IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005509

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Harrison William Ladd
Date of birth:	6 July 1997
Date of death:	23 September 2022
Cause of death:	1(a) Combined drug toxicity
Place of death:	506 San Mateo Avenue Mildura Victoria 3500
Keywords:	Combined drug toxicity; SafeScript; substance use

INTRODUCTION

1. On 23 September 2022, Harrison William Ladd was 25 years old when he was found deceased at his home in Mildura, Victoria. At the time of his death, Mr Ladd lived with his partner, Krista Melville, her (then) six-year-old daughter from a prior relationship, and Ms Melville's mother, Karen Melville.

2. Mr Ladd was described by his family as a very family-oriented person and noted that he spent a lot of time with his family and boxing at the family's boxing gym. He was well-liked, was never a "*troublemaker*" and did not have any issues at school.

3. When Mr Ladd was about 18 years old, he started going out to nightclubs and partying with friends. It was at about this time that he started using illicit drugs including methylamphetamine. His boss at the time started noticing he was "*not himself*" at work and he started taking sick days. Eventually, his manager dismissed him and Mr Ladd returned to work (intermittently) in his father's carpet cleaning business.

4. Mr Ladd's medical history included attention deficit hyperactivity disorder (**ADHD**), anxiety disorder, substance (alcohol, psychoactive substances, prescription medication) use disorder, borderline intellectual skills, borderline personality traits/disorder, depression and drug-induced psychosis. Mr Ladd consulted with several general practitioners (**GPs**) at Ontario Medical Clinic (**OMC**), including Dr Philip Webster and Dr Warwick Wishart, GPs at Tristar Medical Group, psychiatrists Dr Santhusa Wijekoon and Dr Sinnatamby Sujeevan, and registered psychiatric nurse (**RPN**), Brett McKinnon.

5. Dr Wijekoon referred Mr Ladd to the Ramsay Clinic Albert Road (**RCAR**) in 2020. Mr Ladd also attended The Hader Clinic for rehabilitation in late-2020. He was admitted to The Melbourne Clinic (**TMC**) under Dr Sujeevan's care twice in 2021.

6. In 2021, Mr Ladd dislocated his knee while boxing and required a knee reconstruction. He was prescribed strong painkillers to assist with the recovery. Unfortunately, he developed serotonin syndrome in January 2022 and was hospitalised as a result. In early-2022, Dr Wishart started weaning Mr Ladd off tapentadol and oxycodone.

2022 medical consultations

January – March 2022

7. Mr Ladd presented to Dr Wishart on 21 January 2022 in the context of his recent hospital admission for serotonin syndrome. Dr Wishart reviewed Mr Ladd's discharge summary and noted that while admitted, Mr Ladd's sertraline was ceased. Dr Wishart advised Mr Ladd to follow up with his psychiatrist. On discharge from hospital, Mr Ladd's medication regime included clonazepam, tapentadol, sertraline (ceased), thiamine, methylphenidate, oxycodone and zolpidem.

8. Mr Ladd presented to Dr Wishart again on 24 January 2022, this time in the company of his mother. Dr Wishart discussed Mr Ladd's functioning, which had not improved despite his medication regime. Dr Wishart counselled Mr Ladd, devised a plan to wean him off tapentadol and noted Mr Ladd's need to wean off benzodiazepines.

9. On 28 January 2022, Mr Ladd presented to Dr Sujeevan via telehealth and reported his serotonin syndrome was worse than when it last occurred in 2019. He reported that he did not wish to continue with sertraline and his mother stated that she did not believe he had improved much after coming back from hospital. His mother wanted him to wean off all medication and have a break. Dr Sujeevan's plan was to reduce Mr Ladd's clonazepam dose to 1mg in the morning for about two weeks, then 0.5mg in the morning ongoing. He noted ongoing prescription of tapentadol 50mg and queried whether he should trial methylphenidate for ADHD.

10. Over February and March 2022, Mr Ladd slowly weaned off tapentadol.

11. Mr Ladd presented to Dr Sujeevan on 18 March 2022 and reported he had not been taking clonazepam for at least six weeks, he ceased taking tapentadol about one week earlier, his knee was healing well and that he was doing some exercise. Dr Sujeevan checked SafeScript and prescribed methylphenidate with fortnightly pick-ups to reduce the chance of overuse or overdose.

12. Mr Ladd returned to Dr Sujeevan on 25 March 2022 and reported feeling anxious with his medication and stated that he did not want to start an antidepressant. Dr Sujeevan continued Mr Ladd's methylphenidate prescription but increased the dose slightly.

<u>*April 2022*</u>

13. Mr Ladd presented to Dr Sujeevan on 20 April 2022 and reported difficulties with sleep due to rumination and anxiety. He noted some side effects from methylphenidate in the beginning, however felt that had settled down. He reported not using any illicit drugs and that he had not

been exercising recently. Dr Sujeevan checked SafeScript and prescribed mirtazapine for assistance with mood and anxiety, and continued methylphenidate.

14. Mr Ladd presented to Dr Webster on 26 April 2022. He reported struggling with anxiety of issues over recent years with ADHD, anxiety and mood disorder, knee surgery and post-operative pain, illicit drug use and various mental health counsellors. Dr Webster reported that he spoke at length to Mr Ladd about online and phone applications that could provide tools for self-management of anxiety. Dr Webster warned Mr Ladd about the relative merits and risks of a short-term benzodiazepine for symptom control, the dangers of tolerance/dependence and provided a prescription for diazepam (50 tablets, no repeats).

May 2022

15. On 5 May 2022, Mr Ladd returned to Dr Wishart who noted that Mr Ladd trialled mirtazapine for a brief period, then self-ceased the medication. Mr Ladd discussed his anxiety, however Dr Wishart refused to prescribe benzodiazepines, due to Mr Ladd's history of substance misuse. Dr Wishart instead prescribed escitalopram to manage his anxiety.

16. On 6 May 2022, Mr Ladd presented to Dr Sujeevan, reported his anxiety was fluctuating and that he self-ceased mirtazapine. He noted that he was also taking diazepam (as needed). Dr Sujeevan documented that Mr Ladd felt Vyvanse (lisdexamphetamine) was "*too activating*" however noted Mr Ladd had not trialled dexamphetamine. Dr Sujeevan noted Mr Ladd's tendency to rely on medications and suggested a trial of dexamphetamine (5mg twice daily, fortnightly pickup) after checking SafeScript.

17. Mr Ladd returned to OMC on 7 May 2022 and consulted with a different GP. Mr Ladd stated that he did not start escitalopram because he was fearful of developing serotonin syndrome again and asked for a script of diazepam. The GP counselled Mr Ladd to start escitalopram and refused to provide a script for diazepam.

18. Mr Ladd consulted with Dr Webster on 9 May 2022 and reported that he found benzodiazepines helpful to "*face his fears at school*". Dr Webster prescribed diazepam accordingly and requested Mr Ladd return in one week.

19. On 13 May 2022, Mr Ladd presented to Dr Sujeevan again and reported he obtained more diazepam from his GP and that he had trialled between 10 to 15mg of dexamphetamine per

day. Dr Sujeevan checked SafeScript and continued Mr Ladd's dexamphetamine prescription (5mg, twice daily, fortnightly pickup).[1]

20. Mr Ladd returned to Dr Webster on 16 May 2022 and reported sleep issues. Dr Webster noted that Mr Ladd was drug-dependent, and it was not safe for him to prescribe benzodiazepines any longer. Dr Webster ceased escitalopram and diazepam and noted that Mr Ladd needed behaviour modification as a primary response to anxiety, rather than pharmacological supports.

June – July 2022

21. On 3 June 2022, Mr Ladd presented to Dr Sujeevan and reported that he had a new girlfriend who is a medium and clairvoyant. He reported that he preferred dexamphetamine over lisdexamphetamine as his sleep was improved on the former. He reported using 15mg twice daily as he was developing some tolerance to 10mg twice daily. He noted he was no longer taking diazepam and was having days off dexamphetamine when he did not have schoolwork to complete. Dr Sujeevan checked SafeScript and increased Mr Ladd's dexamphetamine dose to 15mg twice daily, with fortnightly pickups.

22. Mr Ladd did not return to his GP clinic until 30 June 2022 when he reported left-sided back tightness. He also reported poor sleep habits and had questions about fertility. Dr Webster provided a prescription for doxylamine to assist with his sleep and referred him for testing, in relation to his fertility queries.

23. On 5 July 2022, Dr Sujeevan issued an e-script for dexamphetamine (15mg, twice daily, 200 tablets per script, five repeats, fortnightly pickup).

24. Mr Ladd saw a different GP at his usual clinic on 12 July 2022 and reported that he misplaced his doxylamine script. The GP briefly discussed sleep hygiene techniques, provided a prescription for doxylamine and recommended that Mr Ladd follow-up with his regular GP.

25. Mr Ladd also contacted Dr Sujeevan on 12 July 2022 and reported that he lost his phone with his dexamphetamine prescription on it. Dr Sujeevan checked SafeScript and noted that Mr Ladd did not fill the script he received on 5 July 2022, so Dr Sujeevan provided a new prescription.

[1] I note that this was later found to be an error as Mr Ladd was using between 10mg and 15mg, twice daily.

26. Mr Ladd attended another GP at OMC on 20 July 2022. He requested tapentadol for back pain, however the GP declined to prescribe same. This GP instead prescribed Codalgin (codeine + paracetamol), one to two tablets, every four hours (as needed). The prescription contained 20 tablets with two repeats. According to SafeScript, Mr Ladd filled these prescriptions on 20, 22 and 26 July 2022 and received 40 tablets on each occasion.

27. Mr Ladd returned to Dr Webster on 28 July 2022 and reported knee pain, that his pain relief was inadequate and poor sleep. Dr Webster discussed an exercise plan and for Mr Ladd to habituate his sleep, however declined to prescribe any medication.

August 2022

28. On 3 August 2022, Mr Ladd attended OMC and saw a different GP. He again reported right knee pain and that the pain was not getting any better, however confirmed he had not sought physiotherapy. The GP refused to prescribe any medication, referred Mr Ladd for an x-ray and recommended that he follow-up with his physiotherapist.

29. On 9 August 2022, Mr Ladd presented to Dr Sujeevan and reported that he "*wanted to try the medication [dexamphetamine] about 3 times a day*", noting he was prescribed 15mg, twice per day. Mr Ladd reported that his girlfriend was prescribed the same medication and that he gave her some of his tablets, so he ran out. He denied that he was using more tablets than prescribed and reported having one medication-free day per week. He also reported using doxylamine to help with his sleep as he was experiencing interrupted sleep. Dr Sujeevan checked SafeScript and noted Mr Ladd filled a prescription for dexamphetamine that day. He continued Mr Ladd on the same dosage.

30. On 18 August 2022, Mr Ladd returned to Dr Webster and reported ongoing issues with anxiety. Dr Webster refused to prescribe diazepam, however decided to prescribe clonazepam as a longer-acting medication in the same family that might alleviate the rise and fall of drug levels. He also recommended that Mr Ladd continue to self-regulate, apply relaxation strategies and self-habituation. Dr Webster provided one prescription of clonazepam (0.5mg tablet), one tablet, twice per day (as needed), 60 tablets (no repeats).

31. On 29 August 2022, Mr Ladd returned to Dr Webster for review. He reported that he was travelling for work and requested a new script of dexamphetamine. Dr Webster refused to provide a script, noting that he was too early for a new prescription (by more than three

months). Dr Webster provided a prescription for clonazepam (0.5mg tablet), two tablets, twice per day, 60 tablets (no repeats).

<u>September 2022</u>

32. On 6 September 2022, Mr Ladd attended Dr Webster and reported that he lost his tablets, however he was vague in his explanation. He reported that his anxiety levels were interfering with his work and that he had limited capacity to apply behavioural strategies to manage his anxiety. Dr Webster decided to prescribe a higher dose of clonazepam (2mg tablet), half a tablet, twice per day, 20 tablets (no repeats). Dr Webster stated that he prescribed a higher dose of clonazepam on this occasion as he was determined to transition Mr Ladd from diazepam to clonazepam as a longer-acting benzodiazepine.

33. Mr Ladd attended Dr Sujeevan on 7 September 2022 and reported that he changed his GP to Dr Webster about three or four months ago, and that Dr Webster had prescribed him clonazepam (1 to 2mg, twice daily). He reported "*a lot of anxiety*" and that he was using clonazepam to assist with same. He noted that he had a "*falling out*" with his mother and he did not attend his brother's wedding one weekend prior. Mr Ladd reported using 10mg of dexamphetamine three times per day and felt that it was effective. Dr Sujeevan checked SafeScript and noted dexamphetamine was last dispensed on 2 August 2022.

34. On 14 September 2022, Mr Ladd called Dr Sujeevan and requested an early prescription for dexamphetamine. Dr Sujeevan spoke to Mr Ladd's pharmacist who noted that Mr Ladd last filled a prescription two weeks earlier, and 84 tablets were dispensed. The pharmacist noted that Mr Ladd reportedly lost about 160 tablets. The pharmacist provided 32 tablets, however Mr Ladd reported that he only got 11 or 13 tablets.

35. Dr Sujeevan spoke to Mr Ladd again and he maintained that he only had 13 tablets, not 32. He also stated that he had to give his girlfriend four tablets. Dr Sujeevan provided a further prescription and recommended weekly pickup of 42 tablets per week, ideally from the same pharmacy each time. Dr Sujeevan opined that Mr Ladd did not require clonazepam, however noted that Mr Ladd needed to discuss this with his GP, who was prescribing same.

36. Additionally, on 14 September 2022, Mr Ladd contacted Silverline Health Care and asked to speak to RPN Brett McKinnon. RPN McKinnon noted that he had previously consulted with Mr Ladd at a different clinic. As RPN McKinnon had availability that day, he agreed to see Mr Ladd. When Mr Ladd attended, he reported that his mood was stable, and his anxiety was

well-controlled. He reported "*many positive things happening in his life*". He reported that he needed a repeat clonazepam prescription, so RPN McKinnon provided a script for clonazepam (2mg, twice daily, as required, 100 tablets with three repeats).

THE CORONIAL INVESTIGATION

37. Mr Ladd'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.

38. 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.

39. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr Ladd's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence. Further inquiries were conducted by the Court at my direction.

40. This finding draws on the totality of the coronial investigation into the death of Harrison William Ladd 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.[2]

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

Circumstances in which the death occurred

41. Mr Ladd's family noted that in the months prior to his death, his relationship with them deteriorated and observed that this coincided with his new relationship with Ms Melville. His family observed a video posted by Ms Melville promoting her business online which

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[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.

reportedly depicted Mr Ladd picking at his face and skin. This sparked their concern that he might have relapsed with illicit substances.

42. In September 2022, Mr Ladd's family travelled to Queensland for the wedding of Mr Ladd's brother. Mr Ladd did not attend, and upon his family returning to Victoria, they observed that Mr Ladd "*wasn't himself*". In the week prior to his death, Mr Ladd told his father that he "*had a psychotic episode and shaved [his] head*".

43. On 21 September 2022, Mr Ladd attended his family's boxing gym and spoke to his brother, Jackson Ladd (**Mr J Ladd**). Mr Ladd attended the gym to purchase boxing gloves, which Mr J Ladd gave to him for $50 as he did not have a lot of money. Mr J Ladd told his brother that he did not "*look right*" to which Mr Ladd responded, "*I promise I'm not on meth*". Mr J Ladd opined that his brother appeared to be quite heightened and appeared to be taking some form of amphetamines.

44. That night, Mr Ladd reportedly did not return home. Ms Melville called him at about 3.00am on 22 September 2022 and he reported that he was still at work, completing a job. Ms Melville opined that he was "*fixated on finishing*" and did not think he slept at all that night.

45. Later that morning, when Ms Melville awoke for work, she noted that Mr Ladd had still not returned home. She went to work and when she returned that evening, noted that Mr Ladd was still not home. Ms Melville called Mr Ladd and told him that he needed to come home because they "*needed to talk in person*".

46. According to Mr Ladd's associate, Cayne Tucker, Mr Ladd asked him if he could help him with a job that Mr Tucker was working on at a local pharmacy. Mr Tucker agreed, and Mr Ladd attended the pharmacy at about 3.00pm on 22 September 2022 to work together. Mr Tucker stated the pair worked "*quite late*" that afternoon/evening and that during their time together, Mr Ladd "*was taking medication*" from his bag.

47. Mr Tucker and Mr Ladd stopped briefly in the afternoon to obtain dinner, then returned at about 6.00pm. Mr Tucker recalled that Mr Ladd called his father to ask him to come to the pharmacy and look at the flooring and provide advice about whether to buff the flooring at that stage. Mr Tucker stated that Mr Ladd's father refused to attend and Mr Ladd "*was immediately down in his demeanour*". Mr Tucker reported that Mr Ladd was very proud and was upset that his father did not want to look at his work. He also noted Mr Ladd started taking more of his medication.

48. After finishing work, Mr Tucker drove Mr Ladd back to his home to have some drinks. As they were driving there, Mr Tucker questioned Mr Ladd about his dexamphetamine use. Mr Ladd explained that he was only taking dexamphetamine, and he was prescribed a high dose, but he "*was okay*".

49. Mr Tucker and Mr Ladd had "*a few beers*" at Mr Tucker's home. Mr Tucker wanted to go to sleep, and Mr Ladd said he was happy to stay the night there. Mr Tucker recalled that Mr Ladd spoke to Ms Melville over the phone at some point that evening and that within an hour of this call, Mr Ladd "*urinated all over the floor*". Mr Tucker's mother told her son to take Mr Ladd home, which he did. At the time, Mr Tucker believed that Mr Ladd was "*bind [sic] drunk*" and did not think that anything was seriously wrong.

50. At about 10.00pm, Ms Melville called Mr J Ladd, worried about Mr Ladd. She was "*in hysterics*" saying that he had not returned home. It appears Mr Ladd arrived home shortly thereafter. Ms Melville recalled that when Mr Ladd arrived home, his bags and belongings were dirty, which was unlike him. Ms Melville stated she was suspicious that Mr Ladd had been using prescription drugs and that he might have taken Valium (diazepam). She opined that he did not appear to be affected by illicit drugs; rather he "*appeared to be drunk and happy*". Ms Melville confiscated his medication and put him to sleep in her daughter's bed.

51. Ms Melville sent Mr J Ladd two text messages at 10.16pm, explaining that she had put Mr Ladd to bed, that he was "*seeing shit*" and that she lay on his chest and could hear his heart racing. She spoke about Mr Ladd's job the following day at the pharmacy and that she would speak to Mr Ladd about it as his "*pride is really big*". Ms Melville sent a further two messages to Mr J Ladd at 10.31pm staying "*I think cayne [sic] drugged harry [sic]*" and "*Im [sic] making sure he doesn't go tomorrow. Ive [sic] messaged caynes [sic] mum*". Ms Melville retired to her own bed and stated that she continued to check on Mr Ladd throughout the night.

52. Ms Melville explained that she awoke at 7.30am on 23 September 2022 to go to work. She reported that she checked on Mr Ladd before she left and noted that he was "*still asleep and snoring*".

53. While at work, Ms Melville stated that she became anxious about Mr Ladd, so she asked her mother to check on Mr Ladd. Ms Melville's mother noted that at about 11.00am, she heard Mr Ladd snoring "*very loudly through the walls*" so she left the house briefly with her granddaughter.

54. Ms Melville returned home at about 2.30pm and noted that she could not hear Mr Ladd snoring. She asked her mother if she had checked on him recently and she replied that she had only just returned home. Ms Melville checked on Mr Ladd in her daughter's room and located him lying on his back with "*a bit of drool running from his mouth down the side of his face*". Ms Melville rolled him onto his side to clear his airways while her mother called Triple Zero. Ms Melville followed the call-taker's instructions to commence cardiopulmonary resuscitation (**CPR**).

55. Firefighters arrived on scene first, removed Mr Ladd from the bedroom and took over CPR until paramedics arrived and continued resuscitative efforts. Paramedics were unable to revive Mr Ladd, and he was declared deceased at the scene.

56. Police also attended the scene and located two bottles of clonazepam and one bottle of dexamphetamine, all in Mr Ladd's name. Police did not identify any suspicious circumstances, no signs of violence or a struggle, no indication of self-harm or suicide and no illicit substances or items located at the scene.

Identity of the deceased

57. On 23 September 2022, Harrison William Ladd, born 6 July 1997, was visually identified by his partner's mother, Karen Melville.

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

Medical cause of death

59. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 27 September 2022 and provided a written report of his findings dated 25 November 2022.

60. The post-mortem examination revealed no unexpected signs of trauma. Multiple linear scars were seen on the forearms.

61. Examination of the post-mortem CT scan showed brain swelling, increased lung markings (particularly in the right lower lobe) and a distended urinary bladder.

62. Toxicological analysis of post-mortem blood samples identified the presence of codeine,[3] amphetamine,[4] clonazepam and its metabolite 7-aminoclonazepam,[5] and diazepam metabolite nordiazepam.[6]

63. Toxicological analysis of post-mortem urine samples identified codeine and its metabolite morphine, amphetamine, clonazepam and its metabolite 7-aminoclonazepam, diazepam metabolites nordiazepam, temazepam and oxazepam, and pholcodine.[7]

64. Ethanol, GHB and novel psychoactive substances were not detected.

65. Dr Young explained that while the concentrations of drugs detected in the deceased's blood are all low, many of them can work synergistically to have an additive effect. This especially pertains to drugs that cause depression of the central nervous system (**CNS**), including codeine, clonazepam, diazepam and pholcodine, CNS depression can cause depressive effects on breathing, leading to death. The history of snoring is noted. The presence of amphetamine may derive solely from prescribed dexamphetamine, or a combination of that and consumed methylamphetamine.

66. Dr Young provided an opinion that the medical cause of death was 1(a) Combined drug toxicity.

67. I accept Dr Young's opinion.

FAMILY CONCERNS

68. Mr Ladd's family submitted extensive concerns regarding his death, the medical/mental health treatment he received prior to his death and the involvement of Mr Ladd's girlfriend. In summary, these concerns are listed are listed below. Note that some of these concerns are beyond the scope of my investigation, however they are listed for completeness.

    a) Receipt of intervention orders applied for by Ms Melville, against Kristen and Steven Ladd.

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[3] Codeine is an opiate found in opium isolated from the plant *Papaver somniferum*.

[4] Amphetamine is an indirectly acting sympathomimetic phenethylamine derivative thought to enhance dopaminergic and noradrenergic neurotransmission. It is both used for its stimulant effects and used therapeutically.

[5] Clonazepam is a nitrobenzodiazepine indicated for the treatment of seizures.

[6] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.

[7] Pholcodine is a semi-synthetic opioid derivative indicated for cough.

b) Why Ms Melville did not call for medical assistance on the evening of 22 September 2022, when Mr Ladd's heart was racing and he was "*seeing shit*".

c) Why Ms Melville left Mr Ladd in her daughter's bed for about 16 hours and whether a duty of care existed between Ms Melville and Mr Ladd.

d) Why Ms Melville alleged to police that Mr Ladd consumed cannabis and ice, and whether he had been "*drugged*" with GHB.

e) That Mr Ladd's relationship with Ms Melville was allegedly controlling and manipulative.

f) Whether Mr Ladd's treating clinicians prescribed correct doses of medication.

g) Concerns that police treated Mr Ladd's death as a simple drug overdose, based on erroneous information given by Ms Melville, and that they did not treat his death as suspicious.

69. Ryan Legal, engaged on behalf of Mr Ladd's family, wrote to the Court to express specific concerns about Mr Ladd's medical and mental health treatment, namely:

a) To what extent Dr Webster, RPN McKinnon and Dr Sujeevan:

i. Were aware or should have been aware of the medications each clinician was prescribing to Mr Ladd.

ii. Discussed with each other the medications each was prescribing to Mr Ladd.

iii. Advised Mr Ladd of any risks associated with taking his medications in combination.

b) The quantities of medications being prescribed to Mr Ladd in the lead-up to his death.

c) The prescriptions of clonazepam to Mr Ladd by a mental health nurse (RPN McKinnon).

d) The appropriateness of Mr Ladd being prescribed benzodiazepines given his history of drug addiction.

FURTHER INVESTIGATIONS

70. Following receipt of the family's concerns, I directed further inquiries be undertaken. The Court obtained further statements and information, which are summarised below.

Medicare, Pharmaceutical Benefits Scheme and SafeScript records

71. The Court obtained Mr Ladd's Medicare and Pharmaceutical Benefits Scheme (**PBS**) records as well as his SafeScript records. The medications Mr Ladd received proximate to his passing were dexamphetamine and clonazepam. He last filled a prescription for diazepam on 9 May 2022 and a prescription for codeine on 26 July 2022.

72. Late in 2021 and earlier in 2022, Mr Ladd was prescribed tapentadol, methylphenidate, mirtazapine, oxycodone, and sertraline. Pholcodine was previously available over the counter at pharmacies (as cough suppressant/syrup) and would not show up on Mr Ladd's PBS or SafeScript records.

Dexamphetamine

73. Mr Ladd usually filled his prescription for dexamphetamine once per month, however there were some occasions on which he refilled his prescriptions earlier than indicated:

    a) 6 May 2022:

        i. Dr Sujeevan issued a dexamphetamine script for 100 tablets; one tablet (5mg) twice daily; fortnightly pickup, no repeats.

        ii. Mr Ladd filled his dexamphetamine prescription – this should have had a sufficient supply for 50 days (one tablet, twice per day).

        iii. If Mr Ladd consumed the full 100 tablets dispensed on 6 May by 13 May, he would have consumed approximately 14.3 tablets per day over seven days.

    b) 13 May 2022:

        i. Dr Sujeevan issued a dexamphetamine script given for 200 tablets; one tablet (5mg) twice daily; fortnightly, one repeat prescription.

        ii. Mr Ladd filled the dexamphetamine prescription issued that day and should have had a sufficient supply for 100 days (one tablet, twice per day).[8]

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[8] As noted below, Mr Ladd's dose was being gradually increased. See further analysis below.

c) 3 June 2022:

    i. Dr Sujeevan increased the dexamphetamine dose to three tablets (15mg), twice daily.

    ii. From 13 May to 3 June, Mr Ladd should have used 42 tablets (if taken as directed). From 3 June to 17 June, Mr Ladd should have used 84 tablets. Given 200 tablets were dispensed on 13 May, he should have still had 74 tablets by 17 June. If all were consumed between 13 May and 17 June, he would have consumed approximately 9.5 tablets per day over 21 days.

d) 17 June 2022:

    i. Mr Ladd filled a repeat prescription from the 13 May 2022 script. At three tablets, twice per day, 200 tablets would last 33.33 days.

    ii. If all tablets from the 17 June refill were used by 12 July, then he would have consumed 8 tablets per day over 25 days.

e) 5 July 2022:

    i. Dr Sujeevan issued a dexamphetamine script given for three tablets (15mg), twice per day, 200 tablets. It does not appear that this script was ever filled.

f) 12 July 2022:

    i. Dr Sujeevan issued a dexamphetamine script for 200 tablets; 15mg (three tablets), twice daily, with five repeats. At three tablets, twice per day, one prescription of 200 tablets would last 33.33 days.

    ii. Mr Ladd filled the dexamphetamine script the same day.

    iii. If all tablets dispensed on 12 July were consumed by 2 August, then Mr Ladd would have consumed approximately 9.5 tablets per day over 21 days.

g) 2 August 2022:

    i. Mr Ladd filled the repeat prescription from the script issued on 12 July 2022. At three tablets, twice per day, one prescription of 200 tablets would last 33.33 days.

ii. If all tablets dispensed on 2 August were consumed by 29 August, then Mr Ladd would have consumed approximately 7.4 tablets per day over 27 days.

h) 29 August 2022:

i. Mr Ladd filled the repeat prescription from the one issued on 12 July 2022, although was only dispensed 84 tablets. At three tablets, twice per day, this would last 14 days.

ii. If Mr Ladd took his tablets dispensed on 29 August as directed, he would be due for a refill on 12 September. He presented for a refill on 14 September, so it appears he was using the correct amount (or slightly less).

i) 14 September 2022:

i. Dr Sujeevan issued a dexamphetamine script for 200 tablets with the same dose (three tablets, twice daily).

ii. Mr Ladd filled the new prescription issued that same day. This prescription would last 33.33 days.

Clonazepam

74. With respect to Mr Ladd's clonazepam prescriptions in 2022, he received and filled his prescriptions as follows:

a) 18 August 2022:

i. Dr Webster prescribed clonazepam 0.5mg, one tablet, twice per day (as needed), 60 tablets, no repeats. This was a non-PBS script and should have lasted 30 days if taken as directed.

ii. Mr Ladd filled this script that same day.

iii. If all 60 tablets dispensed on 18 August 2022 were consumed by 29 August 2022, this would have equated to 5.45 tablets per day over 11 days, which was more than twice the prescribed dose.

b) 29 August 2022:

i. Dr Webster prescribed clonazepam 0.5mg, two tablets, twice per day, 60 tablets, no repeats. This was a non-PBS script and should have lasted 15 days if taken as directed.

ii. Mr Ladd filled this script that same day.

iii. If all 60 tablets dispensed on 29 August 2022 were consumed by 6 September 2022, this would have equated to 7.5 tablets per day over eight days.

c) 6 September 2022:

i. Dr Webster prescribed clonazepam 2mg, half a tablet twice per day, 20 tablets, no repeats. This was a non-PBS script and should have lasted 20 days if taken as directed.

ii. Mr Ladd filled this script that same day.

iii. If all 20 tablets dispensed on 6 September 2022 were consumed by 14 September 2022, this would have equated to 2.5 tablets per day over eight days.

d) 14 September 2022:

i. RPN McKinnon prescribed clonazepam 2mg, twice per day, 100 tablets with three repeats. This was a PBS script and if taken as directed, one script should have lasted 50 days (all three scripts would have lasted 150 days).

ii. Mr Ladd filled this script that same day.

Codeine

75. Mr Ladd only had a brief prescription for codeine from a different GP at OMC in July 2022. It is unclear whether this was the source of the codeine detected in his post-mortem samples, or whether he obtained the codeine via some other means.

a) 20 July 2022 - GP prescribed Codalgin 500mg/8mg, one to two tablets every four hours (as needed). The quantity prescribed according to the OMC records was 20 tablets with two repeats and was a non-PBS script. However, according to SafeScript, a Panamax-Co (another generic name for Codalgin) was dispensed, with a quantity of

40 tablets. According to NPS MedicineWise,[9] the maximum dose of Panamax Co is eight tablets per day, and this prescription should have lasted five days.

b) 22 July 2022 – Mr Ladd refilled his codeine prescription. If 40 tablets were dispensed on 20 July, he would have consumed 20 tablets per day over two days.

c) 26 July 2022 – Mr Ladd refilled his codeine prescription. If 40 tablets were dispensed on 22 July, he would have consumed 10 tablets per day over four days.

Statement of Associate Professor Dimitri Gerostamoulos

76. The Court obtained an expert opinion from Associate Professor Dimitri Gerostamoulos (**A/Prof Gerostamoulos**), the Head of Forensic Sciences and Chief Toxicologist at the VIFM. In particular, A/Prof Gerostamoulos was asked about the presence of amphetamine in Mr Ladd's post-mortem blood and urine, in the absence of methylamphetamine.

77. A/Prof Gerostamoulos explained that amphetamine is an indirectly acting sympathomimetic phenethylamine derivative, thought to enhance dopaminergic and noradrenergic neurotransmission. It is both abused for its stimulant effects and used therapeutically.

78. Amphetamine is also a metabolite of other drugs, including fenethylline, fenproporex, lisdexamphetamine, methylamphetamine and prenylamine. Only lisdexamphetamine is listed on the Australian Register of Therapeutic Goods.

79. Having reviewed Mr Ladd's toxicology report, A/Prof Gerostamoulos noted that there is only amphetamine detected in blood and urine (noting there were other drugs detected) which indicates the use of amphetamine in the absence of methylamphetamine use. Alternatively, it may be that methylamphetamine was consumed at some stage (but not within the few days prior to the death) as the drug methylamphetamine has been eliminated. A/Prof Gerostamoulos noted that additional prescribing and medical records may aid in better interpreting the toxicology results.

Statement of RPN Brett McKinnon

80. RPN McKinnon explained that he was unsure when Mr Ladd first became his patient, as he did not have access to the medical records from Tristar Medical Group (where he first consulted with Mr Ladd). He estimated that he consulted with him in mid-2019 at that clinic

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[9] https://www.nps.org.au/assets/medicines/4575c788-fa4b-4dff-a4c4-a53300feeb5c.pdf

and that he had not seen him for several months at Silverline Health Care, prior to his presentation in September 2022.

81. RPN McKinnon was specifically requested to detail his appointment on 14 September 2022. He explained that Mr Ladd's presentation was "*as good as I have ever seen him*". He noted that his moods were stable, his anxiety appeared well-controlled, and he detailed many positive things in his life.

82. RPN McKinnon noted that Mr Ladd had been "*discharged*" by his psychiatrist and that Mr Ladd would provide a copy of his discharge summaries at the next appointment. Mr Ladd reported that he was due for a new script of clonazepam, and RPN McKinnon provided same. RPN McKinnon "*remind[ed] him of maintaining appropriate use and commend[ed] him on his progress*". Mr Ladd denied any risks and RPN McKinnon's management plan focused on maintain good health and wellbeing, including ongoing pharmacological reviews and psychotherapy.

83. RPN McKinnon noted that his rationale for prescribing clonazepam was due to Mr Ladd asking for it and explaining that it was part of his medication and treatment regime. RPN McKinnon noted that Dr Wijekoon previously prescribed clonazepam and this was successful at the time. RPN McKinnon noted that Mr Ladd was also prescribed dexamphetamine.

84. RPN McKinnon noted Mr Ladd's history of illicit and prescription substance misuse. He reported that he had a good rapport with Mr Ladd, and they always had open, transparent and frank conversations about his substance use. Mr Ladd was pleased to report that he had been drug-free for nearly one year and that clonazepam was a catalyst for his recovery. Given that his mental state was stable at the time and he had many positive things occurring in his life, RPN McKinnon stated that he was comfortable that Mr Ladd's recreational drug use was no longer an issue.

85. Upon a review of the Silverline Health Care medical records, Mr Ladd was last seen by Dr Wijekoon at that clinic on 21 May 2020. This therefore suggests a gap of more than two years prior to his attendance on 14 September 2022.

86. Furthermore, the Mr Ladd's SafeScript records indicate that RPN McKinnon did not check SafeScript prior to prescribing clonazepam. If he had, he would have seen Mr Ladd last received a prescription for clonazepam eight days earlier, on 6 September 2022, and therefore was not yet due for another prescription of same.

87. It also appears that while Dr Webster prescribed 2mg tablets (half tablet, twice per day) on 6 September 2022, RPN McKinnon prescribed 2mg tablets (one tablet, twice per day, as needed) on 14 September 2022. RPN McKinnon's dose was therefore double the dose prescribed by Dr Webster.

Statements of Dr Sinnatamby Sujeevan

88. Dr Sujeevan provided two statements to the Court dated 28 September 2023 and 9 May 2024. Dr Sujeevan noted Mr Ladd had a history of anxiety disorder (mostly social), ADHD (mixed inattentive and impulsive/hyperactivity subtype), substance misuse disorder, borderline intellectual skills, borderline personality traits/disorder, depression and drug-induced psychosis.

89. Dr Sujeevan explained that at the time of Mr Ladd's death, he prescribed dexamphetamine and gave instructions to the pharmacist to dispense 42 tablets per week. At three tablets, twice per day, 42 tablets should last for exactly seven days.

90. Dr Sujeevan noted that Mr Ladd was also prescribed clonazepam by his new GP, however he encouraged Mr Ladd not to see any new doctors or obtain prescriptions for clonazepam or other benzodiazepines.

91. Dr Sujeevan explained that at the time of Mr Ladd's death, he had stopped seeing his drug and alcohol counsellor, however, was still regularly seeing his psychologist and he encouraged Mr Ladd to continue with this therapy.

Dexamphetamine prescriptions

92. Dr Sujeevan noted the reason he prescribed dexamphetamine is because it is considered a first-line treatment for ADHD. Given Mr Ladd's history of methylamphetamine use, he trialled methylphenidate and the longer-acting version of methylphenidate first. Mr Ladd reported a poor response and difficulties tolerating these medications. Dr Sujeevan also considered lisdexamphetamine, however Mr Ladd reported that he tried it in the past and found that he experienced anxiety during the day. Hence Dr Sujeevan's decision to prescribe dexamphetamine.

93. Dr Sujeevan noted that there were several concerns regarding the prescription of dexamphetamine to Mr Ladd and outlined the measures taken to address same. Dr Sujeevan noted the following concerns:

a) Mr Ladd’s history of alcohol, psychoactive substance and prescription medication abuse.

b) Mr Ladd’s history of drug-induced psychosis when he was abusing methylamphetamine.

c) Concerns raised from Mr Ladd’s family.

d) Mr Ladd’s tendency to rely on medication/pharmaceuticals to manage symptoms, some of which were related to his psychosocial circumstances and were not necessarily psychiatric illnesses.

e) That without adequate treatment, the symptoms of ADHD could continue to disable Mr Ladd and may increase his vulnerabilities/risk.

94. Dr Sujeevan explained that despite the concerns involved, ADHD treatment was continued as he noted that there is evidence that when well-managed, it can significantly improve quality of life, productivity and reduce risks/vulnerabilities (especially impulsivity). To manage the risks, Mr Ladd agreed to regular reviews, and he generally kept his appointments as scheduled.

95. Dr Sujeevan further explained that to reduce the risk of Mr Ladd obtaining more than the prescribed quantity of dexamphetamine, he directed the pharmacy to dispense medication fortnightly. From 14 September 2022, Dr Sujeevan directed the pharmacy to dispense the medication weekly.

96. With respect to prescribing dexamphetamine and clonazepam, Dr Sujeevan explained that there are generally no major concerns about the concurrent prescription of a stimulant such as dexamphetamine and a benzodiazepine such as clonazepam. He noted that these two types of medications can be combined relatively safely, especially at the doses he was prescribed. Nevertheless, Dr Sujeevan noted Mr Ladd’s propensity to abuse prescription medications (in particular, benzodiazepines and analgesics) and his recent change of GP. Dr Sujeevan encouraged Mr Ladd not to find another GP (so as to maintain consistency of treating practitioners) and to discuss his clonazepam prescription with his GP. Dr Sujeevan also opined that Mr Ladd did not require clonazepam and recommended that he focus on psychological techniques to reduce symptoms of anxiety.

97. The Court queried Mr Ladd’s presentation on 14 September with Dr Sujeevan, when he advised that he lost his prescription for dexamphetamine. Dr Sujeevan explained that this was

the first time that Mr Ladd had reported that he lost a prescription, and he estimated that he lost a quantity not exceeding the amount needed for one fortnight. As Mr Ladd was employed, reported a good response to his symptoms on dexamphetamine and this was the first time that this happened, Dr Sujeevan decided to provide a new dexamphetamine prescription. In order "*to prevent further mishaps*", Dr Sujeevan directed the pharmacy to start dispensing weekly.

98. I note from Dr Sujeevan's medical records that on 12 July 2022, Dr Sujeevan issued an e-script for dexamphetamine as Mr Ladd reported "*he lost his phone and script with it*".[10] During his appointment on 9 August 2022, Dr Sujeevan recorded that Mr Ladd's girlfriend was also on the same medication as him and he gave her some of his dexamphetamine, causing him to "*run out*". He reported that he was not taking more medication than prescribed.

99. During a previous appointment, Dr Sujeevan recorded that Ms Melville "*[h]as a history of addiction but does not use*". This would suggest that this was not the first time that Mr Ladd lost a script. The notes from 9 August 2022 were also concerning for the possibility that Mr Ladd was diverting his prescription to others (Ms Melville).

Communication with GP/other clinicians

100. Dr Sujeevan explained that Mr Ladd was first referred to him by Dr Adeola Akadari by referral dated 11 November 2020. Following Dr Sujeevan's first review of Mr Ladd on 4 June 2021, he sent a letter to Dr Akadari on 7 June 2021.

101. Mr Ladd was admitted to TMC from 5 to 11 September 2021 and 19 September to 16 October 2021. Mr Ladd nominated Dr Wishart as his GP at the time of his admissions to TMC. Following each admission, the discharge summaries dated 10 September, and 15 October 2021 were sent to Dr Wishart. These discharge summaries would have also been available for other GPs practising at OMC.

102. On 7 September 2022, Mr Ladd informed Dr Sujeevan that he had a new GP, Dr Webster. Dr Sujeevan stated that he did not have any correspondence with Dr Webster as Mr Ladd died a few weeks later.

103. Dr Sujeevan noted that his usual practice is to communicate with a patient's regular GP after he receives a referral. He also stated that he provides updates when the 12 months referral is renewed. If there are major changes to the treatment or there are concerns about the patient,

[10] This is addressed in further detail below.

he would ordinarily write to the GP to advise same. Dr Sujeevan explained that if Mr Ladd had not passed away on 23 September 2022, he would have requested his consent to communicate with Dr Webster and updated him of Mr Ladd's treatment.

Statements of Dr Philip Webster

104. Dr Webster provided two statements to the Court dated 29 August 2023 and a later (undated) supplementary statement. Dr Webster outlined his consultations with Mr Ladd, particularly in 2022, which were largely in the context of anxiety and mental ill-health.

105. At the time of his consultations with Mr Ladd, Dr Webster "*understood that he was taking no other prescription medication, except for a prescription of Escitalopram in May 2022 which he ceased due to adverse effects, a prescription of Restavit I provided to him in June 2022 and a prescription for Codalgin provided to [Mr Ladd] by my colleague*".

106. Dr Webster explained that the shared notes on the medical record indicated the "*collective wisdom of several doctors dealing with [Mr Ladd] over this journey*". Dr Webster explained that he had no reason to believe that Mr Ladd was using the benzodiazepines prescribed to him concurrently with other prescription medication. He further explained that the complex nature of Mr Ladd's diagnosis and history with prescribed and illicit drugs was always a concern, however this did not (and should not) stop clinical judgment and trust in a well-motivated patient.

107. From Dr Webster's statement, it is unclear whether he was aware that Mr Ladd was being prescribed dexamphetamine by Dr Sujeevan. However, based on the medical records it appears that he was aware of the dexamphetamine prescription. For example, on 29 August 2022, Dr Webster documented that Mr Ladd requested a new dexamphetamine script, however he documented that "*Authority system says too soon by more than three months*". It therefore appears that Dr Webster was aware of Mr Ladd's dexamphetamine prescription.

Benzodiazepine prescriptions

108. Dr Webster noted that he first commenced prescribing diazepam for Mr Ladd, however as it was short acting with a rapid onset and offset, and "*noting [Mr Ladd's] fast consumption, [he] determined that a similar medication which was longer acting was ideal*". Dr Webster explained that this was his rationale behind prescribing clonazepam.

109. Dr Webster explained that he prescribed Mr Ladd less quantities of medication and restricted his clonazepam "*to try and ensure a closer connection through the process*". Dr Webster noted his usual practice when prescribing benzodiazepines to a patient is to discuss the risks of dependence, which he did with Mr Ladd on 26 April 2022.

SafeScript compliance

110. According to Mr Ladd's SafeScript records, Dr Webster checked SafeScript on the following dates:

    a) 18 August 2022

    b) 6 September 2022

111. Dr Webster did *not* check SafeScript before prescribing medication on the following dates:

    a) 26 April 2022, when prescribing diazepam.

    b) 9 May 2022, when prescribing diazepam.

    c) 29 August 2022, when prescribing clonazepam.

Expert Opinion – Professor Edward Ogden

112. The Court obtained an independent expert opinion from Professor Edward Ogden (**Prof Ogden**), who is an addiction medicine consultant and specialist, and works part-time as a GP. The Court posed specific questions to Prof Ogden, which are referenced further below.

General comments on ADHD

113. Prof Ogden noted that Mr Ladd was diagnosed with ADHD (mixed inattentive and impulsive/hyperactivity subtype) in 2021. He noted that ADHD is a common neurodevelopmental disorder resulting from subtle differences in brain chemistry leading to dysregulation in attention, movement, and impulses. Individuals with ADHD often experience difficulties maintaining their attention unless highly interested, feel the need to move constantly, and may act impulsively without considering consequences. ADHD is typically managed with a combination of medication, coaching and counselling.

114. Prof Ogden explained that psychostimulants are typically the first-line treatment for ADHD due to their efficacy in managing core symptoms of inattention, hyperactivity and impulsivity.

The international consensus is that treatment should commence with a long-acting stimulant, given the reduced risk of misuse and diversion of short acting drugs. There is robust evidence that active treatment does not increase the risk of substance use disorders.

General comments on anxiety disorder

115. Prof Ogden noted that anxiety is normal and can be beneficial and improve performance, when the level of anxiety is consistent with the demands of the situation. Inappropriately high levels of anxiety can cause distress and disability; however, this can respond to treatment. Some people self-medicate with drugs or alcohol, which can lead to developing a substance use disorder.

116. ADHD and Social Anxiety Disorder (**SAD**) often co-occur. Children with ADHD receive a lot of criticism for their impulsivity and inattentiveness. This can cause social difficulties with peers and adults, increasing the risk of developing social anxiety.

117. Mr Ladd was diagnosed with generalised anxiety, especially SAD, which is an intense fear of social situations where a person may feel judged, embarrassed, or scrutinised by others. This fear often leads to avoidance of social interactions and can cause significant distress and impairment in daily functioning.

General comments on substance use disorder

118. Prof Ogden explained that people may initially use drugs out of curiosity, seeking to alter their state of consciousness or experience new sensations. However, those who develop drug-related problems often turn to substances as a coping mechanism. For many, drug use serves as a way to escape emotional pain, manage unresolved trauma, or alleviate symptoms of mental health disorders such as anxiety, depression, or post-traumatic stress disorder.

119. Repeated drug use leads to tolerance and dependence, two critical physiological processes. Tolerance develops when the body requires larger doses of the substance to achieve the same effect, while dependence arises when the absence of the drug triggers withdrawal symptoms, which can be both physically and mentally distressing. This combination of tolerance and dependence forms the core of addiction.

120. Once a person becomes dependent on drugs, they feel compelled to continue using them to relieve the discomfort of withdrawal. Even after a period of detoxification and sobriety, the power psychological association between drug use and relief from suffering remains. This

often drives individuals to seek out drugs during times of emotional or physical difficulty, perpetuating the cycle of addition.

General comments on prescribed medications

121. Prof Ogden provided a general explanation of the prescription drugs prescribed to Mr Ladd in the 12 months prior to his passing:

    a) Clonzaepam is a benzodiazepine tranquilliser. It is a potent drug with a half-life of 22 to 54 hours. It is subsidies on the PBS for the treatment of generalised epilepsy and myoclonic seizures. It is not subsidised as a treatment for anxiety, however it is often used for the management of anxiety and related conditions. It is also popular as an illicit drug due to its potency and long-duration of action.

    b) Diazepam is a benzodiazepine tranquiliser. It is rapidly absorbed, with peak levels reached within 30 to 90 minutes of ingestion, however, has a long half-life of 24 to 72 hours. while the risk of death from diazepam alone is low, especially at therapeutic doses, combining it with other sedatives greatly increases the risk of respiratory depression, which can be fatal.

    c) Lorazepam is a benzodiazepine with a rapid onset of action and medium duration of action with half the drug still present after 12 to 16 hours. It is not listed on the PBS, however it is registered for use in Australia for the treatment of anxiety and insomnia.

    d) Oxycodone is a synthetic opioid drug. It is like morphine in its action on the brain and is listed as a drug of addiction. It is indicated for the treatment of severe pain which does not respond to non-narcotic painkillers. Tolerance and physical dependence tend to develop upon repeated administration. There is a potential for abuse and for development of strong psychological dependence, especially in situations where pain could be treated with less addictive drugs.

    e) Tapentadol is a synthetic opioid drug. It is like morphine in its action on the brain and is listed as a drug of addiction. It is indicated for the treatment of severe pain not responding to non-narcotic painkillers. Tolerance and physical dependence tend to develop upon repeated administration. There is a potential for abuse and for development of strong psychological dependence, especially in situations where pain could be treated with less addictive drugs.

Whether additional clinicians/services should have been involved with Mr Ladd

122. Prof Ogden opined that Mr Ladd would have benefited from an integrated specialist addiction service comprising a multidisciplinary group of professionals who work together to address his complex and varied needs. The key components of an addiction service involves:

    a) Additional medicine or addiction psychiatrist specialist

    b) Nurse practitioner or nurse specialist

    c) Counselling from a psychologist, social worker, or alcohol and other drugs counsellor, according to need

    d) Peer support worker

123. Prof Ogden noted that in 2022, there was no such addiction service available in Mildura. Private practice clinicians are unable to provide for the complex and integrated care that Mr Ladd required. Prof Ogden noted that in 2020, Dr Wijekoon declined to further treat Mr Ladd, noting "*[m]y apologies for not taking on as his case is too complex to see in a private setting*".

124. A clinician at the Hader Clinic referred Mr Ladd to the Emotional Management Program at TMC due to his ongoing anxiety and emotional instability. His care was later taken over by Dr Sujeevan, who maintained regular contact with Mr Ladd via telehealth.

Communication between Mr Ladd's healthcare providers

125. Prof Ogden opined that the communication between Mr Ladd's healthcare providers was not unreasonable, given the challenges of the COVID-19 pandemic, and the additional strain placed on GPs and other clinicians. However, Prof Ogden noted that Mr Ladd's case management would have likely benefited from regular case discussion between the practitioners involved.

126. He explained that communication in medical practice is largely via written documents that are exchanged in isolation from interaction with the patient. There is usually no opportunity to share concerns or collaboratively discuss management. He opined that the referrals in Mr Ladd's case were very brief, however they were typical of the referrals he observes in his own practice.

Appropriateness of prescribing dexamphetamine

127. Prof Ogden noted that the choice of dexamphetamine for the treatment of ADHD is reasonable, however noted that given Mr Ladd's history of drug use, a long-acting stimulant may have been preferrable. He quoted the Australian Evidence-Based Clinical Practice Guidelines:

> *5.4.1 Methylphenidate or dexamphetamine or lisdexamphetamine should be offered as the first-line pharmacological treatment for people with ADHD, where ADHD symptoms are causing significant impairment.*
>
> *5.4.2 The decision to start with a short-acting or long-acting formulation should be based on clinical decision, together with the wishes of the person with ADHD, by considering the advantages and disadvantages of each. For example:*
>
> - *A short-acting formulation may be preferred when close monitoring is required*
> - *A long-acting formulation may be preferred for convenience, or when there is a medical contraindication.*
> - *Consideration of any potential cost implications.*

128. Prof Ogden noted Mr Ladd's history of substance use and prescription medication misuse. He referenced the International Consensus Statement for the Screening, Diagnosis, and Treatment of Adolescents with Concurrent ADHD and Substance Use Disorders (**SUD**), which advises:

> *26. Pharmacological treatment of ADHD requires careful titration and monitoring of its effect and possible adverse effects. Higher doses of psychostimulants may be required in patients with ADHD and concurrent SUD than in those without SUD for a favourable effect on both the ADHD symptoms and reduction of substance use.*
>
> *27. First-line pharmacotherapy of ADHD in adolescents with concurrent ADHD and SUD consists of long-acting psychostimulants (e.g., methylphenidate, lisdexamphetamine, dexamphetamine and mixed amphetamine salts). As second-line pharmacological treatments, atomoxetine, guanfacine XR [extended release] or bupropion can be considered.*

129. Prof Ogden opined that the dose of dexamphetamine chosen by Dr Sujeevan was relatively low. Typically, a person who has been using methylamphetamine needs a slightly higher dose

than usual until their brain shows some signs of recovery. In a review of the use of prescription stimulants for the treatment of stimulant use disorder, Prof Ogden noted research which found that prescription of stimulants in low doses had no effect on prolonged abstinence and that robust doses were required to promote abstinence.

Dr Webster's management of Mr Ladd in 2022

130. Prof Ogden opined that the ongoing prescription of benzodiazepines by Dr Webster was not unreasonable. Dr Webster's experience over time was that the benzodiazepines were the only medication that had been effective in treating Mr Ladd's anxiety.

131. Prof Ogden explained that benzodiazepines have well-established efficacy in treating anxiety. Like all medications, benzodiazepines have the potential for both harm and benefit. Even when taken at the recommended dosages, their use can lead to misuse, abuse, and both physical and psychological dependence. He noted the Royal Australian College of General Practitioners (**RACGP**) clinical guidelines states:

> *Rarely, ongoing therapy with benzodiazepines may be necessary in patients with severe, treatment-resistant anxiety. Although concerns have surrounded the risks of tolerance and SUD with long-term use of benzodiazepines, there is little evidence of tolerance to their anxiolytic effects. Problematic use is a risk in those with a history of SUD, but is otherwise uncommon.*

132. In November 2019, shortly prior to Mr Ladd's admission to RCAR, Dr Wijekoon increased the clonazepam dose. In Dr Sujeevan's statement to the Court, he explained that he did not support the use of clonazepam and stated:

> *Given his propensity to abuse prescription medication (Benzodiazepines and Analgesics), and the recent change of his General Practitioner, he was again discouraged from seeking prescriptions for Clonazepam (or any other Benzodiazepine) from different General Practitioners, and it was reiterated that according to my opinion he does not need these medications, such as Clonazepam, and should be practicing psychological techniques, including the breathing exercises he mentioned he was doing, and to increase his physical exercise.*

133. However, in November 2021, Prof Ogden noted that Dr Sujeevan was prescribing clonazepam 2mg and noted that this demonstrates the clinical tension between not wanting to prescribe

clonazepam for a person with a known tendency to misuse drugs, and the reality that Mr Ladd repeatedly reported that it improved his mental health.

Appropriateness of prescribing clonazepam by RPN McKinnon on 14 September 2022

134. Prof Ogden opined that RPN McKinnon's decision to prescribe 100 tablets of clonazepam with repeats was "*ill-judged*", particularly in circumstances where RPN McKinnon had not seen Mr Ladd for some time. Prof Ogden noted that RPN McKinnon should have accessed SafeScript to verify the current medications prescribed to Mr Ladd and to identify which doctors were treating him at the time.

135. If RPN McKinnon checked SafeScript, Prof Ogden opined that he would have recognised the need to contact Dr Sujeevan and/or Dr Webster to clarify Mr Ladd's medication regime at the time, as well to discuss as his treatment plan. If Dr Sujeevan and/or Dr Webster were unavailable, RPN McKinnon should have considered prescribing a controlled quantity of clonazepam, for example, 14 tablets to last one week, while he sought further clarification. Prof Ogden opined that this situation would apply to any healthcare professional prescribing for Mr Ladd in isolation from his wider treating team.

136. RPN McKinnon advised the Court that Mr Ladd told him that he had been "*discharged*" from his psychiatrist. If this were true, Prof Ogden opined that it would have been unethical for a practitioner to "*discharge*" a complex patient like Mr Ladd without making appropriate follow-up arrangements. RPN McKinnon stated that he was relying on Mr Ladd to provide a "*discharge summary*". However, Prog Ogden stated that it is not the patient's responsibility to provide a discharge summary, and the appropriate course of action would have been to obtain written consent and request communication directly from Dr Sujeevan.

137. Prof Ogden opined that the clonazepam prescription was inappropriate, in the absence of attempts to understand the clinical context, and the provision of the clonazepam tablets without reference to SafeScript or other prescribers.

Outline the appropriate considerations and actions that would have been appropriate for clinicians to take, in order to mitigate the risk posed by Mr Ladd's history of substance misuse

138. Prof Ogden made the following suggestions to regulate Mr Ladd's access to prescription medication:

    a) Avoiding the risk entirely by not prescribing drugs that can be used; or

b) Minimising access to large quantities of medication with daily, weekly or fortnightly dispensing, depending on the perception of risk (noting Dr Sujeevan did this for dexamphetamine prescriptions, however there is no evidence that Dr Webster or RPN McKinnon did same).

139. In addiction practice, Prof Ogden explained that it is common to have people pickup medications frequently to minimise the risk of having quantities of drugs on hand. For example, patients prescribed methadone may be required to collect their medication daily. Prof Ogden explained that this regular contact with pharmacists provides another layer of professional supervision. Prof Ogden noted that the pharmacist is an essential member of the healthcare team in his practice.

140. Prof Ogden opined that regardless of how the supply of Mr Ladd's medication was to be handled, communication with other professionals involved, including the pharmacist, would have added an important and additional layer of safety.

Use of SafeScript by clinicians

141. Prof Ogden noted that Dr Sujeevan and Dr Wishart appropriately referred to SafeScript on every occasion that they provided a monitored medication. However, Prof Ogden noted several instances where other clinicians did not comply with their requirement to check SafeScript, for example:

a) Dr Webster – did not check SafeScript on 26 April 2022 or 9 May 2022 when prescribing diazepam. Although not noted by Prof Ogden, Dr Webster also did not check SafeScript when prescribing clonazepam on 29 August 2022.

b) RPN McKinnon – did not check SafeScript on 14 September 2022 when prescribing clonazepam.

142. I note that there were other practitioners who did not check SafeScript, as noted earlier in this finding.

143. Prof Ogden emphasised that in order for SafeScript to achieve its aims, all practitioners including pharmacists, must check SafeScript each time they write or dispense a prescription for SafeScript monitored drugs.

144. Prof Ogden noted in his own practice, he regularly encounters patients with opioid use disorder who have rarely, if ever, had SafeScript checked before being prescribed opioids by

doctors. He regularly reminds clinicians of their obligations under the legislation, especially when assessing a new patient who is requesting a high-risk medication.

145. Prof Ogden noted that this is not a unique problem to Victoria, and suggested that the Medical Board of Australia, the Pharmacy Board of Australia, professional indemnity insurers and the professional colleges should take a lead role in ensuring national awareness of prescription-seeking behaviour. Additionally, he noted these bodies should take a lead role in reminding practitioners and pharmacists of their obligations to check SafeScript. Prof Ogden suggested that the Australian Commission on Safety and Quality in Health Care should consider making compliance with real-time prescription monitoring a standard to be assessed under the National General Practice Accreditation Scheme.

Natural justice/procedural fairness responses

146. As a matter of procedural fairness, the Court wrote to Dr Webster, Dr Sujeevan, RPN McKinnon and one other GP involved with a copy of Prof Ogden's report, and to provide an opportunity to respond to proposed adverse comments.

Response of GP who consulted with Mr Ladd on 20 July 2022

147. As noted above, Mr Ladd consulted with a GP at OMC on 20 July 2022 via telehealth and requested tapentadol for back pain. The GP explained that he was not comfortable prescribing tapentadol as he was not Mr Ladd's regular GP and it was a telehealth consultation. Given his report of back pain, the GP prescribed Codalgin (paracetamol and codeine), 20 tablets, with two repeats.

148. The GP explained that it is his usual practice to advise patients that are not his regular patients to make an appointment for an in-person consultation with their regular GP. With the passage of time, the GP was unable to explain why SafeScript did not record a check before he provided the prescription. The GP explained that "*SafeScript automatically opens in our software system when we create an e-prescription and so I am perplexed as to why there is no record of any check having been undertaken*".

149. I note in Coroner Ingrid Giles' recent finding into the death of death of Mr IKL, her Honour noted that the Department of Health have advised that simply viewing an automatic alert inside a doctor's clinical software is not a substitute for checking SafeScript itself.[11] The

[11] Finding into death without inquest – Mr IKL, 31.

Department of Health advised the Court that a clinician must still log onto SafeScript before prescribing a monitored drug. According to the Department of Health, clinicians are provided with education on this particular requirement and therefore should be aware that they must log onto SafeScript manually. This case (and others before this Court) demonstrates that not all clinicians are necessarily aware of this requirement. I therefore intend to recommend that the Department of Health implement an education campaign to remind clinicians of their obligations to independently check SafeScript, above and beyond the alerts that may exist in their clinical software.

Dr Webster's response

150. Solicitors acting on behalf of Dr Webster reiterated the challenges associated with working with a complex patient such as Mr Ladd and noted the additional complexities in a rural/regional GP practice. While Prof Ogden noted that Mr Ladd would have benefited from an integrated specialist addiction service, Dr Webster's solicitors reiterated that no such service existed in Mildura in 2022.

151. Dr Webster's solicitors noted Prof Ogden's opinion, namely, that the prescription of benzodiazepines was reasonable. Furthermore, the solicitors noted Dr Webster's experience that benzodiazepines were the only medications that appeared to be effective in treating Mr Ladd's anxiety. The solicitors noted various contemporaneous records which evidenced Dr Webster's awareness of the dangers of prescribing benzodiazepines, for example:

    a) On 26 April 2022, Dr Webster emphasised to Mr Ladd that the solution for anxiety is not medication. While medication has a role, the solution is behaviour change. Dr Webster told Mr Ladd about online and mobile phone programs that could assist with self-management. Dr Webster warned Mr Ladd about the dangers of tolerance, driving escalation of dose and dependence.

    b) On 16 May 2022, Dr Webster made a note in Mr Ladd's records that short-acting benzodiazepines were not appropriate. Dr Webster discussed the need for behaviour modification as a primary response to anxiety.

    c) On 18 August 2022, Dr Webster rejected short-acting benzodiazepines as a suitable medication for Mr Ladd and considered that long-acting benzodiazepines would be more appropriate. He prescribed clonazepam at a low dose with a plan to review and monitor Mr Ladd.

d) On 29 August 2022, Dr Webster prescribed Mr Ladd a higher dose of clonazepam as he was determined to transition Mr Ladd off diazepam onto clonazepam.

152. Notwithstanding Dr Webster's knowledge of the dangers associated with benzodiazepine use, Dr Webster has since completed 11 education modules via his medical indemnity insurer. Dr Webster's solicitors submitted that completion of these modules confirms that Dr Webster is committed to improving his practice.

153. Dr Webster's solicitors did not comment on the issue of him not checking SafeScript on 26 April, 9 May or 29 August 2022, and did not provide an explanation for same. They also did not provide any response to the concern that Mr Ladd was refilling his clonazepam scripts earlier than intended, indicating that he was using a higher that prescribed amount (5.45, 7.5, 2.5 tablets per day.

154. Dr Webster's solicitors concluded that Dr Webster recognised the difficulty in prescribing benzodiazepines to patients, especially when the patient is less inclined to explore non-pharmacological treatment options. He advised that he would continue to encourage patients like Mr Ladd to engage with non-pharmacogenic treatment options and will only prescribe benzodiazepines as a last resort.

155. Dr Webster's solicitors submitted that in all the circumstances, I should not make adverse comments regarding Dr Webster's care or management of Mr Ladd, nor find that his care and management may have contributed to the death.

156. I commend Dr Webster for proactively undertaking further education regarding safe opioid prescribing, the SafeScript system and prescribing principles, amongst other topics.

RPN McKinnon's response

Checking SafeScript

157. RPN McKinnon conceded that he did not check SafeScript itself and instead relied upon his clinical software (as discussed above). Based on Mr Ladd's history, RPN McKinnon explained that the clinical software would not have flagged Mr Ladd as high-risk, as there needed to be four or more prescribers or four or more pharmacies in a 90-day period. RPN McKinnon noted that his clinic has since had detailed conversations with the Department of Health and all staff are now aware that they must check the SafeScript website itself and not solely rely on their clinical software.

Prescription of clonazepam

158. In relation to the quantity of clonazepam prescribed, RPN McKinnon stated that he remained "*bewildered*" as he typically does not issue repeat prescriptions for benzodiazepines. RPN McKinnon submitted that this would be the only anomaly in his long history of prescribing medications. RPN McKinnon acknowledged Prof Ogden's view that the prescription was "*ill judged*" however submitted that the prescription on this occasion was an error, rather than a conscious judgment. RPN McKinnon further noted that the clonazepam detected in Mr Ladd's post-mortem samples was not elevated, so Mr Ladd may have been relatively compliant with his clonazepam dose at the time of his death.

159. RPN McKinnon further noted that the use of the term "*ill judged*" by Prof Ogden implies recklessness, which was not the case. RPN McKinnon submitted in the context of Mr Ladd's post-mortem toxicology results, the scripting error (adding repeats), Mr Ladd's assessed level of wellness, that Mr Ladd was not demonstrating signs of drug misuse and a history of effectiveness with clonazepam, this prescription was not, in fact, "*ill judged*".

160. I have no evidence to suggest that RPN McKinnon ordinarily prescribed clonazepam (or indeed other benzodiazepines) in the way he did on 14 September 2022. In those circumstances, it appears that this may have been an error, rather than evidence of ongoing inappropriate prescribing practices. RPN McKinnon submitted that such a conclusion creates a false narrative in relation to his usual practice, and it would be unfair and detrimental to his professional reputation to make such a comment. As noted above, there is no evidence that RPN McKinnon's prescribing on any other occasion was inappropriate or "*ill judged*", only that there was an error in prescribing on this occasion. In those circumstances, I make no adverse comment or conclusion in relation to RPN McKinnon's usual practice, as there is no evidence upon which to make such a conclusion. I also note that RPN McKinnon has clearly reflected upon this case deeply and takes his job very seriously.

161. However, even as an isolated error, RPN McKinnon's omission in checking SafeScript meant that he was unaware that Dr Webster prescribed clonazepam only eight days' earlier and prescribed more clonazepam. This also occurred in the context of Mr Ladd's last presentation to the clinic more than two years' prior. RPN McKinnon noted that he created a safe space for Mr Ladd to be open and frank, and he felt comfortable at the time to provide this prescription.

162. In response to Prof Ogden's view that the clonazepam prescription was "*inappropriate*" without reference to SafeScript or other prescribers, RPN McKinnon submitted that this "*sells*

short [his] historical knowledge of Mr Ladd, the treatment benefits that clonazepam held for Mr Ladd and the assessment of him at the time for which Prof Ogden was not present". Obviously, Prof Ogden was indeed not present at the time of the assessment. However, by not checking SafeScript, RPN McKinnon did not have the benefit of additional information that may have changed his assessment of Mr Ladd and consequently, may have impacted his prescription. I also note that RPN McKinnon had not seen Mr Ladd for more than two years and therefore did not have *recent* clinical information about Mr Ladd's presentation. I accept that he believed he had a good relationship with Mr Ladd, however, had not seen him for some time. While RPN McKinnon believed his prescription was appropriate given his assessment of Mr Ladd, his assessment was not informed by all available information and was therefore inherently limited.

163. In relation to staged supplies of medication (noting Dr Sujeevan used staged supplies), RPN McKinnon restated that his clinical assessment informed the decisions made in this case. He submitted:

> *You could random sample 100 prescribers and you may find different approaches to prescribing for all and including prescriber comfort in staging or limited medications. I have many colleagues who choose not to prescribe benzodiazepines, narcotic analgesics, psychostimulants in any amount, despite potential benefits that they may hold*".

164. As I have noted above, RPN McKinnon's clinical assessment was not as informed as it could (or should) have been, as he did not consult SafeScript.

Summary from psychiatrist

165. In relation to receipt of the summary from a psychiatrist, RPN McKinnon noted that Mr Ladd told him that he had this summary and would bring it to their next appointment. RPN McKinnon noted that Mr Ladd appeared to be forthcoming with this information and had no reason to believe he did not actually have such a document. RPN McKinnon noted that if Mr Ladd did not provide the letter in a subsequent appointment, he would have chased up the document himself.

Collaboration and use of an integrated specialist addiction service

166. RPN McKinnon agreed that a collaborative approach is the gold standard for complex patients like Mr Ladd. Aside from conversations with Mr Ladd's psychologist, parents and his first

psychiatrist (Dr Wijekoon), RPN McKinnon did not hear from any other clinicians. He opined that time impost and high service demands are the biggest detractor from comprehensive service provision in this space. He agreed that case discussion for Mr Ladd occurred in "*silos*" and agreed that shared care including case conferencing would be advantageous in complex cases.

167. RPN McKinnon agreed that there was no integrated specialist addiction service in Mildura in 2022. RPN McKinnon asserted that as Prof Ogden had not reviewed Mr Ladd personally, he may have discredited RPN McKinnon's personal and longer-term knowledge of Mr Ladd. RPN McKinnon explained that Mr Ladd told him he had ceased using recreational drugs about 12 months earlier and his life was getting on track. RPN McKinnon noted that he also saw Mr Ladd's partner as a patient and noted multiple positive achievements in their relationship.

168. In circumstances where RPN McKinnon did not believe Mr Ladd was using illicit substances, he submitted that an addiction service would not have accepted a referral for RPN McKinnon. He also noted such a service is voluntary and would have required Mr Ladd's consent. I agree and accept that such a service is voluntary, however I do not accept that Mr Ladd would have necessarily been turned away from such a service. While he may not have been using illicit substances, he had developed a dependency upon prescription medications, which could have been addressed through such a service. Ultimately, I cannot determine whether such a service would have accepted Mr Ladd and if so, whether it would have prevented the fatal incident. I therefore cannot take this issue any further.

<u>*Dr Sujeevan's response*</u>

Choice of ADHD medication and dose

169. Dr Sujeevan agreed with Prof Ogden that for patients with SUD and ADHD, long-acting preparations and methylphenidate are used first. In Mr Ladd's case, methylphenidate was trialled first, and Mr Ladd took up to 60mg per day, but found it becoming less effective over time. After this trial, in January 2022, Dr Sujeevan discussed long-acting preparations with Mr Ladd including Concerta and methylphenidate-LA or lisdexamphetamine. Mr Ladd opted to trial Concerta, then changed his mind and requested methylphenidate. Dexamphetamine became the last choice, after all other long-acting preparations had been considered/trialled.

170. Dr Sujeevan agreed with Prof Ogden that higher doses are generally more effective in patients with a history of methamphetamine use. However, he noted that Mr Ladd's history of

methamphetamine use was from 2019 to 2021 and he was abstinent from same at the time of his treatment for ADHD.

171. In my view, this issue does not require further investigation as the prescription of dexamphetamine did not directly cause or contribute to the death.

Prescribing large quantities/Mr Ladd having access to large quantities of ADHD medication

172. Dr Sujeevan acknowledged my concerns that multiple clinicians who treated Mr Ladd were prescribing medication in large quantities and/or earlier than indicated, which may have contributed to the death. Dr Sujeevan noted at the time of prescribing, he was basing his decision-making on the information before him and Mr Ladd's reported symptoms.

173. In relation to the prescription on 6 May 2022, which was first prescription for dexamphetamine 5mg, twice a day, fortnightly pickup, 100 tablets, no repeats, Dr Sujeevan provided further context. He explained that dexamphetamine prescriptions were initially commenced at a low dose of 5mg (noting maximum dose of 40mg per day). As per his usual practice, Dr Sujeevan stated that he had a discussion with Mr Ladd about increasing the dose gradually, however acknowledged he did not record this in his notes. He explained that it was not unusual or unexpected that Mr Ladd reported increasing the dose to 30mg per day and finding this more effective. 30mg was still less than the recommended maximum dose. Therefore, Dr Sujeevan stated he would have agreed for him to continue at this dose.

174. If Mr Ladd was taking up to six tablets per day, a prescription of 100 tablets would have lasted much less than 50 days (~16 days). I accept that while Dr Sujeevan did not record Mr Ladd's need to gradually increase his dose, this likely explains why Mr Ladd was taking more than was initially prescribed. However, even at six tablets per day, the 6 May script should have lasted about 16 days. It remains unclear why a new prescription was issued seven days later (less than half the time the script should have lasted).

Script issued on 13 May 2022

175. Dr Sujeevan noted the prescription on 13 May 2022 was 5mg, twice daily, fortnightly pickup, 200 tablets, one repeat, however he believed 5mg was likely an error, noting that Mr Ladd was using 10mg to 15mg twice per day (i.e. 20mg to 30mg per day). Dr Sujeevan therefore prescribed 200 x 5mg tablets with one repeat on 13 May 2022, on the basis it would last 33 days.

176. Mr Ladd filled the repeat prescription on 17 June 2022, which equated to a maximum of 5.7 tablets per day. This is less than Dr Sujeevan's maximum dose of six tablets per day. I accept Dr Sujeevan's explanation that in the context of Mr Ladd taking up to six tablets per day, he appeared to be using his medication appropriately during this time. I make no adverse finding or criticism in relation to this prescription.

Prescriptions filled 12 July, 2 and 9 August 2022

177. Dr Sujeevan agreed with my calculations for the patterns of subsequent filling of prescriptions equating to the use of 8, 9.5 and 7.4 tablets per day, respectively. With the benefit of hindsight, Dr Sujeevan conceded that he could have calculated the use of medication at each appointment and clarified again if Mr Ladd had any medications left from the previous prescription. He also could have contacted the pharmacy for clarification of the medication that had been dispensed.

178. Nevertheless, while Dr Sujeevan noted the prescription quantity was high, the dispensation was limited, as he advised the pharmacy to dispense medication weekly or fortnightly. He noted that the pharmacy usually contacts the prescriber (and he would do the same) if the patient is requesting refills more frequently. He noted that frequent filling of prescriptions is noticeable when checking SafeScript.

Lost prescriptions and medication

179. In correspondence to Dr Sujeevan, the Court communicated my preliminary views/concerns about lost prescriptions and medication. Dr Sujeevan clarified that in his statement dated 9 May 2024, he stated that on 14 September 2022, Mr Ladd requested an early prescription for dexamphetamine and that he had lost the remaining medication. In the 9 May 2024 statement, Dr Sujeevan explained that this was the first time that Mr Ladd had reported to him that he had *lost his medication.* Dr Sujeevan explained that he was trying to convey that this was the first time that Mr Ladd reported losing *medication* that had been dispensed to him.

180. Dr Sujeevan acknowledged that Mr Ladd had reported losing his mobile phone which contained a copy of the *e-script* (not the medication itself) dated 5 July 2022. He requested another script, which Dr Sujeevan issued after checking SafeScript and noted that the 5 July 2022 prescription had never been dispensed.

181. Dr Sujeevan explained that he issued the script on 14 September 2022 (instead of refusing the script) as Mr Ladd said he was employed and he found the medication helped him to get on

top of his tasks, prioritise and be organised. However, he imposed further restrictions on dispensing (moving to weekly dispensing). I accept there is a difference between losing a script and losing medication itself and make no adverse comment or criticism about same.

Benzodiazepine prescriptions

182. Dr Sujeevan noted that his prescription of clonazepam in November 2021 was part of a reduction regime agreed upon when Mr Ladd was discharged from hospital, as Dr Sujeevan was not comfortable prescribing him benzodiazepines. He noted that the reason for not continuing clonazepam was not because it was not effective or because Mr Ladd did not have anxiety, but because it was hard to prescribe and monitor benzodiazepines with Mr Ladd. The main risk was Mr Ladd taking higher than prescribed doses and Dr Sujeevan encouraged Mr Ladd to consider other strategies such as exercising.

183. Given these concerns, Dr Sujeevan regularly asked Mr Ladd about his use of benzodiazepines during their appointments. If Mr Ladd had obtained benzodiazepines from multiple different doctors/pharmacies, this would have been flagged on SafeScript, of which there were no such alerts. Dr Sujeevan noted that he repeatedly advised Mr Ladd to continue to see one GP and have one main prescriber, rather than multiple prescribers. If there was evidence of regular benzodiazepine prescriptions or higher doses of same, he would have contacted the GP directly to discuss the risks.

Multidisciplinary approach to treatment and collaboration with other clinicians

184. Dr Sujeevan agreed with Prof Ogden that a multidisciplinary approach is the most effective strategy in managing alcohol and SUD. Mr Ladd changed his GP in the months before his death and once he had established a relationship with that GP, Dr Sujeevan would have communicated with the GP directly (with Mr Ladd's consent). Dr Sujeevan accepted that he should have communicated with Mr Ladd's psychologist, for optimal care.

185. Dr Sujeevan noted that Mr Ladd's mother was invited to participate in reviews, to share her concerns and provide collateral information. Dr Sujeevan's records indicate this occurred on at least two occasions. Dr Sujeevan also appropriately communicated with Mr Ladd's pharmacy to ensure safe dispensation of medication.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Harrison William Ladd, born 6 July 1997;

b) the death occurred on 23 September 2022 at 506 San Mateo Avenue, Mildura Victoria 3500, from combined drug toxicity; and

c) the death occurred in the circumstances described above.

187. Having considered all of the circumstances, I am satisfied that his death was the unintended consequence of the deliberate ingestion of drugs. I note that Mr Ladd was only prescribed clonazepam and dexamphetamine at the time of his death, however, was previously prescribed diazepam (May 2022) and codeine (July 2022). It is unclear whether he was using his old prescriptions at the time of his death, or whether he sourced these drugs elsewhere. There is no evidence to suggest that Mr Ladd had a cold/flu at the time of his death, so it is unclear why he was using pholcodine (other than in circumstances where he was misusing it).

188. Although Mr Ladd would have benefited from a multidisciplinary approach to care, with coordination from all his treating clinicians, unfortunately this did not occur for various reasons. While Mr Ladd was not 'doctor shopping' in the traditional sense, it appears he was still using more prescription medication than he was prescribed, and regularly refilled prescriptions earlier than indicated. Due to the variable compliance of clinicians checking SafeScript, it does not appear that any clinicians were aware that Mr Ladd was using more of his prescription medication than prescribed.

189. Despite some identified deficiencies and issues in the treatment Mr Ladd received prior to his death, I am not satisfied to the requisite standard that the treatment he received directly caused or contributed to the death. I note that Mr Ladd appeared to be using prescription and over-the-counter medication that was not prescribed to him at the time of his death (codeine, pholcodine, diazepam). I cannot determine whether the codeine and diazepam were sourced via older prescriptions (noting he had older prescriptions for same) or if they were obtained illicitly. There is no evidence that Mr Ladd's treating clinicians were aware that he was misusing additional prescription medication and, in those circumstances, I am not satisfied to the requisite standard that Mr Ladd's death was preventable.

COMMENTS

190. Pursuant to section 67(3) of the Act, I make the following comments:

a) Although some of Mr Ladd's healthcare practitioners made attempts to restrict the quantity of medication he was prescribed, it is clear that Mr Ladd was still obtaining scripts earlier than indicated, and therefore potentially using more than the recommended/prescribed daily dose. It appears he was also using over the counter medications and did not advise his treating clinicians of same.

b) This case is a tragic and timely reminder that while SafeScript can provide prescribing clinicians and dispensing pharmacists with critical information, it is only effective if *all* clinicians comply with their requirements. I intend to direct a copy of this finding be provided to the Department of Health, for their consideration.

RECOMMENDATIONS

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

(i) That the **Department of Health** implement an education campaign to remind clinicians of their obligations to independently check SafeScript, above and beyond the alerts that may exist in their clinical software.

I convey my sincere condolences to Mr Ladd's family for their loss.

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.

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

Steven & Kristen Ladd, Senior Next of Kin (C/- Ryan Legal)

Department of Health

GP

Dr Philip Webster (C/- Wotton + Kearney)

Dr Sinnatamby Sujeevan (C/- Avant Law)

RPN Brett McKinnon

First Constable Shaylyn Ryan, Coronial Investigator

Signature:

Coroner Kate Despot

Date: 17 April 2026

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.