IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 3678

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 JAMIE LAURENCE APAP
without holding an inquest:
find that the identity of the deceased was JAMIE LAURENCE APAP
born on 25 October 1975
and the death occurred on 23 September 2010
at 8 Cornhill Avenue, St Albans VIC 3021

from:

1(a) MIXED DRUG OVERDOSE (HEROIN, METHDONE, CODEINE, DIAZEPAM, NITRAZEPAM, OXAZEPAM AND DOXEPIN)

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

1. Jamie Apap was born on 25 October 1975 and was 34 years old at the time of his death. He resided at St Albans and is survived by his sisters Mandy and Joanne.

2. A coronial brief was provided by Victoria Police to this Court, comprising statements obtained from family, friends, 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 Apap had a longstanding history of illicit drug use and prescription drug abuse dating back to early adolescence. In 1987 Mr Apap's mother passed away and his sister Joanne reported to police that he found it difficult to cope. At this time Ms Apap observed that her brother commenced using cannabis and subsequently progressed to 'popping pills' and using heroin. Mr Apap left the family home at the age of 14 and maintained intermittent contact with his

family. Joanne reported that her brother lived with her at times when he required accommodation and she observed that when he consumed drugs he became incoherent and unable to perform tasks through to completion. Ms Apap reported that heroin ran her brother's life and he couldn't live without it.[1]

4. On 23 April 2002 Mr Apap sought medical treatment for heroin dependence and was commenced on the methadone program by general practitioner Dr Noah Diner. Dr Diner reported that during follow up consultations Mr Apap consistently showed evidence of benzodiazepine use. Mr Apap stated that other doctors were prescribing benzodiazepines for his insomnia and at times when he could not obtain a script, he would purchase them 'from the streets'.[2]

5. In April 2010 Dr Diner reported that Mr Apap presented with symptoms consistent with anxiety and depression. At this time he was commenced on the antidepressant Deptran and advised to seek counselling, which he declined to pursue.[3]

6. On 4 June 2010 Mr Apap moved into the Sunshine Hostel but was asked to leave after he gave a fellow resident his methadone, causing that resident to fall ill.[4]

7. On 14 July 2010 Mr Apap moved into Ozanam House, a St Vincent de Paul crisis accommodation facility, due to homelessness and his drug addiction. He attended sessions with the Ozanam House social worker however he often failed to keep appointments and presented as substance affected at the appointments he did keep. The social worker reported that Mr Apap was not interested in addressing his homelessness or substance addiction, rather he was preoccupied with getting more medication.[5]

8. While residing at Ozanam House Mr Apap was heavily involved in the distribution of prescription medication. Other residents reported that Mr Apap bullied them into attending consultations with doctors to obtain specific prescription medications, have the scripts filled and give the medications to Mr Apap. On 10 September 2010 Mr Apap was evicted from Ozanam House following ongoing allegations of bullying and assault. Mr Apap stated to his

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[1] Statement of Joanne Apap, dated 29 October 2010, Coronial brief 12-13.

[2] Statement of Dr Noah Diner, dated 9 February 2011, Coronial brief 14.

[3] Ibid.

[4] Statement of Joanne Apap, above n 1, 12.

[5] Statement of Michael Peacock, dated 9 November 2010, Coronial brief 17-18.

social worker that he was angry at being evicted and claimed that numerous residents owed him money.[6]

9. On 16 September 2010 Mr Apap moved into crisis accommodation at St Albans. Residents at the property reported that Mr Apap was preoccupied with drugs and spoke about using Diazepam and methadone. On one occasion Mr Apap asked a fellow resident for the oxycodone she was therapeutically prescribed. Residents observed Mr Apap consuming Diazepam and reported that he became clearly drug affected: his speech became slurred and his eyes became unfocused.[7]

10. On 22 September 2010 at approximately 9.00am Mr Apap and his friend Shane Cox attended Ozanam House and were escorted from the premises for intimidating residents.[8] Mr Cox reported that Mr Apap was extremely drug affected at this time and struggled to walk. The two men then caught a tram into the city and disembarked at Elizabeth Street.[9] At 12.25pm police on foot patrol observed Mr Apap attempting to hold onto a tram guard rail but slowly falling to the ground. Police attended to Mr Apap, observed that he was visibly drug affected and carried him from the tram area to the footpath. At approximately 12.30pm Police requested an ambulance to attend the scene. Paramedics arrived a short time later and conveyed Mr Apap to St Vincent's Hospital by ambulance.[10]

11. Doctors at St Vincent's Hospital reported that Mr Apap became difficult to rouse during ambulance transport and upon admission presented with an altered conscious state. Mr Cox told doctors that it was likely that Mr Apap had taken a polypharmacy overdose of two oxazepam tablets, two diazepam tablets, 130mg of methadone and two dothiepin tablets. Mr Apap was monitored and treated with intravenous saline solution and Naloxone, an opiate antagonist. Once Mr Apap became more alert he reported that he had consumed approximately 10-15 dothiepin tablets and that the overdose had been unintentional. He did not express any suicidal ideation and requested that he be released so he could take his methadone. After an observation period of seven hours doctors observed that his vital signs were normal, he had

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[6] Ibid, 18.

[7] Statement of Michelle Bawden, dated 23 September 2010, Coronial brief 37.

[8] Statement of Michael Peacock, above n 5, 18-19.

[9] Statement of Shane Cox, dated 23 September 2010, Coronial brief 20.

[10] Statement of Senior Constable Andrew Morrison, dated 4 January 2011, Coronial brief 25-27.

returned to a normal conscious state and he was subsequently discharged from the Emergency Department. He was offered drug counselling, which he refused.[11]

12. At approximately 10.30pm Mr Apap returned home and attended Mr Cox's room. Mr Cox observed that Mr Apap appeared more conscious but became progressively drowsy and incoherent during the conversation. Mr Apap stated that he had to get ready as he had things to do and exited Mr Cox's room. Approximately 30 minutes later Mr Cox located Mr Apap asleep on the couch in the common hallway. Mr Apap awoke and retired to his bedroom.[12]

13. At approximately 12.30am on 23 September 2010 a fellow resident told Mr Cox that he located Mr Apap asleep on the floor of his bedroom. Mr Cox walked to Mr Apap's bedroom and located him on the floor with his head towards the base of his bed. Mr Cox unsuccessfully attempted to lift Mr Apap onto the bed and subsequently rolled him onto his side. Mr Cox reported that Mr Apap was breathing and mumbled what he took to be a thank you. Mr Cox reported that he had observed Mr Apap in this condition on numerous occasions and was not concerned. He left Mr Apap on the floor to sleep and retired to his bedroom.[13]

14. On 23 September 2010 at approximately 6.30am resident Michelle Bawden entered the common kitchen and observed Mr Apap's legs on the floor of his bedroom. She attended to him, observed that he was blue and unresponsive and contacted emergency services. Mr Bowden attempted to roll Mr Apap onto his back but was unable to do so due to the stiffness in his body.[14] Paramedics attended and confirmed that Mr Apap was deceased. Police attended the scene and observed that Mr Apap's bed did not appear to have been slept in. Police located drug paraphernalia as well as numerous prescription medications and scripts in Mr Apap's bedroom.[15] Mr Cox reported that Mr Apap was located in the same position he had left him in the previous night.[16]

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[11] Statement of Dr Jonathan Karro, dated 2 December 2010, Coronial brief 28-30.

[12] Statement of Shane Cox, above n 9, 20-21.

[13] Ibid.

[14] Statement of Michelle Bawden, above n 7, 37-38.

[15] Statement of Detective Senior Constable Nathan Parker, dated 1 March 2011, Coronial brief 60-63.

[16] Statement of Shane Cox, above n 9, 21.

MR APAP'S DRUG SEEKING BEHAVIOUR

15. At my request, the Coroners Prevention Unit[17] reviewed the medical management of Mr Apap in respect to his drug seeking behaviour. I have used this information to assist my finding.

16. Mr Apap's drug addiction saw him attend numerous doctors with the aim of obtaining benzodiazepines, including nitrazepam, oxazepam and diazepam, and the opiate pain-reliever tramadol.[18]

17. General practitioner Dr Noah Diner was Mr Apap's treating practitioner and pharmacotherapy provider from 2002 to 2010. In the 12 months leading up to Mr Apap's death, Dr Diner prescribed him a single prescription of nitrazepam on 8 April 2010 and 23 July 2010, to treat acute short-term insomnia, and Deptran 150mg daily on 8 April 2010. Mr Apap's urine drug screens showed evidence of benzodiazepines inconsistent with the times it was prescribed by Dr Diner, and when questioned about this, Mr Apap informed that other doctors were prescribing benzodiazepines for his insomnia, and that if he could not get a script he would buy them from the streets.[19]

18. According to the patient record provided by Millennium Medical Centre, Mr Apap saw general practitioner Dr Ananda Krishnan on one occasion, 26 February 2010. Dr Krishnan noted that Mr Apap was suffering left forearm pain, and prescribed him nitrazepam (25 tablets, 5mg dose strength, Alodorm). Dr Krishnan did not provide any explanation for why he prescribed nitrazepam, and did not record that Jamie Apap was suffering insomnia (the only condition for which nitrazepam is specifically indicated).[20]

19. General practitioner Dr Pathak saw Mr Apap on 17 September 2010 and 20 September 2010. The first consultation was to organise Mr Apap's transfer to the Melbourne Central Medical and Dental Clinic for pharmacotherapy. On the second consultation, Mr Apap complained of anxiety, but could not give any reason for it. Dr Pathak prescribed Diazepam 5mg - two tablets twice a day, and Serepax 30 mg - two tablets at bed time, and counselled him in relation to his anxiety. Dr Pathak stated that it was his understanding that Mr Apap was only seeing Dr Diner,

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

[18] The medical records of Mr Apap.

[19] Flemington Medical Centre Medical Records of Mr Apap; Statement of Dr Noah Diner, dated 30 November 2011.

[20] Millenium Medical Centre Medical Records of Mr Apap.

and was unaware that Mr Apap was getting multiple benzodiazepines from elsewhere and was an opioid dependent patient. [21]

20. Mr Apap attended at Dr Orgonas surgery for consultation on seven occasions between 28 January 2010 and 15 April 2010, and on each occasion was prescribed nitrazepam to treat his insomnia. Dr Orgonas could not recall the reason for prescribing nitrazepam on 28 January 2010, although he was aware that this medication had previously been prescribed to Mr Apap by another practitioner. He confirmed that his nitrazepam prescriptions in February and March 2010 were to treat Mr Apap's insomnia, however he could not recall the reason for the prescriptions for the consultations in April 2010, but accepts it was likely for insomnia. Dr Orgonas reported that he now understands that he was manipulated by Mr Apap into prescribing in circumstances where, with the benefit of hindsight, he should have refused beyond the third consultation.[22]

21. General practitioner Dr Phan saw Mr Apap three times at the same surgery where Dr Orgonas practiced. At the first consultation, on 12 February 2010, he prescribed nitrazepam because Mr Apap claimed to have lost a prescription from Dr Orgonas. During the second occasion, on 24 February 2010, Dr Phan concluded that Jamie Apap was seeking nitrazepam for substance abuse purposes and refused to prescribe. Dr Phan again refused to provide Jamie Apap a prescription for nitrazepam on the third occasion on 22 April 2010.[23]

22. Dr Arron Veltre and Dr Ronald Suss both worked at the North Melbourne Medical Centre when they prescribed nitrazepam to Mr Apap on 6 September 2010 and 20 September 2010 respectively. Both doctors have since left the Medical Centre. Statements were requested, however were unable to be obtained.

23. Mr Apap'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.[24] His medical records

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[21] Statement of Dr Pathak, dated 7 November 2013; Statement of Dr Pathak, dated 16 December 2010, Coronial brief 16.

[22] Statement of John Petts, TressCox Lawyers, on behalf of Dr Orgonas, dated 17 February 2014; Patient Health Summary.

[23] Statement of Dr Phan, dated 21 November 2011; Patient Health Summary.

[24] 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

reveal numerous instances where he obtained benzodiazepines, including nitrazepam, oxazepam and diazepam, and the opiate pain-reliever tramadol concurrently from different doctors. [25] He obtained benzodiazepines from at least seven different doctors in the 12 months leading up to his death.

24. Medicare Australia's history of medications dispensed to Mr Apap under the PBS for the twelve months leading up to his death contained material that suggested he was prescription shopping. In a six-week period from late January 2010 to early March 2010 Mr Apap was supplied 250 nitrazepam 5mg tablets using prescriptions from two different doctors. Mr Apap's medical history records numerous examples of him obtaining multiple medications including diazepam,nitrazepam, oxazepam and doxepin (all of which were found to have contributed to his death) by attending multiple doctors in August and September 2010. In total, Mr Apap obtained benzodiazepines from at least seven different doctors in the 12 months leading up to his death.

25. Despite his drug seeking behaviour, Mr Apap 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[26] and Mr Apap did not meet this criteria based on the medications dispensed to him under the PBS.

26. It is notable that between May 2008 and September 2010, Medicare Australia's Prescription Shopping Information Service received four calls regarding Mr Apap. 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.[27] Medicare Australia never provided advice to any medical practitioner

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> 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.

[25] The medical records of Mr Apap.

[26] 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.

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

that Mr Apap was a prescription shopper, and no medical practitioner ever contacted the Information Service to report that Mr Apap may have been involved in prescription shopping.

POST-MORTEM EXAMINATION AND REPORT

27. A post-mortem examination and report was undertaken by Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Lynch reported that there was evidence of recent haemorrhage on both the left and right hands and also changes typical of chronic drug use. Noted as an incidental finding was chronic hepatitis. The cause was not apparent.

28. Toxicological analysis detected heroin metabolites (6-monoacetyl-morphine [0.3mg/L] and morphine [13.5mg/L]) in urine. Codeine which is often found as an impurity in heroin was also detected (2.4mg/L) in urine. Methadone (~0.6mg/L) and its metabolite (~0.1mg/L) were detected in blood as were the benzodiazepines nitrazepam (~0.1mg/L), its metabolite 7-aminonitrazepam (~0.4mg/L), diazepam (~0.2mg/L), its metabolite nordiazepam (~0.2mg/L) and oxazepam (~0.4mg/L). Also detected was the antidepressant doxepin (~0.8mg/L).

COMMENTS

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

29. Mr Apap's ability to obtain benzodiazepines from multiple 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.[28] 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.[29] The

[28] n = 756, 51.9%

[29] 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.

benzodiazepine diazepam was the most frequent contributing drug in Victorian overdose deaths between 2010 and 2013, contributing to 36.2% of deaths examined.[30]

Benzodiazepine guidelines

30. As discussed above, benzodiazepine prescribing to Mr Apap was characterised by a number of suboptimal practices. Multiple general practitioners co-prescribed benzodiazepines on an ongoing basis without other interventions in place.

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

32. 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.

[30] 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.

> 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.[31]

33. 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.

Real time prescription monitoring

34. 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.[32] Such a system can be of significant benefit to medical practitioners involved in the care of patients such as Mr Apap 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.

35. 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

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

[32] 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.

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'.[33]

36. 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.

37. 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 Apap'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. 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

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

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

38. A significant missed opportunity to intervene in Mr Apap's drug seeking behaviour pertained to Medicare Australia, through their Prescription Shopping Program,[34] advising callers on four occasions that Mr Apap had not been identified as a prescription shopper at the time of the call.

39. 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.

    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.[35]

40. The circumstances leading up to Mr Apap'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

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[34] 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.

[35] 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.

Prescription Shopping Program, concerned doctors were told that he was not a prescription shopper.

41. 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,[36] but also that they can learn more about the patient, which in turn creates potential opportunities for interventions.

42. 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.[37]

43. In the comments above, I have identified some potential issues with the medical treatment Mr Apap 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:

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[36] 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

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

Recommendation 1

44. 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

45. 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 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.

46. 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

47. 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

48. 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

49. 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.

50. I find that Jamie Apap died on 23 September 2010 and that the cause of his death is mixed drug overdose (heroin, methadone, codeine, diazepam, nitrazepam, oxazepam and doxepin).

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

The family of Jamie Apap
Investigating Member, Victoria Police; and
Interested parties.

Signature:

JOHN OLLE
CORONER
24 July 2015