IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 000042

FINDING INTO DEATH WITHOUT INQUEST

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

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of JIM ZANIS without holding an inquest:
find that the identity of the deceased was JIM ZANIS
born on 27 October 1980
and that the death occurred on or about 3 January 2014
at 1 Fishburn Court, Mill Park, Victoria
from:

1 (a) MIXED DRUG TOXICITY (HEROIN, BUPRENORPHINE AND BENZODIAZEPINES)

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

1. Mr Zanis was a 33 year old, single, unemployed cabinet maker, who lived with his parents in Mill Park. Mr Zanis was a known abuser of benzodiazepines[1], an occasional heroin user, had used a buprenorphine implant in the past[2] and had a history of mental illness.

2. Mr Zanis commenced using cannabis as a teenager, progressing to heroin and methamphetamine addiction around 2001. According to his parents he was a consummate "doctor shopper' and would trade his prescription medication for drugs or money in order to feed his addiction. Whenever his parents attempted to remove the stockpiles of prescription medication from his possession, he became extremely angry and occasionally violent. On these occasions intervention orders were taken out against him by his parents. Mr Zanis was admitted to the Northern Psychiatric hospital on two occasions for psychotic episodes caused by methamphetamine use.

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[1] Diazepam, Alprazolam, Oxazepam, Temazepam, all with sedative/ hypnotic and relaxant properties.
[2] Implantable, sub-dermal, partial opioid agonist device, used to treat opioid addiction.

3. Mr Zanis would 'shop' around in order to gain access to the drugs he wanted. In the twelve month period preceding his death, he had seen Dr Kingsley Joseph from the Alpha Medical clinic; Dr Naveed Mughal, Dr Samuel Beitner and Dr D Seneviraline from Mill Park Super Clinic; and Dr Ken Bowles from the Thornbury Medical Clinic.

4. Mr Zanis' family was well aware of his proclivity for medication shopping. His mother started to intervene some years ago by notifying practitioners about her son's addictions and asking them not to provide scripts to him. On one occasion in 2013, she attended a practice to inform the doctor not to give her son more medication and specifically, not to tell him she had been there as it would defeat the purpose. According to Mrs Zanis, the doctor disregarded her plea and repeated the conversation to her son, who unsurprisingly, was very angry with her.

5. A letter from Dr Bowes at the Thornbury Medical Clinic indicates Mr Zanis attended for six months from June to December 2013. Dr Bowes' documentation revealed he suffered from schizophrenia, anxiety states, depression, poly-substance abuse and a benzodiazepine dependency. In November 2012, he had been treated with a naltrexone implant by Dr Jagoda in North Melbourne. In June 2013 he commenced on Suboxone[3] 6mg daily and a reducing Diazepam regime by Dr Bowes. He was also seeing a psychologist at the Northern Mental Health Service and had an appointment to see a psychiatrist at the Mill Park Super Clinic. When he was seen at the Thornbury Clinic in December 2013, he denied heroin and methamphetamine use.

6. On 4 December 2013, Dr Beitner prescribed Oxazepam to Mr Zanis and on the 18 December 2013, he prescribed Oxazepam and Diazepam.

7. On 19 December 2013, Mr Zanis was found collapsed in the street and resuscitated by paramedics. He refused transportation to hospital by the ambulance on that occasion. He returned home and told his mother he "didn't want to die like that in the gutter' and she pleaded with him to see a doctor but he refused.

8. On 23 December 2103, Mr Zanis again attended Dr Beitner at the Mill Park Super Clinic. He did not advise the doctor of his recent overdose and was prescribed Oxazepam and Diazepam again.

9. On 24 December 2013, Mr Zanis called an ambulance himself, apparently in an effort to access medication. When this was refused, he asked his parents to take him to the Northern Hospital, where he was admitted overnight and discharged with a script for alprazolam. He

[3] Opioid agonist containing buprenorphine and naloxone at a ratio of 4:1.

did not advise the hospital of his recent overdose and was reportedly annoyed about the small amount of prescription medication he was able to gain access to that day.

10. On 30 December 2013, he attended Lorne Street Pharmacy and collected three 6mg doses of Suboxone before attending the nearby Priceline Pharmacy and collecting diazepam prescribed by Dr Bowes.

11. On 31 December 2013, Mr Zanis attended Epping Medical Centre to access more prescription medication. His mother contacted the clinic to advise them not to prescribe medication to her son and, on this occasion, he came home empty handed.

12. On 2 January 2014, Mr Zanis left the house early and was picked up by a friend. He returned mid-morning and told his parents he wanted to sleep and not to disturb him. His parents heard him snoring during the afternoon, and knew from past experience not to wake him if he did not want to be disturbed.

13. On 3 January 2014, Mr Zanis was in his bedroom and could be heard snoring during the morning. His mother checked on him from the doorway of his room around 1.00 or 2.00pm and decided to let him sleep. At about 5.00pm his mother went to wake him and noticed he was still in the same position as she saw him earlier. She then approached and realised that his skin was pale and his body cold. She called her husband who turned their son over realising he was deceased. They called emergency services who instructed them to commence CPR but they knew Mr Zanis was already deceased. Paramedics attended a short tune later and confirmed Mr Zanis was deceased.

14. After his death, Mr Zanis' sister contacted the friend he was with the day before. According to that friend, Mr Zanis had consumed large amounts of diazepam in combination with heroin that day, despite being warned by his friend of the high risk associated with quantities and type of drugs he was taking.

15. Police attended the scene and found no suicide note, no drug paraphernalia located nearby or attached to Mr Zanis and no fresh needle marks. All medication was provided by his mother from a cupboard in the kitchen. Prescription medication in the cupboard included Oxazepam, Alprazolam, Suboxone, Diazepam, Pregablin[4], paroxetine[5], Clopixol[6] and a multi-vitamin. A used syringe was found in the kitchen bin.

16. Dr Paul Bedford, Forensic Pathologist with the Victorian Institute of Forensic Medicine reviewed the circumstances of the death as reported by police to the coroner and performed an

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[4] Neuropathic pain relief and anti-seizure properties.
[5] An antidepressant.
[6] Zuclopenthixol, an antipsychotic.

autopsy on Mr Zanis' body. External examination revealed no signs of injury to cause or contribute to death and no injection sites were identified on the arms or feet. Dr Bedford's anatomical findings at autopsy included mild coronary atheromatous disease, gallstones and a mildly enlarged spleen. He advised that he found no significant pathology likely to have caused or contributed to death.

17. Routine toxicological analysis of post-mortem blood detected morphine at ~ 0.2mg/l, codeine at ~ 0.06mg/l, diazepam at ~ 0.8mg/l and its metabolite nordiazepam at ~ 0.7mg/l, temazepam at ~ 0.05mg/l, oxazepam at ~ 0.2 mg/l and zuclopenthixol[7] at ~9.4ng/ml. Analysis of urine detected the heroin specific metabolite 6-monoacetylmorphine at a concentration of ~ 0.3mg/l, morphine at > 0.5mg/l, codeine at ~ 0.6mg/l, diazepam at ~ 0.3mg/l and its metabolite nordiazepam at >1mg/l, temazepam at >1mg/l, oxazepam at > 1mg/l and the metabolite norbuprenorphine was detected.

18. Dr Bedford advised that it would be reasonable to attribute Mr Zanis' death to multi-drug overdose including heroin.

19. I find that Mr Zanis died as a result of the inadvertent or unintentional overdose of heroin and other drugs, including notably benzodiazepines.

COMMENTS

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

1. Mr Zanis 'prescription shopped' for and stockpiled prescription medication which he used in combination with illicit substances leading to his death. Medicare and Pharmaceutical Benefits Scheme records provided in the course of this investigation show that he was dispensed 850 tablets of Alprazolam, 1000 tablets of Diazepam and 125 tablets of oxazepam, in the twelve months immediately preceding his death, among other drugs. This was despite his parents' efforts to curb his access to multiple medical practitioners/prescribers.

2. Routine post-mortem toxicological analysis detected 6-monacetylmorphine, a heroin-metabolite, morphine and codeine consistent with heroin use, diazepam, temazepam, oxazepam, zuclopenthixol and norbuprenorphine, a metabolite of buprenorphine.

3. The phenomenon of combined heroin and benzodiazepine toxicity continues to wreak havoc within the community. Of the 420 overdose deaths that occurred in Victoria in 2015, 168 deaths involved heroin and 220 involved benzodiazepines. Moreover, there was substantial

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[7] Anti-psychotic medication.

overlap between the drugs: 86 (52%) of the 168 heroin overdose deaths also involved benzodiazepines. Efforts to reduce the harms and deaths associated with benzodiazepine consumption (benzodiazepines are particularly dangerous because they enhance the central nervous system depressant effects of heroin as well as a broad range of other drugs) are undermined by an addicted individual's ability to access multiple sources of prescription medication by 'prescription shopping'.

4. As I noted in a previous coronial investigation, [8] the 2015 publication of information and guidelines by DPR and the Royal Australasian College of General Practitioners, respectively, in relation to the prescription of medications including benzodiazepines to drug-dependent and non-drug-dependent patients is commendable. As is the Commonwealth Department of Human Services Prescription Shopping Programme, encompassing the Prescription Shopping Alert Service and the Prescription Shopping Information Service. However, these programmes only provide *retrospective* information to prescribers.

5. In April 2016, the Victorian Government announced funding of $29.5 million over four years for the implementation of a *real time prescription monitoring computer software system* [RTPM], that allows pharmacy dispensing records for certain medicines to be transmitted in real time to a centralised database, which can then be assessed by doctors during a consultation and pharmacists at the point of dispensing. While the announcement is very welcome, the restricted scope of drugs to be monitored is disappointing.

6. Currently, drugs to be included in the scheme are schedule 8 drugs of addiction, including drugs such as alprazolam (Xanax), Endone and Oxycontin. *Not* included are the schedule 4 benzodiazepines such as diazepam and antipsychotics such as zuclopenthixol.

7. An analysis of Victorian coronial data for 2009-2015 undertaken by the Coroners Prevention Unit demonstrates that some schedule 4 drugs are significantly implicated in overdose deaths each year. For example, diazepam contributed to 104 of 379 overdose deaths in 2009; 109 of 342 overdose deaths in 2010; 124 of 362 overdose deaths in 2011; 132 of 368 overdose deaths in 2012; 164 of 379 overdose deaths in 2013; 168 of 384 overdose deaths in 2014 and 176 of 420 overdose deaths in 2015. It follows that if RTPM is to assist in reducing the number of preventable overdose deaths, it needs to encompass those schedule 4 drugs known to be implicated in overdose deaths.

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[8] Dean Wayne Wright COR 2011 000727

RECOMMENDATION

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

1. That the Department of Health and Human Services' Real-Time Prescription Monitoring Taskforce consider the inclusion of diazepam and other schedule 4 drugs within the RTPM scheme.

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

Jim and Helen Zanis;
Constable Matt David 39853;
Dr Ken Bowes;
Dr Samuel Beitner; and
Department of Health and Human Services' Real-Time Prescription Monitoring Taskforce

Signature:

PARESA ANTONIADIS SPANOS
Coroner
Date: 6 June 2016