IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 004438

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Linda Joy Bridle
Date of birth:	3 November 1951
Date of death:	1 August 2024
Cause of death:	1(a) Combined drug toxicity (tapentadol, fluoxetine) Contributing factors Subdural haemorrhage
Place of death:	18 Newhaven Crescent, McLoughlin's Beach, Victoria

INTRODUCTION

1. On 1 August 2024, Linda Joy Bridle was 72 years old when she died in circumstances suggestive of an accidental drug overdose. At the time, Mrs Bridle lived at McLoughlin's Beach with her husband.

2. Mrs Bridle had a happy upbringing in Brunswick with three sisters and a brother. At the time of her death, Mrs Bridle was a mother of three children from her first marriage, grandmother of six, and great grandmother of one.

3. Mrs Bridle met her second husband Danny Bridle in about 1987, and they were married in June 1990. In 2004, they purchased a home at McLoughlin's Beach where they lived together until Mrs Bridle's death.

4. Mrs Bridle had a long history of illness. In the years leading up to her death, she received treatment for chronic back pain, atrial fibrillation, heart failure, chronic leg ulcers, hip and knee replacement, gastric ulcer, anxiety, recurrent urinary tract infection, and osteoporosis. Medical records indicate a remote history of alcohol abuse and that she had recently recommenced drinking after many years of sobriety. She had no history of illicit drug use or medication abuse.

THE CORONIAL INVESTIGATION

5. Mrs Bridle'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.

6. 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.

7. 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.

8. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mrs Bridle'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 – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into Mrs Bridle's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Identity of the deceased

10. On 1 August 2024, Linda Joy Bridle, born 3 November 1951, was visually identified by her husband, Danny Bridle, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

12. Forensic Pathologist, Dr Joanne Chi Yik Ho, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 6 August 2024 and provided a written report of her findings dated 9 December 2024.

13. The post-mortem examination was consistent with reported circumstances.

14. A post-mortem computerized tomography (**CT**) scan showed a subdural haematoma (*on the left extending up to the left posterior occipital region with no mass effect*). There was no skull fracture. According to Dr Ho, a subdural haematoma is a blood clot that forms between the protective layers of the brain as a result of tears to the veins around the brain caused by sudden movement, usually due to some form of blow to the head, such as a fall.

[1] 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.

15. Routine toxicological analysis of post-mortem samples detected prescription medications tapentadol[2] and fluoxetine (and its metabolite norfluoxetine)[3] at levels consistent with excessive use. Amitriptyline (and metabolite nortriptyline),[4] temazepam,[5] pregabalin[6] and meloxicam[7] were also detected. According to the toxicologist's report, the combination of drugs detected may lead to increased synergistic central nervous system (sedation) and respiratory depression.

16. Dr Ho provided an opinion that the medical cause of death was "*1(a) Combined drug toxicity (tapentadol, fluoxetine)*", with a contributing factor of subdural haemorrhage.

17. I accept Dr Ho's opinion.

Circumstances in which the death occurred

Background circumstances

18. Mrs Bridle was a patient of Clocktower Medical Centre, Sale. She was under the care of general practitioner (**GP**) Dr Rakesh Nandha until February 2024, at which point he stated he changed his work routine and was unable to see her. Dr Nandha stated that, to his knowledge, Mrs Bridle was "compliant with her medications and requested these appropriately".

19. Mr Bridle said his wife was prescribed a "plethora of medications" for her various medical conditions. These included long-term prescriptions including diuretics, selective serotonin reuptake inhibitor antidepressants, and analgesics including pregabalin and opioids. Her daughter stated Mrs Bridle often did not take her diuretics when she was planning to go out.

[2] Tapentadol is a centrally acting synthetic analgesic indicated for moderate to severe pain. The dual mechanism of mu-opioid receptor agonism and inhibition of norepinephrine reuptake yields a synergistic effect to maintain analgesia whilst significantly improving tolerability and reducing adverse effects compared to classic opioids.

[3] Fluoxetine is a selective-serotonin reuptake inhibitor indicated for major depression, obsessive compulsive disorder, and premenstrual dysphoric disorder. Trade names include Fluotex, Lovan, Prozac, Prozet and Zactin.

[4] Amitriptyline is a tricyclic antidepressant that inhibits the reuptake of noradrenaline and serotonin. It is indicated for major depression, panic disorder, neuropathic pain and enuresis. Trade names include Endep and Entrip.

[5] Temazepam is a sedative/hypnotic drug of the benzodiazepine class. Proprietary medicines containing this drug are Normison (10 mg tablets), Temaze (10 mg tablets), Temtabs (10 mg tablets).

[6] Pregabalin is a GABA and gabapentin analogue clinically used for treatment of partial seizures and neuropathic pain. Trade names include Lyrica, Pregaredi, Sudorega, Lypralin, Prelinaccord, Neuroccord, Lyraccord, Algerika, Lyzalon, Brillior, Lyrilin, Lyrigalin, Neurica, Gabrica, Pregabica and Prebalin.

[7] Meloxicam is a cyclooxygenase-2-inhibitor used as an anti-inflammatory. Meloxicam is available in Australia as Mobic (7.5 mg tablets).

20. On 6 February 2024, at her final appointment with Dr Nandha, Mrs Bridle was issued the following prescriptions (all of which she had been prescribed previously):

Endone tablet 5mg, 1 every 4 hours if needed for breakthrough pain

Oxynorm capsule 10mg, 1 every 4 hours as needed

Targin modified release tablet 30mg/15mg, 1 tablet twice a day

Furosemide tablet 40mg, 1 daily

Mobic capsule 15mg 1 daily as needed

Potassium chloride modified release tablet 600mg, 1 twice a day

Fluoxetine capsule 20mg, 2 daily

Lyrica capsule 150mg, 1 twice a day

Lyrica capsule 25mg, 1 twice a day to be used as directed

Lyrica capsule 75mg, 1 twice a day

Pariet enteric-coated tablet 20mg, 1 daily

Prolia syringe 60mg/1ml, 1 every 6 months

21. On 14 March 2024, Mrs Bridle was admitted to Sale Hospital with chest pain and palpitations on a background of a history of known heart failure. She was found to be in atrial fibrillation with rapid ventricular rate up to 170 beats per minute. She was commenced on anticoagulation treatment and prescribed apixaban 5mg twice daily. Records from this admission indicate Mrs Bridle had been taking less than her prescribed doses of fluoxetine and frusemide.

22. On 10 May 2024, Mrs Bridle had her first appointment with Dr Devkota at Clocktower Medical Centre. She expressed a desire to reduce her pain medications, including opioids. Records indicate she made similar requests during at least three earlier appointments with other GPs at the same clinic between September 2023 and February 2024. She reported that she had already reduced her daily dose of Lyrica from 375mg to 300mg and asked for help to reduce it further. Dr Devkota's notes indicate he discussed starting Mrs Bridle on tapentadol, which she was happy to trial. He ceased her prescriptions for Endone (oxycodone hydrochloride) and Targin (oxycodone/naloxone) and instead prescribed sustained release tapentadol 150mg twice per day and immediate release tapentadol 50mg four times a day. He also issued repeat prescriptions, including for Oxynorm (oxycodone hydrochloride) 10mg every four hours as needed and Lyrica (pregabalin) 75mg twice per day and 150mg twice per day. Dr Devkota's notes indicate that he intended to review her response to the new medication regime in two weeks.

23. Pharmaceutical Benefits Scheme (**PBS**) records indicate that the medications Dr Devkota prescribed were dispensed on 17 May 2024. On review of the medical records, it appears that Dr Devkota initially inadvertently issued electronic prescriptions for sustained release tapentadol in both 150mg and 50mg tablets before realising his error and issuing a subsequent prescription for immediate release tapentadol 50mg, as originally intended. However, the PBS record indicates only the prescriptions for sustained release tapentadol (at both 150mg and 50mg) were dispensed to Mrs Bridle. The PBS record indicates no future prescriptions for 50mg immediate release tapentadol were ever dispensed.

24. On 23 May 2024, Mrs Bridle was admitted to Sale Hospital with increased confusion, unsteadiness on her feet, and acute on chronic lower back pain. According to medical records, her husband reported she had started drinking again three months prior to this admission but had not had a drink in the last three days.

25. Medical records indicate concern about Mrs Bridle's polypharmacy that led her treating team to rationalise her medications before discharging her on 30 May 2024 with the following prescriptions to be dispensed in a Webster pack:

    Tapentadol sustained-release tablet 100mg, twice a day
    Apixaban tablet 5mg, twice a day
    Frusemide tablet 40mg, daily
    Metoprolol tablet 50mg, half a tablet twice a day
    Rabeprazole enteric-coated tablet 20mg, daily
    Potassium chloride modified release tablet 600mg, twice a day
    Mirtazapine tablet 15mg, 1 at night
    Paracetamol tablet 500mg 2 tablets three times a day
    Thiamine tablet 100mg 1 in the morning

26. PBS records indicate these prescriptions were dispensed on 31 May 2024.

27. A copy of the discharge plan, which included "GP to monitor and up-titrate tapentadol as needed", was sent to Clocktower Medical Centre and placed on Dr Nandha's file.

28. On 7 June 2024, Mrs Bridle had a telehealth appointment with Dr Devkota. Mrs Bridle told Dr Devkota about her recent hospital admission. She reported she had been taking Lyrica 75mg twice a day and tapentadol 150mg and she was in significant pain that was disrupting her sleep. She again told Dr Devkota that she was trying to cut down her pain medications.

Dr Devkota's notes indicate he advised her to increase tapentadol to 200mg twice a day (sustained release) and 50mg twice a day (immediate release) and increase Lyrica to 150mg at night and continue 75mg in the morning. Dr Devkota issued updated prescriptions for tapentadol. His notes state Mrs Bridle had an appointment scheduled with Dr Nandha "next week" to discuss pain management options, however there is no record of such an appointment taking place.

29. PBS records indicate that the prescription for sustained release tapentadol 200mg was dispensed on 8 June 2024.

Immediate circumstances

30. On 29 July 2024, Mrs Bridle attended an appointment with Dr Raaghav Sudan at Clocktower Medical Centre's "Script Clinic". In his statement to the court, Dr Sudan explained the Script Clinic offers ten-minute appointments for patients who need renewal of regular prescriptions, and who do not need a standard appointment to see their usual GP. During that appointment, Dr Sudan issued prescriptions (described in his notes as her "usual repeats") for medications including tapentadol (immediate release 50mg twice a day as needed, and sustained release 200mg twice a day), fluoxetine 20mg two daily, and temazepam 10mg at night as needed.

31. According to her husband, Mrs Bridle initially refused to take the pain medication prescribed following that appointment.

32. PBS records indicate the prescription for tapentadol sustained release 200mg was filled on 30 July 2024. According to her husband, Mrs Bridle did not take any of "that medication" (which I understand to mean tapentadol) until the evening of 31 July 2024. Forensic photographs of medication found at Mrs Bridle's home immediately after death indicate that at least four tapentadol 200mg tablets had been used from this prescription by the time of her death on the following day.

33. On the morning of 1 August 2024, Mrs Bridle's husband observed her to be "very frail and vague" and "not making a lot of sense". They had made plans to meet a friend at Commercial Hotel, Yarram, for lunch. According to her husband, Mrs Bridle insisted on attending despite being unwell.

34. Mr Bridle stated he had to dress his wife that morning as she was unable to dress herself, and once they arrived at lunch, she was unable to order her meal, so he ordered for her. Mrs Bridle

did not eat or drink anything and remained extremely vague during the meal. At the end of the meal, Mrs Bridle was unable to get up and she fell over. Mr Bridle and their friend carried her to the car, where they lay her down in the back seat.

35. According to her husband, Mrs Bridle repeatedly refused to be taken to hospital. He drove her home to 18 Newhaven Crescent, McLoughlin's Beach, arriving at about 3.00pm.

36. Mr Bridle left Mrs Bridle in the car while he retrieved her walking frame from inside the house. When he returned, she was unresponsive. He called emergency services and commenced cardiopulmonary resuscitation (**CPR**).

37. Ambulance Victoria responded and took over CPR without success. Paramedics verified death at 5.13pm.

38. Victoria Police also responded. Police located a large supply of prescription medications in Mrs Bridle's name, including boxes of amitriptyline, pregabalin, fluoxetine and apixaban, some of which appeared to have been dispensed several years prior.

39. Police investigations did not reveal any evidence of suspicious circumstances.

FAMILY CONCERNS

40. In her statement to the Court, Mrs Bridle's daughter, Nadine Earp, expressed concern about her mother's appointment with an unfamiliar doctor in the days before her death. Ms Earp was concerned that the prescriptions issued at that appointment may have contributed to her mother's passing.

FURTHER INVESTIGATION

41. As part of my investigation, I obtained additional statements from Drs Devkota and Sudan about their care and management of Mrs Bridle in the months and days leading up to her death. I also obtained a statement from the pharmacist and proprietor of the pharmacy where her prescriptions where dispensed, and SafeScript records relating to Mrs Bridle.

Statement of Dr Devkota

42. Dr Devkota stated that when he treated Mrs Bridle in May and June 2024, he was undergoing his first rotation as a general practice trainee. As such, he discussed more complex patient presentations, including Mrs Bridle's, with his supervisor. He stated he did not seek input

from Dr Nandha or any other practitioners who had prescribed medication for Mrs Bridle in relation to his treatment of her.

43. Dr Devkota stated that during his first consultation with Mrs Bridle on 10 May 2024, she stated she wanted to reduce her opioid medications. He implemented a plan to switch her opioid analgesics (Targin and Endone) for a lower equivalent dose of tapentadol. Dr Devkota explained that opioid rotation is a recognised approach to taper opioid doses.

44. Dr Devkota stated he did not have a copy of Mrs Bridle's recent hospital discharge summary available during his 7 June 2024 consultation with her. He stated the discharge summary was addressed to Dr Nandha, and explained the process was that hospital discharge summaries were faxed to the centre where they were put in the doctor's holding file until cleared by the doctor to whom they were addressed.

45. Dr Devkota stated he did not apply for a Schedule 8 permit to prescribe opioids to Mrs Bridle because he thought it preferable that her regular GP hold the permit, and he understood her intention was to return to Dr Nandha for ongoing care.

46. Dr Devkota stated Mrs Bridle had used a combination of Lyrica and opioid analgesics for a number of years. He stated he was aware of the potential for opiates and other medications to interact to increase the risk of side effects including sedation and respiratory depression, but in relation to Mrs Bridle, he opined "it would be anticipated that she would have developed a level of tolerance which made it unlikely that the combination of medications would be an issue for her".

Supplementary statement of Dr Sudan

47. In his supplementary statement to the Court dated 13 February 2026, Dr Sudan stated that during his 29 July 2024 consultation with Mrs Bridle, she did not report any side effects from her medications and did not have any features of central nervous system depression or cardiorespiratory depression. He noted the duration of tapentadol use (since May 2024) and stated she had no features of aberrant drug-seeking or drug-use behaviours.

48. He stated he was aware that the combination of tapentadol, temazepam, pregabalin and fluoxetine could cause cardiorespiratory depression, sedation, cognitive impairment, and falls, and that the combination of spironolactone, furosemide and propranolol could cause fluid and electrolyte disturbances. However, he noted Mrs Bridle had been taking the same medications

for at least two months without any reported side effects and formed the opinion that she was tolerating the medications well.

49. Dr Sudan stated he did not seek any input from Mrs Bridle's other prescribers before renewing her prescriptions without change. According to Dr Sudan, Mrs Bridle told him she would see Dr Nandha in three weeks' time, and he anticipated her pain management would be reviewed at that appointment.

50. Dr Sudan stressed that this appointment was his first and only consultation with Mrs Bridle, and that it was a brief appointment for renewal of her regular prescriptions. He stated he had to prioritise what could be addressed in that short time.

51. Dr Sudan further stated that Clocktower Medical Centre had implemented a written practice policy in response to Mrs Bridle's case, which included the following changes:

    (a) Patients on monitored medicines are not to be booked into the Script Clinic for renewal of prescriptions but must be booked to see their usual GP.

    (b) If a patient on monitored medications sees a GP other than their usual GP, they must be given an extended appointment to allow the treating GP enough time to undertake all reviews and checks (including checking SafeScript, considering any permit requirements, and considering signs of drug dependence) before issuing any prescriptions.

    (c) Any patients of concern that are on monitored medications are discussed at the clinic's fortnightly meeting.

    (d) Updated orientation protocol to ensure GP registrars are aware of SafeScript and Schedule 8 medication permit requirements from the start of their employment.

    (e) Require GP registrars to discuss their patient's care with their supervisor before initiating any monitored medicines, or if they are concerned about their patient's use of monitored medicines.

    (f) The Royal Australian College of General Practitioners' *Prescribing drugs of dependence in general practice* clinical guidelines are available in the clinic's policy manual for reference and access by doctors as required.

Department of Health records

52. Records obtained from the Department of Health indicate Dr Devkota checked SafeScript on 10 May 2024, but he did not check SafeScript during Mrs Bridle's subsequent appointment on 7 June 2024. Dr Sudan did not check SafeScript at all. Neither doctor (nor any other) applied for a permit to prescribe opioids to Mrs Bridle.

Coroners Prevention Unit review

53. As part of my investigation, I obtained advice from the Coroners Prevention Unit (**CPU**)[8] about the medical care Mrs Bridle received in the months leading up to her death. The CPU referred to statements provided by each of Mrs Bridle's treating clinicians, medical records, Medicare and PBS records, and records obtained from the Department of Health.

SafeScript

54. The CPU noted that on most occasions when Mrs Bridle's GPs prescribed monitored medications, they did not check SafeScript. Dr Devkota stated:

> "It is my usual practice to check SafeScript prior to prescribing Schedule 8 medications. I note from the medical record that a red alert prompt has been recorded and I believe that I would have reviewed the full Safescript record at the consultation on 7 June 2024. However, I have not recorded that it was checked in the entry for the consultation."

55. The SafeScript record shows that the Dr Devkota did not check SafeScript on 7 June 2024. The CPU advised that it is likely that Dr Devkota did not understand the difference between viewing an alert on prescribing software and opening SafeScript itself to check the record. The CPU noted this misunderstanding appears to be widespread among clinicians. SafeScript compliance issues have been identified in many cases before this court. For example, I examined the issue, and recent changes to legislation, in my finding into the death of LT (name redacted).[9]

---

[8] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[9] Finding into Death without Inquest regarding LT, dated 8 January 2026, available at: https://www.coronerscourt.vic.gov.au/sites/default/files/COR%202022%20001217%20-%20LT_Form%2038%20-%20Finding%20into%20Death%20without%20Inquest.pdf

56. However, the CPU concluded that while Mrs Bridle's prescribers did not check SafeScript as required, the available evidence does not support a finding that this failure contributed to Mrs Bridle's death.

Schedule 8 permits

57. The CPU noted that a Schedule 8 permit was required to prescribe Mrs Bridle opioids at the dosage and duration for which they were prescribed, however, none of Mrs Bridle's clinicians applied for a permit.

58. The CPU explained that the function of a permit is for a clinician to alert other doctors that they are prescribing Schedule 8 medications to a patient, so that other doctors do not inappropriately supply additional opioids.

59. Mrs Bridle's only opioid-prescribing doctors were at Clocktower Medical Centre. They were all aware of one another and had reference to one another's notes. The CPU explained that, in these circumstances the existence of a permit would not have made a difference to the prescriptions issued to Mrs Bridle or to her death.

Responsibility for treatment

60. The CPU noted that, in the months leading up to Mrs Bridle's death, it appears no clinician took primary responsibility for her treatment.

61. In their statements, Drs Devkota and Sudan both indicated their belief that Mrs Bridle had scheduled appointments with Dr Nandha for follow up and review. However, there is no indication that these appointments ever occurred. Dr Nandha stated he had not treated Mrs Bridle since February 2024 due to a change in his work patterns.

62. One result of this was that when the hospital discharge summary was sent to Clocktower Medical Centre on 30 May 2024, it was addressed to Dr Nandha, and therefore Dr Devkota was unaware of its contents when reviewing Mrs Bridle on 7 June 2024.

63. Of greater significance, the CPU was of the view that the lack of a primary clinician resulted in Mrs Bridle not receiving proper supervision during her opioid rotation to ensure she was taking the opioids and other medications as directed.

Opioid rotation

64. The CPU explained that opioid rotation is a challenging area of medicine with known clinical risks. They explained it requires skill and assertive follow-up while a clinician ceases a patient on a dose of one opioid, shifts them to another, and titrates the new dose to achieve analgesic effect without veering into excessive sedation (too much opioid medication) or unmanaged pain (too little opioid medication).

65. The CPU were of the view that it was unusual for a general practice trainee such as Dr Devkota to attempt opioid rotation with a patient such as Mrs Bridle who had been taking high dose opioids for an extended period.

Self-managing medications

66. The CPU also noted irregularities in the dispensing of Mrs Bridle's medications indicating she was not taking them as prescribed.

67. On 8 June 2024 Mrs Bridle was dispensed 20 tablets of 50mg tapentadol (take one tablet twice per day) and 28 tablets of 200mg tapentadol (take one tablet twice per day). This equates to about a two-week supply of opioid medication if taken as directed. However, it was almost two months later when Mrs Bridle was next dispensed tapentadol on 30 July 2024.

68. The CPU noted that Mrs Bridle had expressed to her clinicians that she wanted to cease opioids altogether and considered the possibility that she was trying to discipline herself to take opioids as little as possible over this period. The CPU explained that a reduction in opioid tolerance occurs within four to six weeks. Mrs Bridle may have lost some tolerance if she had been taking less than her prescribed dose of tapentadol for several weeks, making her more susceptible to overdose at the time of her death.

69. Finally, the CPU noted that toxicological analysis of post-mortem blood samples identified the presence of amitriptyline (which was last prescribed about a year before her death) and did not detect medications Mrs Bridle was expected to be taking at the time (such as metoprolol, apixaban, and furosemide). The CPU was of the view that this further indicated Mrs Bridle was likely self-managing her medication without clinical oversight.

Procedural fairness responses

70. In accordance with principles of procedural fairness, the Court wrote to Drs Nandha, Devkota and Sudan to provide them with an opportunity to respond to potentially adverse comments within this finding.

71. On 12 June 2026, Dr Nandha responded to the Court indicating that going forward he will ensure he applies for a permit for any patients taking the equivalent of 100mg morphine daily and highlight this in the medical records for the benefit of any other treating clinicians.

72. On 23 June 2026, Dr Devkota (via his lawyers) made submissions to the Court relating to the language used in paragraph 42 of this finding. In response to Dr Devkota's submission, I have amended paragraph 42 to more clearly reflect the care he provided to Mrs Bridle.

73. On 25 June 2026, Dr Sudan (via his lawyers) wrote to the Court noting that he had considered and reflected on my proposed findings and taken on board my comment that no doctor at Clocktower Medical Centre took responsibility for replacing Dr Nandha as Mrs Bridle's primary treating practitioner. In response, Dr Sudan informed the Court of an intended update to clinic policy whereby if a doctor is reducing their work hours or workload, or going on leave, there is to be a formal handover of any complex patients to the clinic's clinical lead.

74. I commend Drs Nandha, Devkota and Sudan for their cooperation and engagement with the Court throughout the investigation.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Linda Joy Bridle, born 3 November 1951;

    (b) the death occurred on 1 August 2024 at 18 Newhaven Crescent, McLoughlin's Beach, Victoria;

    (c) the cause of Mrs Bridle's death was combined drug toxicity involving tapentadol and fluoxetine with subdural haemorrhage noted as a contributory factor; and

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

76. The available evidence supports a finding that Mrs Bridle died in the circumstances of an accidental or inadvertent overdose, that is her death was the unintended consequence of the deliberate ingestion of multiple prescription medications.

77. While aspects of the clinical management and care provided to Mrs Bridle in the period immediately preceding her death could have been improved, the available evidence does not support a finding that there was any want of clinical management or care on the part of Drs Nandha, Devkota or Sudan that caused or contributed to her death. This is largely due to Mrs Bridle's variable compliance with her medication regime and somewhat chaotic dispensing habits as evidenced by the date some prescriptions were dispensed and the presence of superseded medications in postmortem toxicology.

78. I convey my sincere condolences to Mrs Bridle's family and friends for their loss.

COMMENTS

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

79. The available evidence indicates that from February 2024 until her death, there was no single practitioner who took primary responsibility for Mrs Bridle's care.

80. Opioid rotation carries significant and known clinical risks, and I agree with the CPU's assessment that it should be done by experienced medical practitioners with regular and assertive follow up and close monitoring. Opioid rotation is a significant clinical event, and close monitoring for opioid efficacy and adverse effects is recommended in most guidelines. Mrs Bridle essentially went without clinical review for eight weeks, enabled in part because no doctor at the clinic took responsibility for replacing Dr Nandha as her primary treating practitioner and actively followed her up.

81. I am also satisfied that Mrs Bridle was likely managing her own medication. In addition to the CPU's observations, I note Mrs Bridle's daughter and husband both indicated in their statements that she was known to take less than her prescribed dose of medications. Police located a large supply of prescription medications at her home, indicating she had been stockpiling rather than taking the medication as prescribed, and PBS records indicate some prescriptions were never dispensed.

82. Mrs Bridle's death sadly illustrates the inherent risks of inconsistent drug use and serves as a reminder that not all drug dependent behaviour looks alike. Her apparent practice of self-

managing medications without clinical oversight put her at heightened risk of inadvertent overdose or adverse event. These risks could potentially have been mitigated had one of Mrs Bridle's clinicians taken primary responsibility for her care.

83. I commend Dr Sudan and the Clocktower Medical Centre for the sensible changes made following Mrs Bridle's death.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

Danny Bridle, senior next of kin
Nadine Earp, daughter
Dr Raaghav Sudan (care of Doris Melara Escobar, Avant Law)
Dr Raghu Devkota (care of Louise Williams, Kennedys Law)
Dr Rakesh Nandha
Senior Constable Lucas Krstic, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 08 July 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day

on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.