IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 002127

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**NJ**[1]
Date of birth:	8 June 1979
Date of death:	1 May 2015
Cause of death:	1(a) COMBINED DRUG TOXICITY
Place of death:	Ripponlea, Victoria

[1] The names of the deceased and her family members have been redacted to protect their identities.

HER HONOUR:

Background

1. NJ was born on 8 June 1979. She was 35 years old when she died from combined drug toxicity.

2. NJ lived in Ripponlea with her partner at the time, JT, and his brother ST. She is survived by her son TB.

3. NJ had a long history of alcohol abuse and illicit and prescription drug use. She suffered from Hepatitis C, depression and chronic pain from an ankle fracture she suffered in 2013.

The coronial investigation

4. NJ's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[2]

6. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

[2] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into NJ's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses, and submitted a coronial brief of evidence.

9. During my investigation I was assisted by the Coroners Prevention Unit (**CPU**). The CPU is a specialist unit within the Coroners Court comprised of practising doctors and nurses as well as researchers. The CPU provides advice to coroners on opportunities for prevention, particularly where the deceased had involvement with health care services. In this case the CPU reviewed the Pharmaceutical Benefits Scheme (**PBS**) Patient Summary in relation to NJ, her medical records, and statements obtained from her treating doctors.

10. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

11. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Circumstances in which the death occurred

12. In approximately 1999 NJ commenced a relationship with YB. They had a son TB together. NJ and YB engaged in illegal drug use together until YB participated in a 12 month rehabilitation program to address his substance abuse. The relationship broke down and YB gained full custody of TB.

13. In early 2014 NJ became friends with JB who was a former partner of YB. NJ and JB subsequently commenced an intimate relationship. They tried to move in together in January 2015, however NJ did not receive approval to add JB as a tenant in her supported accommodation in South Melbourne.

14. On 2 February 2015 JB hanged herself at NJ's supported accommodation, leaving a suicide note. NJ found JB at about 2.00am the following morning. NJ subsequently moved out of this accommodation.

15. On 30 April 2015 NJ was with JT and ST at their apartment in Ripponlea, drinking alcohol and watching television. NJ asked if either JT or ST would buy methylamphetamine or

heroin for her, but they refused. At approximately 4.00pm, ST took his sleeping medication and went to bed.

16. At approximately 5.45pm NJ left the apartment to collect her methadone and oxazepam prescriptions. A short time later she returned and knocked on the window for JT to let her back in. They continued to watch television until around 11.00pm when they went to bed. NJ fell asleep at the end of the bed with her feet and legs on the floor.

17. At approximately 3.00am on 1 May 2015 ST awoke and went to get a drink of water. He noticed that NJ appeared to be slumped on the end of her bed, fully clothed. He considered taking off her shoes and putting her into bed properly but felt he did not know her well enough. He assumed she would move herself if she was uncomfortable and returned to bed.

18. At around 9.45am JT woke up. NJ was still lying at the end of the bed slumped over. He tried to wake her but was unsuccessful. He noticed she was very cold and her skin was blue.

19. JT woke his brother and they tried to roll NJ over, but she was very stiff and could not be moved. JT telephoned triple-0. Ambulance officers attended and confirmed NJ was deceased.

20. Police officers attended the apartment at approximately 9.56am. One of the attending officers observed: *'The apartment was in extremely bad condition and looked as if it had not been cleaned in a long time with rubbish littered around the room, syringes capped and uncapped on the bedroom floor and a large amount of empty alcohol containers on every piece of furniture that could hold them'*.

21. Police located and seized a number of medications and medication containers in the apartment, mostly in NJ's name, including pregabalin, methadone, mirtazapine and oxazepam.

Identity of the deceased

22. NJ was visually identified by her partner and housemate JT on 1 May 2015. Identity was not in issue and required no further investigation.

Medical cause of death

23. On 7 May 2015, Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy on the body of NJ after reviewing a post mortem CT scan. The autopsy revealed some natural disease including chronic asthma, liver disease, mild coronary artery disease and minor thyroid disease.

24. Toxicological analysis of post mortem specimens taken from NJ identified the presence of **methadone**, a very high level of **pregabalin**,[3] **methamphetamine** and its metabolite, **diazepam** and its metabolite, **oxazepam**, **mirtazapine**, **promethazine** and **paracetamol**. Dr Burke opined that this combination of drugs was consistent with causing death.

25. After reviewing toxicology results, Dr Burke completed a report, dated 29 June 2015, in which he formulated the cause of death as '1(a) combined drug toxicity'. I accept Dr Burke's opinion as to the medical cause of death.

Source of the pharmaceutical drugs taken by NJ

Methadone

26. NJ was a former heroin user and was opioid dependent. She commenced Opioid Replacement Therapy (**ORT**) on 23 August 2000 under the care of Dr Paul Blatt in St Kilda. She continued treatment intermittently between 2000 and 2015, occasionally changing to a new doctor or temporarily ceasing therapy. At the time of her death, NJ was being treated by Dr Ewa Conroy at the Albert Park Medical Centre, who had held an ORT permit since 26 November 2013. Dr Conroy also previously held permits on behalf of NJ in 2004, 2005 and 2010.

27. In the 12 months leading up to her death NJ's daily methadone dose ranged between 110mg and 140mg, depending on her presentation and description of symptoms. Dr Conroy authorised five unsupervised doses of methadone per week for the entire period. She last prescribed methadone to NJ on 26 March 2015, over the telephone. There is no evidence to suggest that NJ obtained methadone from any other source.

[3] 40mg/L (i.e., per litre of blood) of pregabalin was detected post-mortem. Peak plasma concentrations in adults given a 50mg dose average 1.9mg/L. A single 300mg dose in adults results in an average peak plasma level of 7.5mg/L. Pregabalin concentrations of between 25 and 180mg/L are associated with fatalities where there are significant levels of at least one other drug.

Pregabalin

28. There is no direct evidence of the reason why doctors prescribed pregabalin to NJ, however given her ongoing reports of pain it was likely part of her pain management strategy. Pain was a recurring theme in her medical presentations, and one doctor she consulted, Dr Daniel Strahan, stated it was one of her chief medical complaints. He also noted that doctors at his clinic, the Carlisle Contemporary Health Practice, prescribed NJ 300mg pregabalin daily.

29. In the 12 months before NJ's death, pregabalin was prescribed to her by various doctors at Carlisle Contemporary Health Practice, Albert Park Medical Centre, Chapel Gate Medical Centre, Alfred Health and the St Kilda Superclinic. In early 2015, NJ was prescribed a large quantity of pregabalin through the following consultations:

- 3 January 2015 – Dr Brian McLaughlin (St Kilda Superclinic) 75mg, 56 tablets, 0 repeats;
- 6 January 2015 – Dr Ewa Conroy (Albert Park Medical Centre) 150mg, 56 tablets, 5 repeats;
- 5 February 2015 – Dr Tian Tu (Alfred Health) 150mg, 56 tablets, 0 repeats;
- 6 February 2015 – Dr David Izon (Albert Park Medical Centre) 150mg, 56 tablets, 0 repeats;
- 22 February 2015 – Dr Stephen Pett (St Kilda Superclinic) 75mg, 56 tablets, 0 repeats;
- 24 February 2015 – Dr Eugene Kalnin (Chapel Gate Medical Centre) 150mg, 56 tablets, 5 repeats;
- 24 February 2015 – Dr Ewa Conroy (Albert Park Medical Centre) 150mg, 56 tablets, 5 repeats;
- 23 March 2015 – Dr Daniel Strahan (Carlisle Contemporary Health Practice) 150mg, 56 tablets, 5 repeats; and
- 8 April 2015 – Dr John Coleridge (Carlisle Contemporary Health Practice) 150mg, 56 tablets, 5 repeats.

30. According to the dosage instructions that Dr Strahan described in his statement to the Court, the quantity of medication that he authorised on 23 March 205 should have been a six month supply. Less than one month later, on 8 April 2015, Dr Coleridge at the same clinic provided a prescription and enough repeat authorities for a further six months[4]. These were the last two prescriptions of pregabalin that were provided to NJ and photographic evidence contained in the coronial brief identified Dr Strahan as the prescribing doctor of an empty pregabalin packet discovered by police at the scene of NJ's death.

31. The pregabalin prescription dated 24 February 2015 provided by Dr Kalnin does not appear in the Chapel Gate Medical Centre records, so the precise dosage instructions cannot be determined. Doctors at the Albert Park Medical Centre and Carlisle Contemporary Health Practice both prescribed pregabalin for twice daily usage. Assuming that all the prescriptions followed the same dosage, NJ would have required 242 tablets between the start of 2015 and 1 May 2015, whereas PBS records show a total of 952 pregabalin tablets were dispensed to her over this period.

Diazepam and oxazepam

32. In the 12 months before her death, NJ obtained overlapping prescriptions for oxazepam and diazepam from at least six different medical practices. Some doctors prescribed both of the drugs to her, occasionally during the same consultation. They were primarily prescribed to treat her anxiety, however she occasionally reported trouble sleeping and it is possible that oxazepam was prescribed for its combined anxiolytic and sedative effects. NJ admitted to several medical practitioners that she had a benzodiazepine dependence and also that she preferred oxazepam to diazepam as she *'needs 3-4 valiums* [diazepam] *to relax, where murelax* [oxazepam] *1-2'*.[5] She told her doctors as early as 2011 that she would purchase alprazolam *'off the street'* when her oxazepam prescription ran out.

33. Some of NJ's prescribing doctors tried to limit her access to diazepam and oxazepam. On 21 November 2011, Dr Carrie Lee at the Chapel Gate Medical Centre prescribed 50 diazepam tablets to NJ. She authorised immediate dispensation of only 25 tablets and the remaining 25 tablets after 12 days. Dr Kalnin at the same clinic adopted the same strategy when he took over prescribing diazepam to NJ in February 2015. Doctors at Chapel Gate

[4] Dr Coleridge gave as one explanation that he may have accidentally pressed the print button and then destroyed the script, however PBS records show that his prescription was dispensed on the same day.
[5] Medical record of Chapel Gate Medical Centre.

Medical Centre also tried to control her supply of oxazepam by occasionally directing her to obtain the medication from a specified pharmacy.

34. Police did not recover any packets of diazepam at NJ's apartment, however they did locate a packet of oxazepam prescribed by Dr Kalnin on 13 April 2015, at which time he also prescribed diazepam to NJ. The PBS Patient Summary indicated both of these prescriptions were dispensed the following day.

Mirtazapine

35. Mirtazapine is an antidepressant indicated for the treatment of major depression. In their statements, Dr Strahan and Dr Kalnin listed depression as one of NJ's medical conditions.

36. NJ had previously taken antidepressants. Most recently she commenced taking mirtazapine in September 2014. Over the next seven months she obtained the following prescriptions:

- 11 September 2014 – Dr Mansi Patel (Eastwood Family Clinic) 30 mg, 30 tablets, 5 repeats;
- 9 October 2014 - Dr Muhammad Shakir (Eastwood Family Clinic) 30mg, 30 tablets, 5 repeats;
- 3 November 2014 – Dr Elspeth Rae (Eastwood Family Clinic) 30mg, 30 orally disintegrating tablets, 5 repeats;
- 6 November 2014 – Dr Daniel Strahan (Carlisle Contemporary Health Practice) 30mg, 30 orally disintegrating tablets, 5 repeats; and 30mg, 30 tablets, 5 repeats;
- 11 November 2014 - Dr Eugene Kalnin (Chapel Gate Medical Centre) 45 mg, 30 orally disintegrating tablets;
- 18 December 2014 - Dr Eugene Kalnin (Chapel Gate Medical Centre) 30mg, 30 tablets, 5 repeats;
- 21 December 2014 – Dr Paul Blatt (own practice) 30mg, 15 orally disintegrating tablets, 0 repeats;

- 28 January 2015 – Dr Eugene Kalnin (Chapel Gate Medical Centre) 45mg, 30 orally disintegrating tablets, 5 repeats; and 45mg, 30 tablets, 5 repeats;
- 5 February 2015 – Dr Tian Tu (Melbourne) 45 mg, 30 tablets, 0 repeats;
- 14 February 2015 – Dr Solmaz Tatari (St Kilda Superclinic) 45mg, 30 orally disintegrating tablets, 5 repeats;
- 13 March 2015 – Dr Eugene Kalnin (Chapel Gate Medical Centre) 45mg, 30 orally disintegrating tablets, 5 repeats; and
- 20 March 2015 – Dr Daniel Strahan (Carlisle Contemporary Health Practice) 30mg, 30 orally disintegrating tablets, 5 repeats.

37. The instructions provided to NJ by doctors at the Carlisle Contemporary Health Practice and the Chapel Gate Medical Centre were to take one tablet of mirtazapine daily. A packet of 30 tablets should therefore have lasted one month, and each of the prescriptions above that included five repeat authorities should have lasted 6 months.

38. The excessive supply of this medication was not entirely due to NJ's attendance at multiple practitioners. For example, Dr Kalnin provided her with a six month prescription of mirtazapine on 11 November 2014 and then a further six month supply on 18 December 2014.

39. Not all of the prescriptions listed above were dispensed. Between September 2014 and April 2015, the PBS Patient Summary shows that 645 mirtazapine tablets were dispensed to NJ. If she only took one tablet per day as prescribed, she would have needed approximately 223 tablets. At the time of her death NJ still held prescriptions with undispensed repeat authorities.

Promethazine

40. Promethazine is an antihistamine used for allergenic conditions such as rhinitis; it also has sedative properties. It is available as an over the counter medication and does not require a prescription. If required, a doctor may still prescribe promethazine to a patient and some formulations will need a prescription. Promethazine is often combined with paracetamol (which was also found in NJ's post mortem samples).

41. There is no evidence in the medical records or PBS Patient Summary that any doctor prescribed promethazine to NJ. It is possible that a doctor whose records do not form part of the coronial file privately prescribed this medication to NJ, or that she simply purchased it over the counter. It is possible that the paracetamol and promethazine detected came from a single store-bought medication containing both drugs. Police did not identify any packets of either drug at NJ's residence.

Prescribing Issues

42. The CPU identified the features of the case that allowed NJ to obtain an excessive supply of pharmaceutical medication were: her *'prescription shopping'*; contra-indicated benzodiazepine prescribing; long-term benzodiazepine prescribing; and unsupervised methadone prescribing to an unstable patient.

Prescription shopping

43. For at least 12 months prior to her death, NJ accessed multiple concurrent medical services to obtain a quantity of pharmaceutical medication in excess of her therapeutic needs. Prescriptions provided by doctors often overlapped with prescriptions she had received from other prescribers. Some examples of overlapping prescriptions include:

- On 6 November 2014, NJ obtained a prescription of diazepam from Dr Strahan at Carlisle Contemporary Health Practice. She then obtained a prescription of diazepam from Dr Conroy at Albert Park Medical Centre on 7 November 2014 and from Dr Lee at the Chapel Gate Medical Centre on 21 November 2014. Although she admitted to purchasing benzodiazepines from illicit sources, there is no indication that she advised her doctors that she was also obtaining the medication from other practitioners.

- On 16 February 2015, NJ obtained a prescription for oxazepam from Dr Kalnin at the Chapel Gate Medical Centre. On 22 February 2015, she obtained a second prescription from Dr Pett at the St Kilda Superclinic and a third prescription on 24 February 2015 from Dr Conroy at the Albert Park Medical Centre.

- On 22 February 2015, NJ obtained a prescription for pregabalin from Dr Pett at the St Kilda Superclinic. Then on 24 February 2015, she obtained prescriptions for

pregabalin from Dr Conroy at Albert Park Medical Centre and Dr Kalnin at Chapel Gate Medical Centre. Each of these three prescriptions were for a large quantity of medication, not requiring a further prescription for six months.

- On 13 March 2015, NJ obtained a prescription of mirtazapine from Dr Kalnin at the Chapel Gate Medical Centre and another on 20 March 2015 from Dr Strahan at Carlisle Contemporary Health Practice. Each of these prescriptions ought to have lasted NJ for six months without the need for further prescriptions.

44. NJ's tendency to engage multiple practitioners in her medical treatment was likely due to her dependence on prescribed medication. Doctors at Carlisle Contemporary Health Practice and the Chapel Gate Medical Centre were aware that NJ was an active ORT patient at the Albert Park Medical Centre. However there are no other indications that these doctors ought to have known which practices she was attending and what medication she had otherwise obtained.

45. Mirtazapine and pregabalin are often identified in drug overdose deaths, following episodes of problematic prescribing. Although mirtazapine and pregabalin are not defined as 'drugs of dependence' in the *Drugs Poisons and Controlled Substances Act 1981 (Vic)*, patterns of drug dependence may still emerge and they are often obtained through prescription shopping. An attraction of Pregabalin to drug dependent people is its ability to enhance the effects of opioid analgesics, benzodiazepines and ethanol. Additionally, studies have shown that people misuse pregabalin for its euphoric effects.[6] These properties not only explain its appeal, but also demonstrate its potential to cause harm.

46. NJ obtained an excessive supply of both mirtazapine and pregabalin, not entirely from overlapping prescribers. Some doctors prescribed before a resupply was due and did not explain the further prescription in their clinical notes. It is possible that doctors are less concerned about prescribing mirtazapine and pregabalin in greater quantities because they are not classified as drugs of dependence and they are not perceived as 'risky' drugs. Certainly, Dr Coleridge confirmed that his view of pregabalin at the time he was prescribing to NJ was that it did not have any significant abuse potential. He advised that he has since

[6] See Evoy KE, Morrison MD, & Saklad SR. (2017). "Abuse and Misuse of Pregabalin and Gabapentin". *Drugs*, vol 77, no 4, pp.403-426.

researched the issue and understands that there are reports and warnings available online about this drug.

47. Neither Dr Strahan, nor Dr Coleridge nor Dr Kalnin formed the view that NJ was a doctor-shopper. Although it is not recorded in his notes, Dr Strahan stated that he recalled contacting the Prescription Shopping Information Service (**PSIS**) on one occasion.[7] Dr Kalnin acknowledged he was aware of the PSIS, but did not use the service because he didn't believe NJ was a prescription-shopper. He also did not believe NJ was attending any other clinics and therefore saw no need to co-ordinate care with other doctors.

48. Dr Conroy stated that she took NJ on as a patient on the proviso that she only see Dr Conroy, because Dr Conroy had checked and confirmed NJ was listed as a doctor-shopper.

Contraindicated benzodiazepine prescribing

49. Benzodiazepines are highly represented in pharmaceutical drug overdose deaths. They are classed as 'drugs of dependence' and are therefore subject to additional prescribing requirements as follows.

50. Of relevance, where a doctor believes that a drug dependent patient is requesting a drug of dependence, or the doctor intends to prescribe a drug of dependence to that patient, the doctor is required to formally notify Drugs and Poisons Regulation (**DPR**)[8].

51. None of the practitioners who prescribed the drugs of dependence that contributed to NJ's death ever made such a notification to DPR, despite evidence in their medical records that they were aware of her substance use disorder. There are several instances where the medical records indicated that such a notification should have been made:

    - There are numerous occasions in the Carlisle Contemporary Health Practice records where NJ's reason for presenting is listed as 'substance dependence'. Doctors as this clinic were responsible for prescribing various drugs of dependence to NJ, including diazepam and oxazepam.

[7] The PSIS requires that certain criteria are met before they release information regarding a patient. It is possible that NJ did not meet these criteria at the point in time when Dr Strahan contacted the service.
[8] *Drugs Poisons and Controlled Substances Act 1981 (Vic)*, section 3. See Schedule 2 of the *Drugs Poisons and Controlled Substances Regulations 2006* for the prescribed form.

- NJ told doctors at the Chapel Gate Medical Centre, as early as December 2010, that she was buying alprazolam from an illegal source and made the same admission several times during her history with the clinic. Doctors at Chapel Gate Medical Centre intermittently prescribed oxazepam and diazepam to NJ across the 12 months preceding her death.

- Dr Conroy at the Albert Park Medical Centre held a Schedule 8 permit with DPR, to treat NJ's opioid dependence through ORT. The fact of such a permit does not, however, relieve a doctor of his or her obligation to notify DPR when a patient requests or the doctor intends to prescribe another drug of dependence such as diazepam or oxazepam.

52. Dr Strahan stated that he was originally unaware of the requirement to notify DPR, but became aware of this requirement and the service provided by DPR during his engagement with NJ. He did contact DPR in late 2013 and they advised him he should seek specialist advice before continuing to prescribe to NJ. He obtained such an advice and provided it to DPR.

53. Dr Kalnin stated that he did form the opinion that NJ was dependent on benzodiazepines, but conceded he was unaware at the time of treating NJ that he was obliged to contact DPR in respect of patients he suspected of drug dependence. He stated he is now familiar with this requirement.

54. Dr Conroy stated she was aware of the obligation to contact DPR, but saw no need to contact them in NJ's case, and did not see how it might benefit NJ's treatment.

55. Also relevant is the Royal Australian College of General Practitioners (**RACGP**) guidelines, the *Prescribing Drugs of Dependence in General Practice, Part B – Benzodiazepines* published in 2015. The guideline is intended to reduce the risks associated with benzodiazepine use and promote clinically appropriate strategies for prescribing these drugs. It provides limited scope to prescribe outside of the key principles, as long as the doctor has a defensible reason for doing so.

56. The guideline contains the following advice regarding contraindicated benzodiazepine prescribing:

- Benzodiazepines should not be prescribed, or prescribed with extreme caution, to:
    - Patients with active substance use disorder, including alcohol (unless it is a part of an alcohol withdrawal program);
    - Patients being treated with opioids for chronic pain or addiction; and
    - Patients experiencing grief reactions, as benzodiazepines may suppress and prolong the grieving process.

57. The doctors who prescribed benzodiazepines to NJ did not appear to follow these principles. The medical records of the Chapel Gate Medical Centre, Carlisle Contemporary Health Practice and the Albert Park Medical Centre all indicated that the doctors at these clinics were aware of NJ's substance use disorder, and specifically were aware of her problematic use of benzodiazepines. The records reveal that NJ admitted to doctors that she also obtained the drug from illicit sources. All three practices were aware that NJ was an active ORT patient but prescribed benzodiazepines while she continued treatment with methadone. Finally, these clinics did not appear to modify their benzodiazepine prescribing practices during times of extreme stress, such as after NJ lost custody of her son, nor after her partner's suicide.

<u>Long-term benzodiazepine prescribing</u>

58. Treatment with benzodiazepines is a short-term strategy and this is widely acknowledged in health policy and literature, including the RACGP *Prescribing Drugs of Dependence in General Practice, Part B – Benzodiazepines* Guideline and the *eTG Complete* therapeutic guideline, which states:

    Benzodiazepine consumption exceeding one month, particularly at high doses, risks development of dependence. The risk increases with the duration of treatment. About a third of patients who have been prescribed benzodiazepines long term may have difficulty in reducing or stopping them. There is little, if any, justification for prescribing benzodiazepines beyond a few days. Clinicians encountering patients taking benzodiazepines long term should encourage them to slowly reduce the dose to zero.

59. NJ was prescribed benzodiazepines over a long term. Doctors prescribed benzodiazepines to NJ for years and in the context of personal instability, while she exhibited several

indicators of problematic use. The medication was prescribed as a long term solution to her anxiety and insomnia, without any lasting support from a mental health practitioner. There is no indication that any of the prescribing doctors developed a strategy to cease her use of this drug.

60. Dr Strahan stated he was not familiar with the RACGP guideline while treating NJ, but is now aware of its contents. In any event, his typical practice was not to prescribe benzodiazepines for longer than eight weeks and claimed he did not do this in NJ's case. Instead, he explained his prescribing as encompassing seven distinct episodes of treatment within a two year period.

61. Dr Kalnin stated he was aware of the RACGP guideline, but has re-familiarised himself with its contents, and intends to make a *'concerted effort to implement the principles outlined in the guidelines'*. Dr Kalnin has since completed several online education modules which contain information relating to the prescribing of drugs of dependence, risks and contemporary prescribing practices.

62. Dr Conroy stated she had a plan to reduce and cease prescribing benzodiazepines to NJ, but this would take a long time. She also noted that if she did not prescribe benzodiazepines to NJ, it was her view that NJ would have obtained them illicitly anyway.

<u>Unsupervised methadone prescribing to an unstable patient</u>

63. Unsupervised or 'takeaway' methadone is an ORT strategy where the prescribing doctor authorises the patient to take home a specified number of their weekly methadone doses. It is designed to minimise the impact that ORT has on a patient's lifestyle, by removing the need for daily attendance at the pharmacy.

64. Whilst it may be convenient, unsupervised methadone dosing presents a significant risk of harm to the patient and the community. Once methadone is dispensed as an unsupervised dose, there is less control over how it is used by the patient and there is a risk that it may be diverted to others or misused, such as being consumed at higher than recommended quantities.

65. The 2013 version of the Victorian Department of Health and Human Services (**DHHS**) *Policy for Maintenance Pharmacotherapy for Opioid Dependence*, was the primary

guideline for Victorian ORT practitioners establishing the framework for unsupervised methadone dosing in the period leading up to NJ's death.[9] Under the heading 'Contraindications to take-away doses' the policy described scenarios that were unsuitable for the authorisation of unsupervised dosing:

- Unstable patters of substance use, including significant use of alcohol, illicit drugs, benzodiazepines or other sedating medication.

- Significant unstable psychiatric conditions, including active psychosis, significant suicidal ideation and depression.

- Unstable medical conditions (for example decompensated cirrhosis, pneumonia).

- Reasonable concerns about diversion of doses for illicit or unsanctioned use. This requires an assessment of the stability of the patient's home environment (for example, whether they are living with another substance abuse), their means of securing the take-away doses away from children and other potential misusers, and their past performance with take-away doses.

66. All of the above criteria applied to NJ's circumstances, at different times. The Albert Park Medical Centre records indicate that NJ was exhibiting unstable drug use in the 12 months prior to her death. In this regard, the following aspects of Dr Conroy's treatment are noteworthy:

- In July 2010 Dr Conroy received a Patient Summary Report regarding NJ, provided by Medicare Australia. The report indicated that NJ met the prescription shopping program criteria and listed the volume of medication that was dispensed to her between April and June 2010. She received a further report in June 2013, indicating an even greater level of pharmaceutical use.

- On 21 January 2014, Dr Conroy had a *'long discussion'* with NJ regarding her concerning use of oxycodone and that she had been *'getting scripts behind my back'*. This was not the only occasion where Dr Conroy had identified evidence of prescription shopping behaviour.

[9]This policy was substantially revised in 2016 and access to unsupervised doses of methadone further restricted.

- On 24 April 2014, NJ admitted to Dr Conroy that she was *'panicking, using drugs'*; likely referring to an episode of illicit drug use.

- On 9 December 2014, Dr Conroy's consultation notes include the comment *'using drugs – ecstasy, ice, heroin + benzos (serapax and valium – buys them from people)'*. The illicit use of benzodiazepines is particularly concerning and Dr Conroy herself continued to prescribe benzodiazepines after this date.

67. Further, although she was not formally diagnosed with a mental illness, NJ often demonstrated signs of instability. Dr Conroy described her life as *'very chaotic'*. Her ongoing contest over the custody of her son was a source of significant emotional distress, as was the suicide of her partner. NJ was attending frequent medical appointments with numerous health concerns and it was arguable this was an indicator of mental instability. Finally there were several notations in the Albert Park Medical Record where NJ reported she was living in temporary accommodation and it is difficult to establish whether she could properly secure her take-away methadone doses.

68. Dr Conroy authorised the maximum of five doses of unsupervised methadone per week, for the entire 12 months preceding NJ's death. There were times during those 12 months when, according to the pharmacotherapy policy, no unsupervised doses should have been authorised. Dr Conroy stated that NJ was already on 5 takeaway doses of methadone when she came under her care. Her proffered reason for continuing this regime was that 'she was a quite busy single mother, moving around Melbourne and generally chaotic so likely to miss her doses'. Further, according to Dr Conroy, there was no suggestion of diversion, misuse or self-harm and she was careful to prevent access by her son. I am not satisfied there were any convincing reasons to authorise unsupervised dosing for NJ. She was unemployed and there were no significant barriers to daily attendance at the pharmacy.

NJ's intention

69. Although the toxicology report indicates that NJ had consumed a large quantity of pregabalin, there is nothing in the circumstances to indicate that she intended to end her life.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was NJ, born 8 June 1979;

(b) NJ died on or about 1 May 2015 at Ripponlea, Victoria, from combined drug toxicity;

(c) her death was the unintended consequence of the deliberate ingestion of drugs; and

(d) the death occurred in the circumstances described above.

Comments

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

1. NJ died after consuming a combination of drugs, including the illegal drug methamphetamine and the pharmaceutical drugs methadone, pregabalin, diazepam, oxazepam, mirtazapine, promethazine and paracetamol. Forensic Pathologist Dr Michael Burke advised that the combination of drugs was consistent with causing death. I note that methamphetamine and opioids (such as methadone) are known to interact and enhance the effects of one another. Additionally the central nervous system depressants methadone, pregabalin, diazepam, oxazepam, mirtazapine and promethazine can have additive or synergistic depressant effects when combined, resulting in exaggerated respiratory depression and sedation.

2. The pharmaceutical drugs that contributed to NJ's death were prescribed to her by at least four different doctors practising at different clinics. It is pleasing to note that during my investigation three doctors (Drs Strahan, Coleridge and Kalnin) all provided responses which indicated a strong commitment to improving their knowledge and practices in relation to drug dependent patients.

3. NJ's treating doctors could not have known the exact quantity of medication that was being prescribed to NJ, because they were unaware of the medications being simultaneously provided by other practitioners. NJ's tendency to engage in prescription-shopping undermined her medical treatment and prevented the doctors from accurately diagnosing her health issues. Thus, her pharmaceutical drug dependence was not formally diagnosed and the doctors continued to treat her based on self-reporting and her presenting medical complaints.

4. I understand that the DHHS is well advanced in its planning for the implementation of a Victorian real-time prescription monitoring system, which will enable doctors to access information on what drugs have been dispensed to patients they see. It is hoped that after this system is implemented, when a patient attends multiple doctors as NJ did, the doctors will be able to use the patient's dispensing history to make better-informed clinical decisions about treatment and prescribing.

5. At present, the DHHS's Real-Time Prescription Monitoring Taskforce is considering what drugs outside Schedule 8 should be included in the scope of monitored drugs. This question is directly relevant to the circumstances of NJ's death. At least four of the contributing drugs (pregabalin, diazepam, oxazepam and mirtazapine) are not Schedule 8 drugs, and yet appropriate prescribing decisions could not be made unless NJ's doctors knew of her use of these drugs. Over the past four years, I with several of my colleagues, have made comments and recommendations in findings regarding the need for Victorian's real-time prescription monitoring system to monitor dispensing of all prescribed drugs. The circumstances of NJ's death provide further support for this position.

6. Further, this matter is yet another illustration of the persistent problem of long-term benzodiazepine prescribing. The Court has previously recommended that the Therapeutic Goods Administration (**TGA**) re-schedule benzodiazepines to Schedule 8, but the TGA has determined not to implement this recommendation. I remain of the view that benzodiazepines should be re-scheduled in the manner recommended by this Court. I therefore distribute this finding to the TGA for their consideration.

7. The methadone that contributed to NJ's fatal overdose, was prescribed by Dr Conroy to treat her opioid dependence. As already noted, Dr Conroy allowed NJ to access five unsupervised methadone doses per week, despite knowledge of various risk factors that under the Department of Health's 2013 *Policy for Maintenance Pharmacotherapy for Opioid Dependence* should have been treated as direct contraindications to unsupervised or 'takeaway' dosing.

8. Approximately 16 months after NJ's death, and at least partly in response to repeated Victorian coroners' recommendations expressing concern about the high frequency of overdose deaths linked to unsupervised dosing for methadone maintenance therapy, the Department of Health and Human Services released a revised *Policy for Maintenance*

Pharmacotherapy for Opioid Dependence. This new (September 2016) version of the Policy included more detailed and explicit guidance about assessing client suitability for unsupervised methadone dosing, and also reduced the maximum number of unsupervised methadone doses allowed per week from five to four, with no more than three consecutive doses to be dispensed.

9. As the death of NJ occurred before this new Policy was introduced, I do not believe it is appropriate to make any recommendation to the Department regarding unsupervised dosing in methadone maintenance therapy. However, I have asked the Coroners Prevention Unit to continue monitoring methadone-involved overdose deaths reported to the Court, to establish whether the new Policy has a detectable impact on these.

10. I distribute this finding for information to the DHHS's Real-Time Prescription Monitoring Taskforce, to assist and inform their implementation efforts and particularly their consideration of what drugs outside Schedule 8 should be included in the scope of the drugs monitored.

11. I distribute this finding to the Royal Australian College of General Practitioners for training and education purposes generally, but particularly in relation to the drug pregabalin. I have grave concerns that not all College members fully appreciate the risk of pregabalin misuse and its potential to interact with other prescribed drugs.

12. Finally, I distribute this finding to the Australian Health Practitioner Regulation Agency for information and so that it may take whatever action it sees fit in light of the facts revealed by this case.

Recommendation

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

> I recommend that the Royal Australian college of General Practitioners provide education to its members as to the need for caution in prescribing pregabalin due to its risk of misuse and its potential for harm.

Publication

As this finding contains a recommendation, pursuant to section 73(1A) of the *Coroners Act 2008*, I order that it be published on the internet

I convey my sincere condolences to NJ's family.

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

Mr PJ and Mrs MJ, joint senior next of kin

JT, partner of the deceased

The Secretary, Department of Health and Human Services;

Dr Malcolm Dobbin, Senior Medical Advisor, Real-Time Prescription Monitoring Taskforce, Department of Health and Human Services;

Therapeutic Goods Administration;

Royal Australian College of General Practitioners;

Avant Law, solicitors for Dr Kalnin;

Dr Julian Walter, MDA National, insurer for Dr Strahan;

Dr Coleridge;

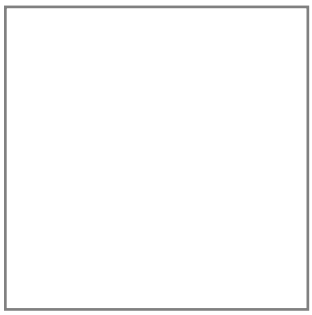
Dr Conroy;

Pharmaceutical Board of Australia;

Australian Health Practitioner Regulation Agency;

Detective Senior Constable Stuart Burnham, Coroner's Investigator, Victoria Police

Signature:



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ROSEMARY CARLIN
CORONER
Date: 4 July 2017