IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2017 003601**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | AUDREY JAMIESON, Coroner |
| Deceased: | Jodie Marie Overstead |
| Date of birth: | 18 January 1983 |
| Date of death: | Between 17 and 24 July 2017 |
| Cause of death: | 1(a) Multi drug toxicity<br>2 Epilepsy |
| Place of death: | Unit 2, 22a Kent Street, Sebastopol, Victoria 3338 |
| Keywords: | Drug overdose, multi drug toxicity, prescription drugs, doctor shopping |

## INTRODUCTION

1. On 24 July 2017, Jodie Marie Overstead was 34 years old when she was found deceased at home during a welfare check. At the time of her death, Ms Overstead was unemployed and lived alone in Sebastopol, Victoria.

2. Ms Overstead was born to parents, Ian and Lyn Overstead, of three children. She had a brother, Corey and a sister, Bobby-Jo Overstead. Bobby-Jo stated she was very close to her sister and said that she was a *"big part of [her] life"*.[1]

3. Ms Overstead had a medical history of anxiety, epilepsy, obsessive compulsive disorder (**OCD**), migraine and chronic pain secondary to a clavicle fracture. Her regular prescribed medications included tramadol, oxazepam, amitriptyline and propranolol.

4. Ms Overstead had a history of drug abuse which developed after being prescribed pain relief medications for migraines and subsequently for chronic pain.

5. Ms Overstead's regular treating general practitioner (**GP**) was Dr Nusrat Naaz at Tristar Medical Group. It appears from the available evidence she also periodically attended other GPs at Eureka Medical and Dental Care Centre and Wendouree Medical Centre.[2]

## THE CORONIAL INVESTIGATION

6. Ms Overstead'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.

7. 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.

8. 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

[1] Coronial Brief (**CB**), Statement of Bobby-Jo Overstead.
[2] Court File (**CF**), Medical Records of Tristar Medical Group, Eureka Medical and Dental Care Centre and Wendouree Medical Centre.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Victoria Police assigned Senior Constable Alexandra Marios (SC Marios) to be the Coroner's Investigator for the investigation of Ms Overstead's death. SC Marios 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.

10. This Finding draws on the totality of the coronial investigation into the death of Ms Overstead 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.[3]

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

### Circumstances in which the death occurred

*Background circumstances*

11. In 2007, Ms Overstead worked as a health and fitness instructor and lived with Bobby-Jo in Melton. Bobby-Jo recalled that although her sister suffered from migraines, she was otherwise *"quite healthy and had no major health issues"*.[4]

12. In the years that followed, Ms Overstead ceased working full-time to concentrate on her health. She later sold her Melton property and moved to Ballarat to live with her mother. Bobby-Jo said that her sister's migraines did not seem to have improved since 2007.[5]

13. In 2012, Bobby-Jo moved in with Ms Overstead to live in her house in Mitchell Park and noticed *"things weren't quite right with Jodie* [Ms Overstead]*"*. She had difficulties sleeping at night but was very prone to fall asleep during the day. Bobby-Jo recalled that her sister also "seemed to fall over a lot".[6]

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[3] 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.

[4] CB, Statement of Bobby-Jo Overstead.

[5] Ibid.

[6] Ibid

14. Bobby-Jo said she did not know the exact medication that Ms Overstead was prescribed or consumed at the time but knew that her sister was taking pain relief medications more than advised. She recalled locating "a whole bag full" of prescription medications.[7]

15. In 2015, Bobby-Jo moved out due to some disagreements with Ms Overstead. She stated that since then, her sister's drug addiction *"went down hill even more"*.

16. On 4 January 2016, Ms Overstead underwent an acromioplasty at Ballarat Hospital on her right shoulder due to two occasions of fall that happened in January and November 2014. She was later referred to a pain specialist at Ballarat Health Services to manage her pain.

17. Dr Nusrat Naaz stated that throughout 2016, Ms Overstead had requested additional scripts of her pain medications on several occasions. She either cited she had lost her medications, or they had been stolen.

18. On 26 December 2016, Ms Overstead suffered a seizure and was admitted to the Emergency Department (**ED**) of Ballarat Base Hospital. Dr Naaz suspected that her seizure was drug-related and likely due to the side effect of tramadol. Dr Naaz then weaned Ms Overstead off tramadol and eventually ceased prescribing her tramadol.

19. Bobby-Jo believed that her sister remained incompliant with her prescriptions and her treating medical practitioners continued to prescribe medication.

*Events proximate to death*

20. Sometime in the week of 10 July 2017, Ms Overstead met up with Bobby-Jo to spend time with their nephew. Bobby-Jo recalled her sister appeared *"heavily medicated"*.[8]

21. Ms Overstead last exchanged text messages with Corey on 12 July 2017. Her Pharmaceutical Benefits Scheme (**PBS**) Patient Summary indicates that she last filled her scripts for metoclopramide, amitriptyline, oxycodone and ondansetron at a pharmacy in Lucas Shopping Centre on 13 July 2017.

[7] CB, Statement of Bobby-Jo Overstead.
[8] Ibid.

22. On 24 July 2017, Bobby-Jo became concerned about her sister's welfare as she had not been in contact for about a week. She then contacted emergency services to request a welfare check on Ms Overstead.[9]

23. At approximately 4.45pm, SC Marios and Senior Constable Grant Egan (SC Egan) attended Ms Overstead's home and managed to enter the house through the rear door. Upon entering the house, SC Egan sighted Ms Overstead was curled up, face down on the kitchen floor and apparently had been deceased for some time.

24. Ambulance Victoria paramedics attended at 4:55pm and declared Ms Overstead deceased.

25. Ballarat Criminal Investigation Unit and Crime Scene Services also attended the scene and commenced an investigation.

26. Police officers located multiple medications and medication containers in a handbag, mostly in Ms Overstead's name, including sodium valproate, frusemide, endone, prochlorperazine.

27. No suspicious circumstances were identified, and no "suicide note" was located.

**Identity of the deceased**

28. On 24 July 2017, Jodie Overstead, born 18 January 1983, was visually identified by her brother, Corey Overstead.

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

**Medical cause of death**

30. On 27 July 20217, Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on the body of Jodie Overstead. Dr Bedford also reviewed the post-mortem computed tomography (**CT**) scan and considered the Victoria Police Report of Death (Form 83), medical records from Tristar Medical Group. Dr Bedford provided a written report of his findings dated 7 December 2017.

31. The autopsy revealed decomposition changes and mild kidney disease. There was no evidence of injury or internal bleeding.

[9] CB, Statement of Bobby-Jo Overstead.

32. Toxicological analysis of post-mortem blood sample identified the presence of tramadol[10] (~12mg/L), codeine[11] (~0.4mg/L), amitriptyline[12] (~0.9mg/L), nortriptyline[13] (~0.6mg/L), paracetamol[14] (~119mg/L), metoclopramide[15] (~0.2mg/L), pseudoephedrine[16] (~4.3mg/L). Morphine[17], nordiazepam[18], oxazepam[19] and prochlorperazine[20] were also identified in urine sample.

33. Forensic Toxicologist Grace Wang commented the concomitant use of tramadol and amitriptyline can adversely affect serotonin imbalance in the brain leading to serious complications, including hypertension, hyperthermia, myoclonus and mental status changes.

34. Dr Bedford noted tramadol, codeine and benzodiazepines, particularly oxazepam, were present at very high levels. He considered the effects of high levels of these drugs would likely result in drug toxicity and respiratory depression, eventually leading to death.

35. Dr Bedford also noted Ms Overstead's significant history of epilepsy and the absence of antiepileptic medication in the toxicology results.

36. Dr Bedford ascribed that the medical cause of death to 1 (a) multi drug toxicity, with epilepsy as the contributing factor.

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[10] Tramadol is a narcotic analgesic used for the treatment of moderate to severe pain. In fatalities attributed to tramadol, the post-mortem femoral blood concentration range from about 10mg/L.

[11] Codeine is a narcotic analgesic related closely to morphine but having approximately one-tenth the activity of morphine as an analgesic and possessing antitussive activity. Codeine is present in numerous proprietary medicines as tablets containing up to 30 mg of codeine phosphate and syrups often in combination with other analgesics such as aspirin and paracetamol.

[12] Amitriptyline is a type of drug called tricyclic antidepressant used to treat depression. It is metabolised to nortriptyline, which is also active as an anti-depressant. Therapeutic concentrations of amitriptyline in post-mortem blood range up to ~ 0.5 mg/L. Similar therapeutic concentration apply to nortriptyline. Amitriptyline has a long residence time in the body exceeding 1 day and will on repeated daily dosing accumulate in the body. The use of high doses or the use of higher than recommended doses may result in the development of toxicity as a result of this accumulation. The presence of other drugs including alcohol may enhance the toxic effects of antidepressants.

[13] See above.

[14] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene.

[15] Metoclopramide is an anti-emetic drug used for the treatment of nausea and vomiting.

[16] Pseudoephedrine is a nasal decongestant and bronchodilator found in numerous proprietary medicines either as the hydrochloride salt or as a sulphate either by itself or in combination with other therapeutic substances including paracetamol, codeine, dextromethorphan and certain antihistamines. Adverse reactions to pseudoephedrine may include headache, dizziness, palpitations, tachycardia, restlessness, tremor, anxiety, insomnia, with higher doses producing convulsions, arrhythmias and cardiovascular collapse.

[17] Morphine is a metabolite of codeine and maybe found in significant quantities in urine following use of codeine, and may also be present in blood in small concentrations following use of codeine.

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

[19] Oxazepam is a sedative/hypnotic drug of the benzodiazepine class.

[20] Prochlorperazine is a drug used to treat nausea, vomiting and vertigo.

## FURTHER INVESTIGATION

37. As part of my investigation, Medicare and PBS records were obtained from the period of 27 July 2016 to 27 July 2017. Both records suggest that Ms Overstead engaged in "doctor shopping" for various pharmaceutical drugs, including those found to have contributed to her death.

38. In the three months prior to her death. Ms Overstead attended at least eight medical practitioners from different medical practices to obtain scripts for prescription-only drugs.

## CORONERS PREVENTION UNIT REVIEW

39. In light of the above concerns, I requested the Coroners Prevention Unit[21] (**CPU**) to review the prescribing practices of Ms Overstead's treating clinicians in the period proximal to her death.

### Sources of drugs contributing to Ms Overstead's death

*Tramadol*

40. The available evidence indicates that Ms Overstead had been prescribed tramadol since April 2014 to alleviate pain in her right shoulder and pain resulting from a humeral head fracture.

41. In the three months before Ms Overstead's death, tramadol was prescribed by four medical practitioners[22] at Eureka Medical and Dental Care Centre and Wendouree Medical Centre.[23] In May 2017, Ms Overstead was prescribed large quantities of tramadol through the following consultations:

    - 3 May 2017 – Dr James Choong (Eureka Medical and Dental Care Centre), Tramal SR[24] 200 mg, 20 tablets, 0 repeats; and Tramadol Sandoz Capsules 50mg, 20 capsules, 0 repeats.

[21] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. 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.

[22] They were Dr Nasrat Naaz, Dr Josephine Salazar, Dr James Choong, Dr Pushparani Ravindranayagam and Dr Gallemannakkara Mendis.

[23] Although Dr Nasrat Naaz at Tristar Medical Group had previously prescribed Ms Overstead tramadol, it was later ceased and replaced by oxycodone in March 2017.

[24] Sustained Release (**SR**), it allows delivery of specific drug at a programmed rate that leads to drug delivery for a prolonged period of time.

- 5 May 2017 – Dr Pushparani Ravindranayagam (Wendouree Medical Centre), Tramal SR 200 mg, 20 tablets, 0 repeats; and Tramadol Sandoz Capsules 50mg, 20 capsules, 0 repeats.
- 11 May 2017 – Dr Choong, Tramal SR 200 mg, 20 tablets.
- 17 May 2017 – Dr Gallenmannakkara Mendis (Wendouree Medical Centre), Tramal SR 200 mg, 20 tablets, 0 repeats; and Tramadol Sandoz Capsules 50mg, 20 capsules, 0 repeats.
- 18 May 2017 – Dr Choong Tramadol Sandoz Capsules 50mg, 20 capsules, 0 repeats.
- 23 May 2017 – Dr Choong Tramadol Sandoz Capsules 50mg, 20 capsules, 0 repeats.
- 25 May 2017– Dr Choong, Tramal SR 200 mg, 20 tablets.
- 29 May 2017 – Dr Mendis, Tramal SR 200 mg, 20 tablets, 0 repeats.

42. Summing up all the scripts in the three months, Ms Overstead was prescribed 460 tramadol tablets which totalling 71,000mg or approximately 789mg a day. The Australian Medicines Handbook and Tramadol Product Information by the Australian Government Therapeutic Goods Administration (**TGA**) both provide that the maximum daily dose of tramadol should not exceed 400mg.

*Oxazepam*

43. The available evidence indicates that Ms Overstead had been prescribed oxazepam since October 2015 to relieve her anxiety.

44. In the three months before Ms Overstead's death, oxazepam was prescribed to her seven medical practitioners[25] at Tristar Medical Group, Eureka Medical and Dental Care Centre, Wendouree Medical Centre and Mind@Home Psychiatry[26].

45. Summing up all the scripts in the three months, Ms Overstead was prescribed 538 oxazepam tablets totalling 16,140mg or approximately 180mg a day. The CPU advised that no medical practitioner appeared to have prescribed more than a daily dose of 60mg.

46. The CPU noted further that the Oxazepam Product Information by the TGA does not specify a maximum recommended daily dose. This is because the dose can vary for different patients.

[25] They were Dr James Choong, Dr Pushparani Ravindranayagam and Dr Gallemannakkara Mendis and Dr Robert Proctor.
[26] It does not appear that Dr Natasha Lambert was from any of these medical practice.

For instance, the maximum dose for each consumption can be as high as 30mg and as frequent as four times a day for patients with severe anxiety.

*Amitriptyline*

47. Ms Overstead was first prescribed amitriptyline by Dr Robert Proctor in November 2016, for migraine prevention.

48. In the three months before Ms Overstead's death, amitriptyline was prescribed to her by Dr Naaz and three other medical practitioners[27] at Eureka Medical and Dental Care Centre, Wendouree Medical Centre and Mind@Home Psychiatry.

49. Summing up all the scripts in the three months, Ms Overstead was prescribed 575 amitriptyline tablets totalling 15,625mg or approximately 174mg a day. The CPU advised that no medical practitioner appeared to have prescribed more than a total daily dose of 50mg.

50. The CPU noted further that the Amitriptyline Product Information by the TGA does not specify a maximum recommended daily dose. This is because the dose can vary for different patients. For instance, the daily maximum dosage for hospitalised adults can be as high as 300mg, whereas outpatient adult patients can take up to 150mg daily.

*Codeine*

51. There is no evidence in the medical records or PBS Summary that any medical practitioner prescribed Ms Overstead codeine-containing medications in the three months before her death.

52. At the time of Ms Overstead's death, codeine-containing medication were not prescription-only drugs. It is possible that a medical practitioner whose records do not form part of the Coronial File privately prescribed these medications to Ms Overstead or that she simply purchased them over the counter.

53. According to photographic evidence contained in the Coronial File, Parapene was discovered by police at the scene of Ms Overstead's death. Additionally, toxicology results indicate the presence of pseudoephedrine, another medication with codeine. Paracetamol and

[27] They were Dr James Choong, Dr Gallemannakkara Mendis and Dr Robert Proctor.

pseudoephedrine detected in her system likely came from Parapene and a nasal decongestant that contains a combination of paracetamol, pseudoephedrine and codeine.

*Diazepam*

54. The available evidence indicates that diazepam was occasionally prescribed to Ms Overstead since December 2015.

55. In the three months before her death, Dr Naaz prescribed Ms Overstead an unrepeated script of 10 diazepam tablets on 19 June 2017.

56. Given that diazepam was only detected in the form of a metabolite (nordiazepam) in the post-mortem urine sample, the CPU was unable to establish the pattern and proximity of diazepam use. Therefore, it cannot be said that diazepam prescribed on 19 June 2017 formed part of drugs that contributed to Ms Overstead's death.

**Prescribing issues**

57. Given the focus of my review, it is important that I also consider the facts surrounding Ms Overstead's ability to access large quantities of prescription medications proximate to her death.

*Whether Ms Overstead's medical practitioners were aware of her drug dependence?*

58. Progress notes requested from three medical practices Ms Overstead frequently attended show that several medical practitioners at their respective medical practice had concerns about Ms Overstead's dependence on her prescription medications, particularly tramadol and benzodiazepines.

59. Progress notes also recorded that Ms Overstead's continuously exhibited drug-seeking behaviour. She consistently presented to different medical practices to request additional scripts. Some examples include:

- On 4 April 2016, Ms Overstead attended Tristar Medical Group requesting further scripts for tramadol and said she had vomited all her medication during a migraine attack.
- On 12 May 2017, Ms Overstead attended Tristar Medical Group requesting a script for oxycodone just one day after she was prescribed and filled her oxycodone

prescription. Corey also contacted Dr Naaz to inform her that Ms Overstead appeared to have consumed all her medications on the evening of 11 May 2017.

- On 19 June 2017, Ms Overstead attended Dr Mendis at Wendouree Medical Centre requesting fresh scripts and cited she had lost her handbag. Dr Mendis acknowledged her previous history of drug seeking and refused her request.

60. According to medical records from Eureka Medical and Dental Care Centre, Dr Josephine Salazar and Dr Zia Ahmed respectively requested for Ms Overstead's Patient Summary Report from the Commonwealth Department Prescription Shopping Information Service between January and July 2016.

61. The report request for the period between January and March 2016 indicates that Ms Overstead saw 18 different prescribers and obtained a total of 120 items of 19 different medications. The report request for the period between May and July 2016 indicates that Ms Overstead saw 13 different prescribers and obtained a total of 82 items of 13 different medications.

*Whether Ms Overstead's medical practitioners were aware of overlapping prescriptions?*

62. On 15 July 2016, Eureka Medical and Dental Centre received a notification from the Victorian Department of Health[28] alerting them of the possible overlapping prescriptions of tramadol by several medical practitioners of the same medical practice.[29]

63. The CPU also informed me that it was likely that Ms Overstead's treating clinicians would have had some knowledge of her attending other medical practices and/or could have easily made enquiries about her attendance at other practices.

*Whether Ms Overstead's medical practitioners have had regard to her epileptic reaction when prescribing tramadol and amitriptyline?*

64. Tramadol is a weak opioid analgesic with serotonergic effects. It acts as a serotonin and noradrenaline reuptake inhibitor. It is commonly referred to as an atypical central-acting analgesic due to the combined effect. The Tramal (tramadol hydrochloride) Product Information by the TGA especially cautioned against using tramadol in patients with seizure risk and explains the following:

[28] As it is now known – previously being the Department of Health and Human Services (**DHHS**).
[29] CF, Medical Records of Eureka Medical and Dental Care Centre.

*Convulsions have been reported in patients receiving tramadol at the recommended dose levels. The risk may be increased when doses of tramadol exceed the recommended upper daily dose limit. In addition, tramadol may increase the seizure risk in patients taking other medication that lowers the seizure threshold.*[30]

65. Furthermore, the product information also warned against using mediations that reduce the seizure threshold. It states that *"tramadol can induce convulsions and increase the potential for selective serotonin re-uptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants, antipsychotics and other seizure threshold-lowering drugs…to cause convulsions".*[31]

66. Amitriptyline is a tricyclic antidepressant primarily used to treat major depressive disorder a variety of pain syndromes such as neuropathic pain, fibromyalgia and migraine. The Amitriptyline Product Information by the TGA also cautioned and warned against the use of amitriptyline in patients with a history of seizures.[32]

67. The CPU noted several medical practitioners that prescribed Ms Overstead tramadol and/or amitriptyline appeared to have no actual knowledge of her seizures. Dr Choong, Dr Mendis and Dr Ravindranayagam continued to prescribe her tramadol up until her death.

**COMMENTS**

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

1. Ms Overstead had an extensive history of migraine and chronic pain. She was also suffering from mental ill health and epilepsy. In such a case, drug misuse and dependence may be masked by the clinical rationale for their use; Ms Overstead was prescribed tramadol for pain relief, but it is unclear whether she genuinely required large amounts to treat her chronic pain effectively. Ms Overstead also required oxazepam to treat her anxiety, but it is questionable whether she required up to 180mg daily.

2. I note Corey and Bobby-Jo's concerns that their sister's medical practitioners continued to prescribe medication to her when allegedly aware that Ms Overstead exhibited drug

[30] Australian Government Department of Health and Aged Care – Therapeutic Goods Administration, *AUSTRALIAN PRODUCT INFORMATION – TRAMAL[tramadol hydrochloride]*.
[31] Ibid.
[32] Australian Government Department of Health and Aged Care – Therapeutic Goods Administration, *AUSTRALIAN PRODUCT INFORMATION ENDEP – Amitriptyline hydrochloride tablet.*

dependency and drug-seeking behaviour. Their concerns are not unfounded. The PBS Patient Summary manifests that Ms Overstead always had her prescriptions dispensed on the same day of prescribing and frequently obtained additional scripts of the same medication from different medical practitioners from different medical practices.

3. It is evident that Ms Overstead's treating clinicians' efforts to provide her treatment and care were sub-optimal. Her tendency to engage in prescription shopping undermined her medical treatment and prevented her treating clinicians from accurately diagnosing her health issues. Thus, her drug dependence as well as her epileptic symptoms that were potentially due to tramadol were not formally diagnosed. Her treating clinicians continued to treat her based on self-reporting symptoms and presenting medical complaints. A more coordinated approach to prescribing would have provided them with richer insights into her actual health issues.

4. Given the passage of time any determination about whether the prescribing practices of Ms Overstead's clinicians were in accordance with good medical practice, is a matter for the regulatory authority, the Australian Health Practitioner Regulation Agency.

5. Since April 2020, a real-time prescription monitoring system (**RTPM**), SafeScript became mandatory in Victoria. Through SafeScript, both prescribers and dispensers can identify and intervene to prevent excessive use of prescribed drugs, use of contraindicated drug combinations, prescription shopping, and other issues that underpin pharmaceutical drug harms. The Department of Health can now centrally monitor the dispensing information to identify prescribing and dispensing of concern and deliver targeted countermeasures to improve clinical practice.

6. While target medications under the RTPM system include strong opioid analgesics such as buprenorphine, codeine, fentanyl, methadone, morphine, oxycodone, tapentadol; benzodiazepines; zolpidem, zopiclone and codeine containing medications, tramadol is not currently part of the target medications.

7. I am aware of the work already undertaken by the Victorian Department of Health towards understanding the harm of gabapentinoid medications and tramadol, and to possibly include these medications as target medications.

8. In March 2017, May 2019 and most recently in December 2021, the Department of Health commissioned Austin Health to review the literature on the evidence of harm caused by

gabapentinoid medications (including pregabalin and gabapentin) and tramadol[33]. This series of reviews were initiated by the Department's consideration of a series of Recommendations made by Victorian Coroners to include pregabalin in SafeScript[34].

9. I commend the Department of Health's proactive initiatives and responses. I also note the Department is currently undergoing a public consultation in determining whether the Victorian Drug, Poison and Controlled Substances Regulations should be amended to include pregabalin, gabapentin and tramadol.

10. Despite the above, a pertinent Recommendation will still follow given the facts surrounding medical practitioners prescribing practice and given tramadol is not currently a target medication monitored through the SafeScript system. I have grave concerns that not all Royal Australian College of General Practitioners members fully appreciate the risk of tramadol and its potential to interact with other prescription medications like amitriptyline.

## RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations:

1. With the aim of promoting public health and safety and preventing like deaths, I recommend that the Royal Australian College of General Practitioners consider developing further training and education materials to highlight the harms and hazardous effects of tramadol, as well as the adverse interactions of the concomitant use of tramadol and other contraindicated medications.

## FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Jodie Marie Overstead, born 18 January 1983;

    b) the death occurred between 17 and 24 July 2017 at Unit 2, 22a Kent Street, Sebastopol, Victoria, 3338;

[33] Liew D, et al, *Evidence informing the inclusion of Gabapentinoids and tramadol on Victoria's SafeScript:a 2021 update*, December 2021.
[34] These Recommendations were made in relation to the investigation into the deaths of NJ (pseudonymised) (COR 2015 2127), Daniel Joseph Hebert (COR 2018 5440) and Samantha Louise Leech (COR 2019 7144).

c) I accept and adopt the medical cause of death ascribed by Dr Paul Bedford and I find that Jodie Marie Overstead, a woman with a medical history of epilepsy died as a result of multi drug toxicity;

d) AND, while the available evidence suggests Jodie Marie Overstead was prescribed and had used tramadol and amitriptyline in the period proximate to her death, I am unable to find with any degree of certainty whether the use and abuse of these medications were the main cause of her epilepsy.

2. Furthermore, in the absence of cogent evidence of intention, I find that Jodie Marie Overstead's death was the unintended consequences of her intentional use and abuse of prescription medications.

I convey my sincere condolences to Ms Overstead's family for their loss.

**ORDERS**

Pursuant to section 73(1A) of the *Coroners Act 2008*, I order this Finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Lyn Overstead

Corey Overstead

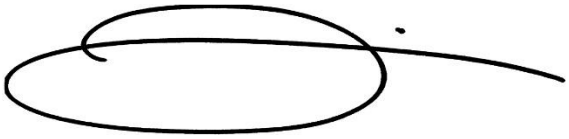
Senior Constable Alexandra Marios, Coroner's Investigator, Victoria Police

The Secretary, Department of Health

Australian Health Practitioner Regulation Agency

Royal Australian College of General Practitioners

Signature:




**AUDREY JAMIESON**

**CORONER**

Date: 4 May 2023

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.