IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2013 0880

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 MILICA (MARY) MINCHEV without holding an inquest:

find that the identity of the deceased was MILICA (MARY) MINCHEV

born 31 January 1965

and the death occurred on 26 February 2013

at 4 Regal Avenue, Thomastown Victoria 3074

from:

1 (a) COMBINED DRUG TOXICITY (OXYCODONE, BENZODIAZEPINES AND OTHERS)

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

1. Milica (Mary) Minchev was 48 years of age at the time of her death. Ms Minchev had two sons. She was separated from her husband and for the past three months had lived with her uncle Sotir Petrovski, in Thomastown. Ms Minchev's medical history included epilepsy, depression, anxiety some self-harm and abuse of benzodiazepines and opioid narcotic analgesics. She was known to 'doctor shop'. Ms Minchev had recently suffered a mild stroke and leg swelling.

2. At around 6.45am on 26 February 2013, Ms Minchev's uncle Mr Petrovski left for work, and knew that she was sleeping in her room. Mr Petrovski returned from work at approximately 6.00pm that night and walked down the hallway of his home. While passing an open doorway, Mr Petrovski located Ms Minchev lying face down on the carpet in a spare room. Her head was between a television set and boxes of clothing; she was wearing her bra and underwear, and her

stockings were around her ankles. Mr Petrovski called another niece and asked her to call Ms Minchev's parents and to come to the house. Ms Minchev's parents attended but were unable to revive their daughter. Emergency services were contacted and Metropolitan Fire Brigade members attended at 7.18pm, followed by ambulance paramedics at 7.21pm and police at 7.54pm. Ms Minchev was unable to be revived, and she was declared deceased shortly after the arrival of emergency services personnel.

INVESTIGATIONS

Forensic pathology investigation

3. Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) performed a full post mortem examination upon the body of Ms Minchev and referred to the Victoria Police Report of Death, Form 83. At autopsy, Dr Dodd observed that Ms Minchev's heart was of a normal size but with a distinct, rounded contour and moderate biventricular dilatation. There was also histological evidence of low grade and scant myocarditis.

4. Toxicological analysis of post mortem blood identified oxycodone at a concentration of 0.8mg/L,[1] diazepam and its metabolite nordiazepam at levels of 0.5 and 0.7 mg/L respectively,[2] alprazolam (0.1mg/L),[3] temazepam (0.06mg/L)[4] and amitriptyline and its metabolite nortriptyline, both at levels of 0.3mg/L.[5] Toxicologist Melynda Hargreaves noted that the concentration of oxycodone was consistent with excessive and potentially fatal use, and in the absence of significant natural disease, the combination of oxycodone, amitriptyline, diazepam and alprazolam could precipitate death. Dr Dodd similarly observed that oxycodone in its own right is a potent suppressor of the cardiorespiratory system; this coupled with mixed benzodiazepines and amitriptyline would act in a synergistic manner.

5. Dr Dodd ascribed the cause of Ms Minchev's death to combined drug toxicity involving oxycodone, benzodiazepines and other drugs.

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[1] Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine used clinically to treat moderate to severe pain.

[2] Diazepam is a sedative/hypnotic drug of the benzodiazepines class. Nordiazepam is the active metabolite of diazepam.

[3] Alprazolam is a triazolobenzodiazepine derivative used as a short acting antidepressant and anxiolytic agent. It is also used to treat generalised anxiety, phobic and panic disorders.

[4] Temazepam is a sedative/hypnotic drug of the benzodiazepine class.

[5] Amitripytline is used to treat depression. It is metabolised to nortriptyline, which is also active as an antidepressant.

Victoria Police investigation

6. Upon attending the Thomastown premises after Ms Minchev's death, Victoria Police did not find any signs of third party involvement. Drugs including alprazolam and oxycodone were found in the home.

7. Senior Constable Penny Lekakis, the nominated coroner's investigator[6] conducted an investigation of the circumstances surrounding Ms Minchev's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Ms Minchev's uncle Sotir Petrovski, brother Jim Panovski, Psychiatrist Associate Professor Peter Doherty and General Practitioner Dr Adeel Tariq.

8. Jim Panovski reported that Ms Minchev had become depressed approximately 15 years prior to her death, in the context of an unhappy marriage. She took antidepressants at this time, and Mr Panovski believed this was when his sister's prescription medication dependency began. Over the following years, Ms Minchev began 'doctor shopping' in the area that she lived. Mr Panovski stated that the family attempted to help Ms Minchev enter drug rehabilitation and contact psychiatrists, but she refused their help and was in denial about her addiction. Mr Panovski reported that Ms Minchev had separated from her husband of 31 years in the year prior to her death. He believed his sister had recently seemed happier, with a new outlook on life.

9. A/Prof Peter Doherty treated Ms Minchev at The Melbourne Clinic from February 2008, and diagnosed her with a substance abuse disorder underpinned by histrionic, dependent and borderline personality traits. Ms Minchev was likeable and outgoing; A/Prof Doherty added that she tended to somatise, seeking treatment and investigations for medical conditions which she did not have. He noted that she often attributed her physical symptoms to transport accidents, seeking compensation. A/Prof Doherty did not believe Ms Minchev had a regular general practitioner. He was not aware of the number of doctors she attended, as she would not tell him who they were. A/Prof Doherty stated that Ms Minchev was never actually suicidal, but was frequently highly emotive, dramatic and threatened to 'end it all' if she did not get her way regarding medication.

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[6] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

10. A/Prof Doherty reported that Ms Minchev knew he considered her an over-user of prescription medication,[7] and for some years he progressively reduced her prescribed psychotropic medication and attempted to contain her benzodiazepine usage. This was achieved by insisting that he was the only doctor prescribing that medication. He stated that given it was an 'authority script', each time he rang for phone approval of alprazolam, he would be informed if another doctor had prescribed it recently. However, A/Prof Doherty said there was no such process of obtaining an authority for the prescription of narcotic analgesics. He refused to prescribe narcotic analgesia for Ms Minchev and noted she would frequently complain and say she would find another doctor.

11. General Practitioner at Epping Medical and Dental Centre, Dr Adeel Tariq, reported that Ms Minchev saw several doctors at the clinic and was known as a 'doctor shopper' with drug dependency. She was taking a number of medications, including amitriptyline, lamotrigine, gabapentin, alprazolam, oxycodone and Targin (containing oxycodone and naloxone). She had also been prescribed Mersyndol Forte on occasion.

12. On 15 February 2013, Ms Minchev informed Dr Tariq that she was travelling to New South Wales for a family holiday, and he provided her with three weeks' worth of medication (50 tablets of amitriptyline 50mg, 50 tablets of alprazolam 2mg, 40 capsules of oxycodone 10mg, and 28 tablets of Targin 40/20mg). On 22 February 2013, Ms Minchev returned to see Dr Tariq and advised she would now be in New South Wales for five weeks and would need more medication. Dr Tariq gave Ms Minchev the benefit of the doubt and prescribed more alprazolam, oxycodone and Targin.

13. On 26 February 2013, Ms Minchev brought her son Daniel to an appointment with Dr Tariq, and asked for more oxycodone and Targin. Dr Tariq stated that it was extremely difficult to get them to leave his consulting rooms, and he ended up prescribing 20 more capsules of oxycodone. However, he warned Ms Minchev that he was not happy to see her anymore and that she would now have to see only Dr Robert Guarino at the clinic. Ms Minchev and Daniel also went shopping on 26 February 2013, before she returned to her uncle's home that afternoon.

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[7] I note that A/Prof Doherty notified the Drugs and Poisons Unit at the Department of Health on 18 March 2009 that Ms Minchev was drug dependent.

Coroners Prevention Unit investigation

14. Following the receipt of the coronial brief, I asked the Coroners Prevention Unit (CPU)[8] to review the prescribing of medication proximate to Ms Minchev's death. The review encompassed, *inter alia*, Ms Minchev's Medicare Patient History Report and Pharmaceutical Benefit Scheme Patient Summary, and medical records from Epping Plaza Medical and Dental Centre, the Northern Hospital, Epping Healthcare, Reservoir Medical Centre, Lalor Plaza Medical Centre and High Street Medical Clinic.

Sources of pharmaceutical drugs

15. The CPU sought to identify the source of the alprazolam, diazepam, amitriptyline and oxycodone prescribed to Ms Minchev. The initial review and reconciliation of prescribing and dispensing information, established that Ms Minchev was prescribed drugs by at least 31 doctors across 12 different medical services (general practices, hospitals and other) in the 12 months leading up to her death. These included a number of one-off prescribing events. To make the medication review a more manageable task, the CPU determined to restrict its review to the medical records of services where there were at least three prescribing episodes to Ms Minchev in the 12 months leading up to her death in February 2013.

Alprazolam

16. Alprazolam is a benzodiazepine indicated for anxiety and panic disorder. Therapeutic ranges vary between 0.25mg to 4mg daily.[9]

17. The review identified that alprazolam was prescribed to Ms Minchev irregularly by clinicians at Epping Healthcare, from 2003 through to her 2013 death. The prescribing was possibly linked to her being diagnosed with panic disorder at Epping Healthcare in 2000.[10] In addition, doctors at several other clinics prescribed alprazolam to her in the 12 months leading up to her death. A summary of this prescribing includes:

    - Epping Healthcare: Ms Minchev received 18 prescriptions for alprazolam from Epping Healthcare, from Dr Vida Dabestani, Dr David Andrew, Dr Martin Miletich, Dr Steven

[8] 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. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

[9] Australian Medicines Handbook (Australian Medicines Handbook Pty Ltd, 2013) p.782.

[10] Medical Records of Epping Healthcare

Qingwu Liu, Dr Lyndsey Kabat and Dr Vivian Ouraha. Each of these prescriptions were for the 1mg strength tablet and usually around 50 tablets with no repeats. Alprazolam appears to have been privately prescribed by doctors at Epping Healthcare during these 12 months, because none of the alprazolam prescriptions in the medical records are reflected in the PBS Patient Summary.

- The Melbourne Clinic: A/Prof Doherty prescribed alprazolam to Ms Minchev on a monthly basis. Each of the 12 prescriptions was for 150 tablets (0.5mg) with no repeats, except his final prescription on 5 February 2013 which also contained one repeat authorisation.

- Epping Plaza: Ms Minchev received 24 prescriptions for alprazolam from Dr Adeel Tariq, Dr Robert Guarino, Dr John Deady, Dr Hossein Yaraghi and Dr Liran O'Kane. Each prescription was for the 2mg strength tablet and ranged between 10 and 50 tablets without repeat authorisations. Only two of these prescriptions were PBS authorised and the rest appear to have been privately prescribed.

- Reservoir Medical Centre: Ms Minchev received four prescriptions for alprazolam from Dr Steven Qingwu Liu at the Reservoir Medical Centre. Dr Liu also practiced at Epping Healthcare, where he also prescribed this medication to Ms Minchev. Each prescription was for the 1mg strength tablets, the dose and quantity are not recorded in the clinical notes. All four occasions were presumed to be private prescriptions, as there was no PBS Patient Summary dispensing entry to match the clinical notes about alprazolam prescribing.

18. The review identified that Ms Minchev's use of alprazolam was problematic. Across the 12 months preceding her death she received alprazolam from 12 different prescribers, at four different clinics. Excluding prescriptions where the quantity prescribed was not recorded by the doctor, Ms Minchev averaged about 15 tablets per day across the 12 months. Although the strength of tablets varied between 0.5mg and 2mg, her intake was clearly above therapeutic levels. Most prescriptions appeared to be private as no PBS contribution was listed on the PBS Patient Summary.

Amitriptyline

19. Amitriptyline is a tricyclic antidepressant indicated primarily for major depression and nocturnal enuresis. Therapeutic dosages range from 25mg to 300mg daily.[11]

20. It was noted that amitriptyline was prescribed to Ms Minchev from at least October 2007 by Epping Plaza doctors. Their medical records also indicated "anxiety with depression" was diagnosed in 2007, so this may have been the clinical rationale for the amitriptyline prescribing. Between February 2012 and 2013 Ms Minchev received prescriptions for amitriptyline from the following clinics:

    - Doctors at Epping Plaza prescribed amitriptyline to Ms Minchev on nine occasions during the 12 months. Almost all of these prescriptions were for 50 tablets with one or two repeat authorisations. The strength varied between 25mg and 50mg, but the dosage stayed consistent at one tablet nightly. Ms Minchev was last prescribed amitriptyline on 15 February 2013, which she collected on the same day.

    - Ms Minchev received one prescription for amitriptyline from each of the Lyndarum Family Clinic, Alpha Medical Clinic and The Northern Hospital.

21. Although the strength of amitriptyline tablets prescribed to Ms Minchev was within therapeutic ranges, the review identified that her use of the medication was above the intended dosage. Taking just the Epping Plaza prescribing, if she was provided the medication to take one tablet per day, a prescription of 50 tablets with two repeat authorities is a five month supply of the medication. Ms Minchev received a prescription for five months of the medication on five different occasions during the 12 months prior to her death. The most obvious explanation was that Ms Minchev was modifying the dosage and taking a greater quantity than prescribed. The review found that prescribing doctors failed to respond to her repeat presentations appropriately and consistently provided more of the medication, without modifying the prescribed dosage.

Oxycodone

22. Oxycodone is a strong opioid, indicated for moderate to severe acute or chronic pain. Therapeutic doses of oxycodone for chronic non cancer pain range from 5-10mg twice daily, to 80mg daily before specialist review is recommended.[12]

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[11] Australian Medicines Handbook (Australian Medicines Handbook Pty Ltd, 2013) p.758.

[12] Australian Medicines Handbook (Australian Medicines Handbook Pty Ltd, 2013) pp.45-58.

23. Ms Minchev was prescribed oxycodone as well as two other opioid analgesics, codeine (in the Mersyndol Forte preparation, which combines paracetamol with codeine phosphate and doxylamine succinate) and morphine, to treat her chronic leg pain, which she particularly reported in her thighs. She was also treated with opioids for pain in her back and episodes of headaches. Most commonly, she received prescriptions for various preparations of oxycodone (immediate release, long-acting, and oxycodone combined with the opioid receptor antagonist naloxone).

24. The review found that Ms Minchev commenced using Mersyndol Forte as early as 2003, in response to her headaches/migraines.[13] Doctors commenced prescribing oxycodone to Ms Minchev following a motor vehicle collision in 2007. The Epping Plaza records indicate that oxycodone was prescribed, initially as slow-release tablets, from December 2007 until her death. In the 12 months prior to Ms Minchev's death:

    - Epping Plaza doctors prescribed variations of oxycodone to Ms Minchev on 64 occasions, sometimes on the same day or within one day of the last prescription. The strength and dose of the medication varied. Between the middle of May and the beginning of November 2012 the 30mg strength capsules were generally provided. From November onwards Epping Plaza doctors reduced the strength of the capsules to consistently 10mg, but increased the quantity provided from 6 or 12, to usually 20 capsules.

    - Epping Healthcare doctors prescribed oxycodone to Ms Minchev on 21 occasions. Only one of these prescriptions did not appear in the PBS patient summary and was privately prescribed. Initially doctors provided only 5mg or 10mg strength prescriptions. From 18 July 2012, Epping Healthcare doctors started providing 30mg capsules for daily use, every 1-2 weeks.

    - Ms Minchev received 16 prescriptions for oxycodone from Dr Steven Qingwu Liu at the Reservoir Medical Centre. At Epping Healthcare, Dr Liu also frequently prescribed oxycodone. From this clinic, Dr Liu initially prescribed 30mg oxycodone capsules until late November 2012, when he started only prescribing 5mg strength capsules but again shifting the quantity from 12 to 20.

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[13] Medical Records of Epping Healthcare

- Doctors at The Northern Hospital prescribed oxycodone combinations to Ms Minchev on six occasions in the 12 months prior to her death. She attended the hospital for a variety of reasons, sometimes following seizures or to investigate her ongoing pain. On 4 February 2013, after being admitted to the Northern Hospital for a neurological review of severe pain and paraesthesia in her right leg, Ms Minchev was discharged with prescriptions for three different strength oxycodone combinations, totalling 68 tablets.
- In the 12 months prior to her death, Ms Minchev also received oxycodone prescriptions from doctors at the following five health services: Lyndarum Family Clinic, Wantirna Medical Clinic, Lalor Plaza Medical Centre, Knox Private Hospital and the Tristar Medical Group. She was also prescribed oxycodone by Dr Maria Szamos, whose clinic was unable to be identified in the review.

25. The review noted that between February 2012 and 2013, Ms Minchev received prescriptions for different strengths of oxycodone several times per month, with some consultations occurring on the same day or only one to two days apart. Most prescriptions were provided by doctors at Epping Plaza and Epping Healthcare.

26. The exact quantity of oxycodone that Ms Minchev was using across this period was difficult to interpret, as the prescriptions consistently varied in strength, dose and quantity. In some instances of private prescribing the medical records did not indicate the dose or quantity of the medication provided. Excluding private prescriptions where the dosage was unclear, Ms Minchev received a daily average of 120mg of oxycodone. For comparison, oxycodone is 1.5 times stronger than morphine, making the morphine equivalent dose 180mg per day. The review suggested that Ms Minchev's intake would have fluctuated across the 12 month period due to the lack of coordination in her supply of the medication. It was considered unlikely that any one doctor could have been aware of the exact scale of her opioid intake.

Diazepam

27. Diazepam is a benzodiazepine indicated for short-term management of anxiety, acute alcohol withdrawal, muscle spasm, conscious sedation and status epilepticus. Therapeutic ranges vary depending on the condition being treated and oral doses normally range between 1-30mg per day.[14]

[14] Australian Medicines Handbook (Australian Medicines Handbook Pty Ltd, 2013) p.783.

28. It was noted that evidence indicated Ms Minchev had historically been prescribed large quantities of diazepam. For example, when A/Prof Doherty submitted a notification to the Department of Human Services (DHS) Drugs and Poisons Unit in 2009 that he believed Ms Minchev was drug dependent, the DHS subsequently provided a Patient Summary Report which showed all PBS benefits paid for diazepam between 1 December 2007 and 29 February 2008. In that three month period, Ms Minchev received 1325 tablets of 5mg diazepam from six different prescribers. That number includes only pharmaceuticals that were subsidised under the PBS and excludes any private prescriptions.

29. However, the review identified Ms Minchev was prescribed diazepam on only two occasions between February 2012 and 2013: once from Dr Kumarasamy Senathirajah at the Lyndarum Family Clinic and once from Dr Hossein Yaraghi at Epping Plaza. Both of these prescriptions occurred in March 2012. The CPU did not identify any other prescriptions for diazepam that were proximate to Ms Minchev's death.

30. The review identified that the presence of diazepam, nordiazepam and temazepam in Ms Minchev's toxicology results in February 2013 clearly indicated the use of diazepam. Ms Minchev's propensity regarding pharmaceutical use made it unlikely that she retained a supply of diazepam from the two prescriptions she received almost a year earlier. The review noted it was possible that she was able to obtain a private script for this medication in the days closer to her death, from a clinic whose medical records the CPU did not request because there was no PBS evidence to suggest they should be sought.

Summary of pharmaceutical prescribing

31. The review noted that between February 2012 and 2013 Ms Minchev, was prescribed a staggering amount of pharmaceutical medication from at least 30 different prescribers from 12 different medical practices. The majority of her medication was prescribed by two clinics: Epping Plaza and Epping Healthcare. Ms Minchev's prescription history included repeated examples of consecutive daily prescribing from doctors at the same practice. Given the wide variety of sources from which Ms Minchev received pharmaceutical medication, it was considered to be impossible to state who exactly prescribed the medication which contributed to her fatal overdose.

Potential issues with the clinical management of Ms Minchev

32. The review of the circumstances of Ms Minchev's death highlighted a number of interrelated issues with her clinical management.

Prescription shopping

33. It was noted that the evidence clearly indicated Ms Minchev was engaged in prescription shopping: attending multiple doctors at different clinics to obtain pharmaceutical drugs in excess of clinical need and without disclosing all attendances and prescriptions to all doctors.

34. The review noted that prescription shopping undermines the ability of medical practitioners to produce a rational diagnosis for a patient's medical concerns, because each doctor involved in the care and prescribing does not have an accurate overall clinical picture and thus cannot develop an effective clinical strategy for patient care.

Poor coordination of care

35. It was identified that while Ms Minchev undoubtedly misled at least some doctors to engage in prescription shopping, there was evidence in the coronial material to suggest that doctors at Epping Healthcare, Epping Plaza and Reservoir Medical Centre knew or suspected she was attending other clinics:

    - The Epping Healthcare Patient Healthcare Summary carried the following warning at the very top of the file: "Dr Shopper, please do not prescribe anything to her esp alprazolam / oxy, see notes April 2012". The reference to "notes April 2012" appears to relate to a 19 April 2012 note by Dr Vida Dabestani about contact with a pharmacist who reported Ms Minchev was doctor shopping.

    - Likewise, the Epping Plaza medical records include a 2007 notification from the Medicare Australia Prescription Shopping Program, that Ms Minchev was identified to be prescription shopping for diazepam and oxycodone, among other drugs.

    - Dr Stephen Qingwu Liu saw Ms Minchev at both Reservoir Medical Centre and Epping Healthcare, so he had first-hand knowledge of her attendances at doctors across both medical centres.

    - Further to this point, Dr Gobind Duggal at Lalor Plaza Medical Centre noted in a 2005 letter to a doctor at Northpark Hospital, that Ms Minchev was drug dependent and engaged in doctor shopping for oxycodone and benzodiazepines.

36. The review found no evidence that the doctors at Epping Healthcare, Epping Plaza or Reservoir Medical Centre made any efforts to identify other prescribers and coordinate care with them.

37. The only doctor for which there was any clear evidence of an attempt to coordinate care, was Associate Professor Doherty. In June 2009, he wrote to Dr John Deady at Epping Plaza, clearly stating that Ms Minchev was a drug dependent person and had been notified to the DHS.

Prescribing drugs of dependence to a drug-dependent patient

38. The review identified that evidence contained within the medical records indicated Ms Minchev's drug dependence was well-documented for some years leading up to her death. For example:

    - The earliest evidence found of this was in the Epping Healthcare medical records, with a note dated 16 June 2003 identifying Ms Minchev as drug dependent and dishonest about drug taking.
    - There was a 9 March 2008 note in the Epping Plaza medical records, that Ms Minchev's pharmaceutical opioid use patterns were consistent with dependence. More recently, in 2009 A/Prof Doherty wrote to Dr John Deady at Epping Plaza to notify him that Ms Minchev was drug dependent.

39. It was noted that while acknowledging Ms Minchev's problematic pharmaceutical use, doctors at these two medical centres – and at a number of other practices - continued to prescribe drugs of dependence (drugs listed under Schedule 11 of the *Drugs Poisons and Controlled Substances Act 1981* (Vic) – 'the Act') to her through to her death.

Prescribing drugs of dependence without DPR notification

40. A medical practitioner is required under Section 33 of the Act to notify Drugs and Poisons Regulation (DPR) at the Department of Health and Human Services (DHHS),[15] if he or she suspects that a patient is drug dependent and either (a) the patient is requesting a drug of dependence, or (b) the medical practitioner intends to prescribe a drug of dependence to the patient.

41. The DPR were contacted on 30 November 2015 in relation to whether any practitioner had made a notification regarding Ms Minchev under Section 33 of the Act. Acting Manager of Treatment Approvals and Projects, Wendy Yang, replied on 2 December 2015, indicating that a doctor provided a notification regarding Ms Minchev on 15 June 2012 (the name of the doctor was not disclosed, but it was established through reviewing medical records that it was Dr John

[15] I note that the Department of Health and Human Services (DHHS) was formerly known as the Department of Human Services (DHS).

Deady at Epping Plaza). The next most recent notification was in 2010. The review concluded that while most doctors knew about Ms Minchev's drug dependence, they did not meet the Section 33 notification requirement in prescribing drugs of dependence to her.

Prescribing Schedule 8 drugs without a permit

42. Further to the above issue, it was noted that oxycodone is a drug of dependence listed under schedule 8 of the Poisons Standard. In Victoria, there are strict prescribing requirements for schedule 8 poisons in addition to the general drugs of dependence notifications. These include a requirement to apply under Section 34 of the Act for a permit to DPR prior to prescribing any schedule 8 poison.

43. A history of Schedule 8 permits issued by the DPR was obtained, which comprised the following four permits:

    - 29 April 2008 to 28 October 2008, permit for Dr John Deady to prescribe oxycodone 20mg daily.
    - 5 January 2009 to 6 July 2009, permit for Dr John Deady to prescribe oxycodone 20mg daily.
    - 9 December 2010 to 10 March 2011, permit for Dr Martin Miletich to prescribe oxycodone 20mg daily.
    - 14 August 2012 to 28 August 2012, permit for Dr Robert Guarino to prescribe oxycodone 60mg daily.

44. On this basis, the review identified that practically all of the oxycodone prescribing to Ms Minchev in the 12 months leading up to her death was done inconsistently with the Schedule 8 permit requirements.

45. Of particular concern was the prescribing at Epping Plaza Medical and Dental Centre. The CPU noted that on at least two occasions (being 5 April 2012 and 29 March 2012), doctors at Epping Plaza were refused Schedule 8 permits by the DPR. The letters of refusal stated that another practitioner had applied for a Schedule 8 permit for Ms Minchev, and further prescribing of Schedule 8 drugs without a permit would be an offence under the Act. The evidence suggested that doctors at Epping Plaza continued to prescribe - despite these warnings - through to Ms Minchev's death.

46. There was evidence identified in consultation notes that the doctors who prescribed oxycodone to Ms Minchev often raised concerns about the lack of permits or the need to stop prescribing the medication. The review noted that some doctors even went as far as discharging her from their care, advising that they would not continue prescribing opioids. In any case, it did not prevent her from accessing the medication even where she simply attended a different doctor in the same clinic.

Medical Record-Keeping

47. It was noted that it is a requirement under the Medicare Benefit Scheme (MBS) that medical practitioners maintain appropriate records of any consultation that claims a Medicare benefit. The Medicare Benefit Schedule Book houses the requirements for each service that can attract a Medicare payment and for general consultations this includes a requirement to keep "appropriate documentation".

48. The Royal Australian College of General Practitioners publishes guidelines advising general practitioners of optimal healthcare practices. The "Standard 1.7 Content of patient health records" provides the following statement about medical records in general practice:

    - Our patient health records contain sufficient information to identify the patient and to document the reason(s) for a visit, relevant examination, assessment, management, progress and outcomes.

49. The RACGP and MBS set out at a minimum standard in regard to medical record keeping, although they are both not specific about which information should be included in patient health records.

50. Many of the consultation notes from Ms Minchev's medical history contained only a simple description of the presenting complaint and which prescriptions were printed. There was no detail to determine the extensiveness of the medical complaint or the doctor's rationale supporting the prescriptions that were provided. In many cases, the consultation notes were silent as to any medical symptoms that were discussed and merely recorded the medication that was prescribed. It could not be determined in these cases, whether the doctor failed to record any clinical discussion with the patient, or whether a discussion even took place.

51. It was identified that on the basis of the brief medical records, it was possible that doctors might have been ill-informed about the current medications that Ms Minchev was receiving. For example, if doctors at Epping Healthcare and Epping Plaza relied on available medical records

to assess Ms Minchev's consultation history, when trying to form an opinion of her medical concerns, they would have encountered great difficulty in understanding what each other had done and why.

52. The lack of detail in the medical records hampered the ability to examine the clinical rationale of the prescribing, particularly with respect to Ms Minchev's drug dependence. The DHHS published a number of guidelines to inform medical practitioners of the best practice for pharmaceutical prescribing and for the treatment of drug-dependent patients. Concerning drugs of dependence, the DHHS guideline "Key prescribing requirements in Victoria" requires that:

    - *Before prescribing a drug of dependence, a medical practitioner must take all reasonable steps to ensure a therapeutic need exists and to confirm the identity of the patient. Issuing a prescription, merely because another prescriber has done so, is unlikely to satisfy these requirements [...] It is an offence to prescribe a drug of dependence merely to support the drug-dependence of a person.*

53. This advice is reinforced in the DHHS guideline "Treating a drug-dependent person", which advises that:

    - *Treatment of a drug-dependent person should involve meaningful objectives and appropriate strategies to reduce the risks associated with providing drugs of dependence to a drug-dependent person. Such strategies typically include limiting a patient's access so that drugs of dependence are prescribed by a single practitioner and supplied, in a controlled manner, by a single pharmacy. [...] Unless a prescriber holds a current Schedule 8 treatment permit to treat a drug-dependent person, he/she must notify DPR if there is reason to believe a patient is a drug-dependent person and the patient seeks a drug of dependence or the medical practitioner intends to prescribe a drug of dependence.*

54. The combined guidelines impose a requirement on practitioners to make an informed clinical assessment prior to prescribing any pharmaceutical medication. Regarding drug-dependent patients the risk of misuse is greater and the risk of prescribing to these patients should be balanced against any therapeutic advantage that pharmacotherapy can provide. The brevity of the records meant that it was not clear whether Ms Minchev's doctors made any reasonable attempts to address her underlying problem of dependency.

Private scripts

55. The review identified several occasions in the 12 months leading up to Ms Minchev's death, where doctors prescribed drugs to her (particularly oxycodone and alprazolam) but there was no corresponding entry in the PBS Patient Summary to show that the drugs had been dispensed. One possible explanation for this might be that Ms Minchev did not present all the scripts she was provided; this was thought unlikely given her drug dependence and efforts at prescription shopping. An alternative explanation was that doctors provided her with private scripts which did not attract a PBS co-contribution.

56. Evidence in support of the latter hypothesis was found in the Epping Healthcare summary of prescriptions on Ms Minchev's patient health summary, which listed each prescription to her as either PBS or non-PBS (ie private).

Combining opioids and benzodiazepines

57. It was noted that there is increasing evidence that simultaneous prescribing of opioids and benzodiazepines can result in adverse treatment outcomes and it is often clinically inadvisable to combine these classes of medication. The following 2012 advice concerning benzodiazepine and opioid prescribing was published in the "Drug and Alcohol Dependence" journal:

    - The co-abuse of BZDs and opioids is substantial and has negative consequences for general health, overdose lethality, and treatment outcome. Physicians should address this important and underappreciated problem with more cautious prescribing practices, and increased vigilance for abusive patterns of use.[16]

58. Ms Minchev was treated with benzodiazepines and opioids over an extended period and the review noted it was difficult to interpret whether her doctors had acknowledged or were even aware of the dangers associated with this kind of prescribing. She acquired medication through consultation with a wide variety of doctors, so a large portion of her medication was prescribed by doctors who did not have full knowledge of her current medications. However, there were at least three clinics that simultaneously prescribed oxycodone and alprazolam to Ms Minchev over the 12 months preceding her death. It could not be established from the consultation notes whether these doctors formulated a plan to offset the potential for harm or for a staged reduction of one of the two medications.

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[16]Jermaine Jones, Shanthi Mogali and Sandra Comer 'Polydrug abuse: A review of opioid and benzodiazepine combination use' (2012) 125 (1-2) Drug and Alcohol Dependence 8-18

59. This prescribing occurred while doctors were already aware that she was drug dependent and there was a heightened risk of misusing the medication. Again, it could not be established from the medical records whether the risks were properly assessed, or whether doctors were even aware of the dangers associated with combined opioid and benzodiazepine use.

Long-term benzodiazepine prescribing

60. It was noted that there is growing recognition of the lack of clinical justification for prescribing benzodiazepines for an extended period. As noted in a recently published Therapeutic Guideline:

    - Benzodiazepine consumption exceeding 1 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.[17]

61. Ms Minchev was identified as drug dependent and engaged in prescription shopping for benzodiazepines. A concern identified by the review is that there might not have been any clinically defensible reason for the long-term, high dose benzodiazepine prescribing to her.

The role of authority scripts

62. It was noted that in A/Prof Doherty's statement to Court dated 30 July 2013, he said regarding his alprazolam prescribing:

    - *For some years I progressively reduced the prescribed psychotropic medication and attempted to contain her benzodiazepine usage. I did so by insisting that I was the only doctor who prescribed that medication. As it is on an "AUTHORITY SCRIPT", each time I rang for phone approval for the medication alprazolam (Xanax/Kalma) I would be informed if another doctor had prescribed any such medication recently. Thus a check was kept on her use of alprazolam.*

63. The review noted that the authority script system does not operate in the way described by A/Prof Doherty; a person calling up for phone approval for a medication can only be informed of other doctors requesting authority scripts for that medication. Any private scripts, or scripts

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[17] eTG Complete, "Benzodiazepines, zolpidem and zopiclone: problem use", Melbourne: Therapeutic Guidelines Limited, June 2013.

on the 'ordinary' PBS, would not be reported via an authority script phone call. From A/Prof Doherty's statement, it appears that he falsely believed he would be kept aware of other prescribing, and was apparently unaware that 11 other doctors at three other clinics had prescribed alprazolam to Ms Minchev in the 12 months leading up to her death.

Statements provided by clinicians

64. Following the receipt of the CPU's review, key prescribing doctors[18] were contacted for further statements, as information contained within the medical records did not provide enough detail to clearly explain the clinical practices of medical practitioners involved in Ms Minchev's care.

Dr Adeel Tariq

65. In a letter from TressCox Lawyers on behalf of Dr Adeel Tariq, dated 8 March 2016, it was acknowledged that the medical records contained evidence that Ms Minchev was a prescription shopper. However Dr Tariq reported that her concerns appeared to be genuine, therefore constituting a legitimate need for medication.

66. Dr Tariq also acknowledged that a more careful review of the medical records may have allowed him to identify Ms Minchev's drug dependence earlier. His statement indicated that he became aware of her drug dependence in January 2013 and that he should have ceased prescribing once he reached that conclusion. Dr Tariq noted that his prescribing continued because he believed that Ms Minchev's need for medication was legitimate and that ceasing the drugs may have invoked seizures.

67. Dr Tariq did not obtain a schedule 8 permit before prescribing to Ms Minchev as he believed that Dr Robert Guarino held a permit, which would have covered his own prescribing. Dr Adeel Tariq did not contact Drugs and Poisons Regulation (DPR) or the Prescription Shopping Information Service, because he believed that other doctors had already done so, thereby absolving him of the need to contact them himself.

68. Dr Adeel Tariq indicated that he has now improved his understanding of drug seeking behaviour in general practice and also noted that his practice has implemented changes that have resulted in a "massive reduction in the amount of drug seeking patients presenting to the clinic". Additionally, he reported undertaking extensive training with the "Drugs and Poisons Department" to prevent the occurrence of similar circumstances in the future.

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[18] Key prescribing doctors were considered to be those who prescribed drugs of dependence to Ms Minchev at least three times in the 12 months leading up to her death.

Dr Robert Guarino

69. Dr Robert Guarino's statement dated 3 May 2016 provided a written summary of the treatment he gave to Ms Minchev including some of the rationale underlying his decisions.

70. Dr Guarino was aware that the records indicated Ms Minchev had a history of prescription shopping and stated that "she was a frequent attender at the clinic. Her presentation at times was reasonable but at other times implausible, devious and manipulative."

71. With regard to oxycodone, Dr Guarino noted that he believed Ms Minchev had a proven medical condition and therefore a genuine need for medication. He qualified this by adding that her discharge from the Northern Hospital with oxycodone validated his own prescribing of the medication. Dr Guarino indicated that he was aware that Ms Minchev had a benzodiazepine dependence but was concerned about the risk of seizure due to abrupt withdrawal as this was mentioned to him in correspondence from the Austin Hospital.

72. In his handwritten statement, Dr Guarino did not appear to have directly responded to questions from the Court about whether or not he had an obligation to notify DPR about his decision to prescribe a drug of dependence to Ms Minchev. Similarly there was no indication that he has now made himself aware of this requirement.

Dr John Deady

73. In his statement dated 5 September 2016, Dr John Deady noted that it was difficult to manage Ms Minchev's medications and that steps were taken to involve specialists in her care. Dr Deady reported that his aim was to gradually decrease the doses of Ms Minchev's medication over time. He was cautious in relation to the rapidity of reducing alprazolam and Mersyndol Forte as he understood that previous rapid changes had led to an increase in the frequency of her seizures.

74. Dr Deady did not recall when he became aware Ms Minchev may be obtaining prescriptions from other doctors, but noted there was an entry in her records in March 2008 that she was a 'doctor shopper'. He did not recall whether he contacted the Prescription Shopping Information Service.

75. Dr Deady noted that therapeutic need often co-exists with drug dependency. He continued to prescribe Mersyndol Forte and alprazolam for Ms Minchev's conditions while attempting to manage and limit her intake of the medications. Dr Deady used strategies including alternate day pickup; specifying a single pharmacy for pickup; refusing to provide repeat scripts earlier

than required; obtaining written agreement from Ms Minchev that she would consult only one doctor; and maintaining a medication diary.

76. In June 2012, Dr Deady notified the Department of Health that he had reason to believe Ms Minchev was drug dependent.

Dr Hossein Yaraghi

77. Dr Hossein Yaraghi acknowledged in his statement dated 23 February 2016 that he was aware of indications in Ms Minchev's medical record that she had a history of benzodiazepine abuse and prescription shopping. However, he believed that she was not engaged in prescription shopping while in his care. Given the risk, he modified his prescribing and with regard to oxycodone provided only small quantities or advised the pharmacy not to dispense until specified dates.

78. Dr Yaraghi coordinated his care with other doctors at his practice through their own patient database and was not aware of any other general practitioners that he would need to coordinate with. Dr Yaraghi sought the opinion of a neurologist at the Austin Hospital regarding his oxycodone prescribing and was advised to wean the medication to zero, replacing it with a weaker opioid.

79. Dr Yaraghi did not contact PSIS to determine if Ms Minchev was prescription shopping. He did not notify DPR that he believed Ms Minchev was drug dependent; he was not aware of his requirement to do this at the time. He reported that he is now familiar with this obligation.

80. Dr Yaraghi advised that he was aware his schedule 8 permit has been refused and explained to Ms Minchev that it would be unlawful for him to continue prescribing. Despite this, he later continued prescribing oxycodone out of concern that Ms Minchev was at risk of withdrawal seizures. He noted that he described his decision to continue prescribing in a letter to DPR on 14 July 2012.

Dr David Andrew

81. Dr David Andrew did not believe that Ms Minchev was a prescription shopper at the time, but acknowledged that he was now aware of indications in the medical records that she was prescription shopping.

82. Dr David Andrew did not form the opinion that Ms Minchev was drug dependent and noted that he felt she had an ongoing "therapeutic need" for alprazolam. Consequently he did not make any notifications to DPR.

83. Dr David Andrew reported that he does not normally prescribe alprazolam but decided to prescribe it to Ms Minchev because it had been provided to her by other doctors and that it held therapeutic benefit for her.

Dr Vivian Ouraha

84. In her statement dated 15 February 2016, Dr Vivian Ouraha said she had not believed that Ms Minchev was engaged in prescription shopping but acknowledged that she could now see such indications in the medical records.

85. Dr Ouraha did not consider herself to be Ms Minchev's usual treating doctor. She reported that her decision to prescribe was appropriate to continue the treatment provided by Ms Minchev's regular general practitioner and because there was an established therapeutic need.

86. Dr Ouraha did believe that Ms Minchev was dependent on the analgesic medication she received for her chronic pain. She was unaware at the time that she had an obligation to notify DPR, and was also unaware at the time of her requirement to obtain a Schedule 8 permit prior to prescribing a schedule 8 medication.

87. Dr Ouraha acknowledged that she was unaware of the requirement regarding drugs of dependence and making a notification to DPR. She advised that she is now aware of this requirement, but noted that since migrating to Australia there was no reference to any of these regulations during her "AMC" exams or during her training.

88. Dr Ouraha also noted that the clinic has now improved its intra-practitioner communication to "ensure that important patient information is accessible and visible."

Dr Vida Dabestani

89. In her statement dated 24 February 2016, Dr Vida Dabestani said did not believe that Ms Minchev was a prescription shopper and stated that she would not prescribe to a patient in her care who was prescription shopping. Consequently she did not contact the Prescription Shopping Information Service. Dr Dabestani noted she was not aware of the operation of the service at the time, but now uses it for her new patients who are receiving opioids. She also noted that she was alerted by a pharmacist that Ms Minchev had obtained medication from other practitioners and responded by cancelling her prescription.

90. As she did not have any suspicions regarding drug dependence, Dr Dabestani did not seek specialist advice to guide her prescribing and was not aware of the involvement of other practitioners, with whom she would have needed to coordinate her treatment. Regarding Ms

Minchev's pain, Dr Dabestani referred her to the Barbara Walker Centre for specialist assistance.

91. Dr Vida Dabestani reported that she obtained a schedule 8 permit when she discovered that her practice had not obtained one. She further advised that her prescribing of schedule 8 drugs ceased after receiving a notification from the Department of Health that Ms Minchev was drug dependent.

92. Dr Vida Dabestani reported that it is not her usual practice to provide private prescriptions, but regarding alprazolam she did this after seeing that it had been privately prescribed to Ms Minchev by other practitioners.

Dr Steven Qingwu Liu

93. Dr Steven Qinqwu Liu reported in his statement dated 29 January 2016 that he was not aware that Ms Minchev was prescription shopping. He noted that "[...] I was not aware that she was obtaining medication from multiple doctors. Her behaviour while under my care was not in my view consistent with prescription shopping, and I had no reason to suspect that she was seeing other practitioners during that time."

94. Dr Liu also did not believe that Ms Minchev was drug dependent and therefore did not contact DPR. Dr Liu reported that he was not aware of the requirement to obtain a Schedule 8 permit before prescribing a schedule 8 drug.

95. Dr Liu maintained that his overall strategy was to reduce the level of medication that Ms Minchev was using, particularly opioids. He stated "I encouraged her towards a goal of reducing opiate use and moving to use of longer acting opiates only in the short term."

Associate Professor Peter Doherty

96. A/Prof Doherty provided a further statement dated 20 March 2016 and noted he believed that Ms Minchev was prescription shopping as early as 2009 and notified the Department of Human Services (DHS). A/Prof Doherty confirmed that he was aware that the authority script system which he used so there was a check on Ms Minchev's use of alprazolam, only provided information on other authority script requests, not 'general' PBS scripts or private scripts for a particular drug.

97. However he reported that he was not aware of the number of other practitioners prescribing alprazolam to Ms Minchev in the months leading up to her death and stated:

- "There is no way I could find out who was prescribing what to her, without her telling me. If any other doctors were prescribing alprazolam and not using authority scripts, I would not know that they were doing that."

98. A/Prof Doherty was aware that Ms Minchev was drug dependent on alprazolam and "narcotic analgesic medication", and included this in his 2009 notification to DHS. He also noted "she was on the Medicare's Doctor Shopping program and I don't know of her ever getting off that listing."

COMMENTS

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

Continuing the prescribing of another practitioner

1. The Department of Health and Human Services' (DHHS) guideline 'Things medical practitioners need to know: Key prescribing requirements in Victoria' contains the following advice for general practitioners:

    - *Before prescribing, a medical practitioner must take **all reasonable steps** to **ensure a therapeutic need exists** and, before prescribing a drug of dependence, must take all reasonable steps to **confirm the identity of the patient.** Issuing a prescription, merely because another prescriber has done so, is unlikely to satisfy these requirements.*

2. A common theme in Ms Minchev's doctors' statements was that they were merely continuing the clinical strategy commenced by another practitioner. For example, I note that Dr David Andrew stated that:

    - "I did not feel it was my role to try to adjust her medication or long-term therapeutic plan as she clearly had a principal doctor at the clinic. Further, I thought that she had access to the Northern Hospital's outpatient resources and would be getting help from psychologists and other paramedical specialists there."

3. This appeared to be a strategy that several doctors adopted, as they believed they were not Ms Minchev's principal general practitioner. Given Ms Minchev's propensity for doctor shopping, it could be argued that none of the clinicians were her primary doctor. However, regardless of

whether a patient is generally managed by one doctor or not, other practitioners must perform their own clinical assessment before prescribing. Accordingly, I have directed this finding be distributed to the doctors who provided statements, in so far as it may assist them to identify the clinically sub-optimal practices that occurred in Ms Minchev's care.

Prescription shopping and management of a drug dependent patient

4. A lack of knowledge about Ms Minchev's drug dependence and prescription shopping was a common theme in clinicians' statements. Seven of the doctors who provided statements to the Court reported that they were not certain or did not believe that Ms Minchev was prescription shopping. All but one of those doctors also admitted that there were indications, either circumstantial or in the medical records, that Ms Minchev was prescription shopping. A/Prof Doherty reported that he knew Ms Minchev was prescription shopping but also advised that he could not have known the full extent of the problem, without her admission.

Real-Time Prescription Monitoring

5. I note that a lack of information and communication appeared to be central undermining features of treatment rendered to Ms Minchev by clinicians, and the circumstances of her death evince the need for real-time prescription monitoring (RTPM) in Victoria. There appears to have been clear evidence that Ms Minchev was engaged in prescription shopping, but doctors did not identify the behaviour or intervene to prevent her access to medication beyond her therapeutic need.

6. The Victorian Government's proposed RTPM system, announced on 25 April 2016, may limit the type of prescribing that occurred in the case of Ms Minchev, if its operation covers the use of all pharmaceutical drugs. Information contained in the DHHS 'Real-Time Prescription Monitoring Initiative FAQ' indicated that all Schedule 8 medications will be covered by the system and that "as part of the implementation of real-time prescription monitoring, the arrangements for treatment permits will be comprehensively reviewed and streamlined." Accordingly, I am optimistic that RTPM may also rectify issues regarding failure to obtain schedule 8 permits and make appropriate notifications regarding drug dependence to DPR.

FINDINGS

Ms Minchev's death serves as a compelling reminder of the perils associated with opioid and benzodiazepine dependence, and the importance of monitoring and circumventing patients' misuse of these powerful medications.

The investigation into Ms Minchev's death has identified a sustained and elevated use of medication; clearly indicating she was dependent upon pharmaceutical drugs for a long period of time. It is apparent that Ms Minchev engaged in extensive 'doctor shopping' to support her drug dependence; in the 12 months leading up to her February 2013 death she attended almost daily consultations with clinicians. In the circumstances, I find that a combination of significant and prolonged clinical failings – at the individual doctor, the clinic and the systemic level – enabled Ms Minchev to access a significant excess of medications which ultimately led to her death.

The investigation has identified that at the time of Ms Minchev's death there were insufficient tools to support doctors in general practice with the complex drug seeking behaviours of certain patients. The investigation has identified that from the doctors who provided statements, there was a lack of understanding and possibly education about their obligations under drugs and poison regulation.

It is anticipated that with the advent of Real Time Prescription Monitoring, doctors in Victoria will be assisted to monitor their patients' medication with far better oversight and attentiveness than was rendered in Ms Minchev's case. Indeed, several of the issues that were contributing factors to Ms Minchev's death may be addressed through its implementation.

I accept and adopt the medical cause of death, as identified by Dr Malcolm Dodd and find that Milica (Mary) Minchev died from combined drug toxicity involving oxycodone, benzodiazepines and other drugs, in circumstances where I find she has died from the unintentional consequences of the use and abuse of prescription medication.

Pursuant to section 73(1A) of the Coroners Act 2008, I order that this Finding be published on the internet.

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

Mr Jason Minchev

Ms Mia Campbell, Avant Law Pty Ltd

Mr John Petts, TressCox Lawyers

Ms Louise Williams, John W. Ball & Sons Lawyers

Australian Health Practitioner Regulation Agency

Dr David Andrew

Dr Vida Dabestani

Dr Peter Doherty

Dr Robert Guarino

Dr Steven Liu

Dr Vivian Ouraha

Dr Adeel Tariq

Dr Hossein Yaraghi

Senior Constable Ruby Koochew

Senior Constable Penelope Lekakis

Signature:

AUDREY JAMIESON
CORONER

Date: **7 October 2016**