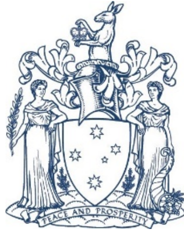

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 2434

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Paresa Spanos, Coroner
Deceased:	AAC
Date of birth:	2 May 1990
Date of death:	On or about 14 May 2019
Cause of death:	1(a) Combined drug toxicity (pregabalin, dihydrocodeine, tramadol, temazepam, lorazepam) in a man with WHO class III obesity
Place of death:	Narre Warren, Victoria

INTRODUCTION

1. On 14 May 2019, AAC was 29 years old when he was found unresponsive in his bedroom by his mother, IC, with whom he was residing in a unit in Narre Warren.

2. AAC had a history of suspected substance use and abuse, for which he had been arrested but not charged. He is also said to have experienced ongoing struggles with the breakdown of his long-term relationship approximately 12 months prior to his death.

THE CORONIAL INVESTIGATION

3. AAC'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. AAC's appeared to be unexpected and/or natural and therefore falls within this definition.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. 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.

6. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of AAC's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of AAC, including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

8. On 13 May 2019, AAC attended one of his treating general practitioners, Dr Milan Katic at the Berwick Superclinic. He was given prescriptions for temazepam and tramadol, medication he was regularly prescribed, which he then had dispensed.

9. At approximately 11.00pm, AAC told his mother that he was not feeling well and had been to the doctor for treatment for the flu and back pain. According to IC, the conversation was normal, and nothing seemed out of the ordinary.

10. On 14 May 2019 at approximately 1.00am, IC said goodnight to her son and went to bed. At some stage later but still in the early hours, IC awoke and noting that her son's bedroom light was on, entered his bedroom. She observed her son lying on the mattress in an "abnormal position" with his face down. IC rolled her son over and observed that he was unconscious and had vomited.

11. Emergency services were called. Ambulance Victoria (**AV**) paramedics arrived a short time later and attempted cardiopulmonary resuscitation (**CPR**) for approximately 45 minutes. Unfortunately, AAC could not be revied and was declared deceased by the AV paramedics at the scene.

12. Victoria Police members and the Country Fire Authority member also responded, arriving a short time after the paramedics.

13. The Victoria Police members found a large quantity of prescription medication, prescriptions and empty blister packs in AAC's bedroom and vehicle and seized these. The items seized included medication and unfilled prescriptions in the names of A-V and AC. They noted that it appeared that two temazepam tablets and 15 tramadol tablets had been taken from those prescribed and dispensed to AAC on 13 May 2019.

[1] 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.

14. No suicide note, or message of any other kind was found to indicate that AAC had intended to end his own life.

15. A coronial investigation was immediately commenced.

Identity of the deceased

16. On 14 May 2019, AAC, born 2 May 1990, was visually identified by his mother, IC, who signed a formal Statement of Identification before one of the Victoria Police members at the scene.

17. Identity is not in dispute and requires no further investigation.

Medical cause of death

18. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 16 May 2019 and reviewed the Victoria Police Report of Death, medical notes from Casey Superclinic, three scene photographs and the post-mortem CT scanning of the whole body undertaken at VIFM. Dr Young provided a written report of his findings dated 18 July 2019.

19. The post-mortem examination revealed AAC had a body mass index (**BMI**)[2] of 51 kilograms/m² and a body weight of 152 kilograms. AAC's lungs showed pulmonary oedema and there was moderate atherosclerosis of the left anterior descending coronary artery. Dr Young commented that the latter was unlikely to be of a degree which may cause death in and of itself.

20. Routine toxicological analysis of post-mortem samples detected pregabalin[3], dihydrocodeine[4], tramadol[5], temazepam[6] and lorazepam.[7]

21. According to the toxicologist, all of the drugs detected in AAC's blood may cause depression of the central nervous system (**CNS**), leading to decreased respiratory drive and death. There is also additive CNS depressive effect when these drugs are taken together.

[2] Obesity is classed using the BMI, which is an index of weight-for-height that is commonly used to classify underweight, overweight and obesity in adults. A person who has a calculation of 30 kg/m2 and above is considered categorically obese. A person with a BMI greater than 40 kg/m² is considered class III obesity.
[3] Pregabalin is clinically used for the treatment of partial seizures and neuropathic pain.
[4] Dihydrocodeine is used for the relief of a dry cough.
[5] Tramadol is a narcotic analgesic used for the treatment of moderate to severe pain.
[6] Temazepam is a sedative/ hypnotic drug of the benzodiazepines class.
[7] Lorazepam is prescribed for the treatment of insomnia and anxiety associated with depressive symptoms, and as a pre-operative medication.

Obesity and positioning of AAC in an "awkward" face down position (as detailed by his mother) would also affect breathing in a sedated individual.

22. Dr Young commented that there was no post-mortem evidence of any injuries which may have caused or contributed to AAC's death.

23. Dr Young expressed the opinion that the medical cause of AAC's death was '1(a) Combined drug toxicity (pregabalin, dihydrocodeine, tramadol, temazepam, lorazepam) in a man with WHO[8] class III obesity'.

24. I accept Dr Young's opinion.

FURTHER INVESTIGATIONS

25. AAC was described by his mother as having been an intelligent man who obtained degrees in neuroscience and pharmaceutical science.

26. One of AAC's treating general practitioners, Dr Milan Katic, detailed that he had an extensive medical history. AAC was being treated for mild hypertension, class III obesity, coeliac disease, insomnia and multiple musculoskeletal problems that primarily affected his hands and feet. AAC was prescribed tramadol and pregabalin for his chronic pain, phentermine as an appetite suppressant, and melatonin and zopiclone for insomnia before changing to temazepam.

27. Dr Katic stated that AAC gave the impression of a stable, well balanced but not always happy man. "His main reason for dissatisfaction was his obesity and inability to pursue numerous attempts of weight reduction." Despite this, AAC never disclosed suffering from depressive symptoms or gave any indication of suicidality. Dr Katic further detailed there was no indication of illicit drug use or abuse. While Dr Katic did recognise that frequent use of analgesics can indicate the possibility of an addiction, he considered that alleviation of AAC's pain was essential.

28. AAC had been in a relationship with Melissa Ratanapintha from 17 years of age. The relationship lasted about ten years before they separated in 2017. Statements obtained throughout the coronial investigation suggest he struggled following the separation. In a letter to the court, Mr Ratanapintha describes a deteriorating and increasingly dysfunctional relationship.

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[8] World Health Organisation.

29. On 21 July 2018, a search warrant under the *Drugs, Poisons, Controlled Substances Act 1981* was executed at AAC's address. AAC was arrested in relation to possession of drugs of dependence-prescription medication and theft. Specifically, it was alleged that AAC was stealing prescriptions left by customers at the pharmacy where he was employed. It was further alleged that he was taking the stolen prescriptions to other chemists to be filled and using the medication himself. Several coffee filters containing an unknown white powder were also located at the scene. It appeared to attending Victoria Police members that AAC was addicted to prescription medication and possibly manufacturing his own drugs.

30. At interview, AAC provided no explanation for the seized goods and was released pending summons. Prior to his death, AAC had not been charged with any criminal offences arising from the execution of the search warrant on 28 July 2018.

31. In September 2018, AAC found himself unemployed and moved back in with his mother.

32. In January 2019, AAC commenced employment at *Chemwatch.*[9] AAC described her son as happy and excited at this job due to the opportunity of travel. AAC told his mother that he was going out to companies and doing product presentations.

33. Chemwatch human relations manager, Kathy Jeddou, provided a contrary account to the Coroner's Investigator, stating that AAC was still in training and was therefore, not liaising with other companies. Ms Jeddou further detailed that she suspected he was taking drugs as she had frequently observed him falling asleep at his desk.

34. A statement was also obtained from <u>Dr Adam Smith</u> of MyClinic Werribee Central. Dr Smith detailed that AAC attended his clinic in relation to health and weight loss and was prescribed phentermine on his second visit to aid in weight loss.

35. On 11 January 2019, AAC again attended on Dr Smith for further prescriptions. Dr Smith identified AAC "to be doctor shopping" by reference to the <u>SafeScript</u> service and refused to issue any prescriptions. AAC denied a history of mental ill health.

36. A statement was also provided by <u>Dr Belinda Hodge</u> of Wyndham Health Care in Werribee, who revealed that AAC attended her clinic between January 2019 and April 2019. AAC presented with a stated medical history of type II diabetes, right sacroiliac joint arthritis, neurogenic pain, coeliac disease and hypertension. His obesity was also noted.

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[9] A chemical management systems company.

37. On 5 January 2019, AAC presented to Dr Hodge with mouth ulcers and pain in his lower right back. He was provided with prescriptions for roxithromycin 300 milligrams, five tablets with no repeats and tramadol 50 milligrams, twenty tablets with two repeats. Dr Hodge stated that this was for intermittent use with an expected one to two-month supply. Review of AAC's Pharmaceutical Benefits Scheme (**PBS**) patient summary reveals that AAC filled his prescription for tramadol on 5 January 2019 and then filled the repeats on 8 January 2019 and 14 January 2019.

38. On 19 January 2019, AAC presented to Dr Hodge for review and reported no issues. He was provided prescriptions for phentermine and tramadol 50 milligrams, twenty tablets with two repeats. The tramadol was an expected minimum two-week supply. A review was scheduled for a month's time. Review of AAC's PBS patient summary shows that he filled his tramadol prescription on 19 January 2019 and filled the repeat prescriptions on 22 January 2019 and 25 January 2019.

39. On 2 February 2019, AAC reattended on Dr Hodge in relation to daytime tiredness, sacroiliac joint dysfunction (**SIJ**) pain and diarrhoea. He was prescribed tramadol 50 milligrams, twenty tablets with two repeats. A review was confirmed for a fortnights' time, as scheduled at his previous appointment.

40. On 16 February 2019, AAC attended his appointment with Dr Hodge and requested a reduction in the dose of pregabalin that had been prescribed by other general practitioners for his neurogenic pain. He was provided with prescriptions for phentermine 40 milligrams, thirty tablets with no repeats, pregabalin 150 milligrams, 56 tablets with five repeats and tramadol 50 milligrams, twenty tablets with two repeats. A review was scheduled for a fortnight's time.

41. Review of AAC's PBS patient summary reveals that he filled the tramadol prescription on 18 February 2019 and the repeats on 24 February 2019 and 28 February 2019. He filled the pregabalin prescription on 16 February 2019 and filled the repeats prescriptions on 5 April 2019, 24 April 2019, 1 May 2019 and 2 May 2019.

42. AAC's PBS patient summary shows that on 23 February 2019, he was prescribed pregabalin by Dr Surendra Naidoo with no repeats. On 3 March 2019, AAC was prescribed pregabalin with five repeats and tramadol with two repeats by Dr Emmet Dalton. On 3 March 2019 again, Dr M M Ali Haidar also prescribed tramadol with no repeats and pregabalin with no

repeats on 10 March 2019. These prescriptions were filled on 3 March 2019 and 10 March 2019.

43. On 24 March 2019, AAC attended Dr Hodge for review. During this consultation, a letter received from the Medicare Doctor Shopper Program was discussed. Specifically, that a pattern of behaviour had been identified. AAC told Dr Hodge he was keen to ensure cooperation with advice and recommendations.

44. On 6 April 2019, AAC consulted on Dr Hodge for the final time. During this consultation, AAC stated that things were intense at home and he was feeling stressed and depressed. He further disclosed suffering from greater sacroiliac joint pain due to increased intensity of training. He was encouraged to pace himself rather than increase his medication. AAC was prescribed tramadol 50 milligrams, twenty tablets with two repeats.

45. According to Dr Hodge, during consultations with AAC, he did not disclose any pre-existing mental health issues, other than situational stress that she did not consider to constitute a significant increase in mental distress or risk of suicidality.

46. It was after his last consultation with Dr Hodge that AAC consulted Dr Saville and Dr Karunathilaka under the assumed names of A-V and AC, as will be discussed below.

47. Victoria Police members who attended the scene of AAC's death found multiple boxes of medication dispensed to "AAC", as well as a number of other boxes of medication dispensed in the April to May 2019 period, including:

    (a) An empty box of pregabalin[10] dated 9 May 2019 with no prescribing doctor listed.

    (b) Prescription medication in the name of "A-V"

        (i) for metformin prescribed by Dr Greg Saville, dated 28 April 2019 (two boxes) and 3 May 2019;

        (ii) Telmisartan prescribed by Dr Greg Saville, dated 28 April 2019 and 3 May 2019, with a repeat prescription (original prescription date of 27 April 2019) for three repeats; and

        (iii) Diaformin prescribed by Dr Greg Saville, dated 3 May 2019.

[10] Pregabalin is a GABA and gabapentin analogue clinically used for treatment of partial seizures and neuropathic pain. It is available in Australia under trade names including Lyrica and Lypralin, among others.

(c) Prescription medication in the name of "AC":

(i) Empty box of pregabalin dated 11 May 2019, prescribed by Dr Laksiri Karunathilaka;

(ii) Repeat prescription for pregabalin, prescribed by Dr Karunathilaka with an original prescription date of 4 May 2019; and

(iv) Prescription for metformin, telmisartan and sodium valproate prescribed by Dr Karunathilaka on 4 May 2019.

48. Investigations revealed that AAC consulted Dr Saville at the Camberwell Junction Medical Clinic on 27 April 2019. He presented as a new patient and provided the personal details of A-V with a date of birth 6 April 1988. It is unclear if he was asked for or provided any forms of identification in that name.

49. AAC informed Dr Saville that he recently arrived from Chile and left his bag in a taxi, which included his medication. AAC detailed being on four regular medications but that he could not remember the name of the anti-anxiety medication. Subsequently, Dr Saville prescribed him telmisartan for high blood pressure, metformin for type II diabetes and pregabalin for epilepsy. Dr Saville advised that he needed to attend a local doctor once had had found out the name of his anti-anxiety medication.

50. A statement prepared by Dr Karunathilaka detailed that AAC attended Mount Waverley Medical Services on 4 May 2019. He presented as a new patient and provided the personal details of AC. AAC informed the clinic's staff that he had recently travelled from Chile and lost his baggage, which included prescriptions for his regular medications. It is unclear if he was asked for or provided any forms of identification in that name.

51. AAC gave a history of hypertension and epilepsy and requested prescriptions for sodium valproate 200 milligrams and pregabalin 300 milligrams. Dr Karunathilaka thought the dose for pregabalin was "quite high but was reluctant to prescribe a lower dose if his epilepsy was well controlled on his current dose". Dr Karunathilaka also prescribed telmisartan for hypertension and metformin for diabetes.

52. On 8 May 2019, AAC returned to Dr Karunathilaka for a "check-up" and requested a prescription for Ativan (lorazepam) for his epilepsy. Dr Karunathilaka provided a reduced

prescription with no repeats and explained it was a restricted medication and that further prescriptions would not be provided.

53. On 9 May 2019, Dr Karunathilaka checked the national prescription medication monitoring database, SafeScript, under the name of AC which was the name that AAC used when consulting him to ensure he had not obtained benzodiazepines elsewhere. He found no relevant alerts under that name.

54. On 11 May 2019, AAC returned to Dr Saville and requested lorazepam 2.5 milligrams at a dosage of two tablets daily. During the consultation, AAC stated that his lost baggage was now back in Chile.

55. The PBS patient summary for AAC shows that in the last twelve months of life, that is between 14 May 2018 and 14 May 2019, he saw about 60 general practitioners, obtained prescriptions at about 38 consultations occasions and, on multiple occasions, attended two clinics on the same day. This does not include prescriptions for which he paid full price (rather than the PBS subsidised price), nor prescriptions that may have been dispensed to him under other identities.

FINDINGS AND CONCLUSION

56. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    (a) the identity of the deceased was AAC, born 2 May 1990;

    (b) AAC died on or about 14 May 2019 at his home at Narre Warren, Victoria;

    (c) The medical cause of AAC's death is combined drug toxicity involving pregabalin, dihydrocodeine, tramadol, temazepam, and lorazepam in a man with WHO class III obesity;

    (d) the death occurred in the circumstances described above; and

    (e) the weight of available evidence supports a finding that AAC was abusing a number of prescription medications for at least the last twelve months of his life and that he died from in the circumstances of an accidental or inadvertent overdose in combination with natural disease in the form of WHO class III obesity;

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments on any matter/s connected with the death, including matters relating to public health and safety or the administration of justice:

1. Pregabalin is a GABA and gabapentin analogue clinically used for treatment of partial seizures and neuropathic pain. According to the toxicologist's advice, gabapentinoids (gabapentin and pregabalin) lack the *wanting* characteristic of traditional drugs of abuse but could become addictive in patients with prior substance use disorder, particularly opioid-dependent patients. People who are drug dependent administer gabapentinoids to potentiate experienced euphoria and reduce withdrawal symptoms whilst producing minimal adverse effects. Pregabalin has a higher addiction risk compared to gabapentin due to its faster onset of action.

2. There are growing concerns about increased prescribing and abuse of pregabalin and its contribution to overdose deaths in Victoria. Analysis of coronial data from 2010 to 2019 shows that pregabalin was not implicated in any coronial deaths in 2010 to 2012 inclusive. Pregabalin was implicated in 17 deaths in 2013; 27 in 2014; 34 in each of 2015 and 2016; 52 in 2017; 69 in 2018 and 66 in 2019,[11] when there was a decrease in overall overdose deaths in Victoria for the first time in a decade. In 2019, pregabalin was the sixth highest contributing drug in overdose deaths behind diazepam, heroin, methamphetamine, methadone and alcohol.

3. Since 1 April 2020, it is mandatory to check SafeScript, Victoria's real-time prescription monitoring system, prior to writing or dispensing a prescription for those medications or drugs which are monitored through the system.[12]

4. Pregabalin prescribing and dispensing is not monitored by SafeScript despite a substantial body of evidence demonstrating that it is a drug that is abused and misused; that it is a substantial contributor to Victorian overdose deaths annually; and that it has been shown not to be effective for many of the clinical indications it was initially approved to treat.

[11] Note that the annual frequency of Victorian overdose deaths fell in 2019, after a decade of consistent year-on-year increases. While the magnitude of the decrease was not particularly substantial (from 542 deaths in 2018 to 516 deaths in 2019, a decline of 26 deaths or 4.8%) it occurred against a backdrop of Victoria's continually growing population. Victoria's crude overdose death rate per 100,000 population, declined quite notably in 2019 for the first time in a decade – from 6.2 per 100,000 population in 2010, steadily increasing to 8.4 in 2018 and decreasing to 7.8 in 2019.

[12] There are exceptions in some circumstances, including when treating patients in hospitals, prisons, police gaols, aged care and palliative care settings.

5. The other relevant limitation of SafeScript pertains to AAC's use of two other identities. He appears to have given plausible explanations for his attendance as a private (non-Medicare) patient and accessed significant quantities of potent medicines from several GPs. SafeScript relies on the patient's details being accurately recorded and will not generally pick up unsafe prescribing or dispensing if the patient is using a different name/s. The only "penalty" for the patient will be the need to pay for the consultation privately and to pay for the medicine without the benefit of a Pharmaceutical Benefits Scheme subsidy, if there is one. For patients who are seeking to obtain a drug in excess of clinical need and/or are drug dependent, and who have the financial means to pay for consultations or scripts, this is not much of a disincentive.

6. In the finding in the death of Mr A delivered 31 October 2019, Coroner Gebert recommended that in order to reduce the risk of harm associated with pregabalin, the (then) Victorian Department of Health and Human Services (the Department) include pregabalin in the drugs monitored by SafeScript system. In their response, the Department refused to add pregabalin to the drugs monitored by SafeScript and, in so doing, set out its rationale, including its intention to continually monitor and review the addition of new medicines in SafeScript.[13]

7. Similarly, and more recently, in the finding in the death of Diane Maria Hillgrove delivered on 28 January 2021, Coroner Bracken made a similar recommendation. The Department has yet to respond to Coroner Bracken's recommendation and has three months from delivery of the finding to do so.

RECOMMENDATION

Pursuant to section 72(2) of the Act, I make the following recommendation on a matter/s connected with the death, including recommendations relating to public health and safety or the administration of justice:

1. I acknowledge the Department's response to Coroner Gebert's recommendation. I trust that the Department and the SafeScript Expert Advisory Group are abreast of coroners' concerns about

[13] The following is part of the Department's response – "While the 2019 review did find evidence of increasing harm from pregabalin, its overall scale of harm was found to be proportionate to supply and was less than medicines currently monitored in SafeScript. The review also found evidence of risk when pregabalin was used in combination with opioids or benzodiazepines, which are monitored through SafeScript, rather than when used alone. Based on this, the SafeScript Expert Advisory Group concluded that pregabalin in SafeScript was not the appropriate regulatory control at this stage, especially given clinicians are adjusting to the new system. A framework has been developed and published to guide future consideration of the addition of new medicines in SafeScript. Using this, the department will continue to observe data and review any new evidence of harm for pregabalin and other medicines not currently monitored."

pregabalin given its now established and ongoing contribution to Victorian overdose deaths.[14] Nevertheless, given my obligation as a coroner to contribute to a reduction in the number of preventable deaths in Victoria, I recommend that the Victorian Department of Health review the circumstances of AAC's death, and particularly the apparent ease with which he presented to multiple clinics, registered as a patient under false names and was prescribed significant quantities of drugs implicated in his death – pregabalin, tramadol, temazepam and lorazepam.[15] Such review should include a re-consideration of the case for adding pregabalin to the list of medicines monitored through the SafeScript system and any other measures that could enhance patient safety in this regard.

PUBLICATION OF FINDING

Pursuant to section 73(1A) of the Act, I hereby direct that this finding, comments and recommendation be published on the Internet in accordance with the rules.

DISTRIBUTION OF FINDING

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

IC, Senior Next of Kin

Detective Senior Constable Catherine Mussared, Coroner's Investigator

Dr Milan Katic

Dr Adam Smith

Dr Belinda Hodge

Dr Surendra Naidoo

Dr Emmet Dalton

Dr M. M. Ali Haidar

[14] I note the following information that appears on the SafeScript website regarding the drugs that are monitored: "In the leadup to SafeScript becoming mandatory in April 2020, and update of the literature review was commissioned in early 2019 to determine if there was any significant new evidence of harm associated with medicines not currently monitored in SafeScript. These findings were then reviewed by the SafeScript Expert Advisory Group. Medicines looked at in detail in the updated review included pregabalin (used for neuropathic pain), tramadol (a synthetic opioid pain reliever) and olanzapine (treatment for psychiatric conditions). The Expert Advisory Group did not recommend any new medicines be added to the list of those currently monitored."

[15] Also implicated is the drug dihydrocodeine (6-alpha-hydrocodol, drocode), is a semi-synthetic opioid that binds to opiate receptors located throughout the body. Dihydrocodeine is used for the relief of a dry cough and is available in several over-the-counter medications.

Dr Laksiri Karunathilaka

Dr Greg Saville

Professor Euan Wallace, The Secretary, Victorian Department of Health

Dr Anita Munoz, Chair, Victoria Faculty Council, Royal Australian College of General Practitioners

Professor Nicholas Lintzeris, Committee Chair and President, Australasian Chapter of Addiction Medicine, Royal Australasian College of Physicians

Mr John Jackson, Victorian Branch President, Pharmaceutical Society of Australia

Signature:

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Paresa Antoniadis Spanos

Coroner

Date: 24 February 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.