiazepines in Mr Dougan's death, as well as in Victorian overdose deaths more generally, indicates that the scope of RTPM systems must extend to cover Schedule 4 pharmaceuticals in order to enhance a doctor's ability to make clinical decisions about their patients.

40. Within the Department of Health and Human Services ('DHHS') response to State Coroner Judge Ian Gray's recommendations in the death of Anne Brain (COR 2011 4797), The DHHS provided a response to this matter:

> Schedule 8 poisons are the minimal set of drugs which a real-time prescription monitoring system should monitor, as they are the prescription medications that pose the highest level of risk to the community. However, the department is very interested in data that the Coroners Prevention Unit has presented in previous findings, which shows that the other prescription drugs such as benzodiazepines also contribute to a significant number of drug-related deaths. Accordingly, the department will certainly consider the best way to deal with this issue.

Prescription Shopping Program

41. A significant missed opportunity to intervene in Mr Dougan's drug seeking behaviour pertained to Medicare Australia, through their Prescription Shopping Program,[32] advising callers on five occasions that Mr Dougan had not been identified as a prescription shopper at the time of the call.

42. Experts have identified a range of issues with the Prescription Shopping Program. These include:

    I. The criteria for identifying a prescription shopper are very strict; it is likely that a large number of prescription shoppers are not detected because their prescription shopping activity is below the detection threshold.

[32] The Prescription Shopping Program involves extracting data from the PBS and using computer algorithms to scan prescribing patterns. If a patient's prescribing history meets any of the criteria listed at n 21, Medicare Australia's compliance pharmacists analyse the prescribing information to determine what action should be taken. In any given quarter, the number of patients identified under the program's criteria range from 15,000-30,000 nationally. Medicare Australia only provides notification regarding the highest risk patients - about 5% of those identified.

II. Medicare Australia only acts on a small percentage of people identified as prescription shoppers under the Program. Most 'ordinary' doctor shoppers are ignored in the pursuit of what are deemed the highest-risk patients.

III. The Prescription Shopping Program does not capture non-PBS drugs or drugs prescribed outside the PBS. This includes medications provided on private scripts, and medications provided through programs run by the Transport Accident Commission and similar entities.

IV. The Prescription Shopping Program does not address negligent prescribing on the part of doctors; it is entirely focused on patients.[33]

43. The circumstances leading up to Mr Dougan's death clearly illustrate these shortcomings. He was undoubtedly engaged in prescription shopping, and doctors were sufficiently concerned to contact the Prescription Shopping Information Service on multiple occasions. However because he did not meet the high threshold for being deemed a prescription shopper under the Prescription Shopping Program, concerned doctors were told that he was not a prescription shopper.

44. It is foreseeable that a concerned medical practitioner might be provided false comfort if, upon contacting the Prescription Shopping Information Service, he or she is told that a patient does not meet the criteria for being a prescription shopper under the Prescription Shopping Program. Additionally, a medical practitioner who contacts the Prescription Shopping Information Service about a potential drug-seeking patient should also be directed to contact Drugs and Poisons Regulation at the Victorian Department of Health, regardless of whether the patient is a Prescription Shopping Program-identified prescription shopper. The benefit for medical practitioners of contacting Drugs and Poisons Regulation is not limited to the legal requirement to report concerns about potential drug-seekers,[34] but also that they can learn more about the patient, which in turn creates potential opportunities for interventions.

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[33] See for example Drugs and Crime Prevention Committee, Parliament of Victoria, *Inquiry into the Misuse/Abuse of Benzodiazepines and Other Forms of Pharmaceutical Drugs in Victoria: Final Report*, December 2007, p.111-113, 215-217.

[34] A Victorian medical practitioner is required under Section 33 the *Drugs Poisons and Controlled Substances Act 2006* (Vic) to notify Drugs and Poisons Regulation if he or she has reason to believe a patient is drug-dependent and the patient requests or is supplied a drug of dependence

45. Drugs and Poisons Regulation staff are empowered to inform medical practitioners about previous notifications received and other practitioners' stated intent to supply drugs or not to the patient, as well as the following other information:

> Whether any other medical practitioner holds a permit to treat a patient with Schedule 8 poisons, including patients receiving methadone or buprenorphine to treat opioid dependence
>
> Aliases that have reportedly been used by drug-seeking patients
>
> Whether reports of forged or fraudulent prescriptions, or of obtaining drugs of dependence by false representation, had been received in relation to the patient.[35]

46. Only one doctor contacted the Department in relation to Mr Dougan. In July 2008 a doctor informed the Department that he had prescribed oxycodone to Mr Dougan, and believed that the patient had also obtained a prescription from another doctor.

47. In the comments above, I have identified some potential issues with the medical treatment Mr Dougan received. These issues in turn suggest some potential opportunities for prevention.

RECOMMENDATIONS

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

Recommendation 1

48. In line with the recent recommendation published by State Coroner Ian Gray in Finding with Inquest into the death of Anne Brain (COR 2011 4797), I recommend that the Victorian Department of Health progress the implementation of a Victorian-based real-time prescription monitoring system as a matter of urgency to prevent ongoing harms and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs.

Recommendation 2

49. While the Victorian Department of Health continues with its efforts to implement a real-time prescription monitoring program for Schedule 8 drug dispensing, it also identifies the legislative and regulatory barriers that might prevent drugs listed in other schedules (particularly Schedule 4) from being monitored within the scope of the program. If any such

[35] Victorian Department of Health, Drugs and Poisons Regulation, "Obtaining information relating to drug-seeking patients: Information for medical practitioners", February 2014, p.2.

barriers are identified, I recommend that the department considers what reforms are necessary so that in due course its real-time prescription monitoring program can be expanded beyond Schedule 8 drugs. This will enhance clinicians' ability to make appropriate clinical decisions about patients.

50. I note that the DHHS has responded to recommendations two and three as made in the Anne Brain finding, however the responses indicate that issues are under consideration and no commitment to action has yet been made, therefore I reiterate recommendations two and three.

Recommendation 3

51. The Australian Government Department of Human Services review how Medicare Australia responds to medical practitioners' Prescription Shopping Information Service queries, to ensure medical practitioners are not being unintentionally misled. In particular, the Department should consider whether Medicare Australia's current practices ensure that a medical practitioner who calls the Information Service understands the limitations of the Service, including that many drug seekers do not meet the Prescription Shopping Program threshold for being identified as prescription shoppers.

Recommendation 4

52. The Australian Government Department of Human Services introduce a practice whereby when a medical practitioner contacts the Medicare Australia Prescription Shopping Information Service regarding a Victorian patient, the medical practitioner is informed that if there are concerns about the patient being a drug seeker, regardless of whether or not the patient is deemed to be a prescription shopper under the Prescription Shopping Program, the medical practitioner should make a notification to Drugs and Poisons Regulation at the Victorian Department of Health as required under the *Drugs Poisons and Controlled Substances Act 2006* (Vic).

FINDING

53. I am satisfied, having considered all of the evidence before me, that no further investigation is required. I am satisfied that there were no suspicious circumstances.

54. I find that James Dougan died on 19 November 2010 and that the cause of his death is mixed drug toxicity (codeine, methadone, alprazolam, diazepam) in a man with coronary artery atherosclerosis.

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

The family of James Dougan
Investigating Member, Victoria Police
AHPRA; and
Interested parties.

Signature:

JOHN OLLE
CORONER
24 July 2015