IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 1321

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Amended pursuant to section 76 and 76A of the Coroners Act 2008 on 22 September 2021[1]

Findings of:	Coroner Leveasque Peterson
Deceased:	DA
Date of birth:	21 December 1980
Date of death:	Between 11 March 2019 and 14 March 2019
Cause of death:	1(a) Mixed drug toxicity
Place of death:	Briar Hill, Victoria, 3088

[1] This document is an amended version of the finding into DA's death dated 8 September 2021. The Finding has been amended by order of Coroner Peterson to replace the names of the deceased and his family members with pseudonyms of randomly generated two letter sequences to protect their identity. A correction has also been made to paragraph 156(b) to reflect that DA's death occurred between 11 March 2019 and 14 March 2019.

INTRODUCTION

1. DA was 38 years old at the time of his death and lived alone in Briar Hill. DA's family described him as a very talented sportsman, with a very driven personality who had a good sense of humour, was caring and well-liked.

2. DA had a longstanding history of severe anxiety for which he received extensive treatment through psychiatrists, inpatient-care and counselling programs. To alleviate and manage his anxiety, DA began overusing codeine-based analgesics and benzodiazepines, and became dependent on drugs of dependence, which he acquired through multiple medical practitioners.

3. On 14 March 2019, DA was found deceased at his home from mixed drug toxicity. A large number of prescription medication packages were found in his bedroom.

THE CORONIAL INVESTIGATION

4. DA'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 result from accident or injury.

5. 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.

6. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[3]

7. Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the

---

[2] 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.

[3] Qantas Airways Limited v Gama (2008) 167 FCR 537, [139] per Branson J, noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal court with reference to s. 140 of the Evidence Act 1995 (Cth); Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd (1992) 67 ALJR 170, 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

8. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[4] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[5]

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of DA's death. The Coroner's Investigator conducted inquiries on behalf of the Coroner,[6] including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. The court also obtained additional information including DA's Medicare, Pharmaceutical benefit Scheme (**PBS**) and SafeScript records, medical records from Northern Hospital, audio records of contact between Ambulance Victoria on 4 January 2019 and statements from health professionals who treated DA.

11. Upon review of the circumstances of DA's death and taking into consideration concerns of care raised by DA's family about his access to medications, the Health and Medical Investigation team of the Coroners Prevention Unit (**CPU**)[7] were asked to review the appropriateness of DA's care. The CPU provided advice which has informed and guided my investigation.

12. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my tasks as coroner and that further investigation was

---

[4] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[5] *Briginshaw v Briginshaw* (1938) 60 CLR 336, pp 362-3 per Dixon J.
[6] I took carriage of the investigation in February 2020.
[7] The 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

not required. 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.

BACKGROUND

13. DA first developed symptoms of anxiety during secondary school, which his family reported had coincided with his being prescribed Roaccutane[8] for treatment of severe acne. Over the following years, DA received inpatient care at Northpark Private Hospital, engaged with the Austin Health Crisis Assessment and Treatment Team, consulted numerous private psychiatrists and psychologists, and was prescribed diazepam,[9] quetiapine[10] and sertraline[11] for severe anxiety and suicidality. Despite this ongoing treatment, DA continued to struggle with anxiety which he found debilitating at times.

14. Before setting out the circumstances immediately proximate to his death, it is necessary for me to first outline DA's clinical history and his interactions with medical practitioners, pharmacists and allied health professionals, particularly in the months immediately preceding his death.

Use of codeine products and benzodiazepines to alleviate anxiety

15. In 2016, DA married TV and they purchased their first home together. Shortly afterwards, it became apparent DA was overusing codeine products, in part, to manage his anxiety. DA sought help from his family General Practitioner (**GP**) Dr Nigel Berry at Nillumbuk Medical Centre, and also consulted Stepping Stones Medical Centre GP Dr Daile Kincaid who referred him to private psychologist Leanne Jackson.

16. DA attended eight sessions with Ms Jackson over a six month period from 17 August 2016 to 8 February 2017. At his first session, DA reported that he wanted to work on reducing his anxiety and improving his relationship with his wife. He disclosed that due to sporting injuries he had been taking over the counter pain medications and TV had become concerned about the levels he was taking. He reported that he had ceased taking this medication a month prior and that he wanted to rebuild his wife TV's trust in him.

---

[8] Roaccutane is a medication primarily used to treat severe acne, and has been linked with depression and anxiety.
[9] Diazepam is a benzodiazepine commonly used to treat a range of conditions including anxiety, seizures, alcohol withdrawal syndrome, benzodiazepine withdrawal syndrome, muscle spasms, insomnia and restless legs syndrome.
[10] Quetiapine is an atypical antipsychotic medication used for the treatment of schizophrenia, bipolar disorder and major depressive disorder.
[11] Sertraline is an antidepressant of the selective serotonin reuptake inhibitor class.

17. During his sessions with Ms Jackson, DA worked on cognitive behavioural therapy for anxiety and more effective ways of communicating with his wife. Ms Jackson observed that DA's anxiety reduced over this time, his relationship had reportedly improved, and he was feeling more secure and positive. DA and his wife had been considering starting a family, which DA was very keen on, and during this time, his wife became pregnant with their first child.

18. On 31 August 2017, DA returned for further counselling with Ms Jackson and attended four sessions until 12 September 2017. On this occasion, DA sought assistance with managing the change in his life of having a new baby, and he reported feeling anxious about being a good father and how he would cope with the responsibilities of fatherhood. DA reported that he found his anxiety was reducing and becoming more manageable after the four sessions.

19. In January 2018, Dr Berry referred DA to private psychiatrist Dr Shahrokh Gudarzi for a second opinion. Dr Gudarzi diagnosed DA with Tourette Syndrome, a chronic complex movement disorder consisting of complex motor and vocal tics, as well as residual symptoms of post-traumatic stress disorder (**PTSD**) related to alleged childhood sexual abuse and extreme anxiety with panic attacks and dissociative symptoms.

20. Dr Gudarzi continued sertraline, reduced the level of quetiapine and introduced low-dose haloperidol[12] for management of the 'tics' associated with Tourette's Syndrome. In May 2018, Dr Gudarzi temporarily replaced diazepam with a very low dose of clonazepam, but by the following month DA had self-ceased this, preferring diazepam 15-20mgs daily. According to Dr Gudarzi, DA agreed to not self-increase the dose.

21. In late February 2018, DA returned to see Ms Jackson for counselling for anxiety about his new job and coping with his responsibilities with his wife and son. He disclosed that his anxiety had increased further after he had a bad reaction to a prescribed analgesic which caused further anxiety and relationship tensions. At the time, he was staying with his parents while he and his wife worked on their relationship. He and his wife continued to spend time together as a family and DA looked after his young son on a regular basis. DA saw Ms Jackson on 13 occasions between 24 February 2018 and 8 December 2018 and continued to work on relationship and parenting issues as well as his anxiety and emotions.

22. On 19 June 2018, DA consulted with GP Dr Matthew Hoo at Wallan Medical Centre for the first time. DA requested diazepam for increased anxiety after recently losing his job and

[12] Haloperidol is a typical antipsychotic medication used in the treatment of schizophrenia, tics in Tourette syndrome, mania in bipolar disorder, delirium, agitation, acute psychosis, and hallucinations in alcohol withdrawal.

feeling overwhelmed by the birth of his son. He also claimed that his wife had lost his panadeine forte[13] script, which he was prescribed for management of pain associated with a sport-related right-hand injury. DA reported to Dr Hoo that 25 tablets of diazepam lasted him 90 days. Dr Hoo considered this was a *"very appropriate"* level of use but noted that DA still felt that he needed more. Dr Hoo also noted that DA was currently being prescribed 100mg sertraline daily and had had 8 counselling sessions for post-natal anxiety.

23. Dr Hoo was satisfied that DA's anxiety management was being managed well and prescribed 2mg diazepam. He agreed to re-prescribe Panadeine Forte, but with the understanding that DA would not lose the prescription again.

Access to drugs of dependence from July 2018 and suspected 'doctor shopping'

24. In response to concerns about the harms associated with the misuse of prescription medications in Victoria, the Victorian Department of Health introduced 'SafeScript', a real-time prescription monitoring system in 2018. The role of SafeScript in assisting health professionals to make safer clinical decisions and reduce the incidence of harm, including death, from the use of pharmaceuticals, is discussed further below.

25. SafeScript was introduced over an 18-month transitional period, and was implemented across Victoria from 1 April 2019. It began collecting data on the prescribing and dispensing of certain high-risk medicines, including codeine products, benzodiazepines and quetiapine from 2 July 2018. DA's SafeScript records from this time until his death are summarised below. However, it is important to note that SafeScript was in a transitional phase at this time and may not represent a complete picture of the medications prescribed to and accessed by DA.

26. On 9 July 2018, DA saw Dr Hoo, this time for analgesia management, requesting panadeine forte prior to hand surgery. Dr Hoo explained to DA that he should continue with long term analgesia medications, but to use panadeine forte for break through pain. Dr Hoo prescribed panadeine forte, two tablets, twice a day.

27. On 16 July 2018, DA saw Dr Gudarzi who noted that DA appeared to be addicted to endone (oxycodone) and was accessing this from two different doctors as well as having some interest in diazepam. Dr Gudarzi spoke with DA about this and provided him with contact details for

[13] Panadeine Forte contains paracetamol and codeine phosphate hemihydrate. It is used to relieve moderate to severe pain and fever.

Drug and Alcohol Services. Dr Gudarzi offered to refer DA to an addiction psychiatrist, but DA declined this offer.

28. At around this time, TV suspected that DA was 'doctor shopping'[14] again, as she had seen emails confirming appointments at various medical centres for DA in Wallan. TV confronted DA about this, who initially lied about the appointments but later admitted to attending one appointment to get another script for his diazepam in addition to what was prescribed by his psychiatrist and GP. TV was unaware of DA taking codeine at this point.

29. On 31 July 2018, DA consulted Dr Hoo requesting more diazepam due to worsening anxiety with daily panic attacks and concern about losing his job. DA admitted to taking more diazepam than previously needed and reported he needed diazepam to help calm his nerves. Dr Hoo noted that DA was already on antidepressant sertraline and noted that there was no suicidality. DA reported that he had hand surgery without complications but had ongoing pain. Dr Hoo agreed to prescribed diazepam and panadeine forte but requested that DA return in a week to discuss long term benzodiazepine use and pain issues.

30. SafeScript records indicate that throughout July 2018, DA consulted 14 prescribers to obtain prescriptions for codeine and diazepam and accessed 700 panadeine forte tablets and 308 diazepam 5mgs tablets from nine pharmacies.

31. On 13 August 2018, DA missed an appointment with Dr Gudarzi who provided an over the phone script for diazepam 5mg (50 tablets) after DA told him he had run out of it.

32. On 27 August 2018, DA returned to see Dr Hoo, four weeks after his last appointment with him. He complained of ongoing throbbing hand pain and requested one more month of panadeine forte. Dr Hoo offered trial of amitriptyline[15] in case it was nerve pain, but this was declined as DA felt the pain was arthritic and aching, rather than nerve pain. Dr Hoo agreed to prescribed panadeine forte for one month *"given just 1.5 months now for chronic complex pain"*. Dr Hoo noted that DA's psychological issues seemed to be dormant at that time.

[14] Doctor shopping is the practice of visiting multiple medical practitioners to obtain multiple prescriptions for medicines, obtaining more medicines than are clinically indicated. often drugs of dependence such as opioid analgesics or benzodiazepines.

[15] Amitryptyline, sold under the brand name Endep, is a tricyclic antidepressant primarily used to treat major depressive disorder and a variety of pain syndromes from neuropathic pain to fibromyalgia to migraine and tension headaches.

33. SafeScript records indicate DA consulted six prescribers for prescriptions for codeine and diazepam and accessed 140 panadeine forte tablets and 250 diazepam 5mgs tablets from six pharmacies throughout August 2018.

34. In September 2018, TV found hidden codeine tablets in DA's car. When she confronted him about this, he denied drug dependence and diminished the period he had been using it.

35. On 10 September 2018, DA again saw Dr Hoo about pain in his right hand. Dr Hoo raised with him the risks of dependence and tolerance to codeine. He advised DA about withdrawal symptoms and how to come off codeine to a lower acceptable dose, advised on alternate pain medicines such as pregabalin[16] given DA's pain appeared to now be suspicious for neuropathic pain, and advised him on the pros and cons of pain medications including risk of serotonin syndrome, drowsiness, efficacy and adverse events profile. Dr Hoo also ensured DA was on a non-steroidal anti-inflammatory medication (**NSAID**) to optimise pain management. Although reluctant, DA eventually agreed to try non-addictive pregabalin and celebrex (an NSAID) and was provided with prescriptions for pregabalin 25mg and panadeine forte.

36. On the same day, DA also saw Dr Gudarzi and reported that he had got a new job and had ceased pain killers after going *"cold turkey"* for ten days. DA reported his tics were controlled with 1.5mg haloperidol and 300mg quetiapine.

37. On 24 September 2018, DA again saw Dr Hoo with a statutory declaration saying his car had been broken into and his prescription for diazepam and panadeine forte had been stolen. Dr Hoo carefully took history to ensure his account was consistent. He did not suspect doctor shopping and provided a re-prescription for diazepam 5mg (one daily as required) and panadeine forte (two tablets, twice a day).

38. SafeScript records show that throughout September 2018, DA consulted four prescribers for prescriptions for codeine and diazepam and accessed 420 panadeine forte tablets and 300 diazepam 5mgs tablets from five pharmacies.

39. In October 2018, TV suggested to DA that they separate for three months so DA could concentrate on his wellbeing and to decrease the heightened anxiety he was experiencing. DA moved back to live with his parents in Greensborough and continued to look after his son every Thursday and alternate weekends.

---

[16] Pregabalin, sold under the brand name Lyrica, is an anticonvulsant and anxiolytic medication used to treat epilepsy, neuropathic pain, fibromyalgia, restless leg syndrome, and generalised anxiety disorder.

Disclosure of overuse of drugs of dependence and commencement of weaning plan

40. On 9 October 2018, DA saw Dr Hoo and had an extended consultation with him to discuss two issues: pain management and anxiety. DA reported to Dr Hoo that he had refractured the fifth metacarpal of his right hand after playing cricket and had been seen at Northern Hospital to have further surgery. Dr Hoo reviewed DA's hand which was in a cast and neurovascularly intact. DA reported that he was on 10 endone (oxycodone) 5mg tablets a day but felt pain killers were not doing much.

41. On further probing by Dr Hoo, DA admitted he had been taking panadeine forte at significantly higher than prescribed rates, which he estimated was 15 tablets per day. Dr Hoo warned DA that this was dangerous, told him that he must cease doing so immediately, and explained the risks of liver injury and death. Dr Hoo ordered blood and liver function tests to ensure that DA's liver was not affected by his overuse of paracetamol in the panadeine forte.

42. During further discussion with Dr Hoo during the consultation, DA admitted that he probably had a codeine addiction and disclosed that his relationship had broken down and his anxiety levels were elevated. Dr Hoo spoke with DA at length about his anxiety, depression, pain management and codeine dependence. When asked, DA reported that he had fleeting suicidal thinking but no plan. His affect was a bit flat, and mood was low. Dr Hoo advised DA to stay with his parents and provided crisis contacts. He commenced a safe weaning plan for codeine with DA, with a plan to address DA's benzodiazepine dependence once he had been weaned from codeine.

43. Dr Hoo prescribed codeine-only tablets 30mgs at 14 tablets daily (420mg daily), to be reduced by two tablets every two weeks, and diazepam 5mgs one tablet daily as required at the same level.

Drugs of dependence prescription agreement

44. On 19 October 2018, Dr Hoo received a letter from the Pharmaceutical benefits Scheme (**PBS**) informing him that DA had been seeking benzodiazepines from multiple prescribers.

45. The following day, on 20 October 2018, Dr Hoo had a lengthy consultation with DA about his use of drugs of dependence. DA admitted to taking five to six tablets of diazepam daily and was candid about his codeine dependence and need to get off it. During the consultation, Dr Hoo realised he had not prescribed enough codeine at the previous visit to wean over the

predicted period and increased the prescription with the aim of DA ceasing codeine in six weeks.

46. Dr Hoo spoke to DA about his obtaining multiple drugs of dependence from different GPs. Dr Hoo gave an in-depth explanation of the problems associated with drugs of dependence and how they can cause tolerance, dependence, withdrawal and addiction and the differences between these. Dr Hoo noted that in light of DA's current stressful circumstances, the weaning of benzodiazepines would stay on hold for now, but that DA would still have to wean off codeine. Dr Hoo noted that DA was to see his psychiatrist on 29 October 2018.

47. Dr Hoo explained to DA that he would only be able to prescribe drugs of dependence to DA if he was nominated as the single prescribing GP for these medications, and if DA nominated a single pharmacy for dispensation of these medications. DA agreed to these conditions, and signed a written contract prepared by Dr Hoo, a 'Drugs of Dependence Prescription Agreement'. The agreement set out the conditions, current dose and weaning plan for codeine and diazepam, with Chemist Warehouse Greensborough Plaza nominated and notified as being the dispensing pharmacy.

48. Dr Hoo took an inventory of DA's current medications, which were recorded at no tablets of codeine and less than 20 tablets of diazepam. DA's current dose of codeine 30mg was recorded as 12 tablets per day (360mg daily), with the aim of weaning to 10 tablets per day by 23 October 2018, followed by a further weaning of two tablets per week until ceased. DA's current dose of diazepam was recorded at five tablets per day, to remain constant until such a time as DA was able to begin weaning from these medications.

49. On 29 October 2018, DA presented to the Austin Hospital Emergency Department with pleuritic chest pain and was diagnosed with bilateral pulmonary emboli. He was commenced on an anticoagulant, rivaroxaban.

50. SafeScript records show that throughout October 2018, DA consulted seven prescribers for prescriptions for codeine and diazepam and accessed 132 panadeine forte tablets, 500 codeine phosphate 30mg tablets and 300 diazepam 5mgs tablets from six pharmacies.

Change to weaning plan due to ongoing struggles with compliance

51. On 2 November 2018, Dr Hoo had a further long consultation with DA for management of drugs of dependence. Dr Hoo took an inventory of DA's remaining medications which was

about 32 tablets less than it should have been, averaging at about one more tablet per day than he had been prescribed. DA admitted he had struggled with the weaning plan.

52. Dr Hoo reviewed their agreement and agreed to slow the rate of weaning, reducing the dose by one tablet per week instead. Dr Hoo created a new written agreement with DA, which recorded that his current weaning dose of codeine 30mg was nine tablets per day (270mg daily), with a further wean of one per week until ceased, beginning with an initial prescription of 150 tablets, with the dose of diazepam remaining at five tablets per day to remain constant until such time as DA was able to begin weaning from that medication.

53. Dr Hoo wrote to Chemist Warehouse Greensborough Plaza to inform them of the change to the agreement and confirmed that he was DA's managing GP. Dr Hoo also arranged for a one-off pickup from Simon Yu Wallan Pharmacy as DA was staying in Wallan and not able to collect from the nominated Greensborough Pharmacy.

DHHS notification, family concerns and efforts to refer DA to addiction services

54. At around this time, Dr Gudarzi was notified by the Department of Health and Human Services (**DHHS**) that DA was overusing diazepam (1000 tablets since July 2018, being an average of 9 tablets or 45mg daily) and was sourcing it from multiple prescribers. Dr Gudarzi also received a telephone call from DA's sister IX who raised concerns about her brother's behaviour and addiction to oxycodone and doctor shopping for diazepam and codeine.

55. Dr Gudarzi confronted DA with this information and provided motivational interviewing in an effort to convince DA to contact drug and alcohol services. DA reported that he had found it difficult to cope and felt low following the birth of his son. He disclosed that he had been suicidal two weeks prior, but that his son was a protective factor. He admitted that he had been abusing prescribed medications (being oxycodone and benzodiazepine) for quite a few years but refused to provide Dr Gudarzi with the names of medical practitioners he had obtained the medications from.

56. DA agreed to contact Turning Point, an addiction research and education centre providing treatment for people adversely affected by alcohol, drugs and gambling. Dr Gudarzi added 50mg desvenlafaxine[17] daily to DA's medications to assist with anxiety and depression and lower the need for other addictive anti-anxiety medications. Dr Gudarzi registered with

[17] Desvenlafaxine is a medication used to treat depression.

SafeScript and advised DA to limit the prescription of diazepam to 10mg daily only and with only weekly pick-ups, which DA was reportedly not happy with.

57. On 14 November 2018, Dr Hoo had a lengthy consultation with DA. Dr Hoo noted that DA was not coping mentally and was unable to wean off medications at this stage. Dr Hoo considered that DA had a dependent personality disorder, with an unhealthy fixation on his marriage as responsible for his wellbeing. Dr Hoo provided support and advice which DA accepted. Dr Hoo considered that due to the recent adverse short term stressors to DA's mental health, he considered it clinically appropriate to give an additional script of diazepam 5mgs one tablet daily, and codeine at 10 tablets daily for one week. At this time, DA's usual dose of diazepam was seven tablets of diazepam 5mg (35mg daily).

58. Dr Hoo informed Chemist Warehouse Greensborough Plaza of the temporary and partial refill, which he considered clinically appropriate as a once off due to recent adverse short-term stressors. Dr Hoo noted that DA understood that this should not happen again and that as long as there is a gradual improvement in his adherence Dr Hoo would continue to support him in this effort to wean himself off the codeine.

59. On 19 November 2018, DA saw Dr Gudarzi. DA admitted he had not contacted the addiction services, claiming that he had been unable to attend as he worked during their opening hours. DA complained of longstanding anxiety over the past 15 years and said that nothing was able to help him. He felt 5mg diazepam was not enough and was unhappy with the limit set by Dr Gudarzi on his access to diazepam. Dr Gudarzi provided support to DA and explored the need for self-responsibility and self-help. DA agreed to contact Turning Point and the Centre Against Sexual Assault (**CASA**) after Dr Gudarzi reassured him that he would issue leave certificates for his attendance at these services.

60. Dr Gudarzi stated that at this time DA was prescribed weekly pick up dose of 10mg diazepam, 300mg quetiapine, 200mg sertraline, 1.5mg haloperidol and 50mg deTVenlafaxine. Shortly after this appointment, DA returned to Dr Gudarzi's room to question the item charged for his attendance. He did not return to see Dr Gudarzi again and this was their last contact.

Overuse of quetiapine and concerns about inability to manage DA's anxiety problems

61. On 22 November 2018, Dr Berry provided DA with a prescription for quetiapine 300mg (60 tablets) with a direction for one tablet daily in the evening, with five repeats. He also provided a prescription for diazepam 5mg (50 tablets) with a direction for three tablets daily as required (15mg), with no repeats.

62. SafeScript records indicate that at this time, DA still had two remaining prescriptions for quetiapine, as prescribed by Dr Gudarzi. Further, despite, the direction for one tablet quetiapine 300mg daily, SafeScript records indicate DA was being dispensed quetiapine more frequently than would appear warranted from his prescription, being dispensed 60 tablets of quetiapine 300mg on 11 September 2018, 5 October 2018, 20 October 2018, 10 November 2018, 22 November 2018 and 18 December 2018 from a prescription with five repeats provided by Dr Gudarzi, and on 28 December 2018, 22 January 2019, 4 February 2019, 26 February 2019 and 11 March 2019 from a prescription with five repeats provided by Dr Berry. DA had attended six different pharmacies in various suburbs to access this medication.

63. On 26 November 2018, Dr Berry contacted Dr Gudarzi expressing concern that he could no longer manage DA's anxiety problems. Dr Gudarzi shared Dr Berry's concerns and responded, providing Dr Berry with an update about his own concerns about DA's abuse of prescription medications and left a message with DA's psychologist Ms Jackson to seek her views on DA's mental state. There is no record of a discussion being held between Dr Gudarzi and Ms Jackson, and it does not appear this was taken any further.

Commitment to weaning plan under Dr Hoo's care

64. On 28 November 2018, Dr Hoo had a long consultation with DA for pain management. DA reported that he was feeling better, his motivation had improved since their last consultation and he felt that he was *"getting somewhere in his mental health journey with regards to owning his condition and situation rather than feeling anxious or controlled by people or circumstances around him"*. DA felt he was now ready to try to wean himself off the codeine. Dr Hoo discussed with DA options for referring him to addiction medicine specialists, but DA declined this, preferring to continue the tapered withdrawal with Dr Hoo without additional intervention.

65. Dr Hoo was willing to continue assisting DA with the weaning plan because of his gradually positive approach to his mental health and increasing determination. He explained to DA about SafeScript, and that provided he abided by the drugs of dependence contract, they would be able to continue weaning safely. DA reassured him that he had not been getting the medications from elsewhere.

66. SafeScript records indicate DA continued to consult multiple prescribers for codeine and diazepam. He consulted five prescribers to obtain prescriptions for codeine and diazepam and

accessed 270 panadeine forte tablets, 410 tablets of codeine phosphate 30mg and 338 diazepam 5mg tablets from nine pharmacies throughout November 2018.

67. Dr Hoo prescribed DA medications in accordance with his weaning plan, with codeine 30mg prescribed at ten tablets daily (300mg daily) weaning by two tablets per week until ceased, and seven tablets diazepam 5mg (35mg) daily to continue until able to commence weaning from diazepam. Dr Hoo also prescribed zolpidem to assist DA with sleep.

68. On 3 December 2018, DA saw Dr Hoo and reported that he had acute short-term stressors with organising upcoming Christmas and birthday plans, reported he had two panic attacks in three days and admitted to having taken a lot more diazepam than he should have.

69. Dr Hoo took an inventory of DA's medications and calculated that DA had used about 11 tablets daily (55mg) of diazepam. Dr Hoo was not surprised that the diazepam had not been effective, because DA's base line use is so high. DA agreed he would not over-use again and Dr Hoo replenished the supply of diazepam to a rate of six tablets daily (30mg, being a reduction of 5mg daily) and advised DA that if this occurred again, he may have to commence daily pick up.

70. On 8 December 2018, DA had an appointment with Ms Jackson. Ms Jackson noted DA did not express suicidal thinking. He refused drug and alcohol counselling as he did not think he had a problem, despite admitting that he relied on alcohol to control his anxiety. DA told Ms Jackson he would see his psychiatrist for a medication review. This was DA's last appointment with Ms Jackson.

71. At about this time, DA was uncharacteristically angry towards TV, which she attributed to his use of alcohol and medication.

Outpatient review for pulmonary emboli

72. On 11 December 2018, DA was reviewed by respiratory and sleep physician Dr Nick Antoniades in the Heidelberg Repatriation Hospital Outpatients Department for review of the pulmonary emboli first identified in late October 2018. DA reported to Dr Antoniades that his medications were rivaroxaban, quetiapine, sertraline and salbutamol[18] and that he consumed

[18] Salbutamol is a short-acting β_2-adrenoreceptor stimulant indicated in the treatment of bronchospasm; acute asthma prophylaxis and as part of asthma management program.

minimal alcohol. He nominated Nillumbik Medical Centre as his treating medical clinic and did not disclose that he was also prescribed codeine and diazepam by Dr Hoo.

73. Dr Antoniades noted that DA presented as well and he was advised to continue the rivaroxaban and provided with a repeat prescription. Dr Antoniades ordered a number of follow up tests to explore and establish an underlying cause for the PE. Medical records indicate that DA underwent a repeat VQ scan on 18 February 2019 which showed almost complete resolution of the PE. However, it is unclear whether DA underwent the other tests ordered. Dr Antoniades sent a letter of the contact, assessment and treatment to the Nillumbik Medical Centre, which was nominated by DA as his treating medical clinic.

Progress on weaning plan

74. On 12 December 2018, DA saw Dr Hoo for his regular prescription. He reported succeeding at weaning dose of codeine and was now at six tablets of codeine 30mg (180mg daily). Dr Hoo conducted an inventory of DA's medications which supported this. DA remained anxious but had no further major panic attacks. He reported disagreements with his parents and was now living alone at his sister's rental property while deciding what to do next.

75. Dr Hoo observed a worsening of negative thoughts, teariness and low mood, but noted that DA was able to continue attending work, perform his tasks and maintain self-care. Dr Hoo encouraged DA to speak with his counsellor about conflict resolution, as he considered that improving the relationship and staying with his parents would help to improve his mental health rather than living alone.

76. Dr Hoo discussed with DA the possibility of inpatient psychiatric treatment, but he was reportedly very resistant to this, saying that he had found it *"completely unhelpful"* the last time he had been admitted. DA denied suicidal attempt or plan. Dr Hoo advised him that if his depression increased further, they would need to add another anti-depressant to his regime or involve more help. DA's diazepam script remained unchanged, with DA's codeine prescription at six tablets daily (180mg daily) with plan for weaning by one tablet per week.

77. On 13 December 2018, DA saw Dr Berry and was prescribed diazepam 5mg (50 tablets), one tablet twice a day (10mg daily), with no repeats. This was the last time DA saw Dr Berry.

78. On 21 December 2018, DA saw Dr Hoo. DA told him that he had lost 50 tablets of diazepam. Dr Hoo listened to DA's story, believed him, and agreed to provide once off permission for early dispensing. Dr Hoo noted that this was the first time DA had lost medication whilst he

had been prescribing it and was happy to accept that this had indeed happened on this occasion.

79. SafeScript records indicate that DA consulted four prescribers for prescriptions for codeine and diazepam and accessed 250 panadeine forte tablets, 220 codeine phosphate 30mg tablets and 280 diazepam 5mg tablets from five pharmacies throughout December 2018.

Struggles on weaning plan and access to additional codeine products

80. On 2 January 2019, DA saw Dr Hoo and told him that he missed his son, that his relationship was not improving, that he was struggling with reducing codeine and was worried about his future. Dr Hoo inventoried and confirmed all medications and prescribed the codeine as requested.

81. Shortly after the consultation, Dr Hoo was contacted by Simon Yu Wallan pharmacy who advised him that DA had recently acquired 200 codeine 30mg tablets on 24 December 2018 from a previously unfilled script provided by Dr Hoo in October 2018. Dr Hoo asked the pharmacy not to dispense any further medication until he had the opportunity to speak with DA.

82. Dr Hoo arranged a further consultation with DA the same day. DA explained that he *"could not control himself"* after receiving a large quantity of codeine and expressed regret for what had happened.

83. Dr Hoo checked SafeScript and identified that DA had been trying quite hard to keep within the weaning limits with only minor infractions of use over recent weeks, and that this was the first time it had happened. Dr Hoo decided to continue the weaning plan with tightened dispensing controls for weekly pick-ups, resuming at four tablets of codeine per day as per the weaning plan. Dr Hoo informed DA that if he had further difficulty controlling his use then they would have to increase the prescribing and dispensation intervals further.

84. Dr Hoo prescribed codeine 30mg four tablets daily, and diazepam and zolpidem as per DA's usual prescription. He noted that DA may have developed resistance to opioid analgesics given his absence of withdrawal and ability to take large amounts of it without any apparent overdosing.

85. SafeScript records confirm that from this point there was a marked reduction in DA's access to drugs of dependence. He collected weekly supplies of codeine from Simon Yu Wallan

pharmacy on 3, 9, 14 and 21 January 2019, who held copies of the letters about the weaning schedule, as did Chemist Warehouse Greensborough Plaza.

Welfare check

86. On 4 January 2019 after spending Christmas break apart, TV told DA she wanted to formalise the separation, at which time DA became upset and left in his car after making comments that indicated an intention to end his life. Concerned for DA's welfare, TV contacted DA's siblings OE and IX to inform them of what had occurred, and with their encouragement she subsequently contacted 000 to request a welfare check at about 7.00pm.

87. At about 7.18pm, First Constable (**FC**) Tom Rossetti and Leading Senior Constable (**LSC**) Jason Turner intercepted DA's vehicle travelling on Northern Highway, Wallan. FC Rossetti and LSC Turner had been performing divisional patrol duties in the Kilmore area and were tasked with attending the welfare check. They observed DA's vehicle travelling at the speed limit, but he appeared to be drifting across the road and unable to remain in its lane. They activated their lights and sirens, and DA complied with their direction to pull his vehicle over.

88. LSC Turner observed alcohol cans sitting on the front passenger seat and floor and noted that DA appeared upset that he had been intercepted by police. DA returned a positive preliminary breath test and smelled strongly of alcohol. LSC Turner asked DA to return with them to Wallan Police Station for the purpose of an evidentiary breath test and an assessment of his mental state.

89. At about 7.30pm, they returned to Wallan Police Station with DA. LSC Turner spoke with DA about his state of mind who told him that he had been going through relationship issues with his wife and that she had just returned home with their child after being away for 10 days. DA stated he had turned to drinking alcohol to help him with his issues.

90. At 8.04pm, DA provided a sample of his breath which returned a positive reading of 0.054 grams of alcohol per 210 litres of breath. DA indicated his reason for driving a vehicle with more than the prescribed concentration of alcohol in his breath as *"stupidity"*. He was given an infringement notice for driving in excess of the prescribed alcohol limit.

91. According to LSC Turner, DA appeared upset at the penalty of losing his licence for 3 months and how it would affect his ability to work as he was a sales representative and was required to drive everywhere. LSC Turner informed him that the loss of licence would not come into effect until 28 days and DA asked about appeal avenues to get his licence back for

employment purposes. FC Rossetti noted that DA talked about how he would manage his occupation without his licence. FC Rossetti observed that DA appeared to be forward planning about managing his occupation without his licence which led him to believe that DA was not an imminent danger to himself or others.

92. LSC Turner spoke with DA about his mental health issues. DA disclosed that he had an argument with his wife after she had returned home and was upset about his relationship breakdown. He denied being suicidal and told LSC Turner that he may have told his wife he was going to kill himself, but this was *"just a comment"* and that he had no plans to self-harm. He told them that the cessation of the relationship had come as a complete surprise to him, and he had left the house to clear his head, not to cause harm to himself. DA reported that his sister was a mental health practitioner, that he had been receiving support from various health services and had support networks in place.

93. LSC Turner believed DA when he stated that he did not have suicidal thinking and did not consider DA met the requirements of Section 351 of the *Mental Health Act 2014* (Vic) to warrant apprehension for the purpose of being taken to hospital or examined by a registered medical or mental health practitioner.[19] However, given the information provided by TV to police about DA's comments about ending his life, LSC Turner contacted Ambulance Victoria to ask if they would attend and assess DA. Ambulance Victoria advised LSC Turner that a mental health nurse would call and conduct an assessment over the phone.

94. At approximately 8.30pm, Ambulance Victoria Mental Health clinician Debbie spoke with DA at length via phone. DA denied he had been suicidal and when asked about TV, stated he did not think it had come to the point when he thought of doing anything irrational. He disclosed some of his medications and past admissions to Northpark Private Hospital and reported that he believed he was supported by his counsellors and family. He spoke about IX's attempts to help him and admitted he was sometimes *"standoffish"*.

95. Following this discussion Debbie informed LSC Turner that she did not believe DA was an imminent threat to himself or others and did not believe he fit the criteria of a Section 351 Mental Health Assessment. Based on this information, LSC Turner believed there was no

[19] Section 351 of the *Mental Health Act 2014* (Vic) provides that a police officer or protective services officer may apprehend a person if they are satisfied that the person appears to have a mental illness and because of the person's apparent mental illness, the person needs to be apprehended to prevent serious and imminent harm to the person or to another person. Under this legislative provision, after the person is apprehended, they are to be taken as soon as practicable to a hospital or registered medical practitioner or mental health practitioner to examine the person.

power to arrest DA for a mental health assessment under the Mental Health Act. However, with DA's consent, LSC Turner submitted an e-referral for mental health support.

96. Whilst DA was in custody, IX rang the police station on two occasions to express her concerns about DA's safety and her opinion that he needed to be taken to the nearest hospital and assessed under the Mental Health Act. IX was informed that DA *"seemed fine"*, and that they had arranged for a mental health clinician to speak with DA over the phone and that they felt he did not require hospitalisation.

97. At approximately 8.45pm, DA was released from custody, with the understanding that he would be picked up by a sibling from the police station and would stay with his family overnight. DA remained in the watch-house until the arrival of his brother OE, who took him to stay with IX at her home.

98. When IX collected DA's car the following day, she found multiple empty packets of codeine and benzodiazepine medicines in the vehicle. DA admitted to her that he was on a weaning plan from his GP but said he would be *"off them soon"*.

99. On 25 January 2019, LSC Turner received an 'Elect to Appear – Notice of Objection' from DA in response to the infringement notice, in which he indicated that he wished to contest the loss of licence and had paid the fine.

100. Over the following months, DA was described by his family as experiencing mood swings, was difficult to talk to and was sometimes angry and irritable. He moved in with IX and her partner, and in mid-February moved to Briar Hill where he lived alone.

Ongoing anxiety, use of drugs of dependence and compliance with weaning plan

101. On 14 January 2019, DA saw Dr Hoo for an extended mental health consult to discuss his anxiety and use of drugs of dependence. DA explained he was having trouble in trying to cope with the weaning dose and his mental health following his separation from his wife and was now living at his sister's place while trying to work out where to stay. He admitted taking an average of five codeine tablets a day (150mg daily), which he was able to stick with for the first week but found by the second week he was using more than directed. Due to his mental health issues, Dr Hoo agreed to allow DA five codeine 30mg tablets a day (150mg daily) for the time being, until he was ready to try weaning again.

102. DA also disclosed to Dr Hoo that he did not feel the antidepressant sertraline was working, and wanted to try more desvenlafaxine. Dr Hoo considered this would be worth trialling to alleviate DA's anxiety symptoms, with weaning of the sertraline to 100mg, and increasing the desvenlafaxine to 100mg. Dr Hoo reiterated to DA that the medicines would not change his need to grieve for the end of his relationship, provided advice to DA on distraction therapy, and encouraged him to consider starting new interests or hobbies, invest in existing relationships and new friendships and to work on having his dog live with him to increase his companionship in his current home.

103. On 25 January 2019, DA had a further long consultation with Dr Hoo to discuss transferring pharmacy, his mental health issues and use of zolpidem.

104. DA told him that he had been given one last chance by his employer to perform consistently at work which led to him using more of his medications that week. Dr Hoo noted that DA's mental health issues were driving his drug use. DA asked for a prescription to be given early and asked whether he could get the prescriptions dispensed that day, which at that time was four days early. Dr Hoo refused to allow dispensation four days early but agreed to write DA a letter allowing him to obtain medications two days early in the circumstances.

105. Dr Hoo reiterated that DA needed to take responsibility for his medication use and he would not be able to have any more until at least within two days of his next dispensing. Dr Hoo also discussed with DA his overuse of zolpidem. DA felt it was not helping him much and agreed to cease it. Dr Hoo encouraged DA to continue talking to his counsellor and advised him to tackle one thing at a time, rather than trying to do everything at once.

106. SafeScript records show that throughout January 2019 DA consulted only Dr Hoo for codeine and diazepam and accessed 140 codeine phosphate 30mg tablets and 300 diazepam 5mgs tablets from two pharmacies. He did not access any panadeine forte tablets.

107. On 7 February 2019, DA saw Dr Hoo. He reported that he had lost his job because he could not concentrate which he blamed on his anxiety. Dr Hoo explained this should also be attributed to his ongoing use of high doses of benzodiazepine and codeine medication, but DA stated that if he did not take them his anxiety was uncontrollable. Dr Hoo provided cognitive strategies focused on gaining self-control. Dr Hoo noted that DA had good insight and no new depressive symptoms or suicidal thinking. DA reported that he wanted the codeine reduced further. He remained on weekly dispensing, with codeine 30mg prescribed at five tablets daily (150mg daily) and diazepam 5mg at seven tablets daily (35mg daily).

108. On 21 February 2019, DA told Dr Hoo he had used an additional 20 codeine tablets above the prescribed amount, which he explained was due to spraining his ankle and taking ten more tablets across two days when he had pain. He reported that his ankle was better now. He also explained that currently, the pharmacy were allowing him script quantities all at once.

109. Dr Hoo agreed that for an indiscretion of 10 tablets, he was willing to not put DA back on weekly dispensing but indicated to DA that this was dependent on his next reconciliation being compliant with the dosing as prescribed. Dr Hoo noted that reassuringly, DA's use of diazepam was stable and his anxiety was improved on desvenlafaxine. Dr Hoo increased the venlafaxine dose to 150mg and reduced the sertraline dose to 50mg with a review in a fortnight.

110. SafeScript records show DA consulted only Dr Hoo for codeine and diazepam and accessed 120 codeine phosphate 30mg tablets and 200 diazepam 5mg tablets throughout February 2019 from two pharmacies. He did not access any panadeine forte tablets.

111. On 6 March 2019, DA saw Dr Hoo again. He reported he had obtained new work. Dr Hoo noted that despite the stress of new work, DA had been able to keep his codeine and diazepam intake stable and in accordance with the prescribed doses which reconciled correctly. DA reported that the reduced dose of sertraline had made no difference, so sertraline was ceased and the desvenlafaxine dose increased. Dr Hoo prescribed 1-2 tablets zolpidem 10mg for insomnia as required at night, to be used alternate nights at most, with codeine 30mg remaining at five tablets daily (150mg daily), and his diazepam 5mg at seven tablets daily (35mg daily). According to Dr Hoo, DA sounded positive during this consultation, reported that he had just started a new job, was continuing to use his medications as per the contract and plan and was going well.

112. The same day, DA filled a prescription of zolpidem 10mg (28 tablets), diazepam 5mg (100 tablets) and codeine phosphate 30mg (80 tablets) as prescribed by Dr Hoo at Simon Yu Wallan pharmacy.

113. SafeScript records show that DA consulted only Dr Hoo for prescriptions for codeine and diazepam from 1 March 2019 until his death. He accessed 80 codeine phosphate 30mg tablets and 100 diazepam 5mg tablets from one pharmacy and did not access any panadeine forte tablets.

114. On 11 March 2019, DA filled a script of quetiapine 300mg (60 tablets) prescribed by Dr Berry with one repeat remaining, and a script of zolpidem 10mg (28 tablets) prescribed by Dr Hoo

at Montmorency Pharmacy. This appears to have been the last time DA was dispensed any medications according to SafeScript records.

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

Circumstances in which the death occurred

115. On Thursday 14 March 2019, at about 6.15pm, DA's parents CL and WR were notified that that DA had not collected his son from childcare as he was scheduled to do.

116. CL immediately drove to DA's home, approximately two minutes away which he had keys to. When CL opened the door, he found that the television and lights to every room were on. CL called out to DA, but there was no response.

117. CL found DA on his bed, lying on his side, with his hands clasped together. He was cold to the touch, and it was apparent he had been deceased for some time.

118. Victoria Police attended and immediately commenced a coronial investigation.

119. Police officers located empty alcohol containers and numerous prescription medication packs and boxes in DA's home and car. The medications included diazepam, rivaroxaban, codeine phosphate, zolpidem, desvenlafaxine, quetiapine, sertraline and haloperidol. Many of the medication packs were empty, but there was one full box of sertraline, one box of sertraline with one tablet missing, one box of desvenlafaxine with six tablets missing and a bottle of haloperidol was approximately 1/3 full.

120. The medications had been prescribed to DA by Dr Hoo, Dr Berry, Dr Gudarzi and Dr Antoniades and administered from six different pharmacies located in Wallan, Bundoora, Greensborough, Montmorency and Briar Hill on various dates between 26 November 2018 and 11 March 2019.

Identity of the deceased

121. On 14 March 2019, DA, born 21 December 1980, was visually identified by his mother, WR.

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

Medical cause of death

123. Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination of the body of DA on 17 March 2019 and reviewed the Victoria Police Report of Death for the Coroner (Form 83), information in the VIFM contact log, and the post mortem computed tomography (**CT**) scan. Dr Lynch provided a written report of his findings dated 18 March 2019.

124. The post-mortem CT scan revealed radiopaque residue within the stomach.

125. Toxicological analysis of post-mortem samples identified the presence of ethanol (0.06 g/100mL), quetiapine, codeine, desmethylvenlafaxine, sertraline, zolpidem and benzodiazepines diazepam, nordiazepam, temazepam and oxazepam. The drugs detected were consistent with excessive and potentially fatal use, and the combination of drugs may cause death in the absence of other contributing factors.

126. Dr Lynch provided an opinion that the medical cause of death was '1(a) Mixed drug toxicity'.

127. I accept and adopt Dr Lynch's opinion.

REVIEW OF CARE

Family concerns

128. DA's sister, IX, wrote to the court to express concerns about the circumstances of her brother's death including DA's access to, doses and combinations of medications prescribed and communication or knowledge of involvement across practitioners involved in DA's care. IX's concerns were echoed in the statements of other members of DA's family, including his father CL and wife TV.

129. In response to these concerns, DA's case was referred to the Coroners Prevention Unit (**CPU**). CPU reviewed and provided advice on the key issues including DA's access to, doses and combinations of medications prescribed by Dr Hoo, and prevention opportunities. This advice is discussed further below.

130. IX also raised concerns regarding the decision-making by Ambulance Victoria and Victoria Police in response to the request for a welfare check on 4 January 2019. She raised concerns regarding alleged failures to:

(a) seek collateral support from DA's family pertaining to his mental state, baseline risks and current risks when Ambulance Victoria conducted the mental health assessment;

(b) conduct a risk assessment about DA's living arrangements or supports in place prior to his release from police custody;

(c) contact IX to discuss the plan to release DA into her care and consult with her about the safety plan;

(d) contact DA's professional supports post phone assessment to inform them about the evening's events.

131. IX explained that "*as a family we felt it was our responsibility to advocate for our family member who had the vulnerabilities of a mental illness, but these were not listened to*".

132. I acknowledge the concerns raised by DA's family with respect to the welfare check and the response of emergency services. The welfare check forms part of the overall picture of DA's mental health history in the lead up to his death. However, the response of Victoria Police and Ambulance Victoria on 4 January 2019 is not sufficiently proximate to be considered causally connected to or contributory towards DA's death. In these circumstances, it is not appropriate for me to investigate these specific matters further, or to make any comment or finding as to the appropriateness or otherwise of the response of the services in this instance.

133. Significant work is underway to improve emergency services' response to mental health crises following recommendations made by the Royal Commission into Victoria's Mental Health System (as discussed in my Comments below). However, the experience of DA's family provides an important opportunity for relevant government entities to consider whether there are further avenues for better engaging with and responding to families when they have requested a welfare check for their loved one. Accordingly, I will also direct that a copy of this Finding be provided to Chief Commissioner of Victoria Police Shane Patton and Chief Executive Officer of Ambulance Victoria, Tony Walker for their review and consideration.

Access to, doses and combinations of prescribed medicines

134. Significant concerns were raised regarding how DA had been able to access such significant amounts of drugs of dependence in the dose and combinations he was prescribed. The CPU provided advice in response to these concerns, having reviewed materials contained in the coronial brief including DA's medical records, Medicare, PBS and SafeScript records, and statements from DA's treating practitioners.

135. The CPU noted that both Dr Gudarzi and Dr Hoo had raised the issues of DA's overuse of codeine and diazepam with him and offered him referrals to specialist addiction services, including a psychiatrist with an addiction speciality and community, residential based, public and private services. DA refused all referrals and continued doctor shopping until he agreed to engage in a treatment contract with Dr Hoo. Although DA was not honest to Dr Hoo about his doctor shopping in the early months of the contract to taper and cease his use of codeine, then diazepam, he did not obtain additional scripts between January 2019 and his death, saw Dr Hoo regularly, complied with the weekly pickup and then managed to control his use when he had access to a large amount to manage after 21 February 2019. He also reported that he was feeling better and had a greater sense of control at his last appointment on 6 March 2019.

136. The CPU considered that the decision by Dr Hoo to prescribe only codeine (not combined with paracetamol) was clinically sound. The accidental damage to the liver of people who take regular high doses of paracetamol has been the subject of multiple coronial investigations. DA's addiction was to the opioid codeine and not paracetamol. Dr Hoo appropriately completed a physical screen including liver function tests to rule out any current liver damage. The medical records support that Dr Hoo discussed the risks with DA and he was advised not to use paracetamol. However, DA continued to doctor shop for panadeine forte for a further two months.

137. CPU considered the rate of tapering of the codeine was appropriate, as was the decision to wean DA from one drug of addiction at a time – codeine first, then diazepam. As noted by the Royal Australian College of General Practitioners (**RACGP**):

> *If you take benzodiazepines for a prolonged time, the body may adapt and get used to the effects of the medication. Stopping the medication can lead to withdrawal symptoms that includes anxiety and restlessness. Withdrawal symptoms are often mild, but can be severe if you are on high doses of a*

benzodiazepine. Serious side effects, including seizures, can occur if you stop taking high doses suddenly.[20]

138. Further, the RACGP supports the following:

> *When reducing patients from long-term, high dose opioids, a step-wise reduction of 10% of the original dose per week is usually well tolerated with minimal psychological adverse effects. As the dose gets lower, the rate of reduction can vary from weekly to monthly.*[21]
>
> *If dependence on benzodiazepines has become established, it is often difficult to treat and can become a long-term distressing problem. All patients with dependence should be encouraged to discontinue the drug and offered a detoxification program at regular intervals. For some patients, discontinuation will be difficult, but the effort should be made. For other patients, a reduction in dose, rather than continuation, will be the first goal.*[22]

139. The CPU concluded that the combination of medications prescribed by Dr Hoo was reasonable as, over time, DA had less types of medications and other than the antidepressant desvenlafaxine, was taking less of them.

140. Further, the CPU noted that DA appeared to have developed a meaningful and therapeutic relationship with Dr Hoo, was more honest with him, was engaged in a plan to stop substance use and manage his anxiety, and had ceased all doctor shopping, despite the reduced rates of codeine prescribed to him. The records showed that Dr Hoo provided extensive periods of psychosocial education and problem-solving to DA and had gained his trust.

141. In this regard, the RACGP notes:

> *Opioid tapers can be done safely and do not pose significant health risks to the patient. Special care needs to be taken by the prescriber to preserve the therapeutic relationship at this time. Otherwise, taper can precipitate doctor shopping, illicit drug use or other behaviours that pose a risk to patient safety. Extremely challenging behavioural issues may emerge during an opioid taper. Behavioural challenges frequently arise when a prescriber is tapering the opioid dose and a patient places great value on the opioid they are receiving. In this setting, some patients may feel overwhelmed or desperate and will try to convince the prescriber to abandon the opioid taper.*[23]

Communication and knowledge of involvement across practitioners

142. The CPU noted that one of the added complexities in DA's care and treatment was that he compartmentalised his treatments. He nominated Dr Berry as his usual GP to Dr Gudarzi,

---

[20] RACGP, 'Prescribing drugs of dependence in general practice, Part A'.
[21] RACGP, 'Prescription drug abuse – a timely update', *Australian Family Physician 2016*
[22] RACGP, 'Prescribing drugs of dependence in general practice, Part B'.
[23] RACGP, 'Prescribing drugs of dependence in general practice, Part A'.

Austin Health and Northern Health. This may have been intentional to keep his current addiction treatments separate, or he simply saw Dr Berry and Dr Gudarzi as looking after his mental and physical health as separate from his addiction. The CPU noted that DA seemed to have trusted Dr Hoo enough to discuss the antidepressants, but not that he was prescribed quetiapine, which he had sourced from Dr Berry in the months before his death.

143. The CPU considered that it could be argued that Dr Hoo should have been more proactive in ensuring DA disclosed all his treating practitioners and then contacted them. The same could be said for all of the prescribers who had been contacted and informed of DA's likely doctor shopping or prescribed opioids and benzodiazepines at one off visits, and those who had proactively consulted SafeScript in the months prior to its implementation in April 2019. However, at that time, no prescriber could be confident that SafeScript presented a complete picture.

144. Further, I note that DA had stopped seeing Dr Gudarzi and Dr Berry some months prior to his death (19 November 2018 and 13 December 2018 respectively), and was not receiving any ongoing treatment from either doctor at the time of his death, although he retained and continued to use repeat scripts provided by Dr Berry for quetiapine.

145. The CPU noted that DA was also responsible for identifying who was involved in his care and was capable of doing so, given his doctor shopping appears to have been well planned and successful in his accessing additional medicines. To be successful in accessing additional medicines, disclosing prescribers to each other would not have been in his interests. Indeed, DA had refused to provide Dr Gudarzi with the names of medical practitioners he had obtained medications from in November 2018.

146. The CPU noted that SafeScript is now mandatory and should provide practitioners and pharmacists with information so they can more easily identify other practitioners involved in a patient's care. However, there are limitations to this, as SafeScript would not have informed other practitioners of DA's treatment in hospitals, or providers who were prescribing medications other than the 27 medicines monitored through Safescript.

Effect of alcohol and other medicines

147. The CPU noted that DA was tapering his use of codeine which he had taken over an extended period and in large amounts and was vulnerable to using other more accessible and sedating substances with which to self-medicate any increase in his anxiety, be it from his mental disorder or from the anxiety associated with the reduction in use and restricted access,

including the rescheduling of over-the-counter codeine products to prescription only in February 2018. Such substances could include other medicines he had access to (such as quetiapine) and alcohol.

148. The CPU noted that the toxicology report identified the presence of quetiapine[24] at ~9.1 mg/L, which is high, but may have been affected by post-mortem redistribution. The CPU noted that SafeScript records indicate that from July 2018, DA had filled scripts for quetiapine 300mgs about twice each month. The prescribed dose was consistent at one tablet at night and had only been prescribed by Dr Berry and Dr Gudarzi with five repeats on each script. At Dr Gudarzi's last appointment in November 2018, the decision was made to start weaning off the quetiapine. Nonetheless, DA continued to be dispensed quetiapine at regular intervals until his death, with an average daily dose of about three tablets or 1050 mg daily, well above the recommended daily dose.

149. CPU noted that the adverse effects of quetiapine include sedation, cardiac and QT Interval changes and risk of sudden death, seizures, venous thromboembolism, and physical health comorbidities including weight gain and hypercholesteremia and the prescribing of it should also require routine physical health monitoring. Many of them are dose related and it is reasonable to consider DA was at risk of experiencing these adverse effects.

150. The CPU also noted that the toxicology report identified the presence of alcohol in post mortem specimens. DA was taking six sedating drugs at relatively high daily doses and the introduction of alcohol could have contributed in two ways: through the emergency of suicidal thinking; and/or contributed to sedation and respiratory depression.

Conclusions

151. The CPU concluded that although DA was reducing his use of codeine and had stabilised his use of diazepam, the bags of medications found in his home and car indicated that obtaining medications and having enough accessible continued to be a focus for him. He had made gains on reducing his use, was engaged in a therapeutic relationship with Dr Hoo, had a longer-term treatment plan and was working and looking after his son as arranged. He continued to report high level of stress and anxiety but reported that his mood had improved in the weeks

[24] Quetiapine is an atypical antipsychotic used to treat schizophrenia and bipolar affective disorder, treatment resistant major depression and generalised anxiety disorder. It causes sedation and is often chosen for that property and taken at night.

proximate to his death and had not raised his Tourette's with Dr Hoo, which he appears to have restricted to Drs Berry and Gudarzi who he had stopped seeing.

152. DA had a dual diagnosis,[25] but resisted involvement of addiction services which he may have benefited from because dual diagnosis demands an integrated approach to assessment and treatment. DA was trying to manage an addiction that was complex and unlikely to respond solely to restricting access to and weaning from prescribed medicines of addiction. The addictions he experienced, when combined with his mental illness, suggests his recovery would have been a lengthy and fluctuating journey.

153. The CPU considered there was a suboptimal level of coordinated care and clinical communications. However, this was heavily influenced by DA's misrepresenting his situation, not being transparent about medications, who he was consulting, what scripts he was accessing and compartmentalising his care.

154. The CPU noted that DA had been able to legally secure large amounts of addictive medicines over many years that had resulted in his addictions. The experience of the Court is that this has not been an isolated instance. However, the introduction of SafeScript (discussed in my Comments below), and the rescheduling of over-the-counter codeine products are policy responses that should reduce the likelihood of iatrogenic addictions.

FINDINGS AND CONCLUSION

155. I convey my sincere condolences to DA's family. I acknowledge the grief and devastation you have endured as a result of your loss.

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

    (a) the identity of the deceased was DA, born 21 December 1980;

    (b) the death occurred between 11 March 2019 and 14 March 2019 at Briar Hill, Victoria, 3088, from mixed drug toxicity; and

[25] A dual diagnosis condition can include a mental health problem or disorder leading to or associated with problematic alcohol and/or other drug use, a substance use disorder leading to or associated with a mental health problem or disorder, alcohol and/or other drug use worsening or altering the course of a person's mental illness. People also can use substances to reduce symptoms of their illness or the unwanted effects of their medication, many people with drug and alcohol problems have higher rates of mental illness than the general community, most commonly depression and anxiety; alcohol and drug use is also common among people experiencing psychosis and other serious mental illness; Population health research shows high rates (up to 50 per cent) of alcohol and drug use among people with severe mental health problems. See https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/specialist-responses/dual-diagnosis, accessed 25 June 2021.

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

157. There is no presumption for or against a finding of suicide.[26] Nevertheless, a finding that a person has deliberately taken his or her life can have long lasting ramifications for families and friends of that person. Therefore, it should only be made when there is clear and cogent evidence.

158. Having considered all of the circumstances, and on the balance of probabilities, I am not comfortably satisfied as to whether or not DA's death was the consequence of an intention to end his own life, or whether it was the unintentional consequence of using multiple sedating medications in combination with alcohol in an effort to alleviate his symptoms of anxiety.

159. The evidence before me shows that DA struggled with a longstanding and complex addiction to opioid analgesics and benzodiazepines, which he relied upon to alleviate his anxiety symptoms. Despite the support of his family and treating practitioners, DA continued to resist efforts to refer him to specialist addiction services who may have been better placed to provide an integrated approach to his assessment and treatment.

160. I consider that Dr Hoo's treatment of DA was reasonable and appropriate in the circumstances, noting the challenges of treating opioid and benzodiazepine dependence. Whilst DA initially struggled to comply with the weaning plan, Dr Hoo continued to offer extensive psychosocial education, support and problem solving to DA, and developed a strong trusting therapeutic relationship such that DA was able to successfully reduce his codeine use, and did not seek any additional scripts for codeine or diazepam between January 2019 and his death.

COMMENTS

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

Royal Commission into Victoria's Mental Health System

161. In February 2019, the Royal Commission into Victoria's Mental Health System (**Royal Commission**) was established to inquire into and report on how Victoria's mental health system could most effectively prevent mental illness and deliver treatment, care and support so that all those in the Victorian community can experience their best mental health, now and

[26] Suicide is defined by the World Health Organisation as *'an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome'.*

into the future. The Royal Commission's final report was tabled on 2 March 2021,[27] and sets out recommendations for systemic and wholesale reform to create a future mental health and wellbeing system that provides holistic treatment, care and support for all Victorians.[28]

162. The Royal Commission set out a 10-year reform agenda to redesign Victoria's mental health and wellbeing system over the short, medium and long-term based on seven guiding principles:

1. *The inherent dignity of people living with mental illness or psychological distress is respected, and necessary holistic support is provided to ensure their full and effective participation in society.*

2. *Family members, carers and supporters of people living with mental illness or psychological distress have their contributions recognised and supported.*

3. *Comprehensive mental health treatment, care and support services are provided on an equitable basis to those who need them and as close as possible to people's own communities – including in rural areas.*

4. *Collaboration and communication occur between services within and beyond the mental health and wellbeing system and at all levels of government.*

5. *Responsive, high-quality, mental health and wellbeing services attract a skilled and diverse workforce.*

6. *People with lived experience of mental illness or psychological distress, family members, carers and supporters, as well as local communities, are central to the planning and delivery of mental health treatment, care and support services.*

7. *Mental health and wellbeing services use continuing research, evaluation and innovation to respond to community needs now and into the future.*

163. The Royal Commission made 65 recommendations including with respect to responding to mental health crises (rec. 8),[29] supporting responses from emergency services to mental health crises (rec. 10),[30] supporting the mental health and wellbeing of prospective and new parents (rec. 18),[31] facilitating suicide prevention and response initiatives (rec. 27),[32] developing

---

[27] Royal Commission into Victoria's Mental Health System, 'Final Report' published February 2021 (available at: https://finalreport.rcvmhs.vic.gov.au/).

[28] Royal Commission into Victoria's Mental Health System, 'Final Report: Summary and recommendations' (available at: https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf).

[29] Royal Commission into Victoria's Mental Health System, Final Report Summary and Recommendations tabled 2 March 2021, p. 44.

[30] Royal Commission into Victoria's Mental Health System, Final Report Summary and Recommendations tabled 2 March 2021, p 46.

[31] Royal Commission into Victoria's Mental Health System, Final Report Summary and Recommendations tabled 2 March 2021, p 54.

[32] Royal Commission into Victoria's Mental Health System, Final Report Summary and Recommendations tabled 2 March 2021, p 63.

system-wide involvement of family members and carers (rec. 30),[33] improving outcomes for people living with mental illness and substance use or addiction (rec. 35),[34] and establishing a new statewide service for people living with mental illness and substance use or addiction (rec. 36).[35]

164. The Victorian Government has committed to implementing all the recommendations made by the Commission.[36] Such a significant overhaul of the mental health system will take time. However, it is hoped that by implementing the reforms, Victoria's mental health system will be more responsive and integrated and that people living with mental illness will be better able to access compassionate services that meet their preferences, strengths and needs.[37] These reforms will assist in providing better treatment, care, support and outcomes for people living with mental illness and experiencing psychological distress.

Real-time prescription monitoring

165. Between 2011 and 2020, 4551 overdose deaths were recorded in Victoria.[38] Of these, pharmaceutical drugs (predominantly benzodiazepines and pharmaceutical opioids, followed by antidepressants and antipsychotics) have consistently remained the most frequent contributors to Victorian overdose deaths, playing a role in just over three-quarters of all deaths, with alcohol contributing to approximately 30%.[39] In addition, by 2020, the proportion of Victorian overdose deaths involving multiple drugs was approximately 74% of deaths, highlighting the need to recognise and respond to the risks of drugs used in combination in harm reduction and overdose prevention initiatives.[40]

166. In response to concerns about the harms and increasing number of deaths associated with the use and misuse of prescription medications, the Victorian Department of Health introduced SafeScript, a real-time prescription monitoring system. SafeScript is computer software that allows prescribing and dispensing records for certain high-risk medicines, including benzodiazepines and opioid analgesics, to be transmitted in real-time to a centralised database which can then be accessed by doctors and pharmacists during a consultation. It provides a

---

[33] Royal Commission into Victoria's Mental Health System, Final Report Summary and Recommendations tabled 2 March 2021, p 66.
[34] Royal Commission into Victoria's Mental Health System, Final Report Summary and Recommendations tabled 2 March 2021, p 71.
[35] Royal Commission into Victoria's Mental Health System, Final Report Summary and Recommendations tabled 2 March 2021, p 72.
[36] https://www2.health.vic.gov.au/mental-health/mental-health-reform.
[37] https://www2.health.vic.gov.au/mental-health/mental-health-reform.
[38] Coroners Court of Victoria, 'Victorian overdose deaths, 2011-2010' published 29 July 2021., p 9.
[39] Coroners Court of Victoria, 'Victorian overdose deaths, 2011-2010' published 29 July 2021, p 9, 11.
[40] Coroners Court of Victoria, 'Victorian overdose deaths, 2011-2010' published 29 July 2021, p 9.

clinical tool for prescribers and pharmacists to make safer decisions about the prescribing or dispensing of high-risk medicines and to facilitate the early identification, treatment and support for patients who are developing signs of dependence.

167. SafeScript was implemented across Victoria from 1 April 2019 but was available for registration and use from 1 October 2018. Since 1 April 2020, it has been mandatory for medical practitioners to check SafeScript prior to writing or dispensing a prescription for a medicine monitored through the system, including quetiapine. This follows worldwide best practice, as mandatory systems adopted in other countries have been shown to provide greater reduction in harms from high-risk prescription medicines. There are some limited exceptions to this, including when treating patients in hospitals, prisons, police gaols, aged care and palliative care.

168. The SafeScript website provides information sheets for patients and their families about the risks associated with prescription medications such as opioids and benzodiazepines, and explains that:

> *If you have been receiving the same medicines, or unsafe combinations, from more than one doctor without each doctor knowing, you could be at risk of harm. Your doctor may consider changes for your safety which might include better coordination of care, safely adjusting your medicine doses or recommending alternative approaches to managing issues such as pain, anxiety or insomnia.*[41]

169. The SafeScript website also offers information for prescribers and pharmacies about use of SafeScript, explaining that:

> *SafeScript does not instruct you on what to do or decide whether a medicine should or should not be prescribed to your patient. This remains your clinical decision to determine whether the medicines prescribed continue to be the safest and best option for your patient's medical needs.*
>
> *Should you decide that a medicine is no longer the safest treatment, you are reminded that good clinical practice involves ensuring that appropriate continuity of care is provided for your patient. Abruptly discharging the patient from your care or abruptly stopping treatment in patients who have been taking high-risk medicines over a long period of time may be contrary to patient safety. There may be implications to discontinuing some medicines too quickly. For example, sudden withdrawal of benzodiazepines may result in rebound insomnia or anxiety, or at worst, seizures.*
>
> *Medical practitioners and pharmacists are also reminded of their responsibilities as part of their professional registration, contained within their code of conduct. It is important that all patients receive the same standard of*

[41] https://www2.health.vic.gov.au/public-health/drugs-and-poisons/safescript/consumers-and-families, accessed 25 June 2021.

care, remembering that anyone can develop a dependency on prescription medicines.[42]

170. Clinicians are encouraged to complete training modules available through the SafeScript website, which includes training on the SafeScript system, high-risk medicines and clinical practice – managing safety concerns, planning approaches for consultations and alternative management options and having challenging conversations – as well as using respectful communication to respond to the needs of patients who may be at risk of harm.[43] The learning outcomes of the training modules include important information about assessing safety concerns and the risks of long-term use and dependence.

171. There are also additional supports available to clinicians, including the GP Clinical Advisory Service which provides a peer-to-peer advice and mentoring service for GPs and nurse practitioners managing patients with high-risk prescription medication use identified through SafeScript.[44] NPS Medicine Wise[45] also offers a free educational webinar on opioid prescribing and strategies for GPs to optimise chronic non-cancer pain management and minimise harms.[46]

172. SafeScript has been a vital tool for prescribers and dispensers to identify and intervene to prevent excessive use of prescribed drugs, use of contraindicated drug combinations, prescription shopping and other issues that emerge from poor coordination of care. The use of SafeScript should prevent the set of circumstances in which DA was enabled to develop addictions to codeine and benzodiazepines.

173. As part of their review, the CPU identified that there may be further opportunities to utilise SafeScript and its associated educational resources to provide further advice and information to prescribers, dispensers, patients and their families about the short term risks of opioid and benzodiazepine use. I agree with this assessment, and consider that there is an opportunity to increase patient safety by:

---

[42] https://www2.health.vic.gov.au/public-health/drugs-and-poisons/safescript/health-professionals, accessed 25 June 2021.

[43] https://vtphna.org.au/our-work/health-system-integration-and-reform-translation/safescript-training-hub/, accessed 25 June 2021.

[44] See https://www.dacas.org.au/clinical-resources/gpcas.

[45] NPS Medicine Wise was established in 1998 as the National Prescribing Service (NPS) Limited with the primary aim of promoting quality use of medicines, connecting with health consumers and health professionals nationwide to change attitudes and behaviours and empower all Australians to make the best possible healthcare decisions.

[46] https://www.nps.org.au/cpd/activities/tga-opioid-reforms, accessed 25 June 2021.

(a) amending the SafeScript training modules for health professionals to include additional advice and training about:

(i) exploring with patients the effect of other medications not recorded in SafeScript which affect the central nervous system, for example antidepressants and antipsychotics, that in combination increase the risk of harm;

(ii) discussing with patients who are prescribed quetiapine the details of its use, time of dosing and risks when taken in combination with other medicines;

(iii) educate patients about the potential for accidental overdose with dosing routines and combinations of high risk medicines even if prescribed; and

(iv) educate patients using multiple sedating medications about the implications of alcohol use due to the central nervous system depressive effect; and

(b) amending the SafeScript educational materials for patients and their families to include information about the potential for accidental overdose and the implications of alcohol use when taking multiple sedating medications.

174. Further, to ensure that General Practitioners and Pharmacists are informed of the learnings and prevention opportunities arising from DA's death, I will direct that a copy of this Finding be provided to the Royal Australian College of General Practitioners and the Pharmaceutical Society of Australia, as well as those medical clinics and pharmacies involved in the prescribing and dispensing of addictive medicines to DA in the six months prior to his death.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. I recommend that the Department of Health review and amend the SafeScript training modules for health professionals to include additional advice and training about:

a. exploring with patients the effect of other medications not recorded in SafeScript which affect the central nervous system, for example antidepressants and antipsychotics, that in combination increase the risk of harm;

b. discussing with patients who are prescribed quetiapine the details of its use, time of dosing and risks when taken in combination with other medicines;

c. educate patients about the potential for accidental overdose with dosing routines and combinations of high risk medicines even if prescribed; and

d. educate patients using multiple sedating medications about the implications of alcohol use due to the central nervous system depressive effect.

2. I recommend that the Department of Health review and amend the SafeScript educational materials for patients and their families to include information about the potential for accidental overdose and the implications of alcohol use when taking multiple sedating medications.

ORDERS AND DIRECTIONS

1. Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Family of DA
Professor Euan Wallace, Secretary of the Department of Health
Royal Australian College of General Practitioners
Pharmaceutical Society of Australia
Associate Professor Tony Walker, Chief Executive Officer of Ambulance Victoria
Mr Shane Patton, Chief Commissioner of Victoria Police
Detective Senior Constable Travis McNama, Coroner's Investigator

Signature:

Leveasque Peterson
Coroner
Date: 8 September 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.