IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005192

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Mr IKL[1]
Date of birth:	[redacted] 1994
Date of death:	Between 14 and 17 September 2023
Cause of death:	1(a) Mixed drug toxicity (gabapentin, codeine, diazepam, oxycodone, doxylamine, promethazine, zolpidem) Contributing factor(s) 2 Cardiac hypertrophy
Place of death:	[redacted], Melbourne, Victoria 3066
Keywords:	Doctor-patient relationship, transgression of sexual boundaries, inappropriate prescribing, SafeScript, Schedule 8 permits, drug dependency, LGBTIQA+ health, Ahpra referral

[1] I have elected to de-identify this finding prior to publication on the Court's website, for those reasons outlined in 'Directions and Orders' at the conclusion of this finding.

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INTRODUCTION

1. On 17 September 2023, Mr IKL (a pseudonym) was 29 years old when he was found deceased at his home in circumstances suggestive of a drug overdose.

2. At the time of his death, Mr IKL lived with a roommate in [redacted], a suburb in Melbourne, Victoria. He worked at [redacted] and was studying paramedicine at university.

3. Mr IKL grew up with his parents and his brother in New South Wales (**NSW**). His brother described Mr IKL as a fun and energetic boy when he was a child. He was very popular at school and enjoyed socialising at parties. He loved soccer and playing video games with his brother, and both played musical instruments.

4. After leaving a challenging workplace environment, Mr IKL struggled to find another job in NSW, so he found a new job in Melbourne, and decided to move there in October 2019. He moved in with a roommate whom he admired as an older brother-figure.

5. Mr IKL struggled with the COVID-19 lockdowns in Victoria and was frustrated that he had moved to Melbourne but was unable to experience everything the city had to offer.

6. Upon relocating to Victoria, Mr IKL engaged with a new General Practitioner (**GP**) and was prescribed a number of medications, including Schedule 4 and Schedule 8 medications (opioids, benzodiazepines and others). Evidence indicates that, over time, Mr IKL became addicted to these medications. The circumstances in which this occurred have been thoroughly investigated and will be addressed in detail later in this finding.

7. Mr IKL's family was initially unaware of any medication-related issues that Mr IKL was experiencing. In October 2022, Mr IKL's brother received a frantic phone call from his parents, stating that Mr IKL called them and appeared disoriented, before hanging up. When Mr IKL's brother eventually reached him by phone, Mr IKL said that their parents were merely overreacting and that he took some painkillers due to sciatic leg and back pain. Mr IKL's brother reported that he had "*a very frank discussion*" about the quantity of painkillers Mr IKL was taking and suggested that he should try physiotherapy or other non-pharmaceutical options.

8. Mr IKL's family last spoke with him on 13 September 2023. His father noted that he "*wasn't one hundred percent, but he was ok*".

THE CORONIAL INVESTIGATION

9. Mr IKL'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.

10. 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.

11. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

12. Victoria Police assigned an officer, Senior Constable Ciaron Connolly, to be the Coronial Investigator for the investigation of Mr IKL's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses such as family, the forensic pathologist, treating clinicians and investigating officers.

13. The Coronial Investigator also provided me with a copy of records contained on Mr IKL's mobile phone which included SMS and WhatsApp messages between Mr IKL and General Practitioner (**GP**), Dr X (a pseudonym), the Clinical Director of [redacted] (**the Medical Centre**). The original coronial brief comprising such materials was provided to the Court on 12 September 2024.

14. Following a review of the original coronial brief, I requested Mr IKL's medical records from the Medical Centre be obtained. These were submitted on 9 October 2024, and I determined pursuant to s115(7) of the Act that they were to be included as part of the coronial brief.

15. I also requested additional materials be obtained by the Coronial Investigator. These included a supplementary statement from Dr Y (a pseudonym) of the Medical Centre, and statements from Mr IKL's psychologist and his former roommate. I determined that these materials were also to be included as part of the coronial brief.

16. Following a review of all available evidence, I subsequently determined to seek advice from the Coroners Prevention Unit (**CPU**)[2] as to appropriateness of the care and treatment provided by Dr X and Dr Y to Mr IKL from 19 May 2020 until Mr IKL's death, which occurred between 14 and 17 September 2023.

17. In October 2024, having identified some issues of serious concern in the materials before me, I sought confirmation from Victoria Police as to whether there was intended to be a criminal investigation in relation to the circumstances of Mr IKL's death. Victoria Police advised that it was considering whether further investigations may be necessary in regard to any issues of potential criminality. In light of this position, I determined to place my investigation on hold.

18. On 17 February 2025, having liaised with Medicare investigators, Victoria Police confirmed there was no ongoing criminal investigation in relation to the circumstances of Mr IKL's death. As such, I determined that it was appropriate to resume to my investigation.

19. I determined to seek a statement from Dr X to respond to specific questions related to the appropriateness of care provided to Mr IKL, including a number of questions related to his prescribing practices.

20. This statement was requested on 18 February 2025 pursuant to section 42 of the Act, with information provided in a cover letter of the same date as to the relevant process by which Dr X could file an application to become an Interested Party or to receive a copy of coronial documents relevant to the investigation. I note that no such application was received prior to Dr X filing a statement dated 28 March 2025 via his medical indemnity insurer.

21. Following the receipt of Dr X's statement, the CPU conducted a full review of all available evidence and provided me with advice, as discussed further below.

22. This finding draws on the totality of the coronial investigation into the death of Mr IKL, including evidence contained in the coronial brief and advice from CPU. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or

[2] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

23. Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.[4]

24. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[5] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[6]

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

Circumstances in which the death occurred

25. Mr IKL first attended the Medical Centre on 19 May 2020. He was seen on this date by General Practitioner (**GP**), Dr X, who is also the owner and operator of this practice.[7]

26. Medical records in relation to this visit do not indicate any "*Reason for visit*." However, it appears that Dr X undertook the following actions:

    a) Conducted an assessment of Mr IKL's mental state using the Kessler Psychological Distress Scale (**K10**);

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[3] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[4] *See generally in this regard Briginshaw v Briginshaw* (1938) 60 CLR 336, 361-363 per Dixon J.; *Adamczak v Alsco Pty Ltd (No 4)* [2019] FCCA 7 at [80]; and *Chief Commissioner of Police (Vic) v Hallenstein* [1996] 2 VR 1, [19-20].

[5] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.

[6] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

[7] Dr X was first registered as a Medical Practitioner in 2004 and became a Fellow of the Royal Australian College of General Practitioners (**RACGP**) in 2012. In addition to his specialisation in General Practice, Dr X trained in [redacted] for five years with [redacted]. According to his statement dated 28 March 2025, Dr X subsequently determined to transition from [redacted] specialisation to General Practice "*in order to provide a more holistic and broad-based approach to patient care*."

b) Prepared a GP Mental Health Treatment Plan (**Mental Health Plan**);

c) Prepared a letter of referral to a psychologist;

d) Prescribed the antidepressant agomelatine; and

e) Requested an asymptomatic sexually transmitted infection (**STI**) screen.

27. The Mental Health Plan prepared on this date recorded:

a) Problems/Diagnoses: Adjustment Disorder;

b) Goals: *"improved self awareness; improves distress tolerance; improved sense of core values"*; and

c) Plan: "*dynamically-informed therapy of psychologists chosen modalities; Valdoxan 25mg nocte.*"

28. While a copy of the referral letter from Dr X does not appear in the Medical Centre records, the psychologist indicated in her statement, "*The referring problem was issues with identity and self-worth and self-esteem following a recent relationship breakup*."

29. Over the following six months, Mr IKL presented to Dr X on 21 July 2020, 3 August 2020, and 2 November 2020. The reasons for these visits were recorded as HIV prophylaxis, GP Mental Health Care Plan review, COVID-19 testing, and weight reduction management.

30. On the basis of WhatsApp messages contained on Mr IKL's phone, it appears that a personal relationship commenced between Mr IKL and Dr X by at least 12 November 2020, on which date Dr X sent Mr IKL a message reading, "*Boo*," which was followed by a photo of himself. Mr IKL responded, "*There ya are sexy fella! Haha,*" and sent a photo of himself in return. In a subsequent WhatsApp message exchange throughout that evening, Dr X and Mr IKL discussed the nature of their relationship and indicated they were both interested in an ongoing sexual dynamic but were not, at that stage, interested in a romantic relationship.

31. During this conversation, Dr X acknowledged a "*need to be careful*" due to the nature of their dynamic and Mr IKL expressed a desire to keep their relationship "*separate from work*." An extract of this conversation is below:

Mr IKL: I still can't believe this is happening hahaha
Mr IKL: I totally thought you were out of my league majorly lol

Dr X: Not at all.

Dr X: But we need to be careful…

Dr X: I do not want to hurt you

Dr X: That would be unbearable and wrong

Mr IKL: Yeah totally get it ay! I was thinking the same thing!

Mr IKL: We might have to discuss haha

Dr X: Exactly

Dr X: Being attracted to each other is one thing.

Mr IKL: Exactly!

Dr X: Not respecting each other is totally something else.

Mr IKL: Yeah 100% agree… communication is key and boundaries

Dr X: Yep

Dr X: Exactly

Mr IKL: And keeping things separate from work will be good

Dr X: That's where the waters muddy

Mr IKL: How so!?

Dr X: Like as in that's where it can leave people in trouble

Dr X: Patients hurt and confused

Dr X: Not knowing where to go.

32. From this date onwards, Mr IKL and Dr X continued to engage in an ongoing personal and sexual relationship as evidenced by available WhatsApp and SMS messages. While the relationship was characterised by regular "*sexting*",[8] exchanges of intimate images and references to in-person sexual encounters, Mr IKL also soon appeared to express an emotional dependency towards Dr X, writing on 31 December 2020, "*I love you daddy,*" and on 2 January 2021, "*You do realise I would literally do anything for ya ay! ...*".[9]

33. Mr IKL and Dr X's personal and sexual relationship appears to have continued until the time of Mr IKL's death, with their last recorded message exchange via WhatsApp message on 14 September 2023. It appears from the available communications that a sexual dynamic existed in which Dr X regularly engaged in acts that involved inflicting pain and injury upon Mr IKL for the purposes of sexual gratification. The acts engaged in were of such a nature that Mr

[8] Defined by the Victorian Government as follows: "'Sexting' ... is the sharing of a sexually explicit picture or video via mobile phones, instant messaging apps, and/or social media sites." https://www.vic.gov.au/sexting

[9] I note that in a statement to the Court from a close friend of Mr IKL's, it was stated that Mr IKL reported that he had strong feelings for Dr X but that Dr X was not interested in a serious relationship.

IKL regularly requested from Dr X, and was provided with, analgesics and anaesthetics in order to withstand the pain involved. On the basis of available messages, it appears that Mr IKL expressed an enthusiastic attitude to Dr X in relation to sexual acts involving the infliction of pain and injury, and there is no suggestion that he was not agreeing to engage in such acts. However, I note that it is not possible in retrospect to ascertain Mr IKL's state of mind at the relevant time, or any factors related to power dynamics which may have contributed to such agreement.

34. Throughout the almost three-year period in which Mr IKL and Dr X maintained a personal and sexual relationship, Mr IKL remained a patient at the Medical Centre with Dr X providing care and management to Mr IKL until at least July 2023, three months prior to his death, when Mr IKL's care was transferred, at least temporarily, to Dr Y. However, Dr X still prescribed medication to Mr IKL in the month prior to his death.

35. In a statement to the Court, which omitted any reference to the personal or sexual relationship Dr X had engaged in with his patient, Dr X indicated that throughout this period, he provided Mr IKL with "*medical and psychological treatment and support across multiple domains, addressing both chronic and acute conditions as they arose.*" He further stated, "*The primary medical concerns that I managed for [Mr IKL] included Generalized Anxiety Disorder (GAD), chronic low back pain with radiculopathy (nerve pain and weakness), persistent insomnia, and recurring dental pain from impacted wisdom teeth. Additionally, I treated [Mr IKL] for various acute illnesses, including respiratory infections and dermatological conditions*."

36. Dr X commenced Mr IKL on a wide range of medications, including escalating doses of several drugs of dependence including both oxazepam and controlled release oxycodone. From 19 May 2020 to 19 July 2023, Dr X prescribed agomelatine, tenofovir/emtricitabine, Panadeine Extra, oxazepam, mirtazapine, phentermine, venlafaxine, Panadeine Forte, cefalexin, oxycodone, Codral Original Day & Night, doxycycline, Elidel 1% cream, melatonin, Advantan 0.1% fatty ointment, fluconazole, clarithromycin, zolpidem, sildenafil, oxycontin slow release, lorazepam, prednisolone, suvorexant, pregabalin, tapentadol, gabapentin, duloxetine, nitrazepam, quetiapine, promethazine, and roxithromycin. Dr Y started prescribing to Mr IKL from 24 July 2023, however Dr X provided one further script for oxazepam on 1 August 2023.

37. Evidence contained in SMS and WhatsApp messages indicates that Dr X repeatedly prescribed and/or used medications, including Schedule 8 and Schedule 4 drugs, without a therapeutic purpose, including:

    a) In response to requests from Mr IKL made outside of a professional context, via WhatsApp or SMS message, without establishing a therapeutic basis (*see, for example*, the transcript of SMS messages at pages 491-494, 606-608, and 669-673; and the transcript of WhatsApp messages at pages 885-886, and 1315-1316); and

    b) For the purposes of managing pain associated with previous and/or planned sexual acts involving Dr X and Mr IKL, including:

        i. Analgesics (*see, for example*, the transcript of SMS messages at pages 591, 606-608, and 819-820, the transcript of WhatsApp messages at pages 1315-1316); and

        ii. Anaesthetics (*see, for example*, the transcript of WhatsApp messages at pages 2248 and 2815).

38. From approximately December 2022 onwards, Dr X expressed to Mr IKL on several occasions that he was reluctant to continue both to provide medical care to Mr IKL and to progress their personal and sexual relationship. In approximately May 2023, Dr X presented Mr IKL with an ultimatum to select which of these two relationships he wished to continue. For example, on 4 June 2023 in response to a request from Mr IKL to "*catch up for dinner chat*," Dr X responded, "*If I am still prescribing medication for you then no. Enough of the middle ground*." It appears from the available messages that both Dr X and Mr IKL subsequently agreed that Mr IKL would transition to receiving clinical care from another practitioner at the Medical Centre, Dr Y, and they would continue their personal and sexual relationship.

39. Throughout these exchanges, Dr X repeatedly expressed an expectation that if discovered, his conduct would result in the end of his career, stating for example on 25 March 2023, *"... You are also right ... there's so much at stake. If anyone suspected anything, it would be a mandatory report. Which means game over for me*." Dr X also appeared to express a clear understanding that another clinician would not continue the approach he had taken in his prescribing practices, stating on 15 December 2022, in relation to the prospect of Mr IKL moving to another doctor, "*Kiss goodbye to painkillers though*."

40. From 24 July 2023, Mr IKL started consulting with Dr Y at the Medical Centre. According to the Medical Centre records, Mr IKL only presented to Dr X once more after this date on 1 August 2023 for the purposes of reviewing a prescription for oxazepam (as noted above). No other notes are recorded in the medical records in relation to this visit, although WhatsApp messages indicate the appointment was requested by Mr IKL via personal message.

41. Mr IKL presented to Dr Y a total of seven times in the period from 24 July 2023 until his death in September 2023. During his first appointment on 24 July 2023, Dr Y recorded that Mr IKL reported that he had "*lost oxycontin in ED – needs repeat … unsure if has lost his duloxetine repeats – too soon for another authority script*." Dr Y provided Mr IKL with a prescription for oxycontin and advised him to return in one week if he was unable to find the repeat script for duloxetine, noting "*can re-issue from first week of august*".

42. Over the following months, Dr Y continued to provide care and treatment, with the reasons for Mr IKL's visits recorded as including review, pneumonia (community-acquired), generalised anxiety disorder, sleep disorder, script, and Upper Respiratory Tract Infection.

43. On 11 September 2023, Mr IKL presented with an Upper Respiratory Tract Infection and to receive scripts for his regular medications. The following day, on 12 September 2023, Mr IKL again presented to Dr Y as he "*forgot to get some repeat scripts yesterday*" and was prescribed further medications.

44. At the time of his death, Mr IKL's current medications were recorded in his medical records as follows:

    a) Duloxetine 30mg one capsule per day (evening);

    b) Elidel 1% cream for atopic dermatitis;

    c) Endone (oxycodone) 5mg, one to two tablets, four times a day as needed for strong pain;

    d) Gabapentin 300mg two tablets, twice per day;

    e) Melatonin 5mg one tablet before bed for sleep disorder;

    f) Mirtazapine 15mg one tablet before bed for generalised anxiety disorder;

    g) Oxazepam 30mg one to two tablets daily as needed;

h) Oxycontin (oxycodone) 20mg slow release one tablet as needed for low back pain;

i) Panadeine Forte (codeine and paracetamol) 500mg/30mg two tablets four times a day as needed for strong pain;

j) Phenergan 25mg one table before bed for sleep disorder;

k) Quetia (quetiapine) extended release 25mg one tablet before bed;

l) Roxithromycin 300mg one tablet daily;

m) Tenofovir/emtricitabine one tablet daily for pre-exposure prophylaxis (**PrEP**) against HIV;

n) Viagra (sildenafil) 100mg one tablet as needed; and

o) Zolpidem 10mg one tablet before bed.

45. Of note is that many of these drugs were prescribed without a clinical indication for same in the medical records, including zolpidem, roxithromycin, quetiapine, oxazepam, gabapentin, and duloxetine.

Circumstances immediately preceding death

46. Mr IKL's roommate, Mr PXM (a pseudonym), last saw him alive on 14 September 2023. Mr PXM told Mr IKL that their rent was due on 15 September 2023. Mr IKL replied, "*I am on it*". Mr PXM noted it was not unusual for him not to see Mr IKL often due to his busy schedule between work and university. Mr PXM reported that Mr IKL spent a lot of time in his room studying.

47. Mr IKL's last WhatsApp message with Dr X occurred on 14 September 2023 and appeared to be in relation to upcoming sexual contact between the pair. The message was 'read' by Dr X, but not responded to.

48. On 17 September 2023, Mr IKL's former roommate and friend, Mr OPL (a pseudonym), contacted Mr IKL's brother as Mr IKL had not responded to his text messages. Mr OPL also contacted Mr PXM, Mr IKL's roommate, out of his concern for Mr IKL. Mr IKL's brother contacted Mr PXM, who in turn entered Mr IKL's bedroom and located him unresponsive on his bed. Mr PXM immediately called '000' and awaited the attendance of emergency services.

49. Ambulance Victoria (**AV**) paramedics attended Mr IKL's home and confirmed he was deceased. Paramedics did not attempt resuscitation as it was clear that Mr IKL had been deceased for some time.

50. Victoria Police members also attended the scene and located multiple packets and blister packs of prescription medication in Mr IKL's room. Police did not identify any suspicious circumstances or evidence of intent (e.g. a suicide note) in connection with Mr IKL's death.

Identity of the deceased

51. On 22 September 2023, Mr IKL, born [redacted] 1994, was visually identified by his sister-in-law.

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

Medical cause of death

53. Forensic Pathologist Dr Yeliena Baber (**Dr Baber**), from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 20 September 2023 and provided a written report of her findings dated 3 April 2024.

54. Dr Baber explained that the death was due to mixed drug toxicity (gabapentin, codeine, diazepam, oxycodone, doxylamine, promethazine, zolpidem). She also noted at autopsy that the heart was enlarged at 420g. According to published data, the expected heart weight for a man of this age, weight and height should be 364g.

55. Dr Baber explained that cardiac hypertrophy refers to increased weight of the heart, which can have severe functional implications and eventually result in dysfunction of the heart muscle, causing cell damage and fibrosis. Fibrosis, in turn, alters the electroconductive properties of the heart, which can cause cardiac arrhythmias, sometimes fatal. Amongst the most common causes of cardiac hypertrophy are hypertension and ischaemic heart disease; other causes include valvular diseases, storage and infiltrative disease, systemic disorders and primary disease of the heart muscle (cardiomyopathies).

56. The autopsy also showed features suggestive of congestive cardiac failure, with a pericardial effusion (fluid within the sac that surrounds the heart) and bilateral pleural effusions (fluid within the lung cavities).

57. Histological testing confirmed the macroscopic findings above. However, it did not reveal any natural disease of a degree that may have caused or contributed to death.

58. Toxicological analysis of post-mortem samples identified the presence of gabapentin[10], codeine and its metabolite morphine,[11] oxycodone,[12] diazepam and its metabolite nordiazepam,[13] oxazepam,[14] zolpidem,[15] mirtazapine,[16] duloxetine,[17] quetiapine,[18] ketamine,[19] doxylamine,[20] promethazine,[21] and paracetamol.[22]

59. Dr Baber noted that gabapentin, in particular, was detected at an elevated concentration. She explained that this, in combination with the presence of multiple other drugs that also depress the central nervous system (codeine, diazepam, oxycodone, doxylamine, promethazine, zolpidem) can cause synergistic central nervous system sedation and respiratory depression. Further, she noted that ketamine and quetiapine are known to cause cardiac arrhythmias.

60. Dr Baber provided an opinion that the medical cause of death was *1(a) Mixed drug toxicity (gabapentin, codeine, diazepam, oxycodone, doxylamine, promethazine, zolpidem)* with *2. Cardiac hypertrophy*.

61. I accept Dr Baber's opinion.

CPU REVIEW – DR X

62. Taking into account the evidence available, I determined to seek advice from the Coroners Prevention Unit (**CPU**) with regard to the appropriateness of care and treatment provided by Dr X and Dr Y to Mr IKL from 19 May 2020 until Mr IKL's death, which occurred sometime between 14 and 17 September 2023.

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[10] Gabapentin is clinically used for treatment of partial seizures and neuropathic pain.
[11] Codeine is an opiate found in opium isolated from the plant *Papaver somniferum*. It is indicated as an effective antitussive and antidiarrheal agent.
[12] Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine used clinically to treat moderate to severe pain.
[13] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.
[14] Oxazepam is a benzodiazepine indicated for anxiety. It may also be used in the management of alcohol withdrawal symptoms.
[15] Zolpidem is used as a hypnotic agent.
[16] Mirtazapine is indicated for the treatment of depression.
[17] Duloxetine is a serotonin and noradrenaline reuptake inhibitor indicated for major depression, generalised anxiety disorder, and diabetic neuropathic pain.
[18] Quetiapine is an atypical antipsychotic agent.
[19] Ketamine is an anaesthetic normally used for short and medium duration operations as an induction agent.
[20] Doxylamine is an antihistamine agent and sleep-inducing agent.
[21] Promethazine is an antihistamine.
[22] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene.

63. The CPU reviewed the available materials and identified a number of serious issues in regard to care provided by Dr X. These related to:

a) Dr X continuing to provide treatment to Mr IKL in the context of a personal and sexual relationship, including specific concerns related to:

i. Prescribing medications including drugs of dependence;

ii. Providing medical advice and management outside of a professional context, including through private text message conversations.

b) Dr X's record-keeping practices, including particular concerns related to:

i. Providing medical advice and management outside of a professional context, including through private text message conversations;

ii. Prescribing medications including Schedule 8 and Schedule 4 drugs on some occasions without recording notes regarding the consultation including any therapeutic justification for the prescriptions provided;

c) Dr X's prescribing practices, including particular concerns related to:

i. Prescribing drugs contrary to what most prescribers would consider reasonable prescribing practice;

ii. Prescribing drugs without an apparent therapeutic purpose, including:

1. In response to requests from Mr IKL made outside of a professional context, without establishing a therapeutic basis; and

2. For the purposes of managing pain associated with previous and/or planned sexual acts involving Dr X and Mr IKL including analgesics and anaesthetics;

3. Prescribing private prescriptions, when alternative therapeutic options were available on the Pharmaceutical Benefits Scheme (**PBS**).

iii. Prescribing drugs in excess of indicated doses;

iv. Prescribing escalating doses of drugs of dependence;

v. Inadequate medication safety measures, in the context of polypharmacy;

vi. Providing scripts for massive quantities of drugs;

vii. Failing to comply with SafeScript requirements; and

viii. Failing to comply with Schedule 8 permit requirements.

64. Further discussion of these issues is contained below.

Concerns regarding the provision of treatment in the context of a personal and sexual relationship

65. The CPU was asked to comment on the appropriateness of Dr X engaging in a personal and sexual relationship with Mr IKL while he was a current patient.[23]

66. In response, the CPU referred to the '*Guidelines: Sexual Boundaries in the doctor-patient relationship*' (**the Guidelines**), released by the Australian Health Practitioner Regulation Agency (**Ahpra**) and the Medical Board of Australia in December 2018. This code was an update of a previous code and is issued pursuant to the *Health Practitioner Regulation National Law*, as in force in each state and territory (**the National Law**).

67. In particular, the CPU noted that the summary section of these Guidelines provides, "*It is never appropriate for a doctor to engage in a sexual relationship with a current patient*," and that, "*Doctors are responsible for maintaining professional boundaries in the doctor-patient relationship*." Further, under section 3.1, the Guidelines note that '*Breaches of sexual behaviour*' include "*engaging or seeking to engage in a sexual relationship with a patient* ***regardless of whether the doctor believes the patient consented to the sexual relationship****"* [emphasis added].

68. In identifying specific risks which may arise where a doctor provides mental health treatment to a patient with whom they are engaged in a sexual relationship, the CPU referenced Section 2 of the Guidelines entitled, '*Why breaching sexual boundaries is unethical and harmful*'. This provides:

[23] While the coronial jurisdiction is not a jurisdiction of blame, nor one in which I am empowered to make findings as to criminal or civil liability, or as to disciplinary matters, I considered that, given the sexual relationship between Mr IKL and Dr X was intimately connected with Dr X's prescribing practices, it was a critical issue to consider in the context of a coronial investigation in which those prescribing practices were central to the scope of my investigation.

Doctors are expected to act in their patient's best interests and not use their position of power and trust to exploit patients physically, sexually, emotionally or psychologically. Breaching sexual boundaries is always unethical and usually harmful for many reasons including:

Power imbalance: The doctor-patient relationship is inherently unequal. The patient is often vulnerable and in some clinical situations may depend emotionally on the doctor. To receive healthcare, patients are required to reveal information that they would not reveal to anyone else and may need to allow a doctor to conduct a physical examination. A breach of sexual boundaries in the doctor-patient relationship exploits this power imbalance.

Trust: Patients place trust in their doctor. They have a right to expect that examinations and treatment will only be undertaken in their best interests and never for an ulterior, sexual motive.

Safety: Patients subjected to sexual behaviour from their doctor may suffer emotional and physical harm.

Quality: A doctor who sexualises patients is likely to lose the independence and objectivity needed to provide them with good quality healthcare.

69. The CPU noted that the available messages indicate that Dr X was conscious of this standard from the beginning of his relationship with Mr IKL,[24] although appears to have regarded it with contempt, stating for example in a WhatsApp message on 21 June 2023:

> *Apparently I'm in a position of incredible responsibility and power who is incapable of balancing personal and professional life. Apparently I need to accept that if I ever cross a boundary that society (as interpreted by some arbitrary fuckers who get themselves into a position of power over others) deems inappropriate then my livelihood is over.*

<u>Prescribing medications including drugs of dependence</u>

70. In commenting on the specific risks of a doctor prescribing medications, including Schedule 8 and Schedule 4 drugs, to a patient with whom they are engaged in a sexual relationship, the

[24] WhatsApp communication 13/11/2020 pages 103-104 of 3211.

CPU referenced section 4.15 of the Medical Board of Australia's, '*Good Medical Practice: a code of conduct for doctors in Australia'* (**Code of Conduct**), which states:

> *Whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship. In most cases, providing care to close friends, those you work with and family members is inappropriate because of the lack of objectivity, possible discontinuity of care, and risks to the patient and doctor. In particular, medical practitioners must not prescribe Schedule 8, psychotropic medication and/or drugs of dependence or perform elective surgery (such as cosmetic surgery), to anyone with whom they have a close personal relationship.*

71. Contrary to the Code of Conduct set out above, the CPU noted that Dr X prescribed Schedule 8 drugs (the opiates oxycodone, tapentadol, codeine), psychotropic drugs (the antidepressants mirtazapine, duloxetine, venlafaxine and the antipsychotic quetiapine) and drugs of dependence (opiates and benzodiazepines such as oxazepam, lorazepam, nitrazepam), the gabapentinoids pregabalin and gabapentin, 'z-class' of sedatives, zolpidem, the antipsychotic quetiapine and the weight-loss drug phentermine.

72. The CPU noted that a number of these medications are also monitored by SafeScript as patients on these prescription drugs are at high risk of death from overdose. The medications subject to SafeScript monitoring include oxycodone, tapentadol, codeine, quetiapine, oxazepam, lorazepam, nitrazepam, pregabalin, gabapentin, and zolpidem.

73. The CPU explained that in its view, there are a number of risks involved in a doctor prescribing the above medications to someone with whom they share a close relationship:

    a) In relation to Schedule 8 and other drugs of dependence, the CPU explained that the doctor may be affected by their emotions for the patient (which may be manipulated by a drug-dependent patient) leading to inappropriate and/or excessive prescribing. The patient risks a pharmacological dependence on the doctor which can then become a psychological dependence. If the patient becomes dependent, the doctor may also be reluctant to refer a patient for treatment of drug dependence for fear of losing their medical licence.

    b) In relation to psychotropic medications, there is a risk that the doctor may prescribe to suit what they want out of the relationship rather than what is in the patient's best interest. It also erodes the patient's ability to make autonomous decisions about their

mental health resulting in a psychological dependence on the doctor. This makes them more prone to manipulation by the clinician and more likely to experience a psychological crisis if the doctor ends either the professional or personal relationship.

Providing medical advice and management outside of a professional context, including through private text message conversations

74. In relation to providing advice outside of a professional context, as Dr X did when providing advice by WhatsApp or SMS message without a medical appointment, the CPU noted this practice blurs the line between the doctor-patient relationship and the intimate partner relationship, often resulting in confusion for both parties. This line is further blurred where the doctor is prescribing psychotropic and addictive medications for both clinical and non-clinical reasons.

CPU conclusion

75. Overall, the CPU provided an opinion that Dr X breached the standards of his profession as contained within the Code of Conduct[25] by engaging in a personal and sexual relationship with a patient and prescribing Schedule 8 drugs, psychotropic medications and drugs of dependence to an intimate partner. The CPU further noted that such breaches by Dr X were intentional, repeated and occurred over a prolonged period of time.

76. The CPU further noted that Dr X's conduct in providing treatment to Mr IKL while maintaining a personal and sexual relationship with him negatively impacted the care received by Mr IKL in several ways, as follow:

    a) There is evidence to suggest that Mr IKL became emotionally and pharmacologically dependent on Dr X.

    b) Dr X told Mr IKL from the start that their personal and sexual relationship needed to remain covert otherwise his career could end, which appears to have contributed to Mr IKL's anxiety.[26]

[25] The Code of Conduct provides that it *"makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community."*
[26] WhatsApp communication 19/7/2023 pg. 2952, 24/7/2023 pg. 2997-3001 of 3211.

c) Despite non-improvement of Mr IKL's presenting symptoms (anxiety, insomnia, and back/radicular pain), Dr X made only tokenistic efforts to refer externally for further support or pursue non-pharmacological therapy options:

   i. While a referral was made to a psychologist, correspondence between the psychologist and Dr X suggests that Mr IKL's relationship with Dr X and his drug use were not discussed. While Dr X indicated in his statement to the Court that he offered to refer Mr IKL to a sleep psychologist, there is nothing in the medical record to indicate that ever happened. No referral to a psychiatrist was ever made.

   ii. In the case of back pain, while referrals were made to an exercise physiologist and chronic pain specialist, Dr X made minimal effort to persuade Mr IKL of the importance of pursuing non-pharmacological treatments when he did not attend such referrals.

   iii. While Dr X indicated that cost was a factor for Mr IKL, this explanation appears to be inconsistent with his decision to prescribe private scripts for drugs of addiction and his conduct in providing Mr IKL with financial support for other purposes.[27]

   iv. On 15 December 2022, Dr X stated in a WhatsApp communication after speaking about the prospect of Mr IKL moving to another clinician in the new year, "*Kiss goodbye to pain killers though*," to which Mr IKL replied, "*Yeah I know haha*". This exchange further demonstrated Dr X and Mr IKL working as a team to exert only a token effort at non-pharmacological therapy options, due to Mr IKL's personal preference for pharmacological treatments.

   v. This 'team dynamic' of not seriously pursuing expert help would be at least partly driven by fear of discovery of the relationship (risking a mandatory Ahpra notification and possible restrictions on practice/livelihood) and partially by Mr IKL's pharmacological and psychological dependency on Dr X; if the doctor is not willing to push very hard and the patient not willing to engage, then optimal treatment will not occur.

[27] WhatsApp communication 28/8/2023, page 3094, Dr X deposited $400 in Mr IKL's bank account for food.

d) Dr X transferred care to another clinician at his practice, Dr Y, without a formal handover or apparent disclosure of his personal relationship with, or reasons for prescribing to, Mr IKL. Without full disclosure by either Dr X or Mr IKL to Dr Y, Dr Y would have had a negligible chance of successfully treating Mr IKL.

Prescribing practices

Prescribing drugs contrary to reasonable prescribing practice

77. The CPU noted that although Dr X provided a statement to the Court in which he set out certain justifications for his prescribing, these justifications were inconsistent with contemporaneous sources of evidence including WhatsApp and SMS messages. The CPU emphasised that it did not dispute that Mr IKL may in fact have experienced back pain, anxiety or insomnia. However, it considered that taking into account all available evidence, it was clear that Dr X prescribed medications for reasons not solely based on these clinical indications.

78. Further, the CPU considered that Dr X's prescribing practices were inappropriate with reference to reasonable prescribing practices, as set out in relevant standards including standards published by the Australian Commission on Safety and Quality in Health Care (**ACSQHC**) and the Therapeutic Guidelines[28] in relation to back pain, generalised anxiety disorder and insomnia, and that he did not adequately manage the risks or consequences of prescribed drug dependence.

79. In summary, the CPU provided advice that:

a) While any one of the agents prescribed by Dr X could be, in isolation, indicated for the short-term treatment of the conditions named, none are indicated for long-term management, particularly when prescribed together. Further, given their addictive and sedative qualities, long term prescription may be inappropriate and dangerous.

b) Minimising the risk of dependence involves maximising the non-pharmacological treatment of each of these conditions; in each case this is considered best practice and

[28] The Therapeutic Guidelines is an Australian independent not for profit organisation that is funded by subscription by health services and GPs, pharmacists and students. The Australian Commission on Safety and Quality in Health Care (ACSQHC) states '*Therapeutic Guidelines is the leading source of independent, evidence-based, practical treatment advice to assist Australian health practitioners with decision making at the point-of-care. It is regularly updated, based on the latest literature, and interpreted by Australia's most respected experts with input from an extensive network of general practitioners, pharmacists, and other users."*

first line. However, in this instance, the CPU considered that Dr X and Mr IKL had put only a token effort into pursuing non-pharmacological treatments, opting instead for a pharmacotherapy-only approach.

c) Maximising the treatment of dependence involves employing mitigation strategies. The following are recommended by ACSQHC in its factsheet titled, '*Real-time prescription monitoring: clinical risk management*' in relation to risk mitigation for prescribers:

i. *"Prescribe a smaller quantity, lower dose or an alternative medicine;*

ii. *Develop a shared action plan for dose tapering or deprescribing;*

iii. *Prepare a treatment agreement with the patient to clearly outline prescribing boundaries and expectations;*

iv. *Staged supply arrangements through pharmacy;*

v. *Referral to specialist medical care and support services"*

80. In this instance, the CPU concluded that Dr X prescribed escalating doses of drugs of dependence, implemented inadequate medication safety measures, and put only a token effort into referring Mr IKL to specialist medical care and support services.

<u>Prescribing drugs without an apparent therapeutic purpose</u>

Prescribing drugs in response to requests from Mr IKL made outside of a professional context, without establishing a therapeutic basis

81. The CPU noted that prescribing any medications without clinical indication is a breach of the standards set in the Code of Conduct because, when weighing the risks and benefits of such an action, there is no chance of clinical benefit while the risk of harm remains.

82. With reference to the WhatsApp and SMS messages, the CPU noted the following examples in which Dr X appeared to prescribe to Mr IKL without clinical indication:

a) Mr IKL initiated a social conversation with Dr X via SMS message in which he asked for prescriptions to be sent to him on 25 August 2020. He requested oxazepam and "*Endone (only for when we catch up)*", implying that either Mr IKL or Dr X, or both, would use the Endone to facilitate or enhance sexual encounters.

b) In SMS messages dated 27 August 2020, Mr IKL and Dr X engaged in 'sexting'. In this exchange, Mr IKL requested prescriptions and in response, Dr X requested sexualised images of Mr IKL.

c) In WhatsApp messages dated 6 October 2021, Mr IKL and Dr X engaged in 'sexting'. Mr IKL sent intimate images of himself when he asked for repeat scripts including oxazepam and "*Endone (if you are feeling generous and loving) hahaha*".

d) During a social conversation via WhatsApp on 3 March 2022, without prompting, Dr X stated "*I guess I should get you the slow release shit for Sunday after the music festival*". Mr IKL responded "*Possibly LOL. If that's OK…you don't have to if it makes you feel uncomfortable*". Dr X replied stating "*The only thing that makes me uncomfortable is the emotional stuff. Kink no problem. Prescriptions no problem*".

e) During a WhatsApp exchange on 12 May 2022, Mr IKL asked Dr X "*Actually if you are still there, chuck us a script of viagra bahaha*". On 13 May 2022, the Medical Centre records show that Dr X recorded a 'non-visit' with no clinical notes other than an e-prescription for Viagra that was sent to Mr IKL. The CPU explained that while Viagra is not a drug of addiction and is not a psychotropic drug, its prescription in the context of a doctor-patient sexual relationship is a clear conflict of interest, particularly in the absence of a clinical indication for its prescription.

Prescribing drugs for the purposes of managing pain associated with previous and/or planned sexual acts involving Dr X and Mr IKL including analgesics and anaesthetics

83. The CPU noted that while prescribing any medication without clinical indication is a breach of the standards set out in the Code of Conduct, Dr X's conduct represented a particularly serious breach in prescribing drugs of addiction to be used by his sexual partner, and possibly himself, in the context of sexual acts.[29] This was because Dr X's prescribing in this context represented a conflict of interest, whereby his decision making was not being propelled solely by his patient's best interests, but also the prescriber's personal interests in sexual gratification.

[29] *See, for example*, SMS messages dated 25/8/2020, page 608, in which Dr X prescribed Mr IKL Endone.

84. Similarly, the CPU considered that using the inhaled analgesic Penthrane[30] and local anaesthetic[31] on a patient so they have an increased tolerance for sexual acts involving pain and injury, which appear to have been initiated by Dr X, represents an extreme departure from the standards set in the Code of Conduct.

85. The CPU further noted that the power imbalance inherent within a doctor-patient relationship might be further exacerbated in a context where Dr X was positioned within their sexual dynamic such that he not only had the power to inflict pain but also had the power to provide analgesia and to select an analgesic associated with euphoria (Penthrane and opiates). The CPU considered that this type of power imbalance was incompatible with a functional therapeutic relationship, as the concepts of patient autonomy and consent become blurred with the doctor's self-interest.

Prescribing private prescriptions, when alternative therapeutic options were available which were available on the Pharmaceutical Benefits Scheme (PBS)

86. The CPU noted that Dr X provided private prescriptions for multiple medications, with no clear rationale. In particular, the CPU noted that Dr X prescribed the benzodiazepines nitrazepam and oxazepam, despite the fact that these medications have no clear therapeutic benefit over other benzodiazepines which are included on the PBS. Of all the drugs privately prescribed by Dr X, only one drug is recommended by the Therapeutic Guidelines while simultaneously not being available on the PBS, being zolpidem for the short-term treatment of insomnia. Given the higher costs associated with private prescriptions, and Dr X's indication that Mr IKL's treatment options were limited by his financial means, the CPU considered that there was no clear reason why Dr X would choose to treat Mr IKL using private prescriptions, rather than PBS alternatives.

Prescribing drugs in excess of indicated doses

87. The CPU explained that when a doctor provides a script for a drug to a patient, the script specifies the indicated dose to be taken, for example, 'one tablet twice daily'. When reviewing script dates and indicated doses, there were several periods during which Dr X provided scripts for quantities of drugs in excess of the indicated doses, for example:

[30] Methoxyflurane inhaler, 'the green whistle', is used by first responders. *See* WhatsApp message 6/7/2023 page 2816.
[31] The CPU noted that both these agents are in a GP's prescriber bag for home visits and is unclear if they were legally prescribed for Mr IKL or just used on Mr IKL

a) When Dr X commenced prescribing oxazepam in November 2020, he provided a script for 25 tablets at a time with directions to take half to one tablet, twice per day. The spacing of the scripts was initially consistent with the indicated dose. However, in October 2022, Dr X started prescribing three repeats with each oxazepam script, meaning 100 tablets were to be dispensed with each script. Over the course of 10 months, Dr X provided scripts for 900 oxazepam tablets in total. This was about three times greater than the number of tablets required to meet the indicated dose.

b) On 11 February 2023, Dr X provided a script of 14 zolpidem tablets with five repeats (84 tablets total) and instructions to take one tablet daily as needed. He provided a further script with repeats for another 84 zolpidem tablets on 25 March 2023, only 42 days after the first script.

c) When Dr X commenced prescribing medications containing codeine (e.g. Panadeine Forte) in August 2020, he provided scripts for between 96 and 240 tablets containing 30mg codeine at a time, with instructions to take up to eight tablets daily. The interval between scripts was initially appropriate and not excessive as Mr IKL received a 30 day supply every 60 days (based on eight tablets per day being a one-day supply). However, this changed in about November 2022, when the interval between scripts decreased and the supply per script increased. Between November 2022 and March 2023, Mr IKL received scripts for more than 10 codeine-containing tablets per day (on average).

d) Dr X prescribed mirtazapine 15mg from November 2020 to June 2023. The instructions varied from taking half a tablet per day to one tablet per day. Over the period, he provided scripts for twice as many mirtazapine tablets as required, if his dosing instructions (half to one tablet) were followed.

e) Dr X prescribed 20mg extended-release oxycodone to Mr IKL regularly between April 2022 and July 2023. The scripts were always for 28 tablets with no repeats, and the directions for use were to take one tablet at night. Over time, and particularly between March and July 2023, Dr X provided scripts for 28 tablets every 15 days (on average). This meant he was providing scripts for nearly twice the indicated dose.

Prescribing escalating doses of drugs of dependence

88. Escalating doses of drugs of dependence are a strong clinical sign that a patient may be developing dependence to the drug. As noted above, there was evidence of dose escalation over time for both oxazepam and oxycodone extended release.

Inadequate medication safety measures

89. Polypharmacy is generally defined as the concurrent use of five or more medications. It carries a range of risks relating to drug interactions, unnecessary medication use, medication non-adherence, and medication errors, amongst other issues.

90. In this case, Mr IKL was a polypharmacy patient. Critically, many of the drugs implicated in his polypharmacy were central nervous system (**CNS**) depressants with significant abuse potential. For example:

    a) On 25 March 2023, Dr X prescribed duloxetine, mirtazapine, oxazepam, two different forms of oxycodone, codeine, paracetamol and zolpidem.

    b) On 14 June 2023, Dr X prescribed promethazine, codeine, paracetamol, zolpidem, oxycodone and oxazepam.

    c) On 14 July 2023, Dr X prescribed oxazepam, quetiapine, zolpidem, codeine, paracetamol and two different forms of oxycodone.

91. Most concerning, according to the CPU, was the prescription of multiple drugs to treat the same condition. For example, in November 2022, Dr X prescribed two different forms of oxycodone, tapentadol, pregabalin and codeine, ostensibly for Mr IKL's pain condition.

92. The CPU opined that a clinician prescribing to a polypharmacy patient (particularly where the medications include CNS depressants and drugs of dependence) must exercise a high degree of caution and put appropriate medication safety measures in place to address any risks. One of the simplest options for this is to restrict the amount of medication that is dispensed to the patient at any one time. This can be achieved through staged supplies or a dose administration aid such as a Webster pack. From the CPU's review of Mr IKL's medical records, there was no evidence of Dr X implementing dispensing controls over most of the drugs he prescribed.

Providing scripts for large quantities of drugs

93. The CPU noted that there were at least two instances where Dr X prescribed large quantities of drugs that are subject to abuse or misuse:

    a) From 11 November to 6 December 2022 (25 days), Dr X provided three sets of pregabalin prescriptions (56 tablets per script, each script with five repeats). This equated to a total of 1,008 pregabalin tablets. The indicated dosage ranged from two capsules daily (11 November 2022 script) to three tablets daily (15 November 2022 script) and four tablets daily (6 December 2022 script). If calculated at four tablets per day, these scripts equated to a 252-day supply.

    b) On 19 April 2023, Dr X provided a script for 100 tablets of 300mg gabapentin with five repeats, which is a total of 600 tablets. The indicated dosage was two capsules, twice per day, which equated to a 150-day supply.

94. There were no explanations in the medical records as to why these quantities of drugs were required or prescribed.

Facilitating early pick-up of drugs of dependence

95. The CPU considered that Dr X's actions in facilitating the early pick up of drugs of dependence was contrary to mitigation strategies recommended by ACSQHC, as discussed above.

96. In particular, the CPU raised concerns in regard to the reasoning provided by Dr X in his statement to the Court in which he cited Mr IKL's concern about benzodiazepine withdrawal as the reason for him to both continue prescribing benzodiazepines and to support the early pick up of medications.[32] The CPU considered that if Dr X believed that Mr IKL was drug-dependent, then under section 34(1) of the *Drugs, Poisons and Controlled Substances Act 1981* (**DPCA**), he would be obliged to obtain a section 34 permit which did not occur. Further, the CPU noted that if is an offence to prescribe a drug of dependence merely to support the drug dependence of a person.[33]

[32] i.e. where Dr X would contact pharmacies to support Mr IKL's early collection of prescription medications.
[33] https://www.health.vic.gov.au/drugs-and-poisons/drugs-of-dependence-and-drug-dependent-persons

97. In this context, the CPU considered that Dr X's conduct in facilitating the early pick up of drugs of dependence, in circumstances where he appeared to consider that Mr IKL was drug-dependent, represented a material departure from reasonable standards of care.

Failure to comply with SafeScript requirements

98. Section 30F of the DPCA requires:

> *Unless the regulations otherwise provide, a registered medical practitioner must take all reasonable steps to check the monitored poisons database for the records or information in relation to a person for whom a monitored supply poison may be prescribed or supplied before prescribing or supplying the monitored supply poison for that person.*

99. Part 20 of the *Drugs Poisons and Controlled Substances Regulations 2017* (Vic) specifies that the main circumstances in which a medical practitioner is not required to check the monitored poisons database (i.e., SafeScript) before prescribing to a person are:

    a) when the person is an inpatient in hospital;

    b) a prisoner treated in prison;

    c) a person treated in a police gaol; or

    d) a resident of an aged care facility.

100. None of these circumstances applied to Dr X's treatment of Mr IKL, so he was required by law to check SafeScript on each occasion before prescribing a drug monitored through SafeScript to Mr IKL.

101. Contrary to the statement provided to the Court, Dr X only checked SafeScript on three occasions – 31 May 2022, 8 February 2023 and 14 July 2023. The overwhelming majority of occasions when Dr X prescribed SafeScript monitored drugs, he was not compliant with the requirement to check SafeScript first.

102. In Dr X's statement to the Court, he explicitly stated that he checked SafeScript before prescribing monitored poisons to Mr IKL on the following dates:

    a) 26 February 2021;

b) 5 August 2022;

c) 28 October 2022;

d) 24 November 2022;

e) 10 December 2022, and;

f) 25 March 2023.

103. Upon a review of Mr IKL's SafeScript records, there is no record of Dr X checking SafeScript on any of these six occasions. Dr X further noted:

> *SafeScript was checked and considered at each prescribing point. Regular follow-up consultations were conducted to assess efficacy and make adjustments as necessary*.

104. Dr X further noted:

> *At each consultation, an evaluation was conducted to assess his reported pain levels, functional status, the timing of prescriptions, and the appropriateness of the requested medication based on clinical need. SafeScript was checked with each prescription, as outlined below, and any discrepancies in prescribed doses or frequency were appropriately addressed.*

105. There is no evidence that the above SafeScript checks occurred, other than the three dates listed above. However, there may be a partial explanation for the discrepancy. Specifically, Dr X noted his SafeScript checking practice as follows:

> *In my usual practice, SafeScript checks occur at two levels:*
>
> *Firstly, an automated check is performed through […] the clinical software used at [the Medical Centre]. This system automatically initiates a SafeScript search when a recognised/listed medication is prescribed. The alerts are structured using a traffic light system:*
>
> - *Red alerts indicate an immediate concern, requiring an external SafeScript check before a prescription can be issued.*
> - *Amber/Yellow alerts indicate a potential concern, prompting the prescriber to conduct additional verification.*
> - *Green alerts indicate no foreseeable issues at the time of prescription.*

This [software] feature has been enabled since [the Medical Centre] opened in April 2020 and was used in every consultation with [Mr IKL], as well as in all other patient interactions.

Secondly, because [the software] is primarily a clinical software tool that relies on proxy information, I manually check the SafeScript website itself before prescribing any medication that is classified as high risk or has the potential for harm.

106. The Court has previously encountered this scenario in other cases, where a clinician claimed they checked SafeScript by viewing the automatic alerts presented through their clinical software. The Court consulted with the Department of Health at length on this issue and the Department confirmed that viewing an automatic alert inside clinical software is not a substitute for checking SafeScript. The clinician is still required to log onto the SafeScript system itself before prescribing a monitored drug. Clinicians receive education on this particular requirement and should be aware that they still need to log onto SafeScript manually in order to discharge their obligations.

107. Furthermore, even allowing for the fact that Dr X may have mistakenly believed that he checked SafeScript when viewing an alert in his clinical software, the SafeScript access history contradicts his claim that he checked SafeScript manually "*before prescribing any medication that is classified as high risk or has the potential for harm*". As highlighted above, there is no record that he checked SafeScript "*manually*" before prescribing oxycodone, codeine or oxazepam on the overwhelming majority of occasions.

108. The purpose of SafeScript is to ensure that no other clinicians are prescribing medications to a patient without their knowledge, that there are no active permits to prescribe issued to other practitioners and that the patient's reported history of compliance with medications aligns with independent records. Dr X noted this purpose in his statement to the Court and is required to be aware of the risk posed when clinicians are not compliant with this requirement.

<u>Non-compliance with Schedule 8 permit requirements</u>

109. Dr X noted that he never applied for a Schedule 8 permit to prescribe Schedule 8 drugs to Mr IKL. He stated:

I did not seek a permit to prescribe Schedule 8 medications for [Mr IKL] during the period he was under my care. The reasons for this are:

a. *The prescribed doses of opiate medications, at any one period of time, provided taken as prescribed and considering the intervals between prescriptions, never exceeded the legal threshold of 100 mg of Morphine Equivalent Dose (MED), as stipulated by Victorian legislation; and*
b. *None of the benzodiazepines prescribed were, or are currently, classified as Schedule 8 medications in Victoria.*

At each consultation, an evaluation was conducted to assess his reported pain levels, functional status, the timing of prescriptions, and the appropriateness of the requested medication based on clinical need. SafeScript was checked with each prescription, as outlined [above], and any discrepancies in prescribed doses or frequency were appropriately addressed.

Had [Mr IKL]'s treatment at any stage required a Permit to Prescribe, I would have applied for one. As an experienced medical practitioner with Medical Assisted Treatment of Opiate Dependence (MATOD) training and expertise, I am fully aware of the legal limitations, requirements, and potential risks associated with prescribing medications that carry a risk of harm.

110. When Dr X prescribed Schedule 8 drugs (oxycodone; tapentadol), he was not required to apply for a Schedule 8 permit if two criteria were met:

1. the prescribing of specified opioids was for less than 100mg morphine equivalent dose daily; and

2. Mr IKL was not a drug-dependent person.

111. The first criterion appears to have been met. However, the CPU opined that Mr IKL did not meet the second criterion (i.e. there were concerns that Mr IKL **was** a drug-dependent person and thus a permit should have been applied for). Dr X's statement included several indications that Mr IKL had developed a dependence on benzodiazepines and was therefore a drug-dependent person. Dr X acknowledged Mr IKL's escalation in oxazepam use, and that dose escalation was a sign of dependence. He also stated that he trialled a longer-acting benzodiazepine (lorazepam) because he believed it might be less likely to produce dependence.

112. Dr X attempted to explain the escalating oxazepam dose:

> *[Mr IKL] stated that he was close to running out of oxazepam and would have no supply remaining before his next scheduled prescription could be dispensed. He expressed concern that a sudden cessation of oxazepam would likely induce withdrawal symptoms, which would render him non-functional for both work and study. Given the risk of benzodiazepine withdrawal, which could result in significant distress and impairment, I provided both a prescription and a letter in each case to ensure the continuity of medication supply.*

113. The CPU noted that experiencing withdrawal is a clinical sign of dependence. Dr X also noted:

> *[Mr IKL] did admit to "relying" on oxazepam to help him "feel normal" as he had in previous consultations and I again reiterated the pattern of dose escalation and dependence that he appeared to be following.*

114. On this basis, the CPU opined that Dr X was required by law to apply for a Schedule 8 permit to prescribe oxycodone to Mr IKL, particularly after October 2022 when his oxazepam prescribing escalated.

CPU conclusion

115. Overall, the CPU considered that Dr X's conduct in respect of prescribing and/or using Schedule 8 and Schedule 4 drugs including analgesics and anaesthetics without a therapeutic purpose amounted to a material departure from the standards of his profession.

116. In providing this opinion, the CPU noted the Code of Conduct states that good medical practice involves *"[o]nly recommending treatments when there is an identified therapeutic need and/or a clinically recognised treatment, and a reasonable expectation of clinical efficacy and benefit for the patient*." Therefore, the CPU considered that prescribing any medications without a clinical indication amounted to a material departure from the standards set out in the Code of Conduct. Furthermore, prescribing Schedule 8 medications to enhance the prescriber's sexual partner's enjoyment of, or willingness to engage in, sexual acts that the prescriber themselves is involved puts the prescriber's desires ahead of the patient's long-term wellbeing.

117. Furthermore, the CPU provided an opinion that Dr X's prescribing practices contributed to the circumstances of Mr IKL's death. In providing this opinion, it noted that:

a) Dr X either commenced prescribing or recommended the prescribing the the medications that were found by Dr Baber, forensic pathologist, to have contributed to Mr IKL's death. None of those medications are recommended by the Therapeutic Guidelines for the long-term management of the conditions being treated (for example, back pain, anxiety, insomnia). None of these drugs had proven long-term benefits, however all had a proven risk of dependence, respiratory depression and death. Although Dr X was no longer prescribing medications at the time of Mr IKL's death, the CPU opined that his inappropriate prescribing practices contributed to Mr IKL's trajectory of drug dependence and misuse.

b) Additionally, the CPU opined that Dr X's decision to functionally transfer care to Dr Y without a full disclosure handover to an employee significantly limited Dr Y's ability to adequately assess and manage a complex situation. This may have also contributed to Mr IKL's death.

118. The CPU recommended that I refer Dr X to Ahpra to consider whether any disciplinary actions may be appropriate. The CPU opined that the available evidence supports a conclusion that Dr X's behaviour amounted to "*sexual misconduct*" and "*a significant departure from accepted professional standards*". The CPU noted there appeared to be a pattern of deliberate, repeated and deceptive behaviour where Dr X prioritised his own interests ahead of his patient's interests and opined that this was a significant contributory factor in Mr IKL's death.

119. Furthermore, the WhatsApp exchanges between Mr IKL and Dr X demonstrate that Dr X was aware of and potentially resented the concept of being subject to professional standards. The CPU was concerned that such a view may give rise to Dr X engaging in a similar practice in the future. As such, the CPU opined that Dr X poses a "*substantial risk to the public*" of harm, justifying a referral to Ahpra.

RESPONSE FROM DR X

120. In accordance with the principles of natural justice, Dr X was provided with an opportunity to respond to the CPU's review and my proposed findings as to circumstances, as set out above. The Court received submissions in response on behalf of Dr X dated 4 August 2025.

121. In these submissions, legal representatives for Dr X stated that, apart from certain minor clarifications discussed below, "*Dr X accepts the factual circumstances arising out of the draft findings, save to say, that at all consultations, Dr X intended to provide Mr IKL with*

appropriate medical care and treatment. It is now appreciated by Dr X, that with distance this was not what occurred." In particular, Dr X did not seek to dispute the personal or sexual relationship between himself and Mr IKL.

122. However, the submissions did seek to clarify certain issues related to referrals and use of SafeScript in order "*to ensure accuracy of the findings*", as outlined below:

    a) In relation to Dr X's referrals, it was submitted that although a referral to a psychologist does not appear in the Medical Centre records, it is evident from the clinical records and subsequent correspondence that a referral was in fact completed during a consultation with Mr IKL in May 2020. In addition, it was submitted that Dr X had offered a referral to a sleep specialist, during a consultation with Mr IKL on 25 June 2022, but that Mr IKL refused the referral due to his limited availability and financial situation, and as a result, Dr X did not progress the referral and did not make a note in his clinical records.

    b) In relation to SafeScript, it was submitted that at the relevant times, Dr X had considered that it was sufficient for him to rely on software used by the Medical Centre called '[redacted]' which has a function that automates a check of SafeScript prior to certain medications being prescribed. This software uses a 'traffic light' system, which means that where a 'red' alert is returned, the prescription of a medication is prohibited until the prescriber logs onto SafeScript and undertakes a manual check. According to Dr X, at no time during his consultations with Mr IKL did the automated program return a 'red' alert. However, following his review of the draft findings, Dr X now "*appreciates that viewing an automated alert is not a substitute for checking SafeScript.*"

123. The submissions stated that following a process of reflection, Dr X "*fully acknowledges that his past conduct was entirely inappropriate, and holds the belief that continuing to practice as an active health professional is no longer a viable career path*." In these circumstances, the submissions stated that Dr X intended to voluntarily surrender his medical registration before 30 August 2025.

124. I note that at the time of this finding, Dr X's name no longer appears in a search of Ahpra's Register of Practitioners.

ANALYSIS OF CPU'S ADVICE AND DR X'S RESPONSE

125. At the outset, I note that it is not the coroner's role to determine blame or to apportion civil or criminal liability; nor is it a matter for the coroner to make findings in relation to disciplinary matters, including those of professional misconduct under the *Health Practitioner Regulation National Law (Victoria) Act 2009* or otherwise. The coroner's role is limited to making findings in relation to reportable deaths as to identity, cause and circumstances of death, as well as any pertinent comments or recommendations connected with the death.

126. However, in considering the evidence before me with regard to the cause and circumstances of Mr IKL's death, including in relation to the appropriateness of relevant prescribing practices, the prospect of adverse comments against Dr X is clearly enlivened.

127. In such circumstances, the law provides that adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.[34] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[35]

128. In contemplating adverse comments against Dr X, I am therefore required to consider the evidence before me having regard to the standards of his (then) profession for the purposes of discharging my statutory functions in making findings as to the cause and circumstances of death.[36]

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[34] *See generally in this regard Briginshaw v Briginshaw* (1938) 60 CLR 336, 361-362 per Dixon J.; *Adamczak v Alsco Pty Ltd (No 4)* [2019] FCCA 7 at [80]; and *Chief Commissioner of Police (Vic) v Hallenstein* [1996] 2 VR 1, [19-20].

[35] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.

[36] I note in this connection that Dr X obviously contemplated his text and WhatsApp correspondence, which constitutes much the evidentiary basis in these proceedings for the improper relationship between Mr IKL and Dr X (the existence of which is not disputed), to have been for Mr IKL's eyes only, frequently commenting on the '*massive, massive risk*' the relationship entailed (p.104/3211 WhatsApp messages) and imploring Mr IKL to keep it secret. Given the circumstances of Mr IKL's death, however, I have considered the conditions of section 8(e) of the *Coroners Act 2008* to be met for the purposes of using and relying on these messages, namely that the public interest in the legitimate use of these messages outweighs protecting information that is otherwise usually personal and private in nature. I note further that the provenance of the messages is not in dispute. No issue has been taken with the authenticity, relevance or acquisition of the messages in question, and I am otherwise satisfied as to these matters. I have attempted in this finding to limit specific references to the content of the messages to only that which is necessary for the discharge of my statutory functions.

129. Following careful consideration, and without straying beyond the limitations of section 69 of the *Coroners Act 2008*, I accept the advice of the CPU that Dr X's conduct in providing care to Mr IKL in the context of a personal and sexual relationship amounted to a material departure from the standards of his profession and, in so doing, contributed to Mr IKL's death. The relationship lasted for almost three years; Dr X maintained his role as Mr IKL's GP for all but three months of this period.

130. I consider that the sexual and personal relationship Dr X had with Mr IKL vitiated – in its entirety – his ability to act in the best interests of his patient.

131. Specifically, I agree with the CPU that Dr X materially departed from the standards of his profession by:

    a) Continuing to provide treatment to Mr IKL in the context of a personal and sexual relationship, including in the context of:

        i. Prescribing medications including drugs of dependence;

        ii. Providing medical advice and management outside of a professional context, including through private text message conversations.

    b) Deeply concerning prescribing practices, including particular concerns related to:

        i. Prescribing drugs contrary to what most prescribers would consider reasonable prescribing practice;

        ii. Prescribing drugs without an apparent therapeutic purpose, including:

            1. In response to requests from Mr IKL made outside of a professional context, without establishing a therapeutic basis;

            2. For the purposes of managing pain associated with previous and/or planned sexual acts involving Dr X and Mr IKL including analgesics and anaesthetics; and

            3. Prescribing via private prescriptions at greater expense to Mr IKL, when alternative therapeutic options were available on the PBS (which I consider was either an attempt to avoid scrutiny of his prescribing practices, or at the very least, constituted evidence that certain medications were being provided 'off-script').

        iii. Prescribing drugs in excess of indicated doses;

iv. Prescribing escalating doses of drugs of dependence;

v. Inadequate medication safety measures, in the context of polypharmacy;

vi. Providing scripts for massive quantities of drugs beyond documented dosages;

vii. Failing to comply with SafeScript requirements; and

viii. Failing to comply with Schedule 8 permit requirements.

132. I accept the CPU advice in this regard as outlined above at paragraphs 62-119 and do not consider that it is necessary to repeat the basis of the advice here.

133. However, I must note that Dr X, while being largely accepting of the CPU review, has responded with certain clarifications, to which I will now turn:

a) In considering Dr X's response to the CPU opinion, I accept those clarifications with regard to Dr X's referral to a psychologist and his attempted referral to a sleep specialist. However, I do not consider that such clarifications alter the conclusion that Dr X made only tokenistic efforts to encourage Mr IKL to pursue non-pharmacological therapy options.

b) In relation to Dr X's explanation with regard to his misunderstanding of SafeScript requirements, I recognise that non-compliance among clinicians represents a widespread problem and that in some instances this may reflect a lack of understanding that viewing an automatic alert inside clinical software is not a substitute for checking SafeScript.[37] However, I do not accept any implication that Dr X's inappropriate prescribing may be explained by a misunderstanding of legislative requirements. Rather, I consider that there is extensive evidence that Dr X materially departed from the standards of his profession by prescribing and/or using Schedule 8 and Schedule 4 drugs including analgesics and anaesthetics without *any* therapeutic purpose. As noted by the CPU, this was intentional, repeated and occurred over a prolonged period of

[37] In the 2024 inquest into death of LI (a pseudonym), finding available here, I heard evidence that the compliance rate for clinicians' mandatory obligations to check SafeScript was as low as 70%, and recommended that the Victorian Department of Health (the Department) develop, as a priority, additional strategies to enhance its oversight and compliance role, including by working with the Royal Australian College of General Practitioners, the Medical Board of Australia and the Pharmacy Board of Australia, to develop related education and training tools for clinicians. In response to my recommendation, the Department indicated it would implement a number of initiatives with the intention of improving compliance. This includes the publication of a suite of educational written resources for users of real-time prescription monitoring systems in Australia, available on the website of the Australian Commission on Safety and Quality and Healthcare. I intend to provide a de-identified copy of this finding to relevant bodies to inform future efforts in this regard.

time. I also note that Dr X provided a detailed account in his statement of March 2025 of his two-step SafeScript-checking process (firstly via notification via his practice software, secondly by logging into and checking SafeScript itself) which demonstrates that he was aware of the legislative requirements of checking SafeScript and how to do so in a way that complied with those legislative requirements.

134. Finally, in considering Dr X's response, I note his contention that, despite pursuing an intimate relationship with Mr IKL, he always *'intended to provide Mr IKL with appropriate medical care and treatment'.*

135. I find this submission very difficult to accept. Dr X's '*care and treatment*' was inextricably intertwined with his personal and sexual relationship with Mr IKL which included Dr X prescribing medications to assist Mr IKL to tolerate painful acts for the purposes of sexual gratification. It included Dr X prescribing massive quantities of medications without clinical rationale. It included Dr X using private prescriptions despite knowing of Mr IKL's financial stress. He did all of this in flagrant disregard of the very foundational tenets of his profession – to '*first, do no harm*'.

136. Such examples clearly demonstrate to me that, whatever his intentions may have been, Dr X was not acting in a manner that served his patient's best interests. Nor was he practising medicine in a manner that was anywhere close to the realm of '*appropriate'.*

137. I consider that Dr X's conduct serves as a powerful reminder for all health practitioners of the critical importance of their professional responsibilities in maintaining appropriate doctor-patient boundaries. Far from '*arbitrary*' as suggested by Dr X to Mr IKL, the Code of Conduct and Guidelines seek to protect the fundamental cornerstone of good medical practice, that is: trust that a doctor will always act in a patient's best interests. Any sexual relationship with a patient necessarily threatens this foundational principle and thereby raises a real and tangible risk that a patient's care, and safety, will be compromised.

138. In particular, I consider that the sexual dynamic initiated by Dr X may have been especially likely to entrench a power imbalance, which was entirely incompatible with a therapeutic relationship. In this respect, I note that Mr IKL first presented to Dr X in relation to mental health concerns, which reportedly included "*issues with identity and self-worth and self-*

esteem following a recent relationship breakup." Mr IKL also sought care in relation to his sexual health as a member of the LGBTIQA+ community.[38]

139. I consider that both of these presentations may raise particular vulnerabilities which serve to exacerbate the pre-existing power imbalance between a doctor and patient. In these circumstances, and noting in particular that the Medical Centre's website presented Dr X's areas of interests and training as including LGBTQIA+ health, sexual health and HIV medicine, Mr IKL could rightfully have expected that Dr X would take particular care in providing treatment in a safe and responsible manner to a member of the LGBTIQA+ community who had particular health needs and who was vulnerable to poorer health outcomes than the population as a whole.[39]

140. Instead, Dr X, who was many years older than Mr IKL, initiated a sexual dynamic which placed him in a position of further power, by pursuing sexual acts with Mr IKL which involved inflicting pain and injury, in circumstances where Dr X was also in a position to provide pain relief through the prescription of analgesics and the use of anaesthetics. A sexualised power dynamic of this nature, in circumstances where Mr IKL faced particular vulnerabilities, may have been especially likely to entrench the already uneven power imbalance between doctor and patient, and thereby raise real risks of harm.

141. I must reiterate that there is no evidence before me that the sexual acts between Dr X and Mr IKL were not consensually entered into.[40] I note further that I have elected not to detail in this finding the types of acts entered into nor the resultant harm, nor engage in what otherwise might be considered undue moral comment on the particular acts embarked upon (i.e. '*kink-*

[38] In Mr IKL's case, over and above the vulnerabilities he faced as a young LGBTIQA+ patient with mental health issues, there is background information available that indicates he may have been an especially vulnerable member of the LGBTIQA+ community. In a Coronial Impact Statement provided to the Court, a close friend described him thusly: '*Mr IKL was not always accepted for being gay and I believe this and other factors from his younger years resulted in a constant search of love and care from those around him. Be it close friendships and romantic relationships. This often lead to him being hurt by those relationships and being taken advantage of*'.

[39] I heard extensive evidence in a cluster inquest convened in 2023 in relation to the vulnerabilities of the LGBTIQA+ population (in that inquest, with a focus on the transgender and gender diverse population), including that LGBTIQA+ Victorians face higher levels of discrimination, stigma and exclusion which leads to poorer health, economic, social and mental health outcomes than other Victorians. See in this regard the *Finding into the death of Natalie Jade Wilson* (COR 2020 004857, 29 August 2024), available here; *Finding into the death of Bridget Erin Flack* (COR 2020 006727, 29 August 2024), available here; *Finding into the death of Matt Byrne* (COR 2021 001636, 29 August 2024), available here; *Finding into the death of 'AS' (a pseudonym)* (COR 2021 002415, 29 August 2024), available here; *Finding into the death of Heather Pierard* (COR 2021 002457, 29 August 2024), available here.

[40] I note that it was not until the end of July 2023, in the month Dr X ceased being Mr IKL's treating GP, that the *Crimes Act 1958* was amended to provide for certain circumstances in which a person does not consent to sex, including where they are so affected by a drug as to being incapable of consenting, or where they are overborne by the abuse of a relationship of authority or trust. I make no comment as to any impact of this legislative change on the appropriate characterisation of the sexual acts engaged in by Dr X and Mr IKL; I simply note this change in the legislative landscape occurred at a point where Dr X largely ceased to treat and prescribe to Mr IKL.

shaming'). The issue is not one of the nature of the sexual acts in and of themselves, but of the power imbalance in the relationship in which they occurred and the potential for such acts to further entrench this asymmetrical dynamic.

142. Having due regard to all available evidence – including with regard to the power imbalance inherent in the doctor-patient relationship, evidence before me that Mr IKL did in fact become pharmacologically and emotionally dependent on Dr X over the almost-three years of their relationship, and that Dr X oversaw a prescribing regime that led to Mr IKL becoming increasingly addicted to prescription medication, including powerful drugs of dependence – I am satisfied that Dr X's inappropriate prescribing regime had a contributory role in Mr IKL's death. I will turn to this further below in my formal findings.

143. Finally, I agree with the CPU that it is appropriate to refer Dr X's conduct to Ahpra for investigation. I consider this remains appropriate despite the fact that Dr X no longer appears on Ahpra's register of medical practitioners.

CPU REVIEW – DR Y

144. In relation to the care provided to Mr IKL by Dr Y, the CPU provided advice on issues including:

    a) Whether Dr Y took steps to facilitate an adequate handover from Dr X;

    b) Prescribing Schedule 8 drugs without a permit;

    c) The appropriateness of prescribing practices; and

    d) Whether Dr Y's prescribing practices may have contributed to the circumstances of Mr IKL's death.

145. These issues will be discussed in turn.

Handover

146. The CPU noted that, when Dr Y assumed care of Mr IKL in July 2023, it was unclear whether Dr Y and Dr X would regard that handover occurred or was even indicated in this instance. Per Dr X's statement, he noted that Mr IKL had not been formally handed over to Dr Y and that he intended to continue being Mr IKL's primary physician. Dr X stated that Dr Y saw Mr IKL because he was unavailable. This is not uncommon in a multi-practitioner practice and

in such circumstances, the covering doctor adheres to the continuing plan in the medical record until the usual doctor resumes care. If the usual doctor is knowingly going to be unavailable for a longer period of time, but wants to continue care of a complex patient, they may instruct the covering doctor about their management plan in their absence. This type of communication involves advice or direction for the covering clinician and is not an actual transfer of ongoing care.

147. The CPU explained that handover (when it occurs) is a conversation *between* two clinicians. It is simultaneously sought by the receiving clinician and given by the referring clinician. Therefore, the onus is on both parties to have this conversation until the receiving clinician feels that they have the information necessary to give the patient optimal care. The CPU further noted that the definition of a complete handover implies that the referring clinician is completely honest and open with all the information that is given. Without that honesty and transparency, the value of a handover can be severely impacted.

148. Dr X stated that he "*may have*" discussed Mr IKL's care with Dr Y but he did not explain what the discussion entailed. Given the statements of Drs X and Y, the medical records and the WhatsApp and SMS messages between Dr X and Mr IKL stating that if their relationship were discovered by another clinician, that clinician would be mandated to report him to Ahpra, the CPU opined that it was highly unlikely that Dr X would have provided a full, open and transparent handover. There is no evidence that Dr Y knew about the relationship between Mr IKL and Dr X.

149. The CPU also noted that Dr X did not disclose his relationship with Mr IKL to the Court in his statement. Furthermore, as Dr X was the clinical director of the Medical Centre (and Dr Y's employer), a power imbalance existed between the pair. Dr Y's ability to question Dr X's clinical reasoning may have been limited by this power imbalance.

Prescribing Schedule 8 drugs without a permit

150. If Dr X obtained a permit for prescribing drugs pursuant to section 34A(2) of the *Drugs, Poisons and Controlled Substances Act 1981* (**DPCA**), then under section 34E(2), Dr Y could prescribe in Dr X's stead if he was unavailable. However, this did not occur.

151. If, however, Dr Y realised that either the opiate prescription had been ongoing for more than eight weeks (which would have been clear on the medical record and prescribing software), or, that Mr IKL was drug dependent (noting that Dr Y checked SafeScript on 24 and 28 July,

8 August and 11 September 2023 and saw a 'high risk' warning), then it would be inappropriate for Dr Y to prescribe those medications. When confronted with the high-risk warning, Dr Y would have had the following options:

e) Refusing to prescribe and referring the patient back to the referring clinician.

f) Obtaining a permit and becoming Mr IKL's primary GP on an ongoing basis to treat his drug dependence and initiate mitigating strategies. It is likely that Mr IKL would have resisted this approach.

g) Refilling the prescriptions as asked in the hope that the referring clinician resumes care.

152. The CPU opined that Dr Y's prescribing of Schedule 8 drugs without a permit amounted to a material departure from the standards of his profession, however stressed that this breach occurred as a continuation of the existing treatment plan, and potentially at the direction of Dr X.

Appropriateness of prescribing practices

153. In his statement, Dr Y stated "*Mr IKL had been counselled about the appropriate use of these medications, and after checking SafeScript, I provided the script*". This statement, particularly the use of the word "*had,*" does not make it clear whether Dr Y performed counselling on the day of the consultation or if he believed Dr X previously counselled him.

154. While Dr Y stated that he checked SafeScript, he did not mention that there were SafeScript 'high-risk' warnings on 24 and 28 July, 8 August and 11 September 2023. The CPU noted that Dr Y appeared to prescribe medications regardless of these high-risk warnings and without consideration of either applying mitigation strategies or applying for a permit. The CPU opined that Dr Y did not prescribe appropriately and did not adequately manage Mr IKL's risks of dependence.

Whether Dr Y's prescribing practices may have contributed to the circumstances of Mr IKL's death

155. The CPU opined that the long-term prescription of drugs of dependence was causal in Mr IKL's death. As Dr Y wrote the final prescriptions for Mr IKL, his conduct was therefore contributory in Mr IKL's passing. The CPU noted, however, the potential mitigating factor in

that Dr Y is an employee of Dr X, and Dr X was responsible for Mr IKL's dependence over multiple years.

RESPONSE FROM DR Y

156. In accordance with the principles of natural justice, Dr Y was provided with the opportunity to respond to the CPU's review and my proposed findings as to circumstances, as set out above. The Court received submissions from Dr Y dated 31 July 2025.

157. In his submissions, Dr Y indicated that prior to receiving the draft findings, he had not been aware of any personal relationship outside of the clinical context between Dr X and Mr IKL and so was "*shocked and surprised*" to learn of this information.

158. In relation to his prescribing practices, Dr Y acknowledged that while he is "*quite conservative*" in prescribing Schedule 8 medications to his own patients, he did find it "*challenging to adhere to this principle in my first year at [the Medical Centre] when [Mr IKL], who had been used to being prescribed higher quantities than I was usually comfortable prescribing, requested scripts.*" He stated that in circumstances where Mr IKL was not his regular patient and had understood that Dr X was retaining primary care, he determined to "*continue the treatment plan,*" being that plan previously devised by Dr X. Dr Y stated that he can now see that Dr X's treatment plan was inappropriate.

159. Dr Y commented that following this incident, he has worked on becoming "*more stringent*" in adhering to his usual prescribing practices and is engaging in further education regarding the prescribing of drugs of dependence. In this respect, Dr Y affirmed that he is committed to ensuring safe prescribing practices in the future.

ANALYSIS OF CPU'S ADVICE AND DR Y'S RESPONSE

160. In considering the adequacy of care provided by Dr Y, I accept the CPU's advice that Dr Y continued the inappropriate prescribing practices of Dr X which ultimately contributed to Mr IKL's death.

161. In arriving at this conclusion, I recognise that there are a number of circumstances which may mitigate the degree of Dr Y's responsibility for continuing Dr X's treatment plan. Most critically, I note that there is no evidence to suggest that Dr Y was aware at the relevant times of any personal relationship between Dr X and Mr IKL. Moreover, while Dr X's private messages to Mr IKL suggest that he may have in fact intended to transfer care to Dr Y on an

ongoing basis, I accept Dr Y's contention that he provided treatment under the assumption that Dr X was retaining primary care. Finally, I note that Dr Y was very much junior in his career in comparison to Dr X, who was also the clinical director of the Medical Centre, such that Dr Y may have felt less able to raise concerns due to a power imbalance in their clinical experience.[41]

162. Despite these circumstances, I nonetheless consider that Dr Y's conduct in continuing Dr X's treatment plan without apparent regard to his own clinical judgement or legislative requirements was inappropriate and represented a material departure from the standards of his profession.

163. This is because, at the time of registration, each medical practitioner accepts personal accountability to act in accordance with their professional responsibilities. As noted in the Code of Conduct, "*[w]orking in a team does not diminish a doctor's personal accountability for professional conduct and the care provided*."

164. Rather, when working with other health practitioners, it is critical that clinicians engage in effective communication so as to ensure any care provided aligns with relevant professional standards. In this instance, I consider that Dr Y should have:

    a) taken further steps to seek out adequate handover information from Dr X;

    b) independently considered whether continuing Dr X's treatment plan aligned with Dr Y's own professional responsibilities and legislative requirements; and

    c) taken steps to address any concerns that arose, including by discussing these with Dr X or otherwise seeking advice from another experienced colleague, doctors' health service,[42] professional organisation or professional indemnity insurer.

165. In addition, Mr IKL's assertions to Dr Y that he had 'lost' prescriptions and required them to be re-issued ought to have been a red flag that he was drug-dependent and struggling.

166. In the circumstances, while I acknowledge the power imbalance between Dr Y and Dr X, and note that Dr Y was a very junior GP at the time of these events, I concur with the CPU that

[41] Ahpra's Register of Practitioners indicates that Dr Y was first registered as a medical practitioner in 2019 and became a fellow of the Royal Australian College of General Practitioners in 2023.
[42] Doctors' health services are available at www.drs4drs.com.au.

Dr Y had a contributory role in Mr IKL's death and consider that it is appropriate to refer Dr Y's conduct to Ahpra for further review.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr IKL, born [redacted] 1994;

    b) the death occurred on a date between 14 and 17 September 2023 in [redacted], Melbourne, Victoria 3066, from *mixed drug toxicity (gabapentin, codeine, diazepam, oxycodone, doxylamine, promethazine, zolpidem)*, with a contributing factor of *cardiac hypertrophy*; and

    c) the death occurred in the circumstances described above.

168. Having considered all of the circumstances, I find that the multiple drugs detected upon post-mortem toxicological testing, almost all of which were prescribed to Mr IKL by doctors at the Medical Centre, caused his death, with natural disease constituting a contributing factor. Certain of these drugs had central nervous system depressant effects, including gabapentin, codeine, diazepam, oxycodone, doxylamine, promethazine, zolpidem, which can cause synergistic central nervous system sedation and respiratory depression, which I consider to be the most likely mechanism of death.

169. It is clear that Mr IKL was struggling in the lead-up to his death. However, there is no direct evidence (by way of suicide note, for example) to suggest that he ingested these medications with an intention to end his life. While the gabapentin levels in Mr IKL's system on post-mortem toxicology were particularly high, which may be suggestive of an intentional overdose, there is no evidence in regard to Mr IKL's state of mind which would support a finding that his death was intentional. I simply find that the overdose occurred in the context of Mr IKL's ongoing use and abuse of prescription medication, upon which he had become increasingly dependent.

170. I find that, while Dr X was no longer prescribing medications to Mr IKL at the time of Mr IKL's death, his inappropriate prescribing practices over a number of years directly contributed to Mr IKL's trajectory of drug dependence and misuse that ultimately led to his death. In this regard, I note that the majority of the medications that were found upon post-mortem toxicology to be contributory to Mr IKL's death were ones recommended and/or initially prescribed by Dr X.

171. I find that Dr Y continued to prescribe these drugs in the regime set up by Dr X, without obtaining a Schedule 8 permit, or otherwise attempting to de-escalate Mr IKL's usage. Dr Y's actions must be construed in terms of the power imbalance between himself and Dr X as the Clinical Director of the practice, however, I do not accept that this mitigated his responsibility to ensure that there was a clear clinical rationale for all drugs prescribed. I do, however, acknowledge that Dr Y has reflected on his own prescribing practices as a result of Mr IKL's death and note the changes made to his own practice.

172. It follows that, while I make findings regarding both Drs Y and X, I consider that the overwhelming source of harm caused to Mr IKL in the lead-up to his death was the conduct of Dr X, who oversaw a deeply inappropriate prescribing regime in the context of a sexual and personal relationship that resulted in Mr IKL becoming drug-addicted, emotionally dependent and which ultimately led to his death.

173. I find that, in this regard, Dr X's conduct departed materially from the standards of his profession and that such conduct contributed to Mr IKL's death. In such circumstances, I find that Mr IKL's death was preventable.

REFERRAL TO AHPRA

174. I hereby refer Dr X and Dr Y to the Australian Health Practitioner Regulation Agency (**Ahpra**) and direct that a copy of this finding be provided to Ahpra for its review.

ACKNOWLEDGMENTS AND CORONIAL IMPACT STATEMENTS

I thank the Coroners Prevention Unit for its detailed review of the circumstances of Mr IKL's death, the Court's Legal and Registry teams for their assistance in this investigation, as well as the Family Laison Officer who has supported Mr IKL's family throughout the proceedings.

I convey my sincere condolences to Mr IKL's loved ones for their immeasurable loss and recognise the tragedy of grieving Mr IKL's death in circumstances I have considered to be preventable. I am especially grateful to Mr IKL's brother for his participation in the coronial process which has been instrumental in ensuring a thorough investigation. While I recognise the challenges of engaging with the coronial process, I am hopeful that my findings may offer some comfort to family who are deeply concerned to ensure that the circumstances of Mr IKL's death are not repeated.

I also wish to express my deep gratitude to Mr IKL's loved ones who took the time to provide the Court with a series of Coronial Impact Statements. I was greatly appreciative of the opportunity to consider such thoughtful reflections on Mr IKL. While the coronial process has been necessarily narrow in focusing on those circumstances which were proximate and causal to Mr IKL's death, I recognise that Mr IKL's life was far greater than his struggles during these final months.

Mr IKL was described as kind, generous, and musical. He was described as funny, and having had a wicked and witty sense of humour. Mr IKL "*love[d] with all his heart*" and was, in turn, a loved son, a younger brother, and a best friend. He will be profoundly missed by his family and friends. I was appreciative of the opportunity to consider such thoughtful reflections on Mr IKL and consider that my investigation into his death, by which I have been deeply saddened, has been richer for being provided with this small insight into who Mr IKL was in life.

DIRECTIONS AND ORDERS

I have elected to de-identify this finding prior to publication on the Court's website, to ensure the privacy of Mr IKL's family and due to evidence provided to the Court of wellbeing concerns on behalf of Dr X in the course of the coronial process. I consider this course of action to be consistent with the Court's prevention mandate and the need to balance the requirements in section 8 of the *Coroners Act 2008* (including the need to minimise the distress of family, friends, and others affected by deaths the Court is investigating, which may be amplified in the circumstances of a finding of this nature), with the principles of open justice and the public interest in publication of the finding.

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

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

[redacted], Senior Next of Kin (identified copy)

[redacted], Brother (identified copy)

Australian Health Practitioner Regulation Agency (identified copy)

Victorian Department of Health (identified copy)

Australian Commission on Safety and Quality in Health Care (de-identified copy)

Royal Australian College of General Practitioners (de-identified copy)

Dr X (C/- Wotton Kearney) (identified copy)

Dr Y (C/- Avant Law) (identified copy)

Senior Constable Ciaron Connolly, Coronial Investigator (identified copy)

Signature:

Ingrid Giles

CORONER

Date: 2 September 2025

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.