IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2013/5488

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 PETER OELFKE

without holding an inquest:
find that the identity of the deceased was PETER OELFKE
born 15 June 1965
and the death occurred on 30 November 2013
at the beach foreshore, Beaconsfield Parade, Middle Park, 3206

from:

1 (a) HAEMOPHILUS INFLUENZAE BRONCHOPNEUMONIA IN THE SETTING OF ALCOHOL AND METHADONE TOXICITY

Pursuant to section 67(1) of the **Coroners Act 2008** there is a public interest to be served in making findings with respect to **the following circumstances**:

1. Peter Oelfke was 48 years of age at the time of his death. He had no fixed address and usually resided in a tent on the beach in the Middle Park area. His medical history included hypertension, opiate and alcohol dependence, back pain and depression.

2. At approximately 7.50am on 30 November 2013, Mr Oelfke's friend, Mr Wakka Kingi, attended his tent and located him on the mattress. At the time, Mr Kingi noticed Mr Oelfke's eyelids flickering, presumed he was asleep and left. Mr Kingi and another friend returned to the tent at approximately 1.55pm and located Mr Oelfke unconscious in the same position. Emergency Services were contacted at 1.59pm, however attending Paramedics were unable to

provide effective medical treatment to Mr Oelfke, who was pronounced dead at approximately 2.45pm.

INVESTIGATIONS

Forensic Pathology

3. Dr Heinrich Bouwer, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed a post mortem examination upon the body of Mr Oelfke, reviewed a post mortem CT scan and reviewed the Victorian Police Report of Death, Form 83. Anatomical findings included bilateral bronchopneumonia, moderate triple vessel coronary artery atherosclerosis, marked hepatosteatosis[1] and a left frontal subgaleal haematoma.[2]

4. Toxicological analysis of blood retrieved post mortem identified the presence of alcohol at a blood alcohol concentration of 0.19g/100ml,[3] methadone (and its metabolite), fluexotine and cannabis. Dr Bouwer noted that according to the Department of Health's records, there was no valid methadone treatment permit for Mr Oelfke at the time of his death.

5. Post mortem microbiology drew haemophilus influenza. Dr Bouwer explained that the mechanism of death was most likely respiratory failure due to severe pneumonia in the setting of drugs that cause central nervous system and/or respiratory system depression. Dr Bouwer further explained that bronchopneumonia often complicates drug use due to the risk of aspiration and decreased consciousness.

6. There was no post mortem evidence of violence or injury contributing to Mr Oelfke's death. Dr Bouwer ascribed the cause of Mr Oelfke's death to haemophilus influenzae bronchopneumonia in the setting of alcohol and methadone toxicity.

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[1] Marked hepatosteatosis refers to a 'fatty liver'.

[2] The skull and intracranial cavity were unremarkable.

[3] The legal limit for blood alcohol for fully licensed car drivers is 0.05g/100mL. BAL in excess of 0.15g/100mL can cause considerable depression of the central nervous system (CNS). Other drugs capable of depressing the CNS will increase the effects of alcohol.

Police Investigation

7. The circumstances of Mr Oelfke's death have been the subject of investigation by Victoria Police. The Police investigation did not identify evidence of third party involvement. No expression of intent in the form of a 'suicide note' was located.

8. Police located a large number of empty wine casks in Mr Oelfke's tent and the surrounding area, and empty bottles of methadone beside the mattress.

9. Police obtained a statement from General Practitioner (GP) Dr Josephine Samuel-King, who practiced at the St Kilda Salvation Army clinic, where Mr Oelfke first attended in May 2011. Mr Oelfke's sister, Ms Trudi Oelfke, did not wish to provide a formal statement, however provided Coroner's Investigator Detective Senior Constable David Clarke with background information relating to her brother via telephone.

10. On the evidence before me, it appears that Mr Oelfke began drinking large amounts of alcohol as early as 14 years of age, and developed a dependence on alcohol shortly thereafter. He began smoking cannabis in his later teenage years. Throughout his twenties and thirties, he began abusing both prescription medication and illicit drugs, primarily heroin, whilst consuming large quantities of alcohol on a daily basis.

11. In or around 2010, Mr Oelfke somewhat withdrew from family contact after they voiced concerns relating to his lifestyle.

12. At some stage in 2013, Mr Oelfke set up a tent on the beach foreshore along Beaconsfield Parade, Middle Park.

13. Mr Oelfke's friends had noticed his alcohol consumption and illicit drug use had significantly increased in the lead up to his death.

14. Dr Samuel-King had been Mr Oelfke's GP and methadone prescriber since early 2013.

15. Dr Samuel-King last consulted with Mr Oelfke on 25 November 2013, and in her statement dated 11 June 2013,[4] recalled that she observed Mr Oelfke to be "severely intoxicated".[5] Dr Samuel-King counselled Mr Oelfke about his substance abuse during this consultation and

[4] Contained in the coronial brief of evidence.

[5] Dr Samuel-King's clinical notes dated 25 November 2013 state that Mr Oelfke was "intoxicated again".

prescribed 70-90mg of methadone daily, three takeaway doses per week, not all at once, with a plan to review Mr Oelfke on 16 December 2013.

16. A review of the St Kilda Salvation Army clinic clinical records demonstrate that Mr Oelfke had a documented history of homelessness,[6] substance abuse,[7] and known instances of mixing methadone with alcohol and cannabis.[8]

Further investigations

17. In August 2014, a history of the Victorian Department of Health (DoH)[9] Schedule 8 permits was obtained. The history indicated that there had been a current permit for methadone in respect of Mr Oelfke at the time of his death.[10]

18. A letter dated 5 November 2014 was sent to Mr Matthew McCrone, Chief Officer, Drugs and Poisons at the DoH by the Coroner's Solicitor on my behalf. The letter sought to clarify the apparent discrepancy regarding the status of Mr Oelfke's methadone permit. The letter also referred to the DoH's 2013 *Policy for Maintenance Pharmacotherapy for Opioid Dependence* (the Policy),[11] which provides, amongst other things, a checklist prescribers are recommended to use to evaluate a patient's suitability for takeaway doses. Mr McCrone was requested to provide comments regarding whether Mr Oelfke's circumstances satisfied the Policy, specifically in relation to his unstable accommodation and his intoxicated state when his last methadone script was obtained.

19. In a letter dated 26 November 2014, Mr McCrone confirmed that a permit was held by Dr Samuel-King to treat Mr Oelfke with methadone and explained the reason for the apparent discrepancy.

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[6] As indicated by clinical record entries of 18 February 2013, 22 February 2013, 12 March 2013, 19 April 2013, 30 May 2013, 27 June 2013, 6 August 2013, 1 October 2013 and 25 November 2013.

[7] As indicated by clinical record entries of 26 February 2013, 28 February 2013, 12 March 2013, 15 March 2013, 19 April 2013, 3 May 2013, 30 May 2013, 29 July 2013, 2 September, 2013, 7 November 2013 and 25 November 2013.

[8] As indicated by the clinical record entry dated 15 March 2013.

[9] As it then was.

[10] The Schedule 8 permit history demonstrates Mr Oelfke had permits in respect of opioid replacements therapy intermittently since 1995.

[11] Drugs and Poisons Regulation, Victorian Department of Health, *Policy for Maintenance Pharmacotherapy for Opioid Dependence*, 2013.

20. Mr McCrone stated that the Policy recommends to prescribers that patients should be a on a high level of supervision if there is no stable accommodation. He also stated that patients presenting to the medical clinic in an intoxicated state might signify unstable patterns of use of alcohol or other drugs, and in such circumstances, the Policy recommends against prescribing takeaway doses.

COMMENTS

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

21. The Policy 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.[12]

22. 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.[13]

23. I note the Policy clearly identifies contraindications to take-away doses as including unstable patterns of substance use, including significant use of alcohol.[14] The Policy also identifies a

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[12] Drugs and Poisons Regulation, Victorian Department of Health, *Policy for Maintenance Pharmacotherapy for Opioid Dependence*, 2013, page 7.

[13] Ibid.

[14] Ibid, page 22.

lack of stable accommodation as a factor that scores a patient as requiring a 'high level of supervision'.[15] According to the Policy, if a patient scores 'high level of supervision' on any single criterion, no take-away doses should be provided to them on a regular basis[16] and they should only be eligible for high level supervised dosing.[17]

24. I also note that the Policy includes methods to assess patient stability. Patient instability is indicated by, amongst other things, alcohol use, intoxicated presentations at medical clinics and a lack of stable accommodation.[18] The policy states that assessment across these domains should occur regularly and be documented, and that if a patient's level of stability changes, the availability of unsupervised medication should be reviewed.[19]

25. I accept that the Policy provides General Practitioners with guidance on safe treatment/prescription and is not intended (in its current form) to replace professional judgment in individual cases.[20] However, on the basis that it appears Dr Samuel-King knew her patient was not in stable accommodation, frequently mixed his methadone with other substances, and frequently presented to the clinic intoxicated, it appears that Dr Samuel-King's continual prescription of methadone to Mr Oelfke, particularly on 25 November 2013, was a significant oversight. I however recognise the complexity of patient presentations faced by primary health care workers on a daily basis, and I do not consider that in this instance, the situation warrants an adverse comment against Dr Samuel-King in this jurisdiction, but rather might be a matter more appropriately addressed by her professional regulating body.

26. The difficulties and consequences associated with the practical implementation of the DoH's Policy is not a matter foreign to the coronial jurisdiction. This issue arises relatively frequently in both intentional and unintentional deaths relating to takeaway doses of methadone, albeit it different circumstances, including following release from prison,[21] and diversion of takeaway methadone.[22]

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[15] Policy, page 26.

[16] Policy, page 22.

[17] Policy, page 26.

[18] Policy, page 28.

[19] Policy, pages 28-29.

[20] Policy, page 27.

[21] COR 2012 2254.

[22] COR 2012 0485.

27. The circumstances of Mr Oelfke's death highlight just how a GP working in a busy practice can exercise their clinical discretion in a manner *prima facie* inconsistent with the guidance provided by the Policy.

28. The core issue appears to be that the Policy functions as a *guideline* rather than providing *criteria* that impact on the permit to provide takeaway doses of methadone to relevant patients. The Policy's guideline status therefore theoretically and practically *allows* for a permit in respect of takeaway methadone doses to continue when the person to whom the permit applies does not comply with the checklist criteria for takeaway doses.

RECOMMENDATIONS

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

It is understandable why the DoH created the Policy, both in its current and previous (2006) forms, to permit practitioner discretion and decision-making in relation to takeaway methadone doses. However, in the years of its operation, it has become apparent that the Policy's practical application in relation to takeaway methadone doses is neither congruous to nor appropriate for the exigencies of modern general practice.

I therefore **recommend** that the Victorian Department of Health and Human Services review the circumstances of Mr Oelfke's death, in considering whether the current takeaway dosing advice in the *Victorian Policy for Maintenance Pharmacotherapy for Opioid Dependence* provides sufficient criteria (rather than guidance) for the ongoing nature of permits for takeaway dosing of methadone, considering the practical realities of general practice medicine, including patient volumes, consequential time allocation, and the broad clinical discretion provided to General Practitioners that ultimately permit the circumstances surrounding Mr Oelfke's (and others') death.

FINDINGS

It appears that Mr Oelfke appeared resistant to suggestions of reducing his alcohol consumption, and rather was observed to increase his alcohol consumption in the months prior to his death.

I accept and adopt the medical cause of death as identified by Dr Heinrich Bouwer and find that Peter Oelfke died from haemophilus influenzae bronchopneumonia in the setting of alcohol and methadone toxicity in circumstances where I am satisfied that he has suffered the unintentional

consequences of intentionally consuming prescription and illicit drugs, mixed with alcohol, when his underlying respiratory status was already compromised.

I direct that the Findings be published on the internet.

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

Ms Jodie Oelfke

Ms Annette Parker

Dr Josephine Samuel-King

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

Dr Pradeep Philip, Secretary, Department of Health and Human Services

Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria

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

Mr John Ryan, Chief Executive Officer, Penington Institute

Australian Health Practitioner Regulation Agency

Detective Senior Constable David Clarke

Signature:

AUDREY JAMIESON
CORONER
Date: **20 January 2015**