IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 006224

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Master S[1]
Date of birth:	[redacted] 2006
Date of death:	13 November 2019
Cause of death:	*Asthma*
Place of death:	[redacted] Victoria
Keywords:	*Asthma; SafeScript*

1. This finding has been de-identified by order of Coroner Sarah Gebert to replace the names of the deceased, his family members and select individuals with pseudonyms to protect their identity and redact identifying information.

INTRODUCTION

1. Master S[1] was 13 years old at the time of his passing. He was a young Aboriginal boy who lived with his mother and siblings in [redacted]. He is survived by his parents Ms S and Mr L as well as younger siblings [redacted], [redacted] and [redacted].

2. Master S's father described his son as *a happy go lucky kid* who was a self-taught *good cook.* Master S had a good relationship with his siblings who were very close. Master S was described by their family friend Mr E as a *happy cheeky, very smart kid.* His school report mentioned *how lovely his character was and how he 'exhibits maturity, self-control and kindness in the classroom'.*[2]

3. On 13 November 2019, Master S was found unresponsive by his brother in the lounge room of the family home. Sadly, he was later pronounced deceased.

THE CORONIAL INVESTIGATION

4. Young Master S's passing 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.

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. 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.

7. Victoria Police assigned Senior Constable Deborah King (**SC King**) to be the Coroner's Investigator for the investigation of Master S's passing. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and compiling a comprehensive coronial brief of evidence. The brief contains a range of statements including

[1] Referred to in this finding as "Master S", unless more formality is required.
[2] Statement of Mr A, Principal [redacted] Secondary College dated 27 July 2020.

from Master S's family, treating health professionals, [redacted] Secondary College, Ramahyuck District Aboriginal Corporation, ambulance paramedics, the forensic pathologist who examined him and investigating officers, as well as other relevant materials.

8. The Court also obtained Master S's records from [redacted] and District Health Services ([redacted]**DHS**), Monash Health, Department of Health and Human Services[3] (**DHHS**). In addition, Master S's Medicare and Pharmaceutical Benefits Scheme (**PBS**) claims history were obtained for the period of 13 November 2018 to 13 November 2019.

9. I also obtained the opinion of an external expert regarding the provision of health services to Master S.

10. This finding draws on the totality of the coronial investigation into Master S's passing 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.[4]

Background

11. Master S developed asthma when he was 4 years old. Adjunct Clinical Associate Professor Robert Roseby (**A/Prof Roseby**) who had treated him over a number of years described Master S as a "…*boy who has the most severe and persistent asthma I have encountered*…".

12. Master S attended [redacted] Secondary College but due to his health issues high absenteeism was recorded. His mother provided a copy of his Asthma management plan and allergy plan to the school which had been developed by A/Prof Roseby. Principal Mr A noted that they were *confident in managing Master S's asthma at school. All staff at the School have first aid and asthma training, and a school nurse is available for further support two days per week*. Master S's mother had also authorised the school nurse to communicate with A/Prof Roseby.

13. Mr A also outlined additional supports which were arranged for Master S, such as the School's Health and Wellbeing team; as well as Professional Consultation meetings which included a range of participants such as [redacted] and District Health Service, DHHS, Monash Hospital and Victorian Aboriginal Child Care Agency (**VACCA**); the development of an

[3] As it then was.

[4] 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.

Individual Learning Plan; and other linkages which included to the Koorie Education Support Officer (**KESO**).

[redacted] Clinic, [redacted] Medical Centre and [redacted] and District Health Service

14. Master S had been seen by doctors at [redacted] Clinic, [redacted] Medical Centre and [redacted] DHS for a number of issues including his chronic asthma.

15. Dr Greg Ivanoff[5] noted following severe asthma attacks that Master S was seen at the [redacted] DHS Urgent Care Centre (**UCC**) and had been transported to Monash Health on 12 September 2017 (by road ambulance) and 4 March 2019 (air ambulance) that,

This was a recurring life-threatening paediatric case in the geographically isolated rural township of [redacted] (Modified Monash Model MMMS) and this case required urgent intervention by the [redacted] and District Health Service Director of Medical Services (OMS).

16. Dr Ivanoff said that Master S's case was subsequently discussed at a VMO Committee meeting with the Director of Medical Services and the Director of Nursing.[6]

17. There was a further similar incident on 19 May 2019, where Master S was again transferred by air ambulance to Monash Health.

18. On 2 July 2019 his presentation at the [redacted] DHS UCC recorded '*life threatening/critical attendance with respiratory for asthma*.' His treatment included the administration of nebulised adrenaline by mask and intramuscular adrenaline. Master S suffered a respiratory arrest and was transferred by the Helicopter Emergency Medical Services (**HEMS**) to La Trobe Regional Hospital and then Monash Health. A/Prof Roseby considered the treatment provided at the [redacted] DHS UCC as *life saving.*[7]

Adjunct Clinical Associate Professor Robert Roseby

19. A/Prof Roseby[8] *knew* [Master S] *well and found him a delightful, clever, likeable boy.* He initially met him in February 2017 in the Paediatric Intensive Care Unit (**PICU**), after which he

[5] Medical practitioner with Specialist Registration and hold dual Fellowships with The Australian College of Rural and Remote Medicine (ACRRM) as well as the Royal Australian College of General Practitioners (FACRRM/FRACGP). Salaried VMO (visiting medical officer) at [redacted] and District Health Service from 31 July 2017 until 20 September 2019. Statement dated 23 July 2020.
[6] Letter to the Court from Ball + Partners dated 23 December 2021.
[7] Letter dated 22 July 2019.
[8] Statement dated 23 April 2020.

saw him in the respiratory clinic on at least 20 occasions over 2017, 2018 and 2019, in addition to his involvement in multidisciplinary team meetings, phone calls and hospital admissions.

20. A/Prof Roseby noted that Master S had a very severe disabling chronic persistent asthma and resided 2.5 hours from a tertiary hospital. Master S had seven hospital admissions including five PICU admissions at Monash Health. Master S also had urticaria, an allergic condition affecting the skin, with multiple triggers which were mostly unknown.

21. A/Prof Roseby further noted that Master S was Cushingoid, in that he had characteristic side effects of steroid medication which he had taken in high doses for his asthma. His Cushingoid features included rapid weight gain in excess of height and characteristic fat distribution. Master S was noted to be obese at 82 kg.

22. A/Prof Roseby advised that Master S had been using inhaled steroid medications, combination products of inhaled steroids plus long acting beta agonists, inhaled tiotropium, oral steroids (prednisolone) and salbutamol for many months. However, due to the steroid side effects they were doing everything they could to minimise his oral prednisolone dose. He noted that this was *a difficult balancing act* and stated, *Steroids can control asthma but at great cost to the body over time, with added risk of numerous problems over time including obesity, diabetes, osteoporosis and muscle weakness, among many other things. This was a continual battle for Master S. Whenever he had a flare of asthma his prednisolone dose would increase and once stable we would need to start again to reduce the dose to the lowest achievable dose which does not lead to an asthma flare.*

23. A/Prof Roseby advised that montelukast (an oral tablet used to prevent and treat asthma), had been tried several years ago but emotional side effects, which occur in 2% of the population with this medication, meant Master S could not take this any longer and it was ceased almost immediately.

24. A/Prof Roseby further stated that Monash Children's Hospital was successful in applying for the use of a new medication which aims to reduce steroid exposure in allergic type asthma. He noted that these "asthma biologics" are expensive (upwards of $20,000 per year) and have strict criteria which have to be met for their subsidised initial and continued use. There were three equivalent 'asthma biologics' for which Master S was eligible, and they elected to

use Mepolizumab. A/Prof Roseby was *never completely convinced that Mepolizumab was helpful* for Master S and Omalizumad was later added.

Master S's final admission

25. Master S's final hospital admission was on 2 July 2019. A/Prof Roseby described it as follows,

This was an extremely serious episode - Master S was very close to death. Prior to his presentation he had had a minor upper respiratory tract infection, a "cold", for a few days. This would be expected to exacerbate Master S's asthma; he would generally need to escalate treatments at such a time. The home treatment escalation depended on severity and persistence of symptoms. I understand Master S awoke at around 0100 on the morning of 2 July 2019 very short of breath and did not ask for help. He reportedly started to treat himself and were it not for a commotion caused by Sunny, the pet bird, others may not have been alerted to his condition. At around 0200 he was reportedly rushed by private car to [redacted] *Medical Centre where he deteriorated further. He was reportedly resuscitated using a bag and mask to help with breathing, given intramuscular adrenaline and a needle was plunged into his bone to administer life-saving medications urgently. Reportedly, he had ongoing support of breathing and intravenous anti-asthma treatments (adrenaline infusion, aminophylline, magnesium sulphate). All of these treatments indicate that he was gravely unwell; I have no doubt they were life-saving. He was stabilised further and was later safe enough to transfer via road ambulance to Monash Children's Hospital paediatric intensive care unit.*

On arrival in intensive care at Monash Children's Hospital PICU at 0715 Master S's asthma had settled, and he continued to improve rapidly such that relatively quick de-escalation of treatment was possible. This was Master S's usual pattern, which is slightly unusual for someone with his severity and persistence of asthma but of course fortunate. He stayed in hospital for only around 36 hours, which is a quick turnaround.

26. A/Prof Roseby described Master S as being highly capable and knowledgeable about asthma, but implored him during the last admission to let his mother know if he was feeling very unwell.

27. Following this admission A/Prof Roseby saw Master S for clinical review on 22 July 2019, 29 July 2019 and again on 09 September 2019. On this last appointment, *he remained relatively well. He had had an exacerbation of his asthma in the setting of a viral upper respiratory tract infection. This episode was able to be managed at home*

without difficulty. His lung function test showed mild small airways obstruction, which means on that day he had mild persistent asthma, which is not as good as it had been 6 weeks earlier but nevertheless this was his second best result for 12 months.

28. A meeting by phone in the week of 22 July 2019 involving health and education professionals was convened by DHHS.

29. A/Prof Roseby described Master S as *quite well* only a few weeks after his admission with the lung function test performed at Monash Lung and Sleep close to perfect. He noted that appointments at Monash Health in addition to the treatment time, involved at least 5 to 6 hours of travel. He said of Master S's mother, [s]*he was a devoted mother and I relied on and trusted her judgement about Master S's asthma.*

Child Protection History

30. Child protection received 10 reports regarding Master S dating from 2008. A current report received in March 2019 raised concerns about Master S's mother's management of his brittle asthma. The report proceeded to investigation and subsequent protective intervention. Master S was subject to protective intervention by child protection at the time of his passing.

31. Master S's mother said that,

[U]*p until November Master S was basically a normal boy, he was still having his injections. He started going back to school and even had sleep overs at his friends house, which he had never been able to do before. He was looking forward to this year because it would have been his first school camp ever*.

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

Circumstances in which the death occurred

32. On 12 November 2019, Master S stayed up late in the lounge room of his family home playing video games. It was his usual habit when he was unable to sleep.

33. Shortly after 7.30am on 13 November 2019, his brother [redacted] found Master S face down on the floor with his nebuliser mask on this face.

34. He called out to his mother who immediately called Triple Zero. At approximately 8.04am, paramedics attended the scene and were joined by police members including the Coroner's

Investigator a short time later. Master S was however unable to be assisted and was pronounced deceased at 8.09am.

35. Police commenced an investigation and collected photographs of the scene. The Coroner's Investigator observed that there *was bird scat on the dining table and chairs. All surfaces were grotty and unclean. The house had a strong smell of uncleanliness.* Close family friend, Mr E said that Master S's mother *isn't the best at keeping the house clean, we do have a point of contention about this issue. The kids personal hygiene was good.*

36. Following their investigation, police found no evidence of suspicious circumstances surrounding Master S's passing.

Identity of the deceased

37. On 13 November 2019, Master S, born [redacted] 2006, was visually identified by his mother, Ms S.

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

Medical cause of death

39. Forensic Pathologist Dr Malcolm Dodd from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 14 November 2019 and provided a written report of his findings dated 19 November 2019.

40. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

41. Dr Dodd formulated the cause of death as *Asthma* and that his death was due to *natural causes.*

42. I accept Dr Dodd's opinion.

FURTHER INVESTIGATION

43. As part of the investigation, Clinical Professor Stephen Stick (**Prof Stick**) provided an expert opinion dated 18 October 2021 regarding the care and management of Master S's asthma. His opinion addressed the following matters:

    a. the general appropriateness of the care provided to Master S;

    b. whether the management of his asthma was reasonable; and

c. the administration of adrenaline in the context of his asthma attack on 2 July 2019, which Master S's mother was concerned about.

44. Prof Stick noted that Master S suffered persistent asthma with life-threatening flare-ups and he had an allergic background associated with high IgE levels and high blood eosinophil counts and also suffered recurrent urticaria. He considered that the appropriate Australian standards of care document in the years prior to his death in November 2019 was the National Asthma Council, Asthma Handbook v1.0 (2014), v.1.1 (2015), v.1.2 (2016) and v.1.3 (2017).

45. In the year prior to Master S's passing he had been prescribed the following medications: fluticasone/vilanterol (corticosteroid/LABA combination) inhaler, salbutamol (a beta-agonist bronchodilator for asthma symptoms and flare-ups) inhaler, tiotropium bromide (a long-acting, antimuscarinic bronchodilator) inhaler, omalizumab (anti-IgE, monoclonal antibody) from June 2019, mepolizumab (anti-IL-5, monoclonal antibody) until June 2019, 36 salbutamol inhalers between 7th January - 3rd July (= > 1/ week) and Cetrizine (an antihistamine).

46. Prof Stick said that PBS records from 7 January 2019 suggest that prescriptions for Master S's asthma medications were dispensed and collected regularly although he could not see a preventer medication prescription dispensed prior to 16 September 2019. Master S's mother said that he was using three preventers at that time.

47. Prof Stick stated that between 7 January and 3 July 2019, 36 salbutamol metered dose inhalers **(MDI)** were dispensed suggesting poor interval asthma control and that this assessment was also supported by the regular prescribing and dispensing of prednisolone (300 tablets between April and July 2019) and ipratropium bromide (240 dose between January and October 2019).

48. Master S's mother advised that this was because Master S was required to leave medications at different locations, including school, so that they were readily available if he needed them outside of his home and that many of the medications remained unopened.

49. Prof Stick noted that there was very low engagement with primary care providers except during emergencies. He commented that,

attending physicians at the [redacted] Urgent Care Clinic appear to have acted in exemplary fashion when Master S presented with life-threatening asthma. They almost certainly saved his life on numerous occasions including on the 2nd of July 2019 when he suffered a respiratory arrest.

50. Master S's mother said that A/Prof Roseby was a specialist in his field and their trusted medical carer who she and her son had formed a strong relationship with over their time together and that they preferred to engage predominantly with him and use the local service (primary care providers) for refilling prescriptions.

51. Prof Stick noted in relation to tertiary care that Master S attended Monash Medical Centre to consult specialists in paediatric respiratory medicine (A/Prof Roseby) and immunology (Dr Sarah Barnes).

52. A/Prof Roseby saw Master S on nine occasions between 7 January and 9 September 2019, during which Master S's control was assessed including measurements of lung function. He noted that treatments were adjusted in accordance with the relevant Asthma Handbook guidelines to improve control and minimise side effects, particularly those associated with corticosteroids that had resulted in Master S having a Cushingoid appearance. A/Prof Roseby communicated by letter to the family's general practice after each visit and with Dr. Barnes directly.

53. After the intensive care admission in July 2019 there was a multidisciplinary meeting to review Master S's ongoing severe asthma, social circumstances, and school attendance. Master S was reviewed regularly by Dr. Barnes and her team to manage his allergic symptoms and provide anti-IgE (omalizumab) and anti-IL-5 (mepolizumab) therapy. He suffered frequent urticaria and had a positive radioallergosorbent test (**RAST**) suggesting allergy to rye grass. Despite this allergic background his severe asthma attacks were usually precipitated by viral infections although some consideration had been given to the potential for environmental triggers including passive tobacco smoke, domestic birds, and wheat flour.

54. With respect to Master S's asthma management Prof Stick noted,

a. Master S's asthma management was consistent with recommendations in the Asthma Handbook v1.3;

b. Master S had a current asthma action plan and emergency plan that was provided to DHS [redacted]rgent Care Centre; and

c. Master S had been referred to a paediatric respiratory specialist whom he saw on a regular and frequent basis.

55. With respect to the administration of Prednisolone he commented that,

Master S clearly had unstable asthma indicated by excessive bronchodilator use, frequent severe asthma exacerbations and variable lung function. At the time of his death, Master S was taking alternate day prednisolone and his asthma action plan included additional bursts prednisolone at a higher dose administered by his mother for several days during acute exacerbations. This is appropriate management and consistent with Australian guidelines.

56. With respect to Bronchodilators/relievers he commented that,

Salbutamol is the most used, rapid acting, bronchodilator for asthma. Master S used both MDI and nebuliser to deliver salbutamol when symptomatic and during acute exacerbations. Thirty-six inhalers were dispensed between January and July 2019. Since each inhaler contains 200 doses, this implies that Master S was using on average 40 puffs of salbutamol per day. Clearly, in addition, he used nebulised salbutamol for acute symptoms. I think that the high usage of salbutamol is likely to have reduced its effectiveness particularly during an emergency. Ipratropium bromide is an inhaled anti-cholinergic bronchodilator used in the emergency treatment of an acute asthma attack. Between 22nd January and 31st October 2019, 240 doses of Ipratropium bromide were dispensed. Therefore, on average Master S was using one ampoule of nebulised ipratropium per day suggesting persistent severe asthma symptoms. Tiotropium, a long-acting anti-muscarinic bronchodilator is effective as an add-on regular therapy in children and adolescents with asthma regardless of their allergic background. Therefore, for Master S with persistent symptoms despite maximal therapy with inhaled corticosteroid and LABA, this additional inhaled therapy was justified. The tiotropium is delivered via a breath-actuated MDI that is effective for individuals with severe airway obstruction.

57. Regarding the appropriateness of administering adrenaline in the context of Master S's asthma attack on 2 July 2019 at [redacted]DHS UCC when he presented *in status asthmaticus*, Prof Stick noted that whilst the use of adrenaline in acute, severe asthma is not generally recommended, he considered in the circumstances of his presentation that the initial adrenaline administered was not inappropriate.

58. Prof Stick concluded,

Master S was an adolescent boy with severe persistent asthma and life-threatening flare-ups. He appears to have been managed appropriately [by] *his mother and medical professionals despite difficult circumstances and his remote location from the tertiary services at Monash Medical Centre.*

59. I accept Prof Stick's opinion on these matters.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Master S, born [redacted] 2006; and

    b) his passing occurred on 13 November 2019 at [redacted], Victoria from *Asthma* in the circumstances described above.

COMMENTS

61. Pursuant to section 67(3) of the Act, I make the following comments connected with Master S's passing.

62. A copy of the expert opinion was provided to A/Prof Roseby (and all other parties) who subsequently wrote to the Court to highlight a potential prevention opportunity. He noted that in formulating his expert opinion, Prof Stick had access to PBS dispensing information that provided a range of potential insights into Master S's asthma management and adherence to treatment and that this,

    important information was not available to me as a clinician caring for Master S at that time.

63. He said,

    […] Professor Stick, was able to access Pharmaceutical Benefits Scheme (PBS) dispensed medication data to make an assessment of how much of the prescribed medication was obtained from a pharmacy. By deduction, the implication is that the amount of medication taken was possibly significantly less than clinicians believed he was taking in 2019, the last ten months of his life. This important information was not available to me as a clinician caring for Master S at that time. […]

    Clinicians ask patients how much medication they are actually taking, but patient recall and description of use is subject to overestimation due to strong social bias in that direction. Had I thought or known objectively that Master S was taking far less preventer medication than prescribed I would have had very different conversations with him and his mother, and likely put measures in place to help increase adherence to the preventer medication regimen. […]

It is possible of course that inhaled preventers could be sourced other than via the PBS, such as from a public hospital, an Aboriginal Medical Service, or elsewhere, and as such I don't know this to be a factor in Master S's case. However the majority of drug dispensing in the community is through the PBS, and hence the ***public interest*** *in this matter.* [emphasis added]

[…]

The above may or may not have helped to prevent the death of this lovely boy,…

64. A/Prof Roseby further explained that the PBS only makes information about drug dispensing available via the My Health Record. Not every patient has a My Health Record, and the records where they exist can be hard to navigate.

65. A/Prof Roseby highlighted the strong need to share patient-specific dispensed medication data with treating clinicians and others (*when Master S was alive when I could have used that data to help him*), other than via the My Health Record. This identified need is clearly consistent with the broader prevention theme that has engaged Victoria's coroners for at least 20 years: how to ensure a clinician knows what drugs a patient has been prescribed and dispensed, so the clinician can make properly informed decisions about treating the patient.

66. To date, Victoria's coroners have primarily explored this prevention theme with respect to drugs of dependence, exploring how to stop patients from accessing greater than clinically indicated quantities of medications that are addictive and can cause fatal overdose when misused. Between 2012 and 2016 several Victorian coroners made recommendations for the Victorian Department of Health (then the Department of Health and Human Services) to implement a real-time prescription monitoring (**RTPM**) system to achieve this goal.

67. Briefly, an RTPM system gathers information on prescription medications immediately as they are prescribed and/or dispensed, and stores this information in a central electronic database where it can be accessed by clinicians when a patient attends for treatment, and by pharmacists when a patient presents a script for a pharmaceutical drug. Through the system, both prescribers and dispensers are able to review a patient's history of prescribed medications, evaluate issues such as medication compliance and access, and thus make better-informed clinical decisions that prevent adverse drug-related outcomes including deaths.

68. As is well known, the Victorian coroners' coordinated push for RTPM culminated in an April 2016 announcement from the Victorian government that a state-wide system would be implemented. The system, named SafeScript, was made available to all Victorian pharmacies

and medical practices in October 2018, initially on a voluntary opt-in basis. From April 2020 it has been mandatory to check SafeScript prior to writing or dispensing a prescription for a medicine (or target drug) monitored through the system.

69. Now that the SafeScript system has been operating on a mandatory basis for two years, it is timely to revisit and consider whether SafeScript is delivering fully on its prevention potential; and A/Prof Roseby's comments about not being able to monitor Master S's preventer medication compliance highlight an area where this prevention potential might still be unrealised.

70. I agree that a clinician would greatly benefit from the capacity to check a patient's preventer medication compliance and consider that this could be facilitated through SafeScript: a system specifically built for the purpose of informing clinicians about their patients' medications.

71. Unfortunately, at present SafeScript only monitors the prescribing and dispensing of a very restricted set of drugs. The Department of Health made the decision that SafeScript's designated target drugs would be only the medications scheduled in Schedule 8 of the Poisons Standard; benzodiazepines; non-benzodiazepine hypnotics zolpidem and zopiclone; antipsychotic quetiapine; and products containing codeine. The preventer medications that A/Prof Roseby prescribed to Master S are not SafeScript target medications, so he could not have used it to inform his clinical decisions in the way he described. However, I understand there is no reason why the scope of SafeScript could not be expanded to include preventer medications and indeed all medications that are prescribed and dispensed in Victoria.

72. I note that in 2012 when my colleague Coroner John Olle delivered his finding in the death of James (COR 2009 005181) which contained the first recommendation for RTPM made under the Act, he specified that the RTPM system should monitor *"all prescription medications that are prescribed and dispensed throughout Victoria without exception"*. More recently, multiple Victorian coroners have advocated for the Department of Health to include pregabalin in monitored drugs because of its involvement in overdose deaths (see for example cases COR 2010 004762; COR 2011 004794; COR 2012 000367). In my own finding in COR 2016 004886, where I supported these calls for pregabalin to be monitored, I also commented:

Victorian Coroners have previously highlighted the harms associated with pregabalin, and have advocated for real-time prescription monitoring in Victoria to encompass all prescribed drugs because, as the case of pregabalin clearly illustrates, different drugs can emerge as problematic over time and most drugs are associated with at least some level of misuse.

73. Master S's tragic death did not result from drug misuse or doctor shopping but highlights from a different perspective the prevention benefits of all prescribed drugs being monitored through SafeScript.

74. I note that in the past, the Victorian Department of Health has raised objections to monitoring all prescribed drugs through SafeScript. These objections include that clinicians may be overwhelmed with information, and that operational capacity requirements for recording so much information would not be offset by equivalent public health benefits. However, now having the benefit of substantial practical experience in running the SafeScript program, I am confident the Victorian Department of Health will be able to address any of these issues if they arise.

RECOMMENDATIONS

75. Accordingly, pursuant to section 72(2) of the Act, I make the following recommendation: *That the Victorian Department of Health expand the scope of drugs monitored by the SafeScript real-time prescription monitoring program, to include all prescription medications that are prescribed and dispensed throughout Victoria without exception.*

76. The passing of a young child is devastating for his loved ones as well as for the community. I convey my sincere condolences to Master S's family for their loss and acknowledge the tragic circumstances in which his death occurred.

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

Ms S, Senior Next of Kin

Mr L, Senior Next of Kin

Shine Lawyers, Other Applicant

Ball+Partner Lawyers, Other Applicant

Adjunct Clinical Associate Professor Robert Roseby, Monash Health, Other Applicant

Liana Buchanan, Commission for Children and Young People, Other Applicant

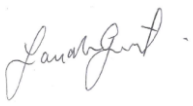
Monash Medical Centre, Other Applicant

Department of Education and Training, Other Applicant

Department of Health

Senior Constable Deborah King, Victoria Police, Coroner's Investigator

Signature:



Coroner Sarah Gebert

Date: 31 October 2022

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.