IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 004193

FINDING INTO DEATH WITHOUT INQUEST

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

I, ROSEMARY CARLIN, Coroner having investigated the death of TERRI ANNE WOOLLEY-PERESSO

without holding an inquest:

find that the identity of the deceased was TERRI ANNE WOOLLEY-PERESSO

born on 2 March 1968

and the death occurred some time between 2 and 4 October 2012

at Narre Warren, Victoria

from:

1(a) UNASCERTAINED

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. Terri Woolley-Peresso was born on 2 March 1968 and was aged 44 when she died. Ms Woolley-Peresso resided alone in Narre Warren, Victoria and is survived by her family. She was unemployed and received a disability support pension.

2. Senior Constable Laura Carter (nee Millard) compiled a brief for the Coroner which included statements from Ms Woolley-Peresso's caseworker, father, ex boyfriend, treating clinicians and investigating officers. I also received correspondence from Ms Woolley-Peresso's daughter and treating clinicians and the Victorian Department of Health. I have drawn on all this material as to the factual matters in this finding.

3. Ms Woolley-Peresso suffered from obesity, chronic back pain and epilepsy. She was a known intravenous drug user and abused prescription medication. Ms Woolley-Peresso consulted with various medical practitioners over the years and was a known 'doctor shopper'.

4. Ms Woolley-Peresso voluntarily received assistance from the Department of Human Services by way of having a caseworker to help her with tasks. Her caseworker, Rachel Royle reported that in the months leading to her death Ms Woolley-Peresso did not relay any fears or say anything to cause Ms Royle to be concerned for her safety.

5. Information from the Drugs and Poisons Regulation (**DPR**)[1] indicates that between 1999 and 2010 DPR issued eighteen successive permits to seven different doctors to prescribe oxycodone to Ms Woolley-Peresso for the purpose of analgesia. The permits were issued to treat Ms Woolley-Peresso for "chronic pain", "chronic renal disease" and "back disorders". It appears that the prescribed dosage of oxycodone increased over time, with the maximum permitted dose fluctuating between 200-240 mg between September 2003 – December 2009.

6. From December 2009 to the time of her death, DPR issued four successive permits to four different doctors to prescribe methadone and/or buprenorphine to Ms Woolley-Peresso for the purpose of opioid replacement therapy (**ORT**). Dr Chow of Central Medical Clinic held the most recent ORT permit. It was issued on 14 March 2012 and was valid at the time of her death. Between March and 2 August 2012 Dr Chow prescribed diazepam[2] and methadone to Ms Woolley-Peresso.

7. In July 2012 Ms Woolley-Peresso commenced seeing general practitioner, Dr Van Rheede at Casey Superclinic. She told him she was on methadone. Between 4 July and 8 August 2012, Dr Van Rheede prescribed diazepam, oxycodone (Endone) and hydromorphone (Jurnista)[3] to Ms Woolley-Peresso.

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[1] DPR is part of the Victorian Department of Health and Human Services and administers the Victorian legislation with respect to prescription drugs, including the issuing of permits to medical practitioners for the prescribing of Schedule 8 drugs, which include strong opioid analgesics (such as buprenorphine, oxycodone, methadone and hydromorphone) and other potentially addictive drugs. DPR issues two types of Schedule 8 permits for opioids, one to treat pain (analgesia permit) and the other to treat opioid dependence (Opioid Replacement Therapy 'ORT' permit).

[2] Diazepam is a Schedule 4 drug and a permit is not required to prescribe it.

[3] Hydromorphone is a very potent opioid, faster acting and much stronger than morphine.

8. On 12 August 2012, Ms Woolley-Peresso was admitted to hospital following seizures. During her stay she was reviewed by the Addiction Medication Unit and a letter (dated 20 August 2012) containing a suggested post care regime was sent to Dr Van Rheede and copied to Dr Chow. The letter noted Ms Woolley-Peresso's misuse of methadone and history of 'doctor shopping for hydromorphone and endone on top of her high dose methadone'. It advised that the Unit had ceased her hydromorphone and that she had refused her methadone with no apparent withdrawal symptoms, raising the suspicion that she had been stockpiling her medication. It recommended that her pain be treated only with paracetamol and NSAIDs and that if she required opioids for her drug dependence, that she only be prescribed Norspan (low dose buprenorphine).

9. On 17 August 2012 DPR received notification from a medical practitioner that Ms Woolley-Peresso had potentially engaged in drug seeking behaviour, in particular she had requested multiple drugs including diazepam, hydromorphone, methadone and oxycodone[4].

10. On 28 August 2012, Dr Van Rheede saw Ms Woolley-Peresso. His records note that she had "been completely off the opiods [sic]" since her discharge and that he ceased her prescription of Jurnista and Endone. Instead, he prescribed non-opioid pain relief, but also Norspan patch. On the same day, he prepared an application for a permit to prescribe morphine, oxycodone and methadone to Ms Woolley-Peresso for pain management ***and*** buprenorphine (Norspan) as ORT.

11. On 31 August 2012 Dr Van Rheede prescribed to Ms Woolley-Peresso the analgesic Tramadol hydrocholoride, a Schedule 4 drug for which a permit was not required.

12. At around midday on 4 September 2012 Dr Van Rheede again prescribed Norspan to Ms Woolley-Peresso. At 4.37 pm on 4 September 2012, DPR sent a notice of intention to refuse Dr Van Rheede's application for a permit to prescribe buprenorphine by facsimile to Casey Superclinic on the basis that an ORT permit was already held by Dr Chow.

4 DPR had received six prior notifications in relation to Ms Woolley-Peresso between 1994 and 2009.

13. On 7 September 2012 Dr Van Rheede prescribed Norspan, diazepam and the analgesic tramadol hydrocholoride to Ms Woolley-Peresso. There is no indication in the clinic records that he had viewed the DPR notice at this time.

14. On 11 September 2011 DPR sent notification of refusal of the permit to Casey Suprclinic. On 18 September 2011 Dr Van Rheede noted in his records that his application for a permit had been declined. In accordance with DPR advice he then referred Ms Woolley-Peresso to a specialised pain management clinic. He did not see her again after this date.

15. On Friday 28 September 2012, Ms Woolley-Peresso's caseworker, Rachel Royle visited her and took her shopping. She got a top up for her mobile phone. Ms Royle then went to work but returned later, at approximately 5 p.m. to drop off a packet of cigarettes for Ms Woolley-Peresso. Ms Woolley-Peresso's whereabouts over the weekend are unknown. On Monday 1 October 2012, Ms Royle attempted to return a call received from Ms Woolley-Peresso, but there was no answer.

16. On Tuesday 2 October 2012, Ms Woolley-Peresso attended at Casey Family Practice medical clinic and saw Dr Richard Shawyer. It was her second visit to this clinic, the first being in 2006 when she was prescribed oxycodone. Ms Woolley-Peresso presented with a referral from Acquired Brain Injury Specialist Service (ARBIAS) requesting 'a seizure management plan'. Dr Shawyer reported to the Court that Ms Woolley-Peresso had a documented history of multiple medical and chronic pain problems. He stated that she told him she was currently on Jurnista for back pain and endometriosis and he sighted a recent CT scan report confirming spinal problems. He did not suspect that she had a history of opioid dependence and it did not occur to him to contact DPR. He prescribed her 14 Jurnista 32mg tablets, once daily. The prescription was filled at the Berwick Pharmacy that day.

17. At about 4 pm on Thursday 4 October 2012 it was reported to Ms Royle that 'Meals on Wheels' had unsuccessfully attempted to deliver meals to Ms Woolley-Peresso on 2 and 3 October 2012. Ms Royle then attended Ms Woolley-Peresso's house. Her knocks and calls were unanswered, but she could hear Ms Woolley-Peresso's dogs barking from inside. Ms Royle called police who attended shortly thereafter.

18. After gaining entry into the house, police located Ms Woolley-Peresso lying in her bed dressed in a nightgown. She was deceased. Police reported that the house was messy, with food scraps and rubbish around. There was also dog excrement about the house, suggesting the dogs had not been outside for some time. Several packets of prescription medication were located at the scene.

19. The attending police did not photograph the scene, nor seize, document or photograph any medication or drug paraphernalia at the house. Ms Woolley-Peresso's father searched the house on 11 October 2012 and located many full packets of prescription medication, methadone bottles and syringes, including a syringe next to her bed.

20. Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an autopsy of Ms Woolley-Peresso's body. Ms Woolley-Peresso's body showed signs of decomposition. The examination revealed evidence of an old head injury capable of causing epileptic seizures. However, there was no evidence of any injury that would have contributed to death. There were no visible puncture injuries to her inside elbow area. There was also no evidence of heart disease which would have led directly to death. Dr Burke did find significant fatty liver and noted that this may be associated with significant metabolic disturbances.

21. Toxicological analysis of post mortem blood samples revealed the presence of diazepam (0.2mg/L), tramadol (0.7mg/L) and hydromorphone (0.04mg/L) in blood[5]. The individual levels of these drugs were non-toxic, however Dr Burke commented that the combination of drugs could possibly have caused death.

22. Dr Burke also noted that if Ms Woolley-Peresso had been on the medications for some time, she would be expected to have developed a level of tolerance. Given the evidence suggesting that Ms Woolley-Peresso was stockpiling drugs, it is difficult to determine from the prescribing history alone what her level of tolerance may have been.

23. Despite extensive investigations, Dr Burke was unable to determine a precise mechanism of death with certainty and reported a medical cause of death as 1(a) Unascertained.

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[5] Care should be exercised in interpreting post mortem drug levels as many drugs are subject to post mortem changes.

24. Although the cause of Ms Woolley-Peresso's death is unascertained, I am satisfied that further investigation is not required. Further investigation will not be able to establish the possible contribution of drugs to Ms Woolle-Peresso's death. There is also no evidence of assault or foul play warranting further investigation.

25. I find that Ms Terri Woolley-Peresso died between 2 and 4 October 2012 from an unascertained cause, but in the setting of prescription medication use.

COMMENTS

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

Police investigation

1. Police attending the scene of an unexpected death should be vigilant to gather all possible relevant evidence, especially where the cause of death is not obvious. Attendance at the scene is sometimes the only opportunity to gather vital evidence. In the case of possible prescription overdoses all medication, prescriptions and drug paraphernalia should be seized, photographed and recorded. The photographs should clearly show the medication labels with details of the prescribing medical practitioner and dispensing chemist. This is because the source of drugs will often be important to the coronial investigation and may not be ascertainable other than by reference to the label[6]. If there is concern about retaining the drugs direction can be sought from the Coroner in due course.

2. In this case, there were no photographs of the scene and the medication was not seized, let alone photographed or recorded. This prevented examination of the drugs stockpiled by Ms Woolley-Peresso and interpretation of their significance. The investigating police member advised the Court that it was her first deceased person and although she sought advice from her Sergeant, she was not advised to take photographs.

[6] Private prescriptions will not be recorded on the Pharmaceutical Benefit Scheme database.

3. It is important that police members who potentially could attend the scene of an unexpected death are properly trained as to how to conduct the investigation on behalf of the Coroner.

4. Since the death of Ms Woolley-Peresso in October 2012, the Victoria Police has updated its procedures and guidelines in relation to the investigation of drug overdoses. The current Victoria Police Manual mandates the attendance of the Criminal Investigation Unit (**CIU**) at the scene of drug overdoses. It also places responsibility for the investigation and preparation of the coronial brief on the CIU. In addition, in April 2015 the Form 83 (used by attending police to provide a quick summary of circumstances to the Coroner) was updated to provide guidance as to relevant matters to include in the summary of various types of deaths, including prescription overdoses.

5. Further, in May 2013 the Victoria Police Drug and Alcohol Strategy Unit invited the Court to contribute advice on good practice for investigating deaths that appear related to pharmaceutical drug use. The Coroners Prevention Unit (**CPU**) drafted the contribution, which was reviewed and endorsed by the State Coroner and the Victorian Institute of Forensic Medicine and provided to Victoria Police in September 2013 for dissemination to members. The CPU report 'Investigation of suspected drug overdose deaths' outlined the rationale for coronial investigation of suspected prescription overdoses as well as best practice for investigating such deaths.

6. I would be hopeful that the changes in police training since October 2012 would prevent a recurrence of the substandard investigation in this case. However, in addition to the information contained in the Form 83 and Victoria Police Manual, police members should be familiar with and follow the advice contained in the CPU report 'Investigation of suspected drug overdose deaths'.

<u>Prescription drugs</u>

1. It will never be known whether a combination of prescription drugs caused Ms Woolley-Peresso's death. The last people to prescribe the drugs in her system were Dr Van Rheede (diazepam and tramadol) and Dr Shawyer (hydromorphone).

2. This Court has long advocated for the introduction of real-time prescription monitoring. Several of my colleagues have recently published findings in which they identified the urgent need for real-time prescription monitoring and made recommendations to this effect. In response to a recommendation from Coroner Jacinta Heffey[7] the Secretary to the Department of Health and Human Services, Dr Pradeep Philip, informed the Coroner by letter dated 25 March 2015, that there have been recent positive developments in Victoria towards a working real-time prescription monitoring system. Given this indication I do not propose to make yet another recommendation for real-time prescription monitoring at this stage.

3. The circumstances of this case demonstrate that general practitioners should entertain a degree of suspicion and exercise caution when requested by new patients to prescribe strong opioid medication. Even in the absence of real time prescription monitoring there are mechanisms available to doctors in such situations to ascertain whether they are dealing with a drug dependent person and doctors would be wise to take advantage of them.

4. Dr Shawyer advised the Court that since his involvement with Ms Woolley-Peresso he has undertaken further training in relation to the treatment of drug dependent and chronic pain patients. He indicated that his initial assessment of chronic pain is now more thorough and that he routinely checks the 'prescriber shoppers hotline'.

5. The 'prescription shoppers hotline' to which Dr Shawyer referred, is the Prescription Shopping Information Service (PSIS) run by the Commonwealth Department of Human Services. A doctor who has concern that a patient is accessing medications in excess of therapeutic need can register with the PSIS and then call a hotline number to find out whether the patient has met the Prescription Shopping Program criteria. The criteria are that within a three-month period the patient has been supplied (a) pharmaceutical benefits from six or more different prescribers, or (b) 25 or more target pharmaceutical benefits, or (c) 50 or more pharmaceutical benefits. If the patient meets the criteria, the doctor is alerted and can find out further information about the medications supplied to the patient and how many prescribers were involved.

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[7] Finding into the death of Paul Kanis COR 2012 0367

6. Whilst I am heartened that Dr Shawyer is now exercising a greater degree of caution in his prescribing, I note that the PSIS would appear to have been of little or no assistance in this case. Rather, the Drugs and Poisons Regulation (DPR) Help Line run by the Victorian Department of Health and Human Services would have been a much more useful resource.

7. DPR administers the Schedule 8 permit system and doctors who call its Help Line can learn whether another prescriber is already supplying strong opioids to the patient. DPR can also inform the doctor whether the patient has ever been identified or reported as a drug seeker, if the patient is known to be drug dependent, and a range of other useful information. DPR advised the Court that it would inform any doctor enquiring about the permit history of a patient whether there are recorded notifications about the patient's drug seeking behaviour because it recognises that such information may be of relevance to the doctor's assessment of the patient and treatment decisions.

8. Had either Dr Van Rheede or Dr Shawyer consulted DPR they would have learned of Ms Woolley-Peresso's drug seeking history and may have modified their treatment or prescribing accordingly.

9. This is one of several recent deaths investigated by Victorian coroners, where a doctor has prescribed strong opioids to a patient without first contacting DPR to find out more about the patient. Additionally, confusion regarding the role of the PSIS, what can be learned from it, and why it should not be relied upon as the sole source of information about patients, has emerged in the evidence of other doctors in recent coronial investigations.

10. The Royal Australian College of General Practitioners has just released its clinical guideline: *Prescribing Drugs of Dependence in General Practice, Part A: Clinical Governance Framework.* Section 4.2.1 of this guideline lists steps that a doctor should consider in assessing a patient before prescribing drugs of dependence, including "prescription shopper communication". However, the guideline does not advocate contacting DPR, nor discuss the difference between the information provided by the PSIS and DPR. Given the difference in this information, it would be prudent for doctors faced with a new patient seeking drugs of dependence to consult both agencies.

11. This case also illustrates the need for general practitioners intending to prescribe opioid medication to ensure they are well informed about their medical, legal and ethical obligations.

12. Dr Van Rheede and Dr Shawyer both prescribed Schedule 8 drugs without holding a permit to do so. The obligations to hold such a permit are contained in the *Drug Poisons and Controlled Substances Act 1981* and include prescribing to a drug dependent person or prescribing for a continuous period of greater than 8 weeks. In a letter to DPU Dr Van Rheede explained that he had only been practising in Australia for 5 years and had a lack of experience and knowledge of the permit system.

13. The Addiction Medicine Unit letter to Dr Van Rheede indicated it was inappropriate to prescribe hydromorphone in addition to Ms Woolley-Peresso's methadone. The letter also recommended that he refer Ms Woolley-Peresso to a specialist pharmacotherapy service if found her difficult to manage. DPR's letter refusing to issue the Schedule 8 permit to Dr Van Rheede similarly noted that therapeutic and evidence based guidelines advise referral to a pain or addiction medicine specialist when prescribing opioids to a patient with a history of drug dependency.

14. Patients presenting with chronic pain and who are potentially or actually drug dependent present a challenge to medical practitioners. Unless a general practitioner is certain that he or she has the necessary skills to deal with such complex patients, it would be wise to refer them to a specialist service for advice and/or management.

15. I acknowledge the assistance of the CPU in this matter.

RECOMMENDATIONS

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

1. The Royal Australian College of General Practitioners review the circumstances of Ms Woolley-Peresso's death and consider how it can better educate doctors about the benefits

of contacting state based drugs and poisons regulators before prescribing potentially dangerous or addictive drugs.

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

The family of Ms Terri Anne Woolley-Peresso;

Australian Health Practitioner Regulation Agency;

Royal Australian College of General Practitioners;

Chief Commissioner of Police;

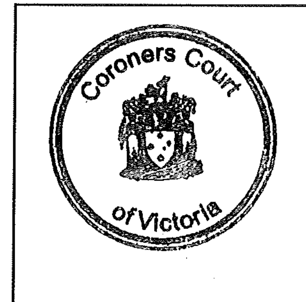
Dr VanRheede;

Dr Shawyer;

Investigating Member, Victoria Police; and

Interested Parties.

Signature:



ROSEMARY CARLIN
CORONER
Date: 23 June 2015