IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2012/2254

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

*Section 67 of the **Coroners Act 2008***

I, AUDREY JAMIESON, Coroner having investigated the death of KIRK STEVEN ARDERN

without holding an inquest:
find that the identity of the deceased was KIRK STEVEN ARDERN
born 25 September 1979
and the death occurred between 14 and 15 June 2012
at the Sacred Heart Mission, 87 Grey Street, St Kilda 3182
from:

1 (a) MULTIPLE DRUG TOXICITY (INCLUDING HEROIN)

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

1. Mr Kirk Steven Ardern was 32-years-old at the time of his death. He had no fixed address and was unemployed.

2. Mr Ardern was located deceased at approximately 7.00am on Friday 15 June 2012 in the grounds of Sacred Heart Mission, St Kilda. He had been paroled from Fulham Correctional Centre on 12 June 2012.

3. Emergency Services were contacted however attending paramedics were unable to render medical assistance to Mr Ardern, as it was apparent that he had been deceased for some time.

INVESTIGATIONS

4. The Victorian Institute of Forensic Medicine (VIFM) Senior Toxicologist Alex Kotsos analysed post-mortem blood samples taken from Mr Ardern and reported that the following drugs were detected:

    a. Heroin metabolite 6-monoacetylmorphine (0.02mg/L);

    b. Morphine (0.4mg/L), which was most likely present as a metabolite of heroin rather than in its own right;

    c. Codeine (0.1mg/L), which may have been present as an adulterant in the heroin;

    d. Methadone (0.4mg.L) and its metabolite EDDP (0.03mg/L);

    e. Diazepam (1mg/L) and its metabolites nordiazepam (0.1mg/L) and temazepam (0.04mg/L); and

    f. Mirtazapine (0.1mg/L).

5. Alex Kotsos advised that the toxicology results were "consistent with recent use of heroin in combination with methadone, diazepam and mirtazapine". VIFM Forensic Pathologist Dr Yeliena Baber performed an external examination upon the body of Mr Ardern and reviewed a post-mortem CT scan. No significant anatomical findings were identified aside from puncture mark wounds on the left arm. Dr Baber concluded that the medical cause of Mr Ardern's death was multiple drug toxicity (including heroin).

6. The circumstances of Mr Ardern's death have been the subject of investigation by Victoria Police. The police investigation did not identify any suspicious circumstances. Police members located the following items in a bag beside his body:

    a. five bottles of 45mg methadone (each "containing some liquid")[1] that, according to the labels on each, were prescribed to Mr Ardern by Dr Maithri Goonetilleke and dispensed at Laird's Pharmacy in Elwood on 13 June 2012

    b. a box of 5mg diazepam, 50 tablets (with four tablets remaining), that according to the label were prescribed to Mr Ardern by Dr Danny Jago and dispensed at Nunawading Day and Night Pharmacy on 13 June 2012[2]

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1 Inquest Brief, p41.

c. a box of 30mg mirtazapine, five tablets (with three tablets remaining), prescribed to Mr Ardern by Dr Maithri Goonetilleke and dispensed on 9 June 2012;[3] and

d. a used syringe and bottle of saline solution.

7. Police obtained statements from the Sacred Heart Mission worker who discovered Mr Ardern's body, Mr Ardern's mother, Ms Jennifer Ardern, Case Manager from LinkOut[4] (Australian Community Support Organisation) Mr Robert Stagg and General Practitioner Dr Sze Hong Wong.

Criminal history

8. The investigation indicated that Mr Ardern served two terms of imprisonment in Victoria between 2005 and 2010 for a range of offences including recklessly causing serious injury, intentionally causing serious injury, burglary, theft, armed robbery, criminal damage, resisting police, obtaining property by deception and trafficking a drug of dependence.

9. Mr Ardern's third term of imprisonment commenced on 23 August 2011, following his 19 August 2011 conviction at Ringwood Magistrates' Court for offences that included cultivating a narcotic plant and possession of a weapon. He was sentenced to a total of three months imprisonment.

10. On 9 September 2011, Mr Ardern was granted appeal bail from prison, pending an appeal against his 19 August 2011 convictions. He was at his then home address on 15 September 2011 when he became involved in an altercation with his former partner and a female acquaintance. Mr Ardern apparently threatened and then assaulted the acquaintance with a tomahawk. Police attended his home and arrested him. It is not clear whether he was immediately held in custody, however he was received into Melbourne Assessment Prison on 23 September 2011.

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2 In Detective Senior Constable Chris Pountney's statement (Inquest Brief p42) he described the diazepam as having been "prescribed by Dr Goonetilleke". However, this appears to have been an error as the photograph clearly indicates the prescriber was Dr Jago. This was confirmed by PBS records.

3 The PBS patient summary for Kirk Ardern shows that he was not dispensed mirtazapine on the PBS proximal to his death. Medications dispensed in prison are not recorded on the PBS.

4 LinkOut is a service run by the Australian Community Support Organisation (ASCO) that assists parolees to reintegrate into their communities.

11. On 30 September 2011, Mr Ardern was convicted of offences at Ringwood Magistrates' Court relating to the 15 September 2011 incident, including recklessly causing injury and possessing a weapon. Additionally, he abandoned his appeals against his 19 August 2011 convictions. He was sentenced to a total of 15 months in prison with a non-parole period of nine months. This marked the commencement of his fourth period of imprisonment in Victoria.

12. After being sentenced, Mr Ardern was assessed at Melbourne Assessment Prison on 12 October 2011 for placement at Fulham Correctional Centre. He was transferred from the Melbourne Assessment Prison to Fulham Correctional Centre on 13 October 2011, where he served the remainder of his sentence.[5]

Medical history

13. Mr Arden had a long history of illegal substance abuse. Drugs and Poisons Regulation at the Victorian Department of Health (DoH) provided the Coroners Court of Victoria (the Court) with a history of the permits issued for physicians to prescribe methadone and/or buprenorphine to treat Mr Ardern's opioid dependence. The permit history confirms that Mr Ardern was receiving opioid replacement therapy regularly from 2002 onwards. In the period leading up to his August 2011 imprisonment, he was receiving methadone from Dr Wong at the Boronia Family Medical Centre (BFMC). Medical records from the BFMC show that between April 2010 and August 2011, Dr Wong provided increasing doses of methadone (commencing at 40mg daily, peaking at 150mg daily) and allowed Mr Ardern access to five takeaway doses per week.

14. During the period when Mr Ardern attended Dr Wong, his Pharmaceutical Benefits Scheme (PBS) patient summary shows he attended several other doctors to obtain benzodiazepines (alprazolam, diazepam, nitrazepam) and the antidepressant mirtazapine. The number of doctors attended and prescription medications obtained suggests he was engaged in prescription shopping. The investigation did not necessarily identify the medical records from all prescribers and therefore any information is not necessarily exhaustive.

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5 With the exception of a seven-day transfer back to Melbourne Assessment Prison in February 2012 to receive medical treatment.

Medical treatment received August 2011 to June 2012

15. Upon admission to Melbourne Assessment Prison on 23 August 2011, Mr Ardern underwent a medical assessment in which it was recorded that he was being treated with 160mg methadone daily for opioid dependence, as well as mirtazapine (brand name Avanza) for depression and alprazolam (brand name Xanax) for anxiety. He was continued on 160mg daily methadone and prescribed 30mg daily mirtazapine, but the alprazolam was ceased.

16. After Mr Ardern was granted appeal bail on 9 September 2011, he re-attended at Dr Wong to continue methadone for opioid replacement therapy. He was prescribed 160mg daily methadone with five weekly takeaway doses.

17. When Mr Ardern was admitted to Melbourne Assessment Prison on 23 September 2011, he was continued on 160mg daily methadone and 30mg daily mirtazapine. After he was transferred to Fulham Correctional Centre on 13 October 2011, he was put on a reducing methadone dose and by June 2012, he was stable on 45mg daily. His main treating doctor for opioid replacement therapy during this time was Dr Maithri Goonetilleke, though other doctors also appear to have been involved.

18. In advance of Mr Ardern's 12 June 2013 release on parole, Dr Goonetilleke made the following arrangements for him to continue opioid replacement therapy in the community:

    a. he contacted Dr Wong to provide post-release treatment

    b. he filled out and submitted a "Notification of release from prison of a patient treated with methadone or buprenorphine for opioid dependence" with Dr Wong as the nominated doctor providing post-release treatment, and submitted this to Drugs and Poisons Regulation; and

    c. he faxed a release script for seven daily doses of 45mg methadone to Lairds Pharmacy, 148-150 Tennyson Street, Elwood.

19. Mr Ardern was instructed to attend at Lairds Pharmacy for his daily supervised methadone, and was instructed also to attend Dr Wong within seven days to organise the continuation of his opioid replacement therapy in the community.

Post-release activities

20. On 6 June 2012, Community Correctional Services (CCS) was advised that Mr Ardern was to be released on 15 June 2012. Staff organised for accommodation at a rooming house in Vautier Street, Elwood commencing on this date. Mr Ardern's release date was subsequently revised to 12 June 2012, and an arrangement was made that he would reside with his mother Ms Jennifer Ardern at the Medina Executive St Kilda Apartments from 12 June to 15 June before moving to the Vautier Street rooming house. Ms Ardern usually resided in New South Wales, and travelled to Melbourne to see her son upon release and assist with his transition back into the community.

21. Mr Ardern met his mother at Spencer Street Station at approximately 10.00am on Tuesday 12 June 2012, soon after his release. They spent the day shopping and attended Centrelink. On two occasions during the day, Mr Ardern spoke with his LinkOut Case Manager Mr Stagg, who was providing post-release support.

22. The next morning, Wednesday 13 June 2012, Mr Ardern and his mother attended Lairds Pharmacy so he could register and receive his first methadone dose, which was dispensed to him at the pharmacy. Following this, at approximately 10.30am, he attended CCS with his mother to meet Case Manager Ms Margaret Sullivan. The case file note from this appointment records that the main rules and regulations of parole were explained to him, and that further induction was to take place on 15 June 2012.

23. Early that afternoon, Mr Ardern attended the Nunawading Family Medical Centre (NFMC) for an appointment with Dr Danny Jago. According to Ms Ardern:

> He told me it was a doctor you just go to after 1.30pm and wait and you don't need an appointment. Kirk said that he had been using this doctor for a number of years, but only for the Valium.[6] We got there about 2.00pm, and the doctor took him in straight away. Kirk had been nervous and was going to tell the doctor a story, I said why don't you just tell him the truth about just getting out from jail and needing something for anxiety, so that is what he did, and the doctor gave him the script. We went directly next door and he had the script filled.[7]

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6 Valium being a brand name of the benzodiazepine diazepam.

7 Inquest Brief, pp21/22.

24. The PBS patient summary for Mr Ardern confirmed that he attended Dr Jago on this date and was provided a script for 50 tablets of 5mg diazepam. The following note from Dr Jago is contained in the NFMC medical record for Mr Ardern: "States in prison last 9 months. Anxiety ⇧(increasing)".

25. The next morning, Thursday 14 June 2012, Mr Ardern attended Dr Wong at the BFMC as required for continuation of his opioid replacement therapy. In a statement dated 11 September 2012 Dr Wong noted:

> [...] I understood he had just been released from prison. At this time he looked well and I did not suspect anything was amiss. I did not think he was using illicit drugs on 14 June 2012. Kirk had no medical illness and there was no incident of note. On this day I prescribed a script for methadone syrup for Ardern to be dosed at Lairds Pharmacy.[8]

26. The BFMC notes indicate that Dr Wong provided a script for 45mg daily methadone with five takeaway doses permitted weekly and on public holidays. The script faxed to Lairds Pharmacy clearly indicated that five takeaway doses weekly were permitted.

27. According to Ms Ardern, she met her son in Box Hill at around 1.00pm on 14 June 2012, after he finished his appointment with Dr Wong. He informed his mother that he had to wait at the doctor's for over an hour for an approval to come from Canberra for his methadone. He further informed her that the approval had been obtained and he would be able to obtain takeaway doses of methadone.[9]

28. Mr Ardern and his mother then attended the Department of Human Services (DHS) together regarding Mr Ardern's children, who were residing with a relative. An intervention order in place at the time barred him from seeing his children, and he wanted the intervention order lifted. The meeting went for over an hour, and Ms Ardern observed that during the meeting her son became upset and angry.

29. Following the meeting, Mr Ardern received a call on his mobile phone from a Victoria Police member who was investigating a report that he had attended a DHS office wearing a

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8 Inquest Brief, p37.

9 Inquest Brief p24.

motorcycle helmet and threatened staff. Both Mr Ardern and his mother denied his involvement, and his mother noted that the exchange seemed to increase his anger.[10]

30. After leaving the DHS, Mr Ardern and his mother travelled to Lairds Pharmacy, where he was dispensed a supervised methadone dose, and was additionally dispensed five takeaway methadone doses in separate labelled bottles. The evidence strongly indicates these were the same bottles located near Mr Ardern after his death.

31. Lairds Pharmacy Pharmacist Ms Elizabeth Yap was contacted on 23 January 2013 to determine why the takeaway methadone doses she dispensed to Mr Ardern on 14 June 2012 were labelled with Dr Goonetilleke as the prescriber, when the script permitting five takeaway doses had been issued by Dr Wong. Ms Yap stated that this was a labelling error.[11] She additionally indicated that when Mr Ardern had attended the pharmacy on 13 June 2012, he was not happy with the methadone being dispensed through Dr Goonetilleke's script on a supervised basis. It appears that he may have attended Dr Wong to expedite arrangements for takeaway dosing.

32. On the way back to the hotel from Lairds Pharmacy, Ms Ardern and her son purchased dinner and alcohol near the hotel before returning to their room for the evening.

33. Ms Ardern stated that after dinner, her son went to sleep for approximately one hour. When he awoke at around 8.10pm, he asked if he could drink her two remaining alcoholic beverage cans. She did not allow this, and the two briefly argued before Mr Ardern packed his belongings and departed the hotel.

34. Mr Stagg states that he missed a call from Mr Ardern at 10.08pm on 14 June 2012, who left a message indicating that he was hoping to access accommodation the Vautier Street rooming house that evening. Mr Stagg sent text messages to Mr Ardern indicating that the Vautier Street accommodation would not be available until the following day, and advising him to contact the St Kilda Crisis Centre. Mr Ardern then telephoned Mr Stagg and informed him that he was outside the St Kilda Crisis Centre, who had provided him with blankets for the evening. Mr Ardern indicated that he had sufficient funds to pay for a hotel room, but did not want to

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10 Subsequent investigations revealed that the person who attended the DHS office was most likely not Mr Ardern. The exact details are not relevant to Mr Ardern's death, other than that the incident contributed to his state of agitation.

11 It appears that the incorrect date, being 13 June 2012, was transcribed onto the five takeaway bottles, as well as the incorrect doctor's name. According to the evidence, the five takeaway methadone doses related to the 14 June 2012 consult with and script from Dr Wong, and were dispensed on 14 June 2012 from Lairds Pharamcy.

allocate his funds in that manner. Mr Stagg and Mr Ardern spoke about attending CCS the next morning and completing paperwork for housing. This was the last time Mr Stagg spoke with Mr Ardern. There is no further information regarding any of Mr Ardern's further movements prior to his being found deceased the next morning.

CORONERS PREVENTION UNIT

35. The Coroners Prevention Unit (CPU)[12] reviewed the circumstances of Mr Ardern's death on behalf of the Coroner. The CPU specifically examined:

    a. the annual frequency of Victorian overdose deaths by contributing drug types and by individual contributing drug

    b. the frequency of Victorian overdose deaths where both methadone and benzodiazepines play a contributory role

    c. the frequency of Victorian overdose deaths involving methadone, where the methadone source was a takeaway dose prescribed in opioid replacement therapy

    d. the frequency of Victorian overdose deaths involving methadone among individuals recently released from prison and/or on parole; and

    e. Victorian and interstate policies regarding takeaway methadone dose dispensing to individuals recently released on parole.

Victorian overdose deaths

36. At my direction, the CPU updated its Victorian overdose death data previously reported for the years 2010-2012[13] to include overdose deaths for 2013. This updated data (see Appendix 1) shows that pharmaceutical drugs including diazepam and methadone (both of which contributed to Mr Ardern's death) continue to play a causal or contributory role in significantly more Victorian overdose deaths than illegal drugs such as heroin, illustrating the immediate need for better controls over pharmaceutical drug prescribing and dispensing in order to reduce these harms.

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[12] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the Coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations.

[13] For example the CPU presentation "Benzodiazepine contribution in Victorian overdose deaths", delivered to Reconnexion on 29 October 2013, available via www.reconnexion.org.au/secure/downloadfile.asp?fileid=1040679.

Victorian methadone overdose deaths

37. The CPU conducted extensive research into Victorian overdose deaths involving methadone to assist Coroner Heffey with her investigation into the death of Helen Stagoll.[14] Addendum 1 to Coroner Heffey's Finding describes the CPU research and is publically available on the Court's website, therefore I do not intend on explaining the research in detail.

38. In summary, the CPU identified 537 Victorian methadone deaths between 2000 and 2012. The annual frequency of these deaths rose steadily over the period, particularly from 2007 onwards, peaking at 74 deaths in 2012. I note that subsequent CPU research undertaken at my direction (see Appendix 1) shows that in 2013, there were 70 methadone overdose deaths, which suggests that methadone-related mortality continues to be a significant public health issue.

39. Among the 537 Victorian methadone deaths identified by the CPU for 2000-2012, 85% were deaths from combined drug toxicity rather than overdoses involving methadone alone. The benzodiazepine group of drugs were the most frequent co-contributors with methadone in these deaths, playing a role in approximately 62% of all methadone overdoses. The most frequent individual co-contributing drugs were the benzodiazepine, diazepam, followed by heroin and then codeine. These findings clearly indicate that the combination of drugs that contributed to Mr Ardern's death – which included methadone, diazepam and heroin – is of broad public health concern, rather than being an issue limited to the circumstances of his death.

40. In assisting Coroner Heffey with Her Honour's investigation, the CPU conducted a pilot study of the 124 methadone overdoses for the years 2010-2011 to establish the methadone source in each death. The CPU was able to confirm the methadone source in 68 of the 124 deaths. Among these 68 deaths, methadone was prescribed for opioid replacement therapy in 61 of these deaths, including 50 deaths where the methadone was prescribed as a takeaway dose rather than for consumption at a supervised dosing point. This data again suggests that Mr Ardern's death – which involved methadone dispensed as a takeaway dose for purposes of opioid replacement therapy – is connected to a broader public health issue relating to methods of methadone prescription and dispensing.

Methadone overdose deaths of parolees

41. At my direction, the CPU reviewed the 537 Victorian methadone deaths between 2000 and 2012 to identify any deaths of individuals recently released from prison. The CPU identified 18

[14] COR 2010/1624

such methadone overdose deaths of individuals recently released from prison or on parole at the time of their death. A proportion of these deaths appear to have occurred in circumstances similar to those of Mr Ardern, which indicates that there are broader systemic issues that should be addressed.

Policy review

42. The CPU looked to Victorian opioid replacement therapy policy with respect to its guidance on takeaway methadone doses for recent parolees.

43. A review of Commonwealth, and other State and Territory[15] policies on opioid replacement therapy was conducted to identify:

    a. any general guidance regarding the provision of opioid replacement therapy to clients recently released from prison; and

    b. any specific guidance regarding the provision of takeaway methadone to this client group.

44. The policy review indicated that all policies included at least some general statements about opioid replacement therapy and release from prison, with advice including that clients recently released from prison are at risk of drug overdose and might require specialised support, and that entry into community programs should be facilitated for clients who were receiving opioid replacement in prison. Only two policies included specific guidance on takeaway methadone dosing - those of South Australia and Western Australia.

45. The Western Australian policy requires that a client must have spent a certain amount of time stable in opioid replacement therapy before being eligible to receive takeaway doses. The policy states that:

> Time on methadone or buprenorphine treatment in prison does not count towards the length of time in treatment for the purposes of calculating eligibility for takeaway doses.[16]

46. The South Australian takes in many respects the opposite position to the Western Australian policy:

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15 Tasmania, South Australia, Western Australia, Queensland, New South Wales and Australian Capital Territory.

16 Drug and Alcohol Office, Western Australia Department of Health, *Clinical policies and procedures for the use of methadone and buprenorphine in the treatment of opioid dependence*, October 2007, p.56.

When calculating the period of treatment [for purposes of calculating takeaway methadone eligibility] it is reasonable to consider previous treatment programs if the client has been stable. A short break in treatment or a short period where the client was incarcerated should also not adversely affect the client's status.[17]

47. Revision of the 2006 and 2013 Victorian policies for the provision of opioid replacement therapy *prima facie* established that neither policy contains any specific guidance on the provision of takeaway methadone doses (nor the provision of opioid replacement therapy more generally) to clients who have recently been paroled from prison. The 2013 policy however establishes that only those who demonstrate stability in treatment and who are unhindered by contraindicated medical and social factors should progress to receiving takeaway doses. The policy further states that the prescriber must assess such stability over *a period of time*, recommending generally that methadone takeaway doses should not be provided in the first month of treatment.

DoH inquiries

48. In October 2013, the Court requested a statement from the DoH to address the following matters:

    a. whether there was a reason why safe prescribing and dispensing of methadone to paroled clients was not explicitly addressed in their 2006 and 2013 policies

    b. whether the DoH are aware of any other guidance material available to assist Victorian doctors in how to prescribe methadone for opioid replacement therapy safely to recently paroled clients who have received methadone in prison

    c. in the situation where a doctor contacted the DoH seeking guidance on this point, what advice might be provided

    d. whether the DoH would object if the Coroner were to make a recommendation for the 2013 Policy to be amended to incorporate specific guidance to doctors prescribing in this situation and that takeaway doses should not be provided until stability in the community is established and monitored; and

    e. whether the DoH has any suggestions for other measures that could be implemented to reduce the likelihood of a death in circumstances similar to Mr Ardern's.

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[17] Government of South Australia, SA Health, *Policy for non-supervised dosing of methadone and buprenorphine in drug treatment programs*, January 2012, p.2.

49. In November 2013, the DoH provided the following response:

a. the DoH pointed out that the 2013 *Policy for maintenance pharmacotherapy for opioid dependence* (Policy) replaces the 2006 policy and the DoH therefore considered it unnecessary to address the 2006 document

b. the DoH considers that prescribers are the group with the clinical expertise to conduct pharmacotherapy and the Policy is therefore not a detailed manual providing specific clinical guidance for individual situations requiring pharmacotherapy - it is rather an overarching document that outlines key principles. The Policy requires that all forms of pharmacotherapy should be applied with reference to the principles for the Quality Use of Medicines (National Medicines Policy)

c. the DoH recognised the importance of research into the vulnerability of newly paroled patients and recognised a number of different circumstances that create similar vulnerabilities, such as discharge from residential drug rehab services, therefore the Policy does not address the increased vulnerability specific to recently released prisoners but attempts to address such circumstances through focus on their common fundamental factors, such as patient stability in treatment;

d. the Policy accordingly emphasises that patients should commence opioid treatment under conditions of supervised administration and that only those who demonstrate stability in treatment and are unhindered by contraindicated medical and social factors should progress to receiving takeaway doses (my emphasis)[18]

e. the Policy also clarifies that such stability needs to be assessed by the prescriber over a **period of time**, recommending generally that methadone takeaway doses **should not** be provided in the first month of treatment (my emphasis)[19]

f. the DoH is not aware of any guidance material specific to recently paroled individuals however notes that some advice is provided in the *Victoria Prison Opioid Substitution Therapy Program, 2003 Clinical and Operational Policy and Procedures* manual[20]

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18 Policy, pp22-23.

19 Ibid.

20 The Court was advised by the DoH that this is an internal Justice Health document used by prescribers working in the prison system that has not been provided to the Court. The Court is unable to confirm the exact title of this document.

g. if a doctor were to contact the DoH seeking guidance in a similar situation to Mr Ardern's, the DoH would advise that the doctor should perform an appropriate assessment and make a clinical decision in compliance with the Policy. The prescriber should only prescribe takeaway doses when the patient has demonstrated an adequate period of stability in treatment, has met the other requirements and is not subject to contraindications listed in the policy[21]

h. the DoH expressed its willingness to consider that recently paroled patients may be a particularly vulnerable group and may require some special consideration. The DoH would welcome the opportunity to consider the Coroner's recommendations framed in appropriate terms

i. currently, the Victorian Prison Opioid Substitution Therapy Program (VPOSTP), operated by Justice Health, uses methadone in preference to buprenorphine formulations, chiefly for ease of management – dosing methadone syrup is effective, quick and easy to supervise, obviating the risk of diversion within the prison system. This has also meant that pending release, prisoners are generally prescribed methadone to continue their treatment within the community. However, a formulation containing buprenorphine combined with the opioid antagonist naloxone is now available in the form of a film, which adheres to the inside of the mouth and dissolves within minutes, making diversion in prison effectively impossible. It has been suggested that it might be appropriate to transfer certain prisoners to the medication during their final few weeks prior to release. Their maintenance program in the community could be continued using this formulation. In any attempt to abuse the medication by injecting it, the naloxone acts as an antagonist to the buprenorphine, causing unpleasant withdrawal symptoms, thus negating the effect of the buprenorphine. The DoH only considers this a partial solution as anecdotal evidence suggests that the majority of opioid users prefer methadone as it appears to suppress cravings more effectively, resulting in higher program retention rates. The DoH also acknowledged evidence that however well the use of pharmacotherapy is managed, a drug overdose often results from multiple drug toxicity

j. the DoH notes that their Chief Adviser Addiction Medicine has opined that the most effective dose for methadone maintenance is between 60-80mg and Mr Ardern's

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[21] Policy, pp 21-22.

dose, having been reduced from 160mg to 45mg within nine months may have meant that he still felt some discomfort when paroled; and

k. the VPOSTP routinely involves pre-release discharge planning sessions. It has been suggested that during this process, patients should also be educated about the use of naloxone for overdose response, and the importance of educating a suitable partner or friend in overdose response. Accordingly, it might be useful to promote and develop the accessibility of naloxone for people at risk of overdose in the community.

MEDICATIONS PRESCRIBED TO MR ARDERN

Takeaway dosing of methadone

50. In a statement dated 11 September 2012 Dr Wong said:

> I think that sometimes Ardern was using heroin while he was on methadone. However when I raised his dose to 150ml on 16 April 2011 and to 160ml on 12 September 2011 I felt that he stopped using heroin as the dose was higher. When I saw Ardern on 14 June 2012 I did not suspect he would use heroin.[22]

51. There were some concerns identified regarding whether Dr Wong's provision of methadone to Mr Ardern on a takeaway dosing basis on 14 June 2012 was consistent with Dr Wong's knowledge of concomitant heroin use, and whether this prescription was appropriate in the circumstances. A further statement from Dr Wong was sought in October 2013 asking for comment on:

    a. confirmation that the information obtained regarding Dr Wong's prescribing methods was factually correct

    b. Dr Wong's clinical rationale for permitting five takeaway doses per week two days after Mr Ardern's release from prison

    c. whether Dr Wong is aware of any guidelines or policies relating to safe provision of opioid replacement therapy to people recently release from prison; and

    d. whether Dr Wong was aware of Mr Ardern obtaining pharmaceutical drugs from any other doctors when he attended Dr Wong two days after being release.

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22 Inquest Brief, p38.

52. Dr Wong provided a response in November 2013 as follows:

a. Dr Wong confirmed the evidence contained in the Inquest Brief as correct;

b. Dr Wong's clinical rationale for prescribing five takeaway doses in the circumstances included:

i. Mr Ardern had said that he did not miss a dose while incarcerated, he reduced his dose at his own request from 160mg to 45mg when he was discharged, which assisted Dr Wong in forming the view that Mr Ardern was stable

ii. Mr Ardern did not use heroin while in prison or when he was released. According to Dr Wong, he objectively looked "normal" with normal pupils (which are smaller when using heroin) and normal veins with no recent puncture wounds. Further, Mr Ardern confirmed that he had not used a stimulant

iii. Mr Ardern informed Dr Wong that he did not use benzodiazepines and Dr Wong did not prescribe any for him

iv. a quick mental state check was performed by Dr Wong with no abnormalities detected

v. Mr Ardern did not have a medical co-morbidity – he had a normal liver, heart, weight and lungs

vi. the practice staff asked Mr Ardern whether his address had changed over the few years they had known him and he said it was unchanged, that he was in stable accommodation with his mother

vii. Mr Ardern was receiving regular dosing in prison with no reported intoxicated presentations at the dispensing point and no reports of missed dosing

viii. there was no concern from Dr Wong's perspective of any abuse or diversion in the few years Mr Ardern was known to him; and

ix. Dr Wong had prescribed five takeaway doses to Mr Ardern of 160mg for one year and 10 months (since 11 October 2010) prior to him going to prison without incident and he was now on a lesser dose

c. Dr Wong is not aware of any guidelines for prisoners, but has been following guidelines for takeaway doses from *Policy for Maintenance Pharmacotherapy for Opioid Dependence* (2006); and

d. Dr Wong was not aware of Mr Ardern obtaining drugs from any other doctors when he attended on 14 June 2012.

Diazepam prescribing methods

53. Current evidence regarding the mechanism by which diazepam enhances the depressive and euphoric effects of opioids such as methadone on the central nervous system is as follows:

> Co-administration of methadone and benzodiazepines is known to produce a substantial 'high' or 'buzz'. Some methadone maintenance treatment patients report taking benzodiazepines to enhance the intoxicating effects of methadone. For many users, a methadone-benzodiazepine combination produces a longer, more intense high than taking either drug alone. Patients report that diazepam, lorazepam, and alprazolam provide the strongest high when combined with methadone.[23]

54. As is well documented, the additive depressive effects of benzodiazepines in combination with other central nervous system depressants such as opioids, alcohol and sedative antidepressants can significantly increase the risk of respiratory failure and death.[24] The CPU data obtained in the course of this investigation demonstrates that one or more benzodiazepines co-contributed in 61.8% of all Victorian methadone deaths between 2000 and 2012, with diazepam the most frequent individual co-contributing drug. Victorian authorities responsible for opioid replacement therapy have issued warnings regarding the abuse of benzodiazepines in combination with methadone, including a recommendation that:

> A single prescriber should supply central nervous system depressant drugs, particularly those subject to illicit use, and particularly if the patient is known to

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23 Trafton J A, Ramani A, "Methadone: A New Old Drug With Promises and Pitfalls", *Current Pain and Headache Reports*, vol 13, no 1, February 2009, p.28.

24 El-Guebaly N, Sareen J, Stein MB, "Are there guidelines for the responsible prescription of benzodiazepines?", *Canadian Journal of Psychiatry*, vol 55, no 11, November 2010, p.709; Charlson F, Degenhardt L, McLaren J, Hall W, Lynskey M, "A systematic review of research examining benzodiazepine-related mortality", *Pharmacoepidemiology and Drug Safety*, vol 18, no 2, February 2009, p.94; Ashton H, "Toxicity and adverse consequences of benzodiazepine use", *Psychiatric Annals*, vol 25, no 3, March 1995, p.158.

engage in illicit drug use. This prescriber should make a careful evaluation of the patient and their drug use, and tightly control supply.[25]

55. Mr Ardern attended General Practitioner Dr Danny Jago for the first time in 10 months,[26] having just been released from prison. It appears that Dr Jago prescribed 50 tablets of 5mg diazepam upon Mr Ardern's request.

56. In October 2013, the Court requested Dr Jago address a number of issued as follows:

    a. confirmation whether the information obtained regarding his prescribing methods are factually correct:

    b. a description of his clinical rationale in prescribing the diazepam, seeing Mr Ardern had not sought treatment from Dr Jago in ten months

    c. whether Dr Jago considered any non-drug treatments before prescribing diazepam

    d. the medical practice notes include material that indicate Mr Ardern was known to be a chronic poly-substance dependent patient who abused heroin and benzodiazepines – was this history factored into Dr Jago's clinical decision making on 13 June 2012

    e. was Dr Jago aware on 13 June 2012 that another General Practitioner was prescribing Mr Ardern with methadone

    f. did Dr Jago contact the DoH regarding Mr Ardern's 13 June 2012 presentation;

    g. are there any programs, initiatives or clinical tools (existing or hypothetical) that might have assisted Dr Jago's clinical decision-making; and

    h. that he provide any suggestions regarding how GPs can be better supported in treating patients with complex presentations such as Mr Ardern.

57. In November 2013, Dr Jago provided a statement with the following responses:

    a. Dr Jago confirmed the evidence obtained as correct

    b. Dr Jago advised that he had regularly been prescribing Mr Ardern with diazepam since 18 May 2009, initially to assist with heroin withdrawal and then to help prevent a relapse of substance abuse, as well as for anxiety, depression and insomnia

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25 See for example Victorian Department of Human Services, *Pharmacotherapy Newsletter*, vol 6, no 1, June 2007, p.4, <http://www.health.vic.gov.au/dpu/downloads/news_vol6 issue1.pdf>, accessed 8 July 2013;

26 The PBS patient summary for Kirk Ardern shows that the last time he attended Dr Jago before 13 June 2012, was on 15 August 2011.

c. Mr Ardern also had a history of seizures and panic attacks for which he consulted a neurologist at Box Hill Hospital in 2010 who advised not to cease benzodiazepines abruptly

d. Dr Jago had commenced Mr Ardern on antidepressant Cymbalta and they had been aiming at slowly reducing his benzodiazepine use with good effect. Mr Ardern seemed well motivated to reduce his benzodiazepine use and remain free from illicit substances; his attendance frequency and benzodiazepine prescriptions had been decreasing in the months *prior* to his imprisonment and he seemed to be "doing quite well"

e. Mr Ardern expressed feeling very anxious when seen on 13 June 2012 and had previously had anxiety relating to running out of tablets, therefore Dr Jago thought that if he had not prescribed the diazepam on 13 June, Mr Ardern would have become more anxious and been at risk of a panic attack

f. Dr Jago provided Mr Ardern with general counselling

g. Mr Ardern did not appear interested in non-drug treatments

h. Mr Ardern consistently denied illicit drug use since 18 May 2009. From Dr Jago's perspective, continued prescription of diazepam was partly to prevent him returning to heroin abuse. Dr Jago had found him to generally be compliant and well-motivated to limit his use of diazepam and did not feel he was likely to abuse benzodiazepines when he presented on 13 June 2012

i. Mr Ardern had stated he ceased methadone in 1999 and he had not been on it since;

j. it was brought to Dr Jago's attention that Mr Ardern had obtained a prescription for diazepam from another doctor in June 2009, and Dr Jago informed him he would not be willing to continue prescribing diazepam if he consulted with more than one General Practitioner. Mr Ardern reassured Dr Jago he would only consult with him

k. Dr Jago was not aware that Mr Ardern was seeing any other General Practitioner or being prescribed methadone at 13 June 2012

l. Dr Jago did not consult the DoH regarding the 13 June 2012 presentation

m. Dr Jago expressed that it would have been helpful to have known about other doctors Mr Ardern was consulting and other medication he was being prescribed, as well as the medical treatment he received while in prison and any ongoing issues that

required follow up. Dr Jago notes the Prescription Shopping Program can be helpful but that Mr Ardern was not identified by this; and

n. Dr Jago noted that General Practitioners might benefit from better education in dealing with complex and difficult patients, substance abusers and discharged inmates. He also suggested that greater access to specialised clinics dealing with substance abuse might help better manage these patients.

FINDING

I find that Mr Kirk Steven Ardern died from multiple drug toxicity (including heroin) in circumstances where I am satisfied that he has suffered the unintentional consequences of intentionally ingesting a combination of prescribed and illegal substances. Although it appears Mr Ardern had experienced some possibly destabilising events in the time proximate to his death, there is no clear evidence that the circumstances would support a finding that he intended to take his own life.

COMMENTS

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

Methadone prescription

58. Australian and international research shows that in the first weeks after release from prison, a person is at a markedly elevated risk of dying from drug overdose.[27] A range of factors appear to contribute to this elevated risk, including:

    a. for a regular opioid user, a period of enforced abstinence from opioids in prison causes the user's opioid tolerance to decrease, meaning a formerly tolerated dose can have fatally toxic effects upon release from prison

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[27] See for example Graham A, "Post-prison Mortality: Unnatural Death Among People Released from Victorian Prisons Between January 1990 and December 1999", *Australian and New Zealand Journal of Criminology*, vol 36, no 1, April 2003, pp.94-108; Farrell M, Marsden J, "Acute risk of drug-related death among newly released prisoners in England and Wales", *Addiction*, vol 103, no 2, February 2008, pp.251-255; Merrall ELC, Karimina A, Binswanger IA, et al, "Meta-analysis of drug-related deaths soon after release from prison", *Addiction*, vol 105, no 9 September 2010, pp.1545-1554; Zlodre J, Fazel S, "All-Cause and External Mortality in Released Prisoners: Systematic Review and Meta-Analysis", *American Journal of Public Health*, vol 102, no 12, December 2012, pp.e67-e75; Turban JW, " Can Parole Officers' Attitudes Regarding Opioid Replacement Therapy be Changed?", Addictive Disorders and their Treatment, vol 11, no 3, September 2012, pp.165-170.

b. there is an elevated risk of suicide among recent parolees and fatal drug overdose is a documented suicide method in this group

c. celebrations relating to prison release may involve risky drug use; and

d. there may be changes relating to the purity of drugs or method of administration between when the user is received into prison and released from prison, which may contribute to fatal outcomes in post-release drug use.

59. The Victorian Policy for opioid replacement therapy (in both its 2006 and 2013 incarnations) is predicated on a harm reduction rather than abstinence model. As explained in the 2013 Policy:

> A harm minimisation philosophy involves accepting that despite all efforts to control supply and reduce demand, many people will continue to have access to licit and illicit drugs, and to use them in a way that puts them and society at risk of serious harm. [...] Harm minimisation does not condone drug use; rather, it refers to policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for the community and the individual.[28]

60. This is reflected in the stated goals of opioid replacement therapy in Victoria, which are described as follows:

> The goals of pharmacotherapy for heroin dependence include normalising the patient's life, integrating them back into the community, and retaining them in treatment as appropriate. For those experiencing problematic pharmaceutical opioid use it assists in managing this problem.[29]

61. The Victorian Policy anticipates that a certain amount of heroin use might occur, and accommodates this. The section of the Policy on treatment termination states:

> In the case of heroin users, continued use of heroin should be discussed, but is not necessarily a reason to terminate treatment, and most patients can still benefit from reduced drug use and decreased risk of opioid overdose. Treatment offers

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28 Drugs and Poisons Regulation, Victorian Department of Health, *Policy for Maintenance Pharmacotherapy for Opioid Dependence*, 2013, p.7.

29 Drugs and Poisons Regulation, Victorian Department of Health, *Policy for Maintenance Pharmacotherapy for Opioid Dependence*, 2013, p.7.

the patient relief from the need to obtain drugs, or control of opioid use, and for heroin users an opportunity to stabilise their lives and remove themselves from the drug-taking culture.[30]

62. Consistent with the approach outlined above, abstinence from heroin is not a precondition for receiving takeaway doses in opioid replacement therapy. Rather, the relevant contraindication to takeaway dosing is: unstable patterns of substance use, including **significant use** of alcohol, illicit drugs, benzodiazepines or other sedating medication.[31]

63. The section of the Policy that clinicians should use to assess eligibility for takeaway dosing, includes the following advice:

    a. a client reporting "nil/infrequent" heroin or other opioid use in addition to methadone, is eligible for up to five takeaway methadone doses per week;

    b. a patient reporting "regular" heroin or other opioid use in addition to methadone, defined as once to twice weekly, is eligible for up to two takeaway doses per week; and

    c. a patient reporting "frequent and regular" heroin or other opioid use in addition to methadone, defined as greater than three times per week, is not eligible for takeaway methadone doses.[32]

64. Dr Wong's knowledge or belief that Mr Ardern might have at times used heroin while receiving methadone in opioid replacement therapy, is not inconsistent with provision of takeaway methadone according to the Victorian Policy.

65. Dr Wong did not act in contravention of the 2006 policy, in situ at the time he prescribed five takeaway methadone doses to Mr Ardern. It is of some concern that Dr Wong referred to the 2006 policy in November 2013, which was superseded in January 2013. I would suggest that Dr Wong and all practitioners inform themselves of the most current policy, which at least

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30 Drugs and Poisons Regulation, Victorian Department of Health, *Policy for Maintenance Pharmacotherapy for Opioid Dependence*, 2013, p.32.

31 Drugs and Poisons Regulation, Victorian Department of Health, *Policy for Maintenance Pharmacotherapy for Opioid Dependence*, 2013, p.22. Boldface type added by CPU.

32 Drugs and Poisons Regulation, Victorian Department of Health, *Policy for Maintenance Pharmacotherapy for Opioid Dependence*, 2013, p.25.

contains some general guidance in terms of medical/social stability and in terms of generally recommended minimum treatment times before takeaway doses should be permitted.

66. Dr Wong prescribed Mr Ardern five takeaway doses of methadone on 14 June 2012, two days after his release from prison, prior to Dr Wong being able to reasonably determine, according to his own clinical judgement, whether Mr Ardern was able to demonstrate stability in treatment. Although Dr Wong did not act in contravention of either policy, I consider the overall appropriateness of Dr Wong's clinical decision-making in providing Mr Ardern with a prescription permitting five takeaway doses in a time so proximate to his prison release and associated foreseeable vulnerabilities is questionable. His prescribing practice does not appear appropriate to Mr Ardern's circumstances.

67. The CPU research suggests that methadone dispensed for opioid replacement therapy on a takeaway dosing basis could be associated with more Victorian deaths than methadone dispensed for supervised dosing. The CPU has prepared a separate report outlining its current advice for reducing deaths associated with takeaway methadone, which is available on the Court's website.[33]

Diazepam prescription

68. A number of concerns have been identified in the prescribing method adopted by Dr Jago, including:

    a. Dr Jago did not contact Drugs and Poisons Regulation at the Victorian DoH to establish whether Mr Ardern was currently being treated with a Schedule 8 opioid

    b. Dr Jago provided the diazepam on request when there is evidence that direct requests for a particular type of medication are a known warning sign for prescription shopping[34]

    c. Dr Jago provided a large quantity of diazepam (50 tablets) without any follow-up apparently arranged

    d. Dr Jago did not pursue alternative first-line non-drug treatments for anxiety and commented only that Mr Ardern did not "seem interested" in alterative therapies; and

[33] Finding into the death of Helen Stagoll, COR 2010/1624.

[34] White J and Taverner D, "Drug-seeking behaviour", *Australian Prescriber*, vol 20, no 3, July 1997.

e. There is no indication that this matter was proactively and/or specifically addressed during the consultation.

69. While Dr Jago's diazepam prescribing practices appear to have been poor, I acknowledge there are a certain number of systemic issues that inhibit general practitioners' ability to appropriately prescribe benzodiazepines.

70. At present a Victorian doctor does not have any real option, short of telephoning Drugs and Poisons Regulation, to establish whether a patient is receiving opioid replacement therapy from another doctor.

Real-time prescription monitoring

71. A real-time prescription monitoring program (RTPM) would facilitate prescribers' ability to ensure that a patient receiving methadone from one prescriber for opioid replacement therapy does not obtain benzodiazepines from other prescribers, so that risks of co-administration are adequately managed.

72. In August 2010, Tasmania became the first state to commit to implementing RTPM, when its Department of Health and Human Services announced that it was developing its own system called DORA (Drugs and Poisons Information System – Online Remote Access) in response to the high rate of harms associated with opioids and benzodiazepines.

73. On 12 February 2012, the Commonwealth Department of Health and Ageing announced that, under the auspices of its Electronic Reporting and Recording of Controlled Drugs (ERRCD) initiative, it had licensed the Tasmanian DORA software to implement a national RTPM system. A press release at the time indicated that the ERRCD system would be made available to doctors, pharmacists and State and Territory health authorities across Australia to monitor the prescribing and dispensing of addictive drugs in real time.

74. There has been little recent news regarding the progress of the ERRCD system development and rollout. The Court therefore contacted the Secretary of the Commonwealth DoH seeking further information regarding the ERRCD initiative. The response received in March 2014 pointed out that the ERRCD is not a Commonwealth system.[35] While the Commonwealth has effectively constructed the system, it will not use the system, and has handed the system over

[35] See Appendix 2.

to the States and Territories for their use via complementary software licence agreements, reflecting that the regulation of the prescribing and dispensing of these medicines is the responsibility of the States and Territories. ERRCD will allow States and Territories to permit prescribers and pharmacists to view certain data to inform their professional practice, and forge agreements on data sharing to prevent patients from doctor shopping within States and Territories and across borders. The Commonwealth Government further advised that the ERRCD in its current form is capable of delivering prescribers and dispensers access to real-time information on prescription dispensing.[36]

75. This information would appear to indicate that the ERRCD is at an advanced stage of implementation. However, a response received from the Secretary of the Victorian DoH, presents a somewhat different perspective.[37]

76. As at March 2014, the Victorian DoH advised that it has commissioned a business case for RTPM in Victoria to analyse the options and determine the potential cost to Victoria of RTPM and the ERRCD initiative. The business case is in its final stages of development and currently under departmental review. The DoH recognised the importance that any RTPM system introduced in Victoria is capable of addressing the aims of the whole-of-government alcohol and drug strategy *Reducing the alcohol and drug toll: Victoria's plan 2013-2017* and be securely maintained and funded into the future. The DoH advised that upon completion of this process, the business case will be submitted to the Minister for Health for consideration.[38]

77. In March 2014, the Commonwealth Government also informed the Court that it had committed $5 million over five years (2010-2015) to support the establishment of the ERRCD system for use by State and Territory regulators. The ERRCD system is currently installed on a secure host server and is operational, waiting for each State and Territory to commence utilisation.[39]

78. The Victorian DoH reported that the Commonwealth Government has withdrawn from the steering committee that is responsible for implementation of the Commonwealth Government's current ERRCD initiative.[40] The Secretary to the Victorian DoH noted that it is not possible to

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36 See Appendix 2.

37 See Appendix 3.

38 See Appendix 3.

39 See Appendix 2.

40 See Appendix 3.

forecast the effect of this withdrawal upon the actual establishment and maintenance of a RTPM, however conceded that it would appear to represent a potential delay to a nationally coordinated system.

79. The Commonwealth and Victorian positions suggests that the Victorian DoH might not be satisfied that the ERRCD initiative can deliver RTPM capability. It also suggests that the ERRCD implementation might be in a holding pattern pursuant to Commonwealth-State and State-State negotiations.

80. I note a recent article relating to the ERRCD initiative's progress voiced a call from the Australian Medical Association (AMA) Victorian branch on the Victorian DoH to urgently implement the ERRCD.[41] The Victorian DoH is not quoted in this article, however a New South Wales spokesperson was quoted as follows:

> The New South Wales Ministry of Health is continuing to work through the financial and practical implications of implementation of the ERRCD system……[f]ull roll out is likely to take three years.[42]

81. The totality of the information would tend to suggest that there may still be several years prior to the implementation of the ERRCD. The likelihood of such a scenario was anticipated in another coronial matter when a Recommendation was made in the following terms:

> The Victorian Department of Health develop a contingency plan to implement a Victorian-based real-time prescription monitoring program in the event that the anticipated Australian Government Department of Health and Ageing information technology infrastructure for electronic recording and reporting of controlled drugs is delayed more than six months beyond the declared July 2012 deadline.[43]

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41 McDonald K, "Urgent Action needed on real-time drug monitoring system", *Pulse+IT Magazine*, 18 March 2014.

42 Ibid.

43 COR 2009/5181, investigation into the death of James (surname redacted), per Coroner Olle, delivered 15 February 2012.

Benzodiazepine guidelines

82. The Royal Australian College of General Practitioners (RACGP), who is the responsible body for prescribing guidelines in general practice, last revised its benzodiazepine guidelines in 2000. In the Finding I delivered on 18 May 2012 in the matter of David Trengrove,[44] I flagged the poor quality of the guidelines and recommended that:

> To reduce the harms and death associated with benzodiazepine use in Victoria, the RACGP should update its guidelines for appropriate prescribing of benzodiazepines in the context of general practice within 12 months. The updated guidelines should explicitly address the following areas: (a) general principles for benzodiazepine prescribing; (b) appropriate use of benzodiazepines to treat specific conditions such as insomnia, anxiety and panic disorder; (c) strategies for identifying and treating patients who are seeking benzodiazepines in excess of medical need; and (d) managing the risk of harm and death associated with benzodiazepine use and misuse.

83. The RACGP accepted the recommendation in a response dated 20 August 2012:

> The RACGP confirms that the Coroner's recommendations will be implemented. The College agrees that the 2000 benzodiazepines guidelines do not reflect current advances in evidence and has therefore removed these from the website until they can be updated.

84. While this is a positive step, guidelines without training are potentially not efficacious. This raises the issue of what current training is provided to medical practitioners in benzodiazepine prescribing. Poor benzodiazepine prescribing practices remain a common theme in drug-related reportable deaths.

85. Training requirements were explored in the Parliament of Victoria Drugs and Crime Prevention Committee's December 2007 *Inquiry into the Misuse/Abuse of Benzodiazepines and Other Forms of Pharmaceutical Drugs in Victoria: Final Report.* The report's authors wrote:

> During this Inquiry the Committee found a wide variation in the knowledge, skill level and willingness of health professionals to effectively address misuse

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[44] COR 2008/4042.

and abuse of benzodiazepines and opioid analgesics, despite many professional boards and bodies having developed clinical and practice guidelines in this area [...].[45]

86. Consequently, the report's authors recommended that the Victorian Government undertake the following action:

    a. Work with professional bodies and university medical faculties to develop and deliver undergraduate, professional and mandatory ongoing education and training for Victorian doctors on best practice benzodiazepine and opioid analgesic prescribing and management. Such training should be updated regularly and provided on an ongoing basis to provide a level of competency standards required of doctors and other prescribing health professionals to practise in Victoria. Such training could include:

        i. risks associated with long-term use of benzodiazepines and analgesic opioids

        ii. importance of regular reviews of benzodiazepine dosing

        iii. alternatives to pharmacological treatments for patients suffering from pain, anxiety or sleep disorders

        iv. appropriate management of benzodiazepine and opioid analgesic withdrawal (including tapering)

        v. identifying signs of dependence in patients and making referrals to a service that can appropriately manage that person's misuse or abuse; and

        vi. Importance of liaison and communication between doctors and pharmacists at a local level.[46]

87. The RACGP were approached in October 2013 to provide the Court with an update regarding their progress towards finalising new benzodiazepine prescribing guidelines in the context of the Recommendations made in the matter of Trengrove.

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45 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.335.

46 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.vii.

88. In October 2013, the RACGP informed the Court that they are currently working towards finalisation of these Guidelines, that a revised version is in draft stage and currently under review by key members of the RACGP National Faculty of Specific Interest – Addiction Medication Network, the National Standing Committee – Quality Care, RACGP staff and other stakeholders. The RACGP estimated that an official draft of the revised Guidelines for stakeholder consultation would be released in March 2014.

89. The RACGP also informed that Court that they had embarked on the development of a Good Practice Guide (GPG) for Addictive Medicine In General Practice, with a purpose of:

    a. improving clinical governance for treatment with addictive medicine within Australian General Practice

    b. supporting General Practitioners to ensure safe prescribing in their facilities

    c. supporting appropriate prescription of benzodiazepines within the Australian regulatory framework

    d. supporting General Practitioners to recognise high risk situations and to manage these appropriately; and

    e. supporting General Practitioners with tools and evaluation processes for complex patients.

90. The RACGP noted that the GPG will articulate their position and framework for benzodiazepine prescribing with the wider context of addictive medicine. It is intended that the guidelines and the GPG will be released together. The RACGP also indicated that work in this area is likely to continue to be a focus throughout 2014.

91. The RACGP did not specifically address whether there is or will be any compulsory training for student doctors or compulsory ongoing training for general practitioners regarding the safe prescribing of benzodiazepines.

92. Victorian Coroners too frequently investigate deaths from combined drug toxicity including benzodiazepines, where multiple doctors appear to have inappropriately prescribed benzodiazepines. Benzodiazepines are currently the most frequent contributing pharmaceutical drug type in Victorian overdose deaths.[47] There appears to be a systematic issue with how

[47] See Appendix 1.

doctors treat this class of drugs. I anticipate the guideline review and development of the GPG will address the issue of how doctors can be (re)educated on the safe prescribing of benzodiazepines, and I look forward to being informed accordingly.

Scheduling of benzodiazepines

93. Shifting benzodiazepines from Schedule 4 to Schedule 8 of the Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP) would create opportunities to identify and prevent inappropriate prescribing. My Recommendations on 18 May 2012 in the matter of David Trengrove included the following:

> To reduce the harms and death associated with benzodiazepine use in Victoria, within 12 months the Therapeutic Goods Administration (TGA) of the Australian Government Department of Health and Ageing should move *all* benzodiazepines into Schedule 8 of the Standard for the Uniform Scheduling of Medicines and Poisons.

94. In its initial response dated 6 November 2012, the TGA rejected this Recommendation for a number of reasons including the cost of tighter regulation to both the government and the pharmaceutical industry, and the lack of evidence that rescheduling would have saved Mr Trengrove's life.

95. On 29 November 2012, the TGA subsequently announced an invitation for public comment regarding a proposal to reschedule benzodiazepines from Schedule 4 to Schedule 8 of the SUSMP. In correspondence with the Court, the TGA confirmed that my Recommendation was being treated as the rescheduling application, and that I was effectively the applicant.

96. Following receipt of public submissions, on 23 May 2013, a Delegate of the Secretary to the Department of Health and Ageing published the interim decision and reasons for decision regarding the proposal to reschedule benzodiazepines from Schedule 4 to Schedule 8 of the SUSMP (the Poisons Standard). The decision was:

    a. that alprazolam be rescheduled from Schedule 4 to Schedule 8

    b. that the scheduling of the remaining benzodiazepines remains appropriate; and

c. that benzodiazepines be included in Appendix D, paragraph 5 of the SUSMP.[48]

97. In essence, the interim decision proposed that alprazolam be rescheduled from Schedule 4 to Schedule 8, and all other Schedule 4 benzodiazepines remain in Schedule 4.

98. The reasons for the interim decision comprised the following:

a. alprazolam has increased morbidity and mortality in overdose with possible increased toxicity. It does not appear to have any additional therapeutic benefits compared with any other substance in the class

b. there has also been a rapid increase in use of alprazolam compared with other benzodiazepines and evidence of widespread misuse

c. concerns of possible increased toxicity

d. concerns that current pack size is inappropriate for indications

e. there is evidence of abuse of the substance and misuse with opioids; and

f. listing in Schedule 8 of alprazolam does not restrict its short-term use for the approved indication.

99. Invitation was sought in response to the Delegate's interim decision. I provided a response dated 6 June 2013 indicating my support of the rescheduling of alprazolam but maintaining my position that *all* benzodiazepines should be rescheduled into Schedule 8. My reasons for this position including, *inter alia*, that other benzodiazepines are just as harmful as (if not more harmful than) alprazolam, and:

> The qualitatively similar pharmacological effects of all benzodiazepines mean that any initiative to limit access to one benzodiazepine will most likely shift harms to other benzodiazepines rather than reducing overall harms.

100. Despite these concerns, the Delegate's final decision was announced on 27 June 2013 and published on 28 June 2013. The Delegate's final decision was consistent with the interim decision and confirmed that alprazolam would be rescheduled to Schedule 8 while other benzodiazepines would be left in Schedule 4.

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[48] The effect of this inclusion is that possession of benzodiazepines without authority (ie other than in accordance with a legal prescription) is illegal.

101. The Delegate's final decision also includes the decision that the scheduling of the remaining benzodiazepines remains appropriate.[49]

102. The CPU data in Appendix 1 provides some early evidence to substantiate my concerns about the consequences of the Delegate's decision.[50] This data clearly demonstrates that diazepam, rather than alprazolam, is the benzodiazepine of greatest concern in Victorian overdose deaths, and that its involvement in deaths has continued to grow over time. Rescheduling alprazolam will have no impact on the burden of diazepam involvement in overdose deaths, and may further exacerbate it as patients are shifted from alprazolam to other benzodiazepines. A global problem cannot be effectively remedied by addressing part thereof.

103. I note a recent article published in the *Medical Journal of Australia* that found most individuals who misuse benzodiazepine sourced the benzodiazepines directly from a medical practitioner rather than via drug diversion. The authors noted that:

> This finding, coupled with the serious harms associated with benzodiazepines (in terms of acute overdose, poorer health and poorer treatment outcomes), is interesting in light of current plans to only monitor the prescribing of S8 benzodiazepines as part of the monitoring of all S8 class drugs in Australia – flunitrazepam and, from 2014, alprazolam. This means that, despite the greater opportunity for prescribers to intervene in benzodiazepine supply, most benzodiazepines will not fall under the current plans for prescription drug monitoring. This also represents a missed opportunity for monitoring the impact of the planned rescheduling of alprazolam on the extent of use of other, unmonitored, benzodiazepines.[51]

104. The reference in this passage to "current plans to monitor [...] all S8 drugs in Australia" is a reference to the ERRCD initiative, which is purported to deliver real-time prescription monitoring capacity for Schedule 8 drugs, but not Schedule 4 drugs. Given that the drug most frequently involved in Victorian overdose deaths is diazepam, which is a Schedule 4 drug, there is a strong rationale to recommend the rescheduling of all benzodiazepines to ensure they

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49 Therapeutic Goods Administration, "Reasons for scheduling Delegates' final decisions, June 2013", <http://www.tga.gov.au/industry/scheduling-decisions-1306-final.htm>, 28 June 2013, accessed 2 July 2013.

50 See Appendix 1.

51 Nielsen S, et al, "The sources of pharmaceuticals for problematic users of benzodiazepines and prescription opioids", *Medical Journal of Australia*, vol 199, no 10, 19 November 2013, p 699.

are brought within the scope of the ERRCD initiative (when implemented), and/or to encourage the ERRCD initiative to be capable of monitoring all drugs of potential addiction, rather than only Schedule 8 drugs.

RECOMMENDATIONS

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

105. I have identified some potential issues with the medical treatment Mr Ardern received after he was released from Fulham Correctional Centre. These issues in turn suggest some potential opportunities for prevention.

106. Dr Sze Hong Wong provided a script that enabled Mr Ardern to access five takeaway methadone doses per week, two days after his release from prison. Mr Ardern was not in stable accommodation (he was staying at a hotel with his mother) and it is not clear whether Dr Wong attempted to assess any other measures of stability to support a decision for such a high level of takeaway dosing. His clinical decision could be referred for critical evaluation to Drugs and Poisons Regulation at the Victorian Department of Health.

107. Separate from the question as to whether or not Dr Wong exercised appropriate clinical judgement, I have identified that the Victorian policy for provision of opioid replacement therapy contains no guidance on safe treatment of recently paroled clients. Given that recent parolees are particularly at risk of overdose death, this would appear to be a significant oversight, especially since the circumstances of Mr Ardern's death are not unique, have happened before, and without specific attention, could occur again.

108. I recognise that the complexity and exigency of primary health care necessitate some latitude in patient treatment. It would be difficult, if not impossible, to develop specific prescribing guidelines applicable to all permutations and combinations of patient presentation. However, I think it preferable that basic general guidance material adopts a more considered and cautious approach aimed at harm reduction.

109. I **recommend** that the Victorian Department of Health amend the January 2013 *Policy for Maintenance Pharmacotherapy for Opioid Dependence*, to incorporate explicit advice on managing vulnerable opioid replacement patients including those recently paroled from prison, to reduce the likelihood a newly paroled client will overdose on methadone. The amended

policy should indicate that a client transferred from prison to a community-based service should be treated in the same way as a new patient commencing treatment, and should not be provided takeaway doses until medical, psychological and social stability in the community is established.

110. The rescheduling of alprazolam from a Schedule 4 benzodiazepine to a Schedule 8 benzodiazepine took effect on 1 February 2014. While I welcome the decision to reschedule alprazolam, I recognise the ongoing risks that all other benzodiazepines pose to the community, as reflected in the continuing trend of deaths associated with benzodiazepines, particularly diazepam, and particularly in combination with methadone-related deaths. I accordingly **recommend** all other benzodiazepines should also be rescheduled to Schedule 8 because they present the same risks as alprazolam.

111. Nearly two years after the Victorian Department of Health indicated it was engaging with the Commonwealth on its Electronic Recording and Reporting of Controlled Drugs initiative, Victoria is still without a real-time prescription monitoring system to assist in addressing the harms and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs. There is no question that the current prescribing system, and therefore the ease of obtaining inappropriate access and/or amounts of drugs, lacks sufficient rigour. In a previous coronial matter, Coroner Olle expressed concern that if the Victorian Department of Health relies on the Commonwealth to deliver a national real-time prescription monitoring system, it might be "waiting for an extended period or even indefinitely while preventable harms and deaths from prescription shopping continue to occur".[52] At that time, then Acting Secretary for the Victorian Department of Health Lance Wallace rejected Coroner Olle's concerns. I note however, that the current state of affairs is unchanged while the same problem remains, illustrated by Dr Jago's observations that a real-time prescription monitoring system would have enabled him to identify other drugs Mr Ardern had received from other doctors and to treat him accordingly.

112. I therefore **recommend** that the Victorian Department of Health explore options for implementing a Victorian-based real-time prescription monitoring system to prevent ongoing harms and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs.

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[52] COR 2009/5181, above n 39, 15 February 2012.

113. As there is practically no discernable publically available information regarding the status of the ERRCD initiative and Victorian progress towards implementing real-time prescription monitoring, I **recommend** that within three months, the Victorian Department of Health should create a page on its website regarding real-time prescription monitoring, the ERRCD system and other related topics. The page should provide up-to-date information regarding the planning and implementation of this crucial public health initiative. Transparent, continuous disclosure of progress would assist a broad range of stakeholders, including peak medical and pharmacy bodies, Coroners and the Victorian public.

I direct that the Finding be published on the internet.

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

Ms Jennifer Ardern

Dr Sze Hong Wong

Dr Danny Jago

Australian Health Professional Regulation Agency

The Hon David Davis, Victorian Minister for Health

The Hon Peter Dutton, Commonwealth Minister for Health

Dr Pradeep Philip, Secretary, Victorian Department of Health

Professor Jane Halton PSM, Secretary, Commonwealth Department of Health

Mr Stephen Marty, Registrar, Victorian Pharmacy Authority

Mr Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association

Mr Bill Suen, Victorian Branch Director, Pharmaceutical Society of Australia

Mr Matthew McCrone, Chief Officer, Drugs and Poisons Regulation, Victorian Department of Health

Dr Liz Marles, President, Royal Australian College of General Practitioners

Detective Senior Constable C Pountney

Signature:

AUDREY JAMIESON
CORONER
Date: **7 April 2014**

APPENDIX 1

Coroners Court of Victoria

Appendix 1

The Drug Overdose Deaths Register

The Coroners Prevention Unit (CPU) developed and maintains a register of drug overdose deaths investigated by Victorian coroners. A drug overdose death is defined as a death for which the acute toxic effects of one or more drugs played a causal or contributory role.[1] Deaths for which no acute toxic effects contributed but other drug effects (such as behavioural effects) may have contributed, are excluded from the Register.[2]

The CPU draws on the determination of the death investigators (coroner, forensic pathologist and forensic toxicologist) to identify relevant deaths, and codes certain information regarding each death into the Drug Overdose Deaths Register. Coded information includes the specific drugs that the expert death investigators identified as playing a causal or contributory role.

The information contained in the Drug Overdose Deaths Register is regularly revised as coroners progress and complete their investigations. Therefore, overdose death data generated from the Register can change over time.

Overdose deaths, Victoria 2010-2013

On 2 April 2014, the CPU used the Drug Overdose Deaths Register to extract data pertaining to all overdose deaths investigated by Victorian coroners in the period 1 January 2010 to 31 December 2013. Data for both completed investigations and investigations still underway was extracted, where the current available evidence indicated the death was an overdose.

Table 1 shows the annual frequency of Victorian overdose deaths by the number of drugs that were found to have caused or contributed to the death. The bracketed figures in the table are the frequencies expressed as percentages of all overdose deaths for the year (for example, in 2013 there were 113 single drug overdose deaths, which was 30.2% of the 374 drug overdose deaths for that year).

The majority of overdose deaths (approximately two-thirds) involved multiple drugs rather than a single drug. There was an overall slight upward trend in frequency over time, from 349 deaths in 2010 to 374 deaths in 2013. The CPU expects that as coroners' investigations progress and causes of death are confirmed, the 2013 frequency will be revised further upwards.

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1 The CPU definition of the term 'drug' is largely consistent with the Australian Bureau of Statistics (ABS) definition, encompassing substances that "may be used for medicinal or therapeutic purposes, or to produce a psychoactive effect". Like the ABS, the CPU excludes tobacco and volatile solvents such as petrol and toluene from its definition of a drug. However, the CPU considers alcohol to be a drug, whereas it is excluded under the ABS definition. See Australian Bureau of Statistics, "Drug-induced deaths: a guide to ABS causes of death data", 8 August 2002, p.2.

2 For example, if a person fatally assaulted another person while his or her mental state is affected by methamphetamine, this death would be excluded. Likewise, if a person drowned after stumbling off a pier while heavily intoxicated by alcohol and quetiapine, this would be excluded. Only drug overdose deaths are included.

Table 1: Annual frequency of overdose deaths by number of contributing drugs, Victoria 2010-2013.

Contributing drugs	2010	2011	2012	2013
Single drug	124 (35.5%)	138 (37.6%)	115 (31.3%)	113 (30.2%)
Multiple drugs	225 (64.5%)	229 (62.4%)	252 (68.7%)	261 (69.8%)
All overdose deaths	349 (100.0%)	367 (100.0%)	367 (100.0%)	374 (100.0%)

Overdose deaths by drug type, Victoria 2010-2013

Table 2a shows the annual frequency of Victorian overdose deaths by broad contributing drug type: pharmaceutical drugs, illegal drugs and alcohol. The bracketed figures are the frequencies expressed as percentages of overall overdose deaths for the year.

In interpreting the Table 2a data, it is important to note that where an overdose death involves more than one drug type, the death is counted under all relevant drug types. For example, a 2012 fatal overdose from heroin and diazepam would be counted both under pharmaceutical drugs (diazepam) and illegal drugs (heroin) for that year. This is why the percentages in Table 2a do not sum to 100%.

Table 2a: Annual frequency of overdose deaths by contributing drug types, Victoria 2010-2013.

Drug type	2010	2011	2012	2013
Pharmaceutical	267 (76.5%)	275 (74.9%)	305 (83.1%)	310 (82.9%)
Illegal	149 (42.7%)	153 (41.7%)	131 (35.7%)	164 (43.9%)
Alcohol	84 (24.1%)	88 (24.0%)	80 (21.8%)	93 (24.9%)

The data indicates that pharmaceutical drugs played a causal or contributory role in around 80% of Victorian overdose deaths between 2010 and 2013, whereas illegal drugs played a role in around 40% of deaths.

To explore the findings from Table 2a in further detail, the deaths involving pharmaceutical drugs were disaggregated by specific contributing pharmaceutical drug types. Table 2b shows the annual frequency and percentage of Victorian overdose deaths by the major pharmaceutical drug types that played a causal or contributory role.[3]

Table 2b: Annual frequency of overdose deaths by contributing pharmaceutical drug group, Victoria 2010-2013.

Pharmaceutical drug type	2010	2011	2012	2013
Benzodiazepines	168 (48.1%)	180 (49.0%)	196 (53.4%)	212 (56.7%)
Opioids	144 (41.3%)	183 (49.9%)	210 (57.2%)	191 (51.1%)
Antidepressants	105 (30.1%)	101 (27.5%)	141 (38.4%)	133 (35.6%)
Antipsychotics	64 (18.3%)	65 (17.7%)	77 (21.0%)	75 (20.1%)

3 Table 2b includes only pharmaceutical drug groups that contributed in an average of at least 12 overdose deaths per year. Pharmaceutical drugs are classified into groups using a slightly modified version of the 2010 Drug Abuse Warning Network (DAWN) Drug Vocabulary classifications; the main modification is that the DAWN 'anxiolytics' group was divided into benzodiazepine and non-benzodiazepine anxiolytics, and the DAWN 'analgesics' group was divided into opioids and non-opioid analgesics.

Non-benzodiazepine anxiolytics	28 (8.0%)	33 (9.0%)	37 (10.1%)	54 (14.4%)
Non-opioid analgesics	24 (6.9%)	30 (8.2%)	52 (14.2%)	41 (11.0%)
Anticonvulsants	13 (3.7%)	12 (3.3%)	9 (2.5%)	36 (9.6%)
Beta blockers	7 (2.0%)	4 (1.1%)	17 (4.6%)	15 (4.0%)
Gastrointestinal stimulants	8 (2.3%)	8 (2.2%)	14 (3.8%)	13 (3.5%)
Antihistamines	11 (3.2%)	11 (3.0%)	10 (2.7%)	11 (2.9%)

As with Table 2a above, if multiple pharmaceutical drug types contributed to a death then the death was counted separately under each drug type, which is why the percentages do not sum to 100%. Table 2b shows that benzodiazepines and opioids were the two most frequent contributing pharmaceutical drug types in Victorian overdose deaths between 2010 and 2013, followed by antidepressants and antipsychotics.

Individual drugs in overdose deaths, Victoria 2010-2013

Table 3 shows the annual frequency of Victorian overdose deaths by individual drugs that played a causal or contributory role.[4] The bracketed figures are the frequencies expressed as percentages of all overdose deaths for the year.

Table 3: Annual frequency of overdose deaths by individual contributing drugs, Victoria 2010-2013.

Drug	Drug type	2010	2011	2012	2013
Diazepam	Benzodiazepine	109 (31.2%)	124 (33.8%)	131 (35.7%)	164 (43.9%)
Heroin	Illegal drug	139 (39.8%)	129 (35.1%)	109 (29.7%)	132 (35.3%)
Alcohol	Alcohol	84 (24.1%)	88 (24.0%)	80 (21.8%)	93 (24.9%)
Codeine	Opioid	56 (16.0%)	66 (18.0%)	91 (24.8%)	71 (19.0%)
Methadone	Opioid	55 (15.8%)	72 (19.6%)	74 (20.2%)	70 (18.7%)
Oxycodone	Opioid	39 (11.2%)	46 (12.5%)	46 (12.5%)	60 (16.0%)
Methamphetamine	Illegal drug	14 (4.0%)	29 (7.9%)	34 (9.3%)	50 (13.4%)
Alprazolam	Benzodiazepine	57 (16.3%)	43 (11.7%)	55 (15.0%)	45 (12.0%)
Quetiapine	Antipsychotic	37 (10.6%)	34 (9.3%)	40 (10.9%)	41 (11.0%)
Paracetamol	Non-opioid analgesic	20 (5.7%)	24 (6.5%)	50 (13.6%)	39 (10.4%)
Mirtazapine	Antidepressant	20 (5.7%)	23 (6.3%)	26 (7.1%)	30 (8.0%)
Nitrazepam	Benzodiazepine	16 (4.6%)	11 (3.0%)	24 (6.5%)	26 (7.0%)
Amitriptyline	Antidepressant	26 (7.4%)	22 (6.0%)	33 (9.0%)	25 (6.7%)
Citalopram	Antidepressant	21 (6.0%)	21 (5.7%)	25 (6.8%)	24 (6.4%)
Tramadol	Opioid	9 (2.6%)	15 (4.1%)	17 (4.6%)	24 (6.4%)
Doxylamine	Non-benzo anxiolytic	16 (4.6%)	11 (3.0%)	20 (5.4%)	23 (6.1%)
Temazepam	Benzodiazepine	23 (6.6%)	48 (13.1%)	36 (9.8%)	22 (5.9%)
Venlafaxine	Antidepressant	12 (3.4%)	16 (4.4%)	15 (4.1%)	20 (5.3%)
Clonazepam	Benzodiazepine	9 (2.6%)	14 (3.8%)	18 (4.9%)	19 (5.1%)
Oxazepam	Benzodiazepine	19 (5.4%)	44 (12.0%)	41 (11.2%)	17 (4.5%)
Olanzapine	Antipsychotic	18 (5.2%)	17 (4.6%)	22 (6.0%)	15 (4.0%)
Zopiclone	Non-benzo anxiolytic	3 (0.9%)	6 (1.6%)	13 (3.5%)	14 (3.7%)
Metoclopramide	Gastrointestinal stimulant	8 (2.3%)	8 (2.2%)	14 (3.8%)	13 (3.5%)
Valproic Acid	Anticonvulsant	9 (2.6%)	5 (1.4%)	5 (1.4%)	13 (3.5%)
Sertraline	Antidepressant	6 (1.7%)	4 (1.1%)	12 (3.3%)	12 (3.2%)

4 Table 3 includes only drugs that contributed in at least 30 overdose deaths across the four-year period. Certain drugs (such as pregabalin and propranolol) were significant contributors in 2013 but not previous years, and were not included in Table 3.

Duloxetine	Antidepressant	5 (1.4%)	7 (1.9%)	14 (3.8%)	11 (2.9%)
Fentanyl	Opioid	2 (0.6%)	5 (1.4%)	17 (4.6%)	11 (2.9%)
Fluoxetine	Antidepressant	9 (2.6%)	8 (2.2%)	14 (3.8%)	10 (2.7%)
Risperidone	Antipsychotic	3 (0.9%)	11 (3.0%)	8 (2.2%)	10 (2.7%)
Amphetamine	Illegal drug	10 (2.9%)	19 (5.2%)	11 (3.0%)	9 (2.4%)
Morphine	Opioid	10 (2.9%)	10 (2.7%)	13 (3.5%)	7 (1.9%)
Promethazine	Antihistamine	10 (2.9%)	8 (2.2%)	8 (2.2%)	6 (1.6%)

As with Tables 2a and 2b, deaths where multiple drugs contributed were separately counted for contributing drug, which is why the percentages do not sum to 100%. Diazepam and heroin were the two most frequent contributing drugs in Victorian overdose deaths between 2010 and 2013, followed by alcohol. Three pharmaceutical opioids (codeine, methadone and oxycodone) comprised the next most frequent contributing drugs.

APPENDIX 2

Australian Government
Department of Health

SECRETARY

Mr Jeremy Dwyer
Acting Manager
Coroners Prevention Unit
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Mr Dwyer

Investigation into the death of Kirk Ardern [Court Reference: 20122254]

Thank you for your letter of 3 February 2014 regarding the above investigation. You seek further information on the Electronic Recording and Reporting of Controlled Drugs (ERRCD) system. Your questions, and my responses, are given below.

Q1: Is the Commonwealth still committed to the national roll-out of the ERRCD system? If so, what progress has the Commonwealth made (other than software development) to support the national implementation of the system?

The Commonwealth has committed $5 million over five years (2010-15) to support the establishment of the ERRCD system for use by state and territory regulators. Software development has been the core funded activity, together with security assessment, licensing, convening Commonwealth-State consultative fora, hosting of the system in a secure environment, and developing specifications for pharmacy and prescriber software system changes so that these systems can 'talk' with the central ERRCD system.

I am pleased to advise that the ERRCD system is currently installed on a secure host server and is operational, waiting for each state and territory to commence utilisation. It should be understood that the ERRCD system is not a Commonwealth system. While the Commonwealth has effectively built the system, it will not use the system, and has handed the system over to the states and territories for their use via complementary software licence agreements. This reflects that the regulation of the prescribing and dispensing of these medicines is the responsibility of the states and territories.

The states and territories regulate the use of controlled drugs within their respective jurisdictions, specify reporting requirements, and issue permits to prescribers to allow them to prescribe controlled drugs. ERRCD will allow states and territories to permit prescribers and pharmacists to view certain data to inform their professional practice, and forge agreements on data sharing to prevent individuals from doctor shopping across borders. For advice on

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Telephone: (02) 6289 8400 Facsimile: (02) 6285 1994

progress with implementing ERRCD by each jurisdiction the court may wish to contact the respective state and territory health departments.

Q2: Is the ERRCD system in its current form capable of delivering prescriber and dispenser access to real-time information on prescription dispensing? If so, what is the progress around Australia towards enabling prescribers and dispensers to access this information in real-time?

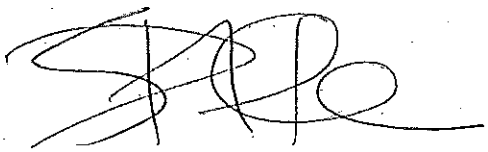
Yes. The ERRCD base system includes this functionality. However, as described above, it awaits action by each state and territory. This is likely to include migrating their existing jurisdictional drug dispensing data to the ERRCD system, managing secure access to the system by prescribers and pharmacists, establishing appropriate alert triggers for health professionals about patients at risk, and other technical matters specific to the needs of each state and territory.

Q3: Have any new hurdles or other issues arisen since your 24 December 2012 response to Coroner Audrey Jamieson, that might inhibit progress towards the national roll-out of the ERRCD system?

There have been no issues arising from a Commonwealth perspective that might affect the capacity for the ERRCD to realise its public health benefits.

I trust this information assists the court. Should you have further questions about the Commonwealth's role in the ERRCD system, please contact Mr Kim Bessell, Principal Pharmacy Advisor and Assistant Secretary, Pharmaceutical Access Branch, directly on (02) 6289 8372.

Yours sincerely



Prof Jane Halton PSM
Secretary

4 March 2014

APPENDIX 3

Department of Health

Secretary

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4 MAR 2014

e3347375

Mr Jeremy Dwyer
Acting Manager
Coroners Prevention Unit
Coroners Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Mr Dwyer

Thank you for your letter of 3 February 2014 on behalf of Coroner Jamieson, seeking an update on Victoria's progress towards implementation of a real-time prescription monitoring system (RTPM).

As you know from previous correspondence, my department has commissioned a business case to analyse the options and determine the potential cost to Victoria of an RTPM, such as the Commonwealth Government's current Electronic Reporting and Recording of Controlled Drugs (ERRCD) initiative. Victoria's business case is in its final stages and is currently undergoing departmental review. It is important that any RTPM system introduced in Victoria can address the aims of the whole-of-government alcohol and drug strategy *Reducing the alcohol and drug toll: Victoria's plan 2013-2017* and be securely maintained and funded into the future. Once this process is complete, the business case will be sent to the Minister for Health for consideration.

Recently, the Commonwealth Government has withdrawn from the steering committee that is responsible for implementation of the ERRCD. While it is not possible to forecast the effect of this upon the actual establishment or maintenance of an RTPM, it does appear to suggest potential delays to a nationally co-ordinated system.

If you have any further questions on this matter, please contact Matthew McCrone, Chief Officer, Drugs and Poisons Regulation on 9096 5066.

Yours sincerely

Pradeep Philip

Dr Pradeep Philip
Secretary

State Government Victoria