IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 0537

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF LI (A PSEUDONYM)[1]

Findings of:	Coroner Ingrid Giles
Delivered On:	24 May 2024
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	12-15 March 2024
Counsel Assisting the Coroner:	Ms Anna Martin of Counsel, instructed by Ms George Carrington, Coroner's Solicitor
Representation:	Ms Rachel Ellyard of Counsel for Dr Agnes Le-Kim, instructed by Avant Law Mr Jayr Teng of Counsel for the Department of Health, instructed by the Department's in-house lawyers Mr Raph Ajzensztat of Counsel for the Department of Families, Fairness and Housing, instructed by Lander & Rogers
Keywords:	SafeScript, real-time prescription monitoring, drug toxicity, opioid use disorder, factitious disorder, borderline personality disorder, young person, 'in care', 'prescription shopping', recommendation.

[1] *See* Pseudonym Order in this matter, dated 30 November 2023.

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SUMMARY

1. LI was found unresponsive in his bedroom on the morning of 29 January 2019 in circumstances suggestive of a prescription drug overdose. He was 16 years of age when he died.

2. At the time of his death, he lived with his grandmother in Ferntree Gully.

3. LI faced extensive mental and physical health issues during his life. His medical history as of late 2018 included diagnoses of borderline personality disorder, factitious disorder, polysubstance abuse, and a significant number of self-harm and suicide attempts.[2]

4. Despite the complex issues that he faced, LI is described by his family as being a beautiful young man, with a kind and gentle way about him. He loved animals, had a big heart, and his beautiful smile made those around him feel warm and happy. He was well-mannered, stylish, charismatic, sometimes shy, but full of fun and adventure.

CORONIAL INVESTIGATION

Jurisdiction

5. LI's death constituted a *'reportable death'* pursuant to section 4(2)(a) of the *Coroners Act 2008* (Vic) (**Coroners Act**), as his death occurred in Victoria and was unexpected, unnatural, or resulted from accident or injury.

6. In addition, LI was the subject of a family reunification order under the *Children, Youth and Families Act 2005* (**CYFA**) at the time of his death.[3] LI's death is therefore also reportable pursuant to section 4(2)(c) of the Coroners Act because he was a person placed in the care of the Secretary of the Department of Families, Fairness and Housing (**DFFH**) at the time of his passing.[4]

[2] Statement of Dr Brett Stewart, Child and Adolescent Psychiatrist, Intensive Mobile Treatment Team, Eastern Health Child & Youth Mental Health Service (**CYMHS**), Coronial Brief (**CB**), pp. 85-86.
[3] Statement of Child Protection Deputy Area Operations Manager, CB, pp. 242-3.
[4] Section 287 of the CYFA states that a family reunification order confers parental responsibility for the child on the Secretary (of what is now called the Department of Families, Fairness and Housing, or 'DFFH'). The definition of 'a person placed in custody or care' in section 3(1) of the Coroners Act includes '(a) a person for

Purpose of the Coronial Jurisdiction

7. The jurisdiction of the Coroners Court of Victoria (**Coroners Court**) is inquisitorial.[5] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

8. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

9. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

10. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.

11. Coroners are empowered to:

    (a) report to the Attorney-General on a death;

    (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.

    These powers are the vehicles by which the prevention role may be advanced.

12. The power to comment arises as a consequence of the obligation to make findings. It is not free ranging. It must be a comment '*on any matter connected with the death*'. The powers to comment and make recommendations are inextricably connected with, rather

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whom the Secretary to the Department of Human Services [now DFFH] has parental responsibility under the CYFA'.

[5] *Coroners Act 2008* (Vic), s 89(4).

than independent of, the power to enquire into a death or for the purpose of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation.[6]

13. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[7] It is important to stress that coroners are unable to determine civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment or any statement that a person is, or may be, guilty of an offence.[8]

14. Whilst it is sometimes necessary to examine whether a person's conduct falls short of acceptable or normal standards, or was in breach of a recognised duty, this is only to ascertain whether it was a causal factor or background circumstance. That is, an act or omission will not usually be regarded as contributing to death unless it involves a departure from reasonable standards of behaviour or a recognised duty. If that were not the case, many perfectly innocuous preceding acts or omissions would be considered causative, even though on a common-sense basis they have not contributed to death.

15. It is also important to recognise the benefit of hindsight and to discount its influence on the determination of whether a person has acted appropriately.

Standard of Proof

16. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[9] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[10]

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[6] *Harmsworth v The State Coroner* [1989] VR 989 at 996.
[7] *Keown v Khan* (1999) 1 VR 69.
[8] *Coroners Act 2008* (Vic), s 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. *See* sections 69(2) and 49(1) of the Act.
[9] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[10] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

17. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[11] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

18. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of evidence commensurate with the gravity of the facts sought to be proved.[12] 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.[13]

Coronial inquest

19. Section 52(2)(b) of the Coroners Act provides that a coroner must hold an Inquest into a death if the death occurred in Victoria and the deceased was, immediately before death, a person placed in custody or care. As LI was a person '*in care*' under the Act, the convening of an Inquest into his death was mandatory under this provision.

20. LI's death was reported to the Court on the 29 January 2019. Dr Matthew Lynch, Forensic Pathologist from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of LI's body and routine full toxicological testing was carried out, following receipt of preliminary toxicological results indicative of drug toxicity.

21. I took carriage of the coronial investigation in October 2023. Detective Senior Constable Jereme Virtue of Maroondah Crime Investigation Unit had been appointed coroner's investigator and compiled the coronial brief, which underwent three iterations.

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[11] (1938) 60 CLR 336.
[12] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J: '*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'*.

22. The Inquest proceeded on the 12-15 March 2024, over four days in total, with Ms Anna Martin appointed as Counsel Assisting the Coroner, and Dr Agnes Le-Kim (LI's general practitioner), the Department of Health (**DoH**), and the Department of Families, Fairness and Housing (**DFFH**) all represented at Inquest. LI's family was present throughout the Inquest, with LI's father attending in person, and LI's grandmother and other loved ones participating via the Webex link. LI's family also provided coronial impact statements for my consideration of the impact of LI's passing on his loved ones.

Scope of Inquest

23. Although the coronial jurisdiction is inquisitorial rather than adversarial,[14] it should operate in a fair and efficient manner.[15] When exercising a function under the Act, coroners are to have regard, as far as possible in the circumstances, to the notion that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death.[16]

24. In *Harmsworth v The State Coroner*,[17] Nathan J considered the extent of coroners' powers, noting they are not '*free-ranging*' and must be restricted to issues sufficiently connected with the death being investigated. His Honour observed that if not so constrained, an Inquest could become wide, prolix, and indeterminate. His Honour stated the Act does *not* provide a general mechanism for an open-ended enquiry into the merits or otherwise of the performance of government agencies, private institutions, or individuals. Significantly, he added:

> *Such an inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death, etc. Such an Inquest could certainly provide material for much comment. Such discursive investigations are not envisaged nor empowered by the Act. They are not within jurisdictional power.*[18]

25. In *Lucas-Smith v Coroners Court of the Australian Capital Territory*[19] the limits to the scope of a coroner's inquiry and the issues that may be considered at an Inquest were also considered. As there is no rule that can be applied to clearly delineate

[14] Second Reading Speech, *Legislative Assembly: 9 October 2008, Legislative Council: 13 November 2008*.
[15] *Coroners Act 2008* (Vic), s 9.
[16] *Coroners Act 2008* (Vic), s 8(b).
[17] (1989) VR 989.
[18] *Ibid*.
[19] [2009] ACTSC 40. *See also* the comments regarding the limits of a coroner's inquiry, including that factual questions related to cause will generally be within the scope of the Inquest.

those limits, 'common sense' should be applied. In this case, Chief Justice Higgins noted that:

> *It may be difficult in some instances to draw a line between relevant evidence and that which is too remote from the proper scope of the inquiry ...[i]t may also be necessary for a Coroner to receive evidence in order to determine if it is relevant to or falls in or out of the proper scope of the inquiry.*

26. Ultimately, however, the scope of each investigation must be decided on its facts and the authorities make it clear that there is no prescriptive standard that is universally applicable, beyond the general principles discussed above.[20]

27. The scope of the Inquest was settled following receipt of submissions from Interested Parties at a Directions Hearing held on 1 December 2023, and was as follows:

> 1. *In the context of LI's physical health, mental health, and substance abuse issues, what if any, drug or combination of drugs caused LI's death?*
> 2. *Challenges faced in the provision and coordination of health-related and other supports to LI in the lead up to his death, including via his regular general practitioner, Dr Le-Kim;*
> 3. *Role of Child Protection in service coordination and ensuring the safety and wellbeing of children and young people facing serious addiction and mental health issues who are subject to Child Protection involvement;*
> 4. *What, if any, role does:*
>
> *a. Medical practitioner prescribing; and/or*
>
> *b. Pharmacy dispensing; and or*
>
> *c. SafeScript; and or*
>
> *d. Other Department of Health initiatives related to 'prescription shopping'*
>
> *have in identifying and monitoring practices of 'prescription shopping', including in relation to people under the age of 18; and*
> 5. *Having regard to the events leading up to LI's death, what, if any opportunities exist to enhance the safety of drug prescribing and dispensing in Victoria, including in relation to people under the age of 18.*

[20] *See* Ruling No.2 in the 'Bourke Street' *Inquest into the deaths of Matthew Poh Chuan Si, Thalia Hakin, Yosuke Kanno, Jess Mudie, Zachary Matthew Bryant and Bhavita Patel* (COR 2017 0325 and Ors), Coroner Hawkins, 23 August 2019, para. 55.

28. Given the length of time since LI's passing and the issues under consideration, the scope was crafted to be forward-focused. Rather than focusing on individuals, the aim was to examine the broader systemic issues that may have enabled LI to obtain the medications he obtained over an extended period.

Pseudonym order

29. Prior to a directions hearing in this matter being convened on 1 December 2023, on 30 November 2023, I issued a pseudonym order in this matter pursuant to section 55(2)(e) of the Coroners Act, requiring that, where in this proceeding, it is necessary to refer to the deceased or members of his family in the hearing of the Inquest or in any publication, pseudonym(s) are to be applied in accordance an annex to that order. The order requires the deceased to be referred to as 'LI', his grandmother as 'LI's grandmother', his father as 'LI's father' and his mother as 'LI's mother'.

30. In the order, I noted that I considered the use of a pseudonym to be necessary to secure the proper administration of justice in this proceeding, including to assist in upholding section 534 of the CYFA, to the extent applicable, and to ensure the family's capacity to actively participate in the Inquest, including to limit trauma and the impacts of the proceeding on the family's wellbeing.

Witnesses

31. The following witnesses were called to give *viva voce* evidence at Inquest:

    (a) Dr Matthew Lynch, Forensic Pathologist and Associate Professor Dimitri Gerostamoulos, Head, Forensic Sciences & Chief Toxicologist, both from the VIFM (giving evidence concurrently);

    (b) LI's father;

    (c) LI's grandmother;

    (d) Dr Agnes Le-Lim, LI's regular treating general practitioner (**GP**);

    (e) Ms Laura Mulligan, Acting Director, Medicines and Poisons Regulation, Department of Health; and

(f) Mr David Atkinson, Executive Director, Child Protection and Care Policy, Department of Families, Fairness, and Housing.

32. As part of the investigation into LI's death, the Coroners Prevention Unit (**CPU**)[21] was asked to provide advice and assistance in relation to the case, including identifying and instructing an appropriate expert to guide the Court's consideration of LI's interactions with medical practitioners and prescribing practices. That expert was Professor Edward Ogden, a medical practitioner and clinical specialist in addiction medicine, who prepared an expert report for the Court and who attended and gave expert evidence on the third day of Inquest.

Closing submissions

33. On 15 March 2024, following the close of oral evidence, Counsel Assisting and legal representatives of Interested Parties were invited to provide closing submissions. In the course of those closing submissions, legal representatives addressed the Court on the findings that are open to be made on the evidence, as well as on potential comments and recommendations, including on matters relating to public health and safety and/or the administration of justice.

Sources of Evidence

34. This Finding draws on the totality of the product of the coronial investigation into LI's death. That is, the court records maintained during the coronial investigation, the Coronial Brief, further material sought and obtained by the Court, the evidence adduced during the Inquest and oral submissions provided by Counsel Assisting and Counsel representing the Interested Parties.[22] In writing this Finding, I do not purport to summarise all of the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence does not imply that it has not been considered.

[21] 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.

[22] In the interests of certainty, this includes: (i) the Court file; (ii) Coronial Brief version 3, dated 16 February 2024; (iii) Additional Materials (containing two sets of documents labelled AM-1 and AM-2); (iv) Exhibits A-H (noting that the Coronial Brief and Additional Materials constitute Exhibits A and B); and (v) Transcripts of evidence and submissions from 12-15 March 2024.

BACKGROUND

35. LI had a complex background. LI's mother was drug-dependent while pregnant. LI was born opiate-dependent and experienced opiate withdrawal from birth.

36. Child Protection became involved in LI's life at an early stage, and he was the subject of thirteen reports to Child Protection from the age of 8 days until his death on 29 January 2019 (at 16 years old), with two such reports proceeding to the protection order phase.

37. Over his lifetime, LI moved between a number of different care arrangements:

    (a) living with both of his parents;

    (b) living with his father full-time, spending one night a fortnight with his mother;

    (c) joint care arrangements between both parents (while they lived separately, and also for a brief time again, together);

    (d) foster care; and

    (e) living with his grandmother and other family members.

38. LI commenced primary school in 2008. A year later he was diagnosed with attention deficit hyperactivity disorder (**ADHD**) and subsequently had a teacher's aide in class. He completed primary school in 2014 after reportedly performing well.

39. LI commenced high school in 2015 and family members recall this as a turning point in his life. It started with what his family described to be minor incidents of disobedience which required LI to be collected from school early.[23] LI's uncle also recalled an incident at home where LI showed a fascination with asthma symptoms suffered by LI's uncle's partner. Approximately two weeks later, LI attended a doctor and obtained a prescription for an asthma inhaler. LI's uncle did not believe that LI had a genuine case of asthma.[24]

[23] Statement of LI's father, CB p. 36; Statement of LI's grandmother, CB pp. 51-52; Statement of LI's uncle, CB p. 44.
[24] Statement of LI's uncle, CB pp. 44-45; Statement of Dr Agnes Le-Kim, CB p. 76 [5].

40. Family members recall that, from approximately 2017, it was a regular occurrence for LI to be taken to hospital for various unexplained illnesses. At times, he would call an ambulance from home or from school. On these occasions, LI would complain that he was suffering from pain, but doctors were unable to diagnose LI with any conditions. He was, however, often provided with pain medication.[25]

41. Over a period of time, family members eventually came to believe that LI was feigning illnesses to receive medication. LI reported a range of symptoms without clear organic basis, including back pain, chest pain, abdominal pain, headache, and seizures.[26]

42. Medicare and the Pharmaceutical Benefits Scheme records show that, despite having a regular GP, Dr Agnes Le-Kim, who emphasised the need for him to see her and her only, LI was known to attend multiple doctors from late 2017 and engaged in so-called 'prescription shopping' to obtain pharmaceutical drugs including opioids and benzodiazepines. Records indicate his prescription shopping escalated from July 2018 and continued through to his death in January 2019.[27]

43. Despite efforts to restrict his access to prescribed medications, LI reportedly visited 70 different doctors in 2018.[28] In the 12 months prior to his death, LI was dispensed 64 PBS prescriptions from scripts provided by 31 different doctors,[29] arising from over 100 consultations. LI spent considerable time visiting practitioners over a wide geographical area.[30]

44. Evidence from at least a dozen GPs suggests that LI presented as a calm, polite, and genuine patient with good understanding of his largely subjective and self-reported medical conditions. LI's young age appears to have lessened suspicion that he was prescription shopping. Nevertheless, suspicions were raised by some doctors, leading them to contact the Prescription Shopping Information Service. However, this generally occurred after the consultation had concluded and after LI had been prescribed to, in some cases followed by a text message instructing LI not to return to the practice.

[25] Statement of LI's father, CB p. 37; Statement of LI's grandmother, CB pp. 51-52; Statement of LI's uncle, CB 44-45.
[26] Statement of Dr Brett Stewart, CB, pp. 85-86.
[27] Pharmaceutical Benefits Scheme Patient Summary, CB pp. 165-169; Medicare Patient History Report, CB pp. 180-189.
[28] Statement of Dr Brett Stewart, CB p. 86.
[29] Pharmaceutical Benefits Scheme Patient Summary, CB pp. 165-169.
[30] Statement of Prof Edward Ogden, CB p. 308 [87]; Medicare Patient History Report, CB pp. 170-189.

45. Between 2015-2019, LI was admitted to hospital on multiple occasions in which records indicate drug overdose and/or intentional self-harm was a factor. By way of example, he was admitted twice to Box Hill Hospital Adolescent Inpatient Psychiatry Unit (**AIPU**) in August 2018. The first presentation on 2 August 2018 related to an intentional overdose of tramadol, oxycodone, and benzodiazepines. The second presentation on 19 August 2018 related to self-harming behaviours (namely multiple lacerations to his left arm) and a suspected opioid overdose.[31]

46. On both occasions, LI was assessed as not requiring acute psychiatric admission. Appropriate referrals were made, and LI was discharged into the care of his grandmother.

47. Other admissions to hospital during this period followed LI swallowing items such as a battery, coin, chain, screws, staples, or a needle.[32]

48. Health practitioners and care providers who were aware of LI's prescription drug misuse and opioid dependence made efforts to engage him with a range of health and wellbeing services. The supports available to LI in the latter half of 2018 included:

    (a) An addiction psychiatrist and addiction medicine specialist at Turning Point Eastern Treatment Services (Eastern Health's alcohol and other drug treatment service), who made a plan with LI in December 2018 to wean him from opioids in conjunction with, *inter alia*, his GP, Dr Agnes Le-Kim;[33]

    (b) Kinship care placement assessment, implementation of a targeted care package, and coordination of services from Anchor Inc, an entity contracted by DFFH to undertake case management in relation to LI and his family and to coordinate fortnightly care team meetings;[34]

    (c) Mentoring from Red Road Horizons Mentoring Service;[35]

[31] Statement of Dr Michael Gardner, Child and Adolescent Psychiatrist, Eastern Health, CB pp. 92-93; Eastern Health medical records, p. 1021.
[32] Statement of LI's grandmother, CB p. 65; Statement of LI's uncle, CB p. 46.
[33] Statement of Dr Matthew Frei, Clinical Director of Turning Point Eastern Treatment Services, CB p. 289.
[34] Statement of Anchor Placement Support Practitioner and Assessments Worker, CB pp. 68-69; Statement of Kinship Care Assessor/Case Manager, CB pp. 71-73.
[35] Statement of Dr Brett Stewart, CB p. 85.

(d) Avenues Education, a government school that works in partnership with Child and Youth Mental Health Services;[36]

(e) The Child and Youth Mental Health Service (**CYMHS**) Intensive Mobile Treatment Team (**IMTT**) at Eastern Health;[37]

(f) Psychological trauma-focused treatment from Knightlamp Consulting and Psychology;[38] and

(g) LI's high school.

49. LI's care team met fortnightly to share information and collaborate in providing services.[39] The supports that were put in place for LI included an activities mentor, who would spend time with LI on the weekend and engage him in physical activities, and assistance with transporting LI to and from school to minimise the risk of him 'prescription shopping'.[40] Dr Le-Kim remained LI's primary GP during this period, though was not formally included in the care team (a point which will be returned to further below).

CIRCUMSTANCES OF DEATH

50. Immediately prior to LI's death, LI was the subject of a family reunification order, made on 29 August 2018, which meant that LI was residing with his grandmother.

51. LI reportedly faced a number of stressors just before his death. On 22 January 2019, he received a caution for trafficking a drug of dependence in relation to an incident at school in October 2018.[41] His grandmother reported that he had developed some feelings for a friend that were not reciprocated, with resultant disappointment and distress.[42] Also in January 2019, LI swallowed a hypodermic needle, for which hospitalisation and endoscopic removal was required.[43] An ongoing intervention order

[36] Statement of Dr Brett Stewart, CB p. 85.
[37] Statement of Dr Brett Stewart, CB p. 85.
[38] Statement of Stephan Friedrich, AM-1, pp. 2-4; Individual Therapeutic Assessment and Plan, dated 18 August 2018, AM-1, p. 7.
[39] Statement of Anchor Placement Support Practitioner and Assessments Worker, CB pp. 68-69; Statement of Kinship Care Assessor/Case Manager, CB pp. 71-73; Statement of Prof Edward Ogden, CB p. 306 [75]-[76].
[40] Statement of Kinship Care Assessor/Case Manager, CB pp. 72-73.
[41] Statement of Dr Brett Stewart, CB p. 87.
[42] Evidence of LI's grandmother; T-68, lines 13-17.
[43] Statement of Dr Brett Stewart, CB, p. 87.

matter involving LI as the protected person and LI's father as the respondent was also finalised in January 2019.

52. On 27 January 2019, which was a Sunday, LI attended three different GPs to whom he was not previously known, and was prescribed the following opioids and benzodiazepines:

    (a) 20 tablets of codeine;

    (b) 20 tablets of alprazolam; and

    (c) 20 tablets of tramadol.

53. That medication was dispensed to him on 28 January 2019 when LI attended three different pharmacies to fill the prescriptions.[44]

54. LI's father spent time with LI on 28 January 2019. His father provided a statement about the conversations he had with LI on that day. He noted that, on the evening of 28 January when he drove LI back to his grandmother's house, LI was happy and '*so excited about all these different things*'.[45]

55. LI died at some stage over the evening of 28 and the morning of 29 January 2019. It was LI's grandmother who found him slumped over the bed on the morning of 29 January 2019 just before 10am. She provided a statement about calling '000' and the commencement of cardiopulmonary resuscitation (**CPR**). Despite the best efforts of his family members, LI could not be revived.

56. A search of LI's bedroom revealed, *inter alia*:

    (a) an empty vial of Targin (tablets containing oxycodone and naloxone);

    (b) an empty blister packet of codeine;

    (c) an uncapped needle (with no syringe attached).[46]

[44] Pharmaceutical Benefits Scheme Patient Summary, CB p. 169.
[45] Evidence of LI's father, T-50, lines 22-23.
[46] Statement of then-S/C Jereme Virtue, CB p. 283; clarified further in statement of Hayden Betts, Ambulance Officer, CB p. 313; Photos of scene, CB pp. 114-118.

IDENTITY OF DECEASED

57. On 29 January 2019, LI, born [redacted] 2002, was visually identified by his grandmother.

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

CORONIAL INQUEST

SCOPE ITEM 1 – The drugs that caused LI's death

59. The first item in the scope of Inquest is '*[i]n the context of LI's physical health, mental health, and substance abuse issues, what if any, drug or combination of drugs caused LI's death?'*. This scope item complements the Court's obligation to find, if possible, the cause of LI's death (including, where possible, the mechanism of death) pursuant to section 67(1)(b) of the Act.

MEDICAL CAUSE OF DEATH

60. Dr Matthew Lynch, Forensic Pathologist (**Dr Lynch**) practising at the VIFM, performed an external examination on the body of LI and provided a written report of his findings dated 31 January 2019 (**Lynch Report**) with the medical cause of death ascribed as *1(a) Mixed drug toxicity.* In the Lynch Report, it was noted that LI had been found at home in circumstances suggesting a possible prescription drug overdose and that Dr Lynch's examination was consistent with that history, following consideration of preliminary toxicology results.

61. A detailed toxicological report following further toxicological testing was issued on 14 March 2019 (**Toxicology Report**). In order to assist in the interpretation of the Toxicology Report at Inquest, I sought a statement from Associate Professor Dimitri Gerostamoulos, Head of Forensic Sciences & Chief Toxicologist at the VIFM (**A/Prof Gerostamoulos**), regarding the significance of the levels of each drug and how the substances may have interacted with each other to cause death. This statement was received on 31 January 2024.

62. Dr Lynch's opinion, supported by that of A/Prof Gerostamoulos, was that LI's codeine level was in itself potentially toxic.[47] Upon consideration of the toxicology report,[48] as well as the report of A/Prof Gerostamoulos,[49] Dr Lynch remained of the view that, while a holistic approach is required to assessing the effects of multiple drugs, codeine was certainly one of the drugs operating at the time of LI's death and '*probably the most significant*'.[50] A/Prof Gerostamoulos agreed that codeine was likely to be the most significant contributor to LI's death.[51]

63. Dr Lynch's opinion was that the likely mechanism of death was respiratory depression and the combination of drugs that could contribute to that respiratory depression should be included in the list of drugs associated with the cause of death being 'mixed drug toxicity'. Dr Lynch explained that his approach was to only ascribe potentially fatal toxicity to drugs that have been identified within the blood at the time of death.[52] According to the toxicology report, codeine, morphine, tramadol, alprazolam, and desmethylvenlafaxine were all detected in LI's blood.[53]

64. A/Prof Gerostamoulos gave evidence that the toxicology results indicated recent ingestion – that is, within 24 hours of LI's death – of codeine, tramadol, alprazolam, and venlafaxine (with morphine likely being a metabolite of the codeine, and the desmethylyenlafaxine being a metabolite of venlafaxine).[54] It is likely those drugs were ingested orally.[55]

65. Dr Lynch further noted that there were some drugs in the urine results that were reflective of recent or previous ingestion but were no longer present in the blood. Those drugs were oxycodone, naloxone, nordiazepam, oxazepam, temazepam, doxepin, and paracetamol.[56] A/Prof Gerostamoulos added that the presence of certain drugs in urine and not blood indicated likely use within the last 24-48 hours, and that the drugs likely to have been ingested that fell into that category were oxycodone and naloxone (likely

[47] Lynch Report, CB p. 18.
[48] Toxicology Report, CB pp. 20-30.
[49] Statement of A/Prof Gerostamoulos, CB pp. 332-336.
[50] Evidence of Dr Lynch, T-18 line 29 – T-19 line 1.
[51] Evidence of A/ Prof Gerostamoulos, T-27 line 29 – T-28 line 1.
[52] Evidence of Dr Lynch, T-19 lines 24-27.
[53] Toxicology Report, CB p. 21.
[54] Evidence of A/ Prof Gerostamoulos, T-21 lines 19-31 (recent use); T 22 line 29 – T 23 line 11 (morphine as a metabolite); T-23 line 14 – T-24 line 8 (use within 24 hours).
[55] Evidence of Dr Lynch, T-25 line 29 – T-26 line 8.
[56] Evidence of Dr Lynch, T-20 lines 6-13.

in the form of Targin, the commercial name for a tablet containing both drugs), doxepin, and paracetamol, as well as metabolites of drugs that suggest diazepine use.[57]

66. Based on this evidence and the revised approach put forward by Dr Lynch, the medical cause of LI's death was asserted to be '*mixed drug toxicity (codeine, morphine, tramadol, alprazolam and desmethylvenlafaxine)*'.[58] I agree with the evidence of Dr Lynch and A/Prof Gerostamoulos and I accept their opinion as to the medical cause of death.

EVIDENCE IN RELATION TO OTHER SCOPE ITEMS

SCOPE ITEM 2 – Challenges in supporting LI

67. The second item in the scope of Inquest is the '*[c]hallenges faced in the provision and coordination of health-related and other supports to LI in the lead up to his death, including via his regular general practitioner, Dr Le-Kim'.*

68. It was submitted to me by Counsel Assisting, and I concur, that the challenges faced in the provision and coordination of LI's treatment and care were significant, complex, and varied. Those responsible for his care on a medium to long-term basis went to great lengths to support LI and his family. Despite their efforts, the following challenges feature as being the most significant in the lead-up to LI's passing:

- Despite the treatment plan devised for him, which included Dr Agnes Le-Kim being his 'regular' GP from August 2017 (to provide oversight of his treatment and prescribed medications), LI continued to visit other general practitioners in an attempt to obtain further prescriptions;
- LI was diagnosed with borderline personality disorder, factitious disorder, and opioid use disorder, the combination of which presented significant challenges to those seeking to treat him, and his acceptance of that treatment; and
- LI's care and treatment needs required multiple agencies and individuals with different areas of expertise. How these services were coordinated, and interacted with each other in the community, was inherently challenging.

[57] Evidence of A/Prof Gerostamoulos, T-21 line 31 – T-22 line 10. Records indicate that LI was prescribed combined oxycodone and naloxone as recently as 24 January 2019, 4-5 days before his death - CB p. 169.
[58] Lynch Report, CB p. 19; Evidence of Dr Lynch, T-18 line 16 – T-19 line 27, T-20 lines 2-6; Statement of A/Prof Gerostamoulos, CB p.334 [14]-[15].

69. It was also raised by Counsel for Dr Le-Kim, and I accept, that further challenges were posed in relation to Dr Le-Kim's care of LI on the basis: (i) that many other services were involved with LI and she was not the one in charge of allocating the resources that she could see he needed; (ii) of the lack of consistency in caregiving for LI; and (iii) that Dr Le-Kim lacked appropriate referral options, including for alcohol and other drug services able to see patients in a timely manner.

LI's prescription-shopping behaviours

70. As previously noted, the evidence before me is that in the year before he died, LI was prescribed and dispensed with 64 Pharmaceutical Benefits Scheme (**PBS**) medications from prescriptions provided by 31 different doctors, arising from over 100 consultations.[59] These medications were primarily Schedule 4 and Schedule 8 medications, including opioids (such as oxycodone, codeine, and tramadol) and benzodiazepines (such as alprazolam). At times, and based on his self-reported symptoms, LI was also prescribed medications for health conditions for which he had no diagnosis, such as dabigatran, which is usually prescribed for atrial fibrillation.

71. The evidence of Professor Ogden was that LI exhibited 'red flags' that should have alerted medical practitioners to the fact that LI was drug-seeking. Despite LI's well-presented and polite demeanour, the doctors were faced with a young person who was:

(a) Unaccompanied by family or any other support person presenting with a '*serious medical condition*';

(b) Refusing permission to contact his family;

(c) Specifying a drug by name and dose;

(d) Often presenting late in the day when his usual practitioner was unavailable;

(e) Travelling far from home to visit the practice; and

(f) Presenting 'evidence' of his need for medication by showing poorly focused images of discharge summaries and other correspondence on an iPad.[60]

[59] Expert Report of Professor Edward Ogden (**Ogden Report**), CB p. 308 [87]; Medicare Patient History Report, CB pp. 170-189; Pharmaceutical Benefits Scheme Patient Summary, CB pp. 165-169.
[60] Ogden Report, CB 309 [93]; Evidence of Professor Ogden, T-204 – T-207.

72. Professor Ogden's opinion is that the appropriate response to LI's requests for medications should have included making further inquiries before prescribing. The red flags described above, should, in his view, have generated further inquiries and a '*healthy degree of scepticism*'.[61]

73. Inquiries might have included checking the Prescription Shopping Information Service, checking SafeScript (noting it was then in its infancy), calling LI's usual doctor, and/or referring LI to an emergency department for acute care.[62] Professor Ogden opined that, by prescribing to LI without making enquiries before doing so, these medical practitioners showed ineffective responses to the clinical situation they were presented with and undermined the 'one-doctor-one-pharmacist' position. Despite the fact that certain GPs noted their suspicions regarding LI's motives for seeking prescriptions, they found it difficult to say '*no*'.[63]

74. The result of 31 different doctors prescribing LI various medications over the course of a year, was that it presented a significant challenge for the rest of LI's care team in attempting to curtail his prescription-shopping behaviours. Evidence from LI's grandmother, LI's father, and Dr Le-Kim was that they, often through LI's Child Protection workers, '*painstakingly*' identified and notified each prescriber they were made aware of that LI was drug-seeking and ought not to receive further prescribed medications. LI's loved ones generally only became aware of new prescriptions by searching LI's schoolbag or locating empty packets in his room.

75. LI's school also reported to his father that LI was reportedly selling and swapping medications with other children,[64] which ultimately became a police matter and for which LI received a caution in January 2019.

76. Further, despite the best efforts of Dr Le-Kim, LI's grandmother and his care team – who were all acting to restrict LI's access to medication and putting arrangements in place to either have an adult administer all his medications or restrict the amount of

[61] Evidence of Professor Ogden, T-207, lines 6-7.
[62] Ogden Report, CB 309 [94].
[63] Ogden Report, CB 309 [90]; Evidence of Professor Ogden, T-209.
[64] LI's Grandmother's letter to the Court, CB p. 32; LI's Father's statement, CB p. 39.

medication he could be dispensed at one time[65] – LI was simply obtaining prescription drugs elsewhere without their knowledge. This presented a significant challenge to LI's care and treatment.

77. The absence of a mandatory real-time prescription monitoring service at a time during which LI was seeking multiple prescriptions for Schedule 4 and Schedule 8 medications from multiple medical practitioners meant that the challenging environment in which his care was being coordinated was heightened. This issue will be addressed further below under Scope Item 4.

LI's mental health issues

78. LI's mental health issues also presented a significant challenge to his treatment and care. Throughout 2018, he experienced suicidal thoughts and behaviours, leading to multiple Emergency Department presentations and admissions to Monash Stepping Stones, an adolescent inpatient mental health unit.[66]

79. A significant challenge for LI's grandmother, father, and Dr Le-Kim was that, while LI had appropriate access to a psychologist and psychiatrist at various points in his treatment, he was lacking ongoing access to psychiatric care throughout all of the periods he required it. Although Dr Le-Kim tried to refer him to various services, and LI was supported by services including Monash Intensive Mobile Outreach Support and later by Eastern Health's Child & Youth Mental Health Service (**CYMHS**),[67] Dr Le-Kim felt at times that she did not have '*any real back-up*' from a psychiatrist or psychologist throughout the period she cared for him,[68] opining that his complex presentation was beyond her scope of practice as a GP.

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[65] Statement of Dr Le-Kim, CB pp. 78-80 [24], [28], [38], [41]; Evidence of Dr Le-Kim, T-81; Statement of Child Protection Deputy Area Operations Manager, CB-255 [53], [55]; Evidence of L I's grandmother, T-72; T-74; T-76 line 27 – T-77 line 9.

[66] Statement of Dr Brett Stewart, CB p. 85; LI's grandmother's letter, CB pp. 32-33 and statement, CB pp. 52, 54-55; LI's father's statement, CB p. 40.

[67] Statement of Dr Brett Stewart, CB p. 86.

[68] Evidence of Dr Le-Kim, T-86 – T-87; T-108; T-110. It appears to be the case that, at times, LI was receiving psychiatric and/or psychological treatment but that Dr Le-Kim was not always notified – *see* CB p. 79 [29]. I also note the submission of Counsel Assisting in closing that, in relation to LI, from late 2017 until his death, and in the context of early mental health referrals for LI that were declined, '*It's not that he wasn't getting any psychiatric care. It is clear, in my submission, though that that [the] continuity of psychiatric care and consistency that Dr Le-Kim was really seeking is evidently absent*'- *see* T-314 lines 13 – 17.

80. LI's family was also of the view that psychiatric treatment was not available when his family considered he most needed it, and that he was considered, respectively, too acute or not acute enough for certain of the services that he was referred to.[69]

81. In December 2018, following Dr Le-Kim's earlier referral of LI to Turning Point Eastern Treatment Services (**Turning Point**), which was facilitated by the CYMHS' Intensive Mobile Treatment Team psychiatry registrar Dr Benham Bastami, LI was seen by an addiction psychiatrist with a plan implemented to address his aberrant medication behaviours. It is thus clear that at least by late 2018, LI was in receipt of coordinated psychiatric and addiction treatment.

82. LI's diagnoses of borderline personality disorder (**BPD**), factitious disorder, and opioid use disorder were noted, and he was recommended to commence opioid replacement therapy. LI declined the recommended treatment but agreed to the weaning of his oxycodone, with his prescribed medications overseen by Dr Le-Kim and dispensed in limited quantities to manage the risk of overdose.[70]

83. Professor Ogden provided evidence about the presentation of such disorders and how this constellation of diagnoses further complicated the effectiveness of LI's treatment and care. He noted that BPD is a severe personality disorder that is usually recognised in early adulthood. BPD is characterised by a pervasive pattern of instability in interpersonal relationships, self-image, and affects, as well as marked impulsivity. Professor Ogden noted that one of the features of BPD is having very raw emotions, and feeling things more acutely than others, with an example provided that even a change in case manager can be experienced by a sufferer of BPD as a major disaster and a rejection.[71]

84. Factitious disorder is a disorder in which people consciously induce, feign, or exaggerate symptoms to get personal attention or to meet some other goal, such as obtaining drugs or avoiding responsibilities. However, as noted by Professor Ogden, it can also lead to a person truly believing the untruths they are telling. The challenge

[69] LI's grandmother's letter, CB pp. 32-33 and statement, CB pp. 54-55, 58-59, 63-64; Evidence of LI's grandmother, T-59 – T-62, T-67 – T-68; LI's father's statement, CB p. 38; Evidence of LI's father, T-48; Dr Le-Kim's statement, CB 81; Evidence of Dr Le-Kim, T-84; Evidence of Professor Ogden, T-202 – T-204. This was compounded at times by LI moving into different services' catchment areas.
[70] Statement of Dr Matthew Frei, Clinical Director of Turning Point, CB pp. 289-290.
[71] Ogden report, pp. 301-302; Evidence of Professor Ogden, T-188 – T-189.

this disorder presents to the treatment of an individual is that it contributes to a breakdown of trust between doctor and patient. Once the clinician is aware of the disorder, they can no longer assume the patient has a genuine health concern or is genuine in the symptoms they report, which can heavily impact the therapeutic relationship. Professor Ogden gave evidence that, in the context of treating a patient with factitious disorder, it is '*a pretty brave step [for a clinician] to say I don't believe what you're telling me.*' [72]

85. LI was also diagnosed with opioid misuse disorder on the basis of his aberrant medication behaviours. This also raised a significant challenge for Dr Le-Kim and LI's treating clinicians, given that he continued to prescription-shop and stockpile medications despite the commendable efforts of his care and treatment team to wean him from opioids and oversee his medication use. He continued to report pain and symptoms for which there appeared to be no organic source.

86. The constellation of health issues faced by LI meant that his treating team faced multiple challenges in managing the risks associated with his ongoing drug use. This was compounded by other psychosocial factors, including reports of sexual abuse, drug trafficking and LI's frequent refusal to attend school.

Challenges presented by multiple agencies involved in LI's care

87. Finally, as submitted by Counsel Assisting, there was the overarching challenge that LI's complex presentation required multiple agencies, medical practitioners, and individuals with different areas of expertise to coordinate their provision of care to LI.

SCOPE ITEM 3 – Child Protection involvement

88. The third scope item is the *'[r]ole of Child Protection in service coordination and ensuring the safety and wellbeing of children and young people facing serious addiction and mental health issues who are subject to Child Protection involvement'.*

89. The Court was provided in August 2021 with a comprehensive statement from the Child Protection Deputy Area Operations Manager for the Bayside area, followed by an additional statement in February 2024 responding to the future-focused scope of

[72] Evidence of Professor Ogden, T-189 line 28 – T-192; Ogden Report, CB p. 302.

this Inquest from Mr David Atkinson, Executive Director, Child Protection and Care Policy, Children and Families Division of DFFH (**Mr Atkinson**). Mr Atkinson also gave evidence on the second day of Inquest.

90. Mr Atkinson explained that the role Child Protection plays when overseeing the care of a young person is predominantly via a case plan which sets out the long-term goals for the child, and objectives for the case. At times, Child Protection will contract another agency to perform all case management tasks and functions within that case plan. Whilst Child Protection therefore maintains oversight of the case plan and retains ultimate case planning responsibility, the contracted agency will have day-to-day management of delivering activities and services to the child and their family.[73] The contracted agency convenes a care team, bringing together the individuals who are supporting a young person's day-to-day care arrangements.

91. As noted above, Child Protection had been involved with LI and his family at various points since the first weeks of his life. For the purposes of the present proceedings, I have focused on Child Protection interventions in the last 12 months of LI's life.

92. In February 2018, Child Protection issued a Protection Application by Emergency Care for LI, and he was made the subject of an Interim Accommodation Order. Following a short period in foster care, LI was placed with his grandmother in April 2018 with support of the Kinship Engagement Team. In August 2018, LI was made the subject of a six-month Family Reunification Order and remained living with his grandmother, with ongoing support being provided to assist her in caring for LI.

93. In July 2018, Child Protection allocated an intensive Targeted Care Package (**TCP**) for LI and his grandmother, amounting to $185,565, with Anchor Inc (**Anchor**) engaged to lead and implement the suite of services funded thereunder. As is consistent with its usual process, Child Protection maintained oversight of LI's case plan and retained ultimate case planning responsibility, with Anchor maintaining day-to-day management of delivering activities and services to LI and his family.[74]

[73] Statement of David Atkinson, CB pp. 342-343; Evidence of David Atkinson, T-161 – T-164.
[74] Statement of David Atkinson, CB pp. 342-343; Evidence of David Atkinson, T-161.

94. Anchor went to great lengths in case managing LI's care.[75] The care team involved an array of specialists and social workers who met fortnightly. Significant efforts were made to curtail LI's drug-seeking behaviour. For example, Child Protection and/or Anchor: (i) traced and contacted every known medical service and pharmacy that issued a prescription and/or dispensed medication to LI from June 2018 onwards;[76] (ii) supported LI's grandmother to keep medication in a locked cabinet and to undertake checks of his schoolbag; and (iii) supported a range of therapeutic interventions for LI, including those targeted at improving his mental health.[77]

95. As put forward by Counsel for DFFH, Professor Ogden was clear in his view that effective services were provided by and on behalf of Child Protection, and that it is difficult to see how the responses of various services could have been improved. Notwithstanding this, the experiences of LI's family and GP during this period, in relation to which I heard evidence at Inquest, are important to note, namely:

(a) LI's grandmother felt she was not informed by Child Protection about the severity of LI's challenges before he was placed to live with her, in particular, the extent of his drug-seeking behaviour, which she struggled to curtail;[78]

(b) LI's grandmother also described her experience of being overwhelmed and '*bombarded*' with workers and appointments, with a lack of continuation of care between workers who were engaged to assist LI, describing the support provided as *'good on paper'* but at times, chaotic in reality;

(c) Following an incident in early 2018 which resulted in LI no longer residing with his father, LI's father felt excluded from his son's care and felt he was not listened to;[79] and

(d) Dr Le-Kim opined that despite being an important part of LI's life as his GP, and a critical part of his medical care and health planning, she was not invited to LI's care team meetings. She noted '*I somehow got lost in the system I*

[75] Statement of Anchor Placement Support Practitioner and Assessments worker, CB p. 67; Statement of Kinship Care Assessor/Case Manager, CB p. 71; Ogden Report, CB p. 306; Statement of Child Protection Deputy Area Operations Manager, CB pp. 253-255.
[76] Statement of Child Protection Deputy Area Operations Manager, CB pp. 254-255.
[77] Statement of Statement of Child Protection Deputy Area Operations Manager, CB pp. 253-258.
[78] Statement of LI's grandmother, CB p. 57; Evidence of LI's grandmother, T-58.
[79] Evidence of LI's father, T-46.

think, that was the problem, yes. There was just too many people looking after him and I was sort of not the most important person'.

Communicating with family members

96. I consider that the those working with and on behalf of Child Protection were working and communicating with LI's family in accordance with their statutory obligations. However, the experience of LI's grandmother and father is relevant for consideration in future cases in which Child Protection is tasked with ensuring the safety and wellbeing of children and young people facing serious addiction and mental health issues and is required to: (i) make decisions and communicate care arrangements to family members, particularly in relation to kinship placements; and (ii) coordinate a complex array of services and service providers. A pertinent comment will follow.

Communicating with health practitioners

97. The experience of Dr Le-Kim is also relevant to consider in the way in which future decisions are made in terms of: (i) the composition of a young person's care team; and (ii) the extent of communication with those involved in a child or young person's care who do not form part of a care team. In the case of LI, Dr Le-Kim might well have been considered an appropriate member of the care team proper, given her important role in his life and attempts to oversee his health issues and prescribed medications. This view was put forward by both Dr Le-Kim and Professor Ogden.

98. However, I acknowledge that, while Dr Le-Kim was not a formal member of the care team, communication between the care team and Dr Le-Kim took place, and I accept the submission of Counsel for DFFH that the current Child Protection protocol on 'care teams' requires: (i) the care team to be kept as small as possible in order to be effective; and (ii) that care team members '*consult and work closely with*', *inter alia*, health and mental health professionals.[80]

99. On this basis, I accept that there is no 'one-size-fits-all' and that there ought not to be a prescriptive approach in relation to membership of a care team. This accords with the evidence of David Atkinson that '*it's intended to be flexible membership to best*

[80] Care Teams Procedure, Child Protection, CB, p. 510.

suit the needs of each case'.[81] Moving forward, DFFH may however consider ways in which it could involve the GP of a young person exhibiting the intensive care and treatment needs of LI where this is indicated, either via care team membership (including funding therefor) or more structured communications.

Identifying the need for mental health support at the earliest possible point

100. Professor Ogden gave evidence that most young people who find their way into drug treatment programs have experimented with pharmaceutical products as children, and that almost all young people with a substance misuse disorder also have a mental health issue.[82] Accordingly, there is a clear need for any required mental health treatment to be considered for those subject to Child Protection involvement at the earliest possible stage. This is consistent with the evidence of LI's father who opined that LI was much easier to engage earlier in his Child Protection journey than later.[83]

101. In this connection, it is noted that the Department of Health and the Department of Families, Fairness and Housing are currently engaged in a working group, which was first convened in February 2024:

(a) to consider outcomes for adolescents with a mental illness who are Child Protection clients; and

(b) to establish mental health practice advisers within Child Protection, to advise and support Child Protection practitioners in the identification of and response to children's mental health needs, including navigation of the mental health system.[84]

102. I consider this to be a very promising development to strengthen Child Protection's workforce capabilities in relation to identifying behaviours associated with mental illness in adolescents, noting the evidence of Mr Atkinson in this regard,[85] and noting the evidence of LI's family that LI required ongoing access to psychiatric care when he first started displaying symptoms of mental ill health.

[81] Evidence of David Atkinson, T-165, lines 5-7.
[82] Ogden Report, CB p. 305; Evidence of Professor Ogden, T-194.
[83] Evidence of LI's father, T-40 – T-41.
[84] Exhibit G: Letter from Lander & Rogers on behalf of DFFH, dated 14 March 2024.
[85] Evidence of David Atkinson, T-174 – T-175.

SCOPE ITEM 4 – Avenues to address prescription-shopping

103. Scope item 4 is '*What, if any, role does: a. Medical practitioner prescribing; and/or b. Pharmacy dispensing; and/or c. SafeScript; and/or d. Other Department of Health initiatives related to 'prescription shopping' have in identifying and monitoring practices of 'prescription shopping', including in relation to people under the age of 18?*'.

I. What is prescription shopping and what is the role of prescribers / dispensers?

104. Professor Ogden notes in his expert report that 'doctor or prescription shopping' is one of the most common and simplest methods to obtain prescription medication for non-medical use. He states that there are people who utilise the 'open nature' of the Australian health care system to visit multiple practitioners to obtain desired medication. They usually have a substance use disorder and are seeking drugs or are suffering from factitious disorder. In addition (as appeared to be the case for LI), medication has a 'street value', and selling drugs may be a source of income for some.

105. A drug-seeking patient is likely to be a 'new patient' of a general practice when their usual doctor is described as being 'unavailable', or they may present to an emergency department feigning a painful condition requiring analgesia such as a migraine, kidney stones, back pain or chest pain. They tend to ignore medical advice on managing their pain or addiction.[86]

106. Clinicians have professional and clinical responsibilities to ensure that every medicine prescribed and dispensed is safe in all of the circumstances, and avenues to address prescription shopping such as SafeScript (described below) are intended to assist clinicians to exercise their judgment having regard to the clinical situation at hand, whether that be in the doctor's consulting room or at the pharmacy counter.

II. Avenues to address prescription-shopping in Victoria

i. SafeScript – real-time prescription monitoring in Victoria

[86] Ogden Report, CB p. 303.

107. Victorian medical practitioners have historically experienced difficulties in establishing who else is prescribing drugs to a patient. In the absence of accurate and honest patient self-reporting, doctors have relied on resources such as the Prescription Shopping Information Service (detailed further below), which can only provide limited information about patients, requires a telephone call to be made (which can be intrusive in a clinical setting), and also has restricted hours of operation.

108. As a consequence of doctors not being able to learn about one another and coordinate their patient care (including for drug prescribing), some patients have been able to attend multiple doctors to access and use drugs in excess of clinical need, thus leading to the development of dependence and contributing to pharmaceutical drug-involved morbidity and mortality.

109. Commencing in 2012, several Victorian coroners made recommendations for the Victorian Department of Health and Human Services (now Department of Health) to implement a real-time prescription monitoring (**RTPM**) system for the state. A RTPM system involves gathering information on target prescription medications immediately as they are dispensed, and storing this information in a central electronic database where it can be accessed by clinicians when a patient attends for treatment, and by pharmacists when a patient presents a prescription for a pharmaceutical drug.

110. Through the RTPM system, both prescribers and dispensers can identify and intervene to prevent excessive use of prescribed drugs, use of contraindicated drug combinations, prescription shopping, and other issues that underpin pharmaceutical drug harms. The dispensing information also can be centrally monitored by health authorities to identify prescribing and dispensing of concern and deliver targeted countermeasures to improve clinical practice.

111. The agitation for RTPM in Victoria culminated in an April 2016 announcement from the Victorian government that a state-wide system would be implemented. The system, named ‘SafeScript’, was made available to all Victorian pharmacies and medical practices in October 2018, initially on a voluntary opt-in basis with a focus on the western Victoria primary health network, but with some ‘early adopters’ signing up beyond the western region. Access to SafeScript was formally announced and promoted by the Victorian Government from 1 April 2019.

112. From April 2020 it has been mandatory to check SafeScript prior to writing or dispensing a prescription for a medicine monitored through the system. Clinicians who fail to take all reasonable steps to check SafeScript prior to prescribing or dispensing a monitored medicine can incur (according to the legislation) a penalty of 100 penalty units.[87] Exceptions to the mandatory use of SafeScript include for prescribing and dispensing when treating patients in hospitals, prisons, police gaols, aged care facilities and palliative care settings.

113. SafeScript monitors all Schedule 8 medicines as well as some Schedule 4 medicines. They include:

- opiates / opioids (including codeine, oxycodone)
- benzodiazepines (including alprazolam, oxazepam, temazepam)
- hypnotics and sedatives (zolpidem, zopiclone)
- stimulants for ADHD or narcolepsy (such as dexamphetamine)
- other high-risk medications (quetiapine, ketamine)

On 3 July 2023, pregabalin, gabapentin and tramadol were added to the list of medicines monitored in SafeScript.

Prescribing and dispensing utilising SafeScript

114. The SafeScript system is integrated with most software packages used for clinical note-taking, prescribing, and dispensing. If a doctor or pharmacist does not use software integrated with SafeScript, they can log in directly on the online SafeScript portal (located at https://www.safescript.vic.gov.au/) before prescribing or dispensing a monitored drug, in order to view the patient's medication history.

115. In the statement of Ms Jaqueline Goodall, then-Director of Medicines and Poisons Regulation, DoH, received on 15 November 2022, it is noted that SafeScript operates on a system of notifications and alerts. Notifications are the red, amber, or green messages that pop up on a prescriber or pharmacist's screen when they are prescribing or dispensing a medicine monitored in SafeScript. Notifications occur outside SafeScript in prescribers' prescribing and pharmacists' own dispensing software. Notifications are integrated into the prescribers' and pharmacists' software to

[87] *See* sections 30E (dispensing) and 30F (prescribing) of the *Drugs, Poisons and Controlled Substances Act 1981*. One penalty unit at the present time is $191.31, meaning a maximum possible penalty of $19,120.

minimise disruption from their workflow. These notifications are designed to signal quickly and clearly to the prescriber or ph6armacist whether their patients are at risk.

116. A **red** notification will appear when there is a current SafeScript alert relating to the prescribing/dispensing history of a patient. Criteria for a red alert include that the patient has been prescribed target drugs by four or more doctors in the past 90 days; or is being prescribed or dispensed certain high-risk combinations of drugs (such as potent opioids in combination with benzodiazepines); or has recently been dispensed opioids in the equivalent dosage of more than 100mg daily morphine.

117. An **amber** notification will appear when there is a current SafeScript alert relating to the prescribing/dispensing history of a patient. One criterion for an amber alert is that the monitored drug has been prescribed by more than one clinician in the past six months, or dispensed at four or more pharmacies during that period. Another criterion for an amber alert is when the SafeScript system detects the patient has recently been dispensed opioids in the equivalent dosage of between 50mg and 100mg daily morphine.

118. A **green** notification will appear when there has not been a prescription issued/dispensed for a monitored medicine in the last six months or when prescriptions for a monitored medicine in the last six months have been issued by the same prescriber/medical practice, and there are no alerts.

119. The alerts specify the potential issue detected (for example *'patient has obtained prescription medicines from at least four different prescribers within the last 90 days*') and prompt clinicians to consider the patient's recent history of prescribed drug use as part of their clinical decision-making. It is important to note that: (i) as a matter of process, the presence of a notification within the prescribing or dispensing software will always require a clinician to then separately log in to SafeScript to access the full alert information; and (ii) SafeScript does not seek in any way to replace the doctor's clinical decision-making or judgment, but is rather a tool to provide additional information relevant to that clinical decision-making.

Active compliance monitoring of SafeScript

120. In the statement of Ms Laura Mulligan, the Director of Regulatory Services in the Department of Health (**Ms Mulligan**), dated 29 January 2024, it was noted that, following the recommendations of Coroner Audrey Jamieson in the coronial investigation into the death of Bradley Liefvoort,[88] DoH commenced daily active monitoring of SafeScript data to detect when clinicians are not fulfilling their obligations to check SafeScript before prescribing or suppling a monitored medicine.

121. This involves running a report from SafeScript to identify and review the profiles of patients who have seen multiple clinicians in a short period of time. From this set of patients, a review is undertaken to confirm that the clinicians have checked the system before issuing a prescription or supplying the medicine.

122. Clinicians who are found not to be checking SafeScript before every prescription or supply of a monitored medicine are sent a formal letter reminding them of their obligation to check under the *Drugs, Poisons and Controlled Substances Act 1981*. The compliance letter requests that clinicians respond confirming that they understand the requirement to check SafeScript on each occasion before prescribing or supplying a monitored medicine.

123. Ms Mulligan stated that DoH is also working more closely with the Australian Health Practitioner Regulation Agency (**AHPRA**) as a co-regulator to improve compliance with the requirement to check SafeScript. AHPRA are notified if clinicians who receive a formal letter from the DoH due to not checking SafeScript ignore the letter and do not commence checking the system in the months following receipt of the letter. AHPRA investigates these notifications independently and is required to inform DoH of their outcome.

124. Ms Mulligan noted further that on 16 October 2023, an email was sent to all (approximately 38,000) registered SafeScript users reminding them of their obligation to check SafeScript under *the Drugs, Poisons and Controlled Substances Act 1981*, and to inform them that the Department is actively monitoring compliance with this.

[88] (COR 2021 2849). Finding dated 25 May 2023. Available: https://www.coronerscourt.vic.gov.au/sites/default/files/COR%202021%20002849%20Form%2038-Finding%20into%20Death%20without%20Inquest.pdf

Further communications about mandatory use of SafeScript in Victoria have also been sent out through medical professional indemnity organisations. Ms Mulligan indicated that these communications have resulted in active SafeScript use increasing by over 20 per cent between September and November 2023.

ii. Schedule 8 permits

125. Ms Mulligan noted in her statement that Schedule 8 permits issued by the Department under the *Drugs, Poisons and Controlled Substances Act 1981* are another regulatory tool to reduce incidence of prescription shopping in Victoria. Generally, a permit is required before prescribing a Schedule 8 drug of dependence to a drug dependent person, before any treatment with opioid replacement therapy or a psychostimulant drug, or when continuous treatment with a Schedule 8 drug of dependence exceeds eight weeks. A failure to do so exposes a prescriber to a penalty of up to 100 penalty units. There are exceptions to these requirements including when a patient is in palliative care, being treated for pain due to cancer, in hospital, or in residential aged care.

126. Ms Mulligan noted that the permit system recognises the special risks associated with Schedule 8 drugs, and the consequent need to coordinate treatments between practitioners to avoid concurrent treatment of a patient with the same or similar Schedule 8 drug by multiple practitioners.

127. The intention of the permit system is to maximise patient safety and to minimise the risk of patients developing or maintaining dependence and to avoid diversion of licit drugs for illicit purposes. Ms Mulligan noted in her statement that the permit system and SafeScript are complementary regulatory tools, though at Inquest opined that the permit system, while still in force in the legislation, now formed somewhat of an '*unnecessary regulatory burden*' given it was largely superseded by SafeScript.[89]

128. It is of concern to me that only one doctor applied for a Schedule 8 permit for LI (which was appropriately cancelled following contact with the applicant from Turning Point and DFFH, noting that LI had an existing GP and that Turning Point was working to assist LI in weaning from opioids). The evidence at Inquest was that LI

[89] Evidence of Laura Mulligan, T-118 lines 18-30.

was known to be drug-dependent, which gave rise to the requirement for a permit to enable prescription of Schedule 8 medications. He was prescribed weaning doses of Schedule 8 medications until his death.

129. However, this is unlikely to have changed the ultimate outcome for LI in circumstances where the one-off prescribers of Schedule 8 medications were not, for the most part, making enquiries before doing so that would have alerted them to the existence of a permit, had it been applied for.

III. Avenues to address prescription-shopping nationally

i. Prescription Shopping Program

130. The Prescription Shopping Program (**PSP**) is a federal initiative run by Services Australia and which operates nation-wide. It identifies patients who may get more PBS-subsidised medicines than they need. The PSP has a Prescription Shopping Information Service (**PSIS**) (a telephone information service that prescribers can register for to determine whether a patient meets the criteria for prescription-shopping) and a Prescription Shopping Alert Service (**PSAS**) (which assesses, on a monthly basis, patients who may be getting more PBS medicines than they need).

131. Patients meet the PSP criteria if they received any of the following within a three-month period:

- any PBS items prescribed by six or more different prescribers
- a total of 25 or more PBS target items
- a total of 50 or more target or non-target PBS items.

132. If a patient meets the criteria, the PSP will provide a summary of the PBS items supplied to them and/or provide a Prescription Shopping Patient Summary Report to the requesting prescriber. The report is a list of PBS medicines supplied to a patient in a 3-month period.

133. One of the GPs that LI attended in July 2018 sought and was provided with a Prescription Shopping Patient Summary Report,[90] which noted 11 different prescribers prescribing 15 PBS items, 11 of which were target items of concern. At the time, the PSIS was one of the main ways prescribers could check when patients were potentially 'shopping' for PBS-listed drugs via multiple doctors.

134. However, Professor Ogden noted that the PSP is '*kludgy to access*', is not real-time, requires the health practitioners to make a telephone call as opposed to using a computer interface, has a different focus to SafeScript (namely PBS medications, which cannot capture private prescriptions) and which has been largely eclipsed in Victoria by the advent of SafeScript.[91]

ii. Development of a national real-time prescription monitoring service

135. The national Prescription Exchange Service captures every digital prescription in Australia which is automatically fed into SafeScript. It does not capture doctors using handwritten prescriptions, the prevalence of which remains unknown (but which are captured electronically at the point of being digitally dispensed).

136. The National Data Exchange is effectively the sharing of information from the Prescription Exchange Service on a national level, which opens up the possibility of a comprehensive Australia-wide RTPM service. Ms Mulligan gave evidence that this is currently being explored by the federal Department of Health and Aged Care with the states and territories.

137. However, this does not appear to be on the national agenda for immediate implementation. Ms Mulligan indicated that the exact date of implementation of cross-border data sharing is unknown at this stage, and that while Victoria is participating in discussions '*it's been a very slow process'*.[92] In subsequent correspondence that followed her in-court evidence, Ms Mulligan indicated that the Department of Health and Aged Care had placed the project on hold due to other priorities, though it may proceed in the 2024-25 financial year.[93]

[90] Exhibit D, Prescription Shopping Patient Summary Report from 1 May 2018 to 31 July 2018.
[91] Evidence of Professor Ogden, T-223 line 7 – T-225.
[92] Evidence of Laura Mulligan, T-123, lines 22-23.
[93] Exhibit H, Letter from DoH to the Coroners Court dated 14 March 2023.

138. Professor Ogden emphasised that a national solution is required for RTPM, noting in his expert report that he '*was recently consulted about a patient who received seven prescriptions in three states in two days*'.[94] I note for completeness that I received no evidence that LI was seeking drugs in other states or territories, though the full extent of the sources of his medication is unknown.[95]

iii. My Health Record

139. The My Health Record system is a secure, consumer-controlled online service operated federally that is aimed at supporting enhanced patient and consumer outcomes through better access to information. Where patients have not 'opted out' of this system, authorised healthcare providers can access My Health Record to view and add patient health information to inform clinical decision-making.

140. My Health Record may contain medical history (shared health, event, and discharge summaries), medicine and prescription details, allergies and adverse reactions, Medical Benefits Scheme (**MBS**) and PBS items, and other items.

141. Dr Le-Kim noted that LI's 'My Health Record' was not available when she was treating him, but that if it were, she would have been able to check whether he had in fact presented to hospital on the occasions that he told her he had done so. Even so, reflecting that in the course of her own treatment of LI (even as his regular GP), he had presented discharge summaries and photos of medications to support his request for pain medication, she would now also make independent enquiries with the hospital, pharmacist or other prescriber to verify the information first.[96]

142. Professor Ogden noted that the My Health Record, by definition, will be incomplete, opining that if '*you've opted in and each of the practitioners with whom you had dealings had the ability to upload to My Health, then it might be complete, but there are plenty of agencies - hospital, community services et cetera - which won't upload anything to My Health*'. He opined that, over and above any other method to assist in

[94] Ogden Report, CB, p. 311.
[95] For example, on 24 January 2019 LI reported to the Turning Point medical officer that he had obtained propofol and midazolam from an '*anaesthetist friend*' – *see* statement of Dr Brett Stewart, CB, p. 85. Child Protection also reported that as of late 2017, he was self-medicating with unprescribed medication purchased over the internet - Statement of Child Protection Deputy Area Operations Manager, CB, p. 245.
[96] Statement of Dr Le-Kim, CB, p. 615.

preventing prescription shopping of monitored medications, SafeScript is by far the best source of information available today. [97]

IV. Is a different clinical approach to young people warranted?

143. There is no differentiated approach to SafeScript for those under the age of 18, for example, by having a lower threshold for responding to potential concerns around prescribing and dispensing to those under the age of 18. Nor is this supported by DoH, with Ms Mulligan stating at Inquest that the introduction of a lower threshold is '*likely to be confusing for clinicians*', noting also that those under 18 are at relatively low risk of death by prescription medicine overdose compared to people over 18.[98]

144. However, Professor Ogden gave evidence that most young people who find their way into drug treatment programs, or into the criminal justice systems, have experimented with pharmaceutical products as children, and many of his patients, as an addiction specialist, admit to misuse of pharmaceutical drugs as children. He also noted a study examining 136,588 young people prescribed opioids after an operation, 5% of whom went on to fill another prescription more than three months after the procedure when it was unlikely that post-operative pain was still an issue.[99]

145. Indeed, for LI, two of the medicines that were included in his cause of death by Dr Lynch - alprazolam and codeine - were SafeScript-monitored from the inception of the RTPM system, with tramadol (a third drug referred to in the medical cause of death) being added as a monitored medicine in July 2023.

146. In the approximate three-month period leading up to LI's death, while no prescriber or dispenser was legally required to check SafeScript at that time, any doctor who considered providing a prescription to LI for either medicine could have registered for and checked SafeScript to find out what other benzodiazepines, opioids and drugs of dependence had been dispensed to him. Likewise, any pharmacist who dispensed alprazolam or codeine to LI could have reviewed on SafeScript how often he was accessing these and other drugs of dependence (and I accept the submissions of

[97] Evidence of Professor Ogden, T-226 – T-227.
[98] Statement of Laura Mulligan, CB, p. 318. *See also* evidence of Ms Mulligan, T-157 line 19 – T-158 line 10. Ms Mulligan was not apprised of data relating to non-fatal overdoses, though noted that this is held by DoH.
[99] Ogden Report, CB p. 305, referencing Harbaugh, C.M., et al., *Persistent Opioid Use Among Pediatric Patients After Surgery.* Pediatrics, 2018, 141(1): p. e20172439; Evidence of Ogden, T-194.

Counsel for DoH that, at times, some clinicians did so). However, while SafeScript was available prior to LI's death, this had not been formally rolled out on a statewide basis, with the monitoring service not formally announced and promoted by the Victorian Government until approximately three months after LI's death.

147. I note that LI was dispensed tramadol on seven occasions in the 12 months prior to his death, but not for five months prior to the 20 tablets on 27 January 2019. By comparison, in the same 12-month period, LI was dispensed codeine (in various formulations) on three occasions, benzodiazepines on five occasions, and oxycodone (in various formulations) on 19 occasions.

148. A lower threshold for young people for alerts in SafeScript may therefore not be supported by the DoH based on data relating to deaths of those under 18 by way of prescription medication, but it may be considered that the evidence base for this issue should not be measured solely by fatal overdoses, noting that LI had multiple non-fatal overdoses in the lead-up to the lethal overdose on 28 or 29 January 2019.

149. In any event, with respect to young people, prescribers and dispensers of monitored medicines ought to remain particularly vigilant in prescribing and dispensing Schedule 4 and Schedule 8 medications. Professor Ogden noted that doctors may consult with and prescribe to patients under the age of 18 in the absence of a parent or guardian, but must have regard to their maturity, any involvement of Child Protection or other court orders, and the best interests of the individual. A prescriptive approach is therefore not appropriate; in the view of Professor Ogden, '*wherever you draw the line, there'll be someone just on the other side of it'*.[100]

SCOPE ITEM 5 – Enhancing the safety of drug prescribing and dispensing in Victoria

150. The fifth scope item is *'[h]aving regard to the events leading up to LI's death, what, if any opportunities exist to enhance the safety of drug prescribing and dispensing in Victoria, including in relation to people under the age of 18?'*

[100] Evidence of Professor Ogden, T-230. On this topic, Dr Le-Kim stated that, these days, '[*i] a patient who was a minor presented to me seeking opioid medication I would request a parent or guardian attend the consultation so there was an adult to support ongoing treatment and help with the safe administration of the medications. If this wasn't possible, I would arrange staged supply and a nominated pharmacist*' – Statement, CB p. 615.

i. Enhancing compliance with SafeScript-checking

151. RTPM provides a powerful tool to prescribing clinicians, especially busy GPs, to easily check a patient's records of prior medications and consultations and to make informed decisions as to their need for requested medications. However, the evidence at Inquest demonstrated that, even in 2024, five years after LI's passing, there is still a long road to be travelled to achieve compliance with clinicians' mandatory obligations to check SafeScript.

152. Ms Mulligan gave very useful evidence at Inquest, noting that, while 99 percent of 'in-scope' clinicians are registered to use SafeScript, which is clearly positive, the rate of compliance – namely clinicians actually checking SafeScript prior to prescribing or dispensing monitored medications – is only **70 percent**.[101]

153. Ms Mulligan identified that the reasons for this might be that clinicians do not wish to be monitored or have their clinical practice overseen by the state. She also noted that there are different rates of compliance amongst different cohorts, and that '*those that have done their medical degree overseas and come and get registered in Victoria sometimes don't always understand that they need to register and use the system*'.[102]

154. She noted that the compliance strategy of DoH has focused on writing to all clinicians registered to check SafeScript to remind those who have failed to check SafeScript prior to prescribing or dispensing monitored medications of their statutory obligations, and where they are not responsive to the letter, referring them to AHPRA for investigation. However, this compliance activity relates only to the very worst offenders:

> '*We wouldn't notify about every single clinician [who is] not checking the system, or we'd be notifying about many, many thousands of clinicians. So we send a list of sort of roughly between 10 and 30 each month to AHPRA*'.[103]

[101] Evidence of Laura Mulligan, T-133 lines 19-27.
[102] Evidence of Laura Mulligan, T-141 line 24 – T-142 line 22.
[103] Evidence of Laura Mulligan, T-155 lines 6-10. Professor Ogden also gave evidence that his experience in addiction medicine practice, was that he still sees patients with opioid use disorder who have rarely, if ever, had

155. When the Court followed up with AHPRA following the closure of Inquest with a request for details to be provided in a non-identified manner regarding any action taken since April 2020 in relation to Victorian medical practitioners or pharmacists for non-compliance with SafeScript, the following information was provided:

- 11 practitioners in relation to 14 notifications had regulatory action taken under section 178 of the National Law and their notifications have been closed; and
- 3 medical practitioners have had interim action taken (immediate action under section 156 of the National Law) and their notifications remain under investigation or before the tribunal.[104]

156. Accordingly, noting that these numbers demonstrating where action has been taken in relation to non-compliant clinicians appear to be very low compared to those referred to AHPRA in relation to non-compliance, there is broad scope for improvement in ensuring compliance with SafeScript checking by clinicians.

157. This is particularly resonant given the evidence at Inquest that during the five years SafeScript has been operational, while a penalty of 100 penalty units exists for failing to check SafeScript, '*[w]e have not ever administered that penalty. My understanding is due to the way the legislation has been drafted we're not actually able to implement that penalty. However, legislation change is happening at the moment so that we are able to penalise people.'*[105]

158. Such improvement in compliance need not be through disciplinary or punitive means – even if the legislation is amended in the future to provide for an easier path to administer penalties for non-compliance. Indeed, Professor Ogden considers there to be an opportunity for DoH to communicate more effectively with clinicians who are subject to the obligations under the *Drugs, Poisons and Controlled Substances Act 1981* to check SafeScript in a non-punitive manner, and to walk alongside those clinicians and reframe '*the very formal legalistic letters that they send out which do sound like you're being naughty when they're actually seeking more information*'.[106]

SafeScript checked before being prescribed opioids by doctors - Ogden statement, CB p. 311; Evidence of Professor Ogden, T-220.

[104] Letter from AHPRA to the Coroners Court dated 10 May 2024, AM-2. These numbers relate to incidents recorded in Victoria where at least one of the reasons recorded for action taken was failure to check SafeScript.

[105] Evidence of Ms Mulligan, T-142.

[106] Evidence of Professor Ogden, T-233.

159. It is clear that, while there may be cultural barriers to checking of SafeScript, there remains the possibility that there is a lack of understanding across all clinicians prescribing monitored medications that checking SafeScript is mandatory. Accordingly, and noting Professor Ogden's opinion that SafeScript will not achieve its aims unless it is checked 100 per cent of the time, compliance with checking SafeScript must urgently be improved. Pertinent recommendations will follow.

ii. Expanding the settings in which SafeScript is required to be used

160. As urged upon me by Counsel Assisting, it is also worth noting in relation to SafeScript that hospital prescribers are not required to check it when prescribing monitored medicines in a hospital setting (due in part to data security issues). While hospital pharmacists are required to check it when supplying monitored medicines to patients for use outside of hospital (such as on discharge or out-patients),[107] there is still a gap in the effectiveness of the system as long as it excludes hospital prescribers.

161. This is relevant in the context of LI's case given how frequently he presented to emergency departments; and in the context of Dr Le-Kim's evidence that following admissions to hospital where patients might have been dispensed with opioids or strong painkillers, they end up attending upon their GP expecting another prescription for Endone or tramadol.[108] An opportunity exists for the Department of Health to continue to consider revisiting the technological barriers to implementing SafeScript throughout hospitals in Victoria to further protect patients.

iii. Expanding the reach of RTPM from a state-based to a federal system

162. Another limitation of SafeScript identified by both Ms Mulligan and Professor Ogden was the fact that it does not currently interact with any federal prescription monitoring service, or other states and territories. The Court received evidence that while cross-border data sharing has been considered at various levels of government, the exact date of implementation of such data sharing is unknown at this stage, with suggestions that it might happen in the 2024-2025 financial year.[109]

[107] Evidence of Professor Ogden, T-217 – T-218; Exhibit E: SafeScript for Hospital Health Professionals (DoH website), pp. 1, 9.
[108] Evidence of Dr Le-Kim, T-98 line 23 – T-99 line 3.
[109] Exhibit H: Letter from DOH to Coroners Court, 14 March 2024.

163. I consider there to be an opportunity for the Victorian Department of Health to continue working with the Commonwealth Department of Health and Aged Care to implement cross-border data-sharing.

iv. Streamlining the regulatory framework

164. Schedule 8 permits appear to be of lesser importance in terms of identifying and monitoring 'prescription shopping', following the implementation of SafeScript. The evidence of Ms Mulligan was that the primary focus of DoH in assessing the requirements for Schedule 8 permits is in checking information that a clinician can access themselves via SafeScript, namely whether there is another permit that has been issued already and whether there are any SafeScript notifications.[110] Ms Mulligan gave evidence that it could be argued the permit system has been superseded by RTPM and may be an unnecessary regulatory burden. She indicated there had been moves by all jurisdictions to reduce the permit requirements to focus, as a regulator, on encouraging use of RTPM as a '*better system*'.[111]

165. At Inquest, evidence was heard that 35,000 permits are issued a year, taking up a significant number of resources. Where the permit system is considered to have been largely superseded, it is difficult to understand why resources ought to continue to be directed at such a system. In circumstances in which SafeScript is considered by the DoH and experts alike as the most important service in this state to assist in the identification and monitoring of prescription-shopping, the focus and resources of the state might be considered better-focused on increasing compliance with this powerful tool.[112]

FINDINGS

1. Having investigated the death of LI, and having held an Inquest in relation to LI's death from 12-15 March 2024 (inclusive) at the Coroners Court at Melbourne, I make the following findings, pursuant to section 67(1) of the Coroners Act:

   (a) that the identity of the deceased was LI, born on [redacted] 2002;

[110] Evidence of Laura Mulligan, T-117 – T-118.
[111] Evidence of Laura Mulligan, T-118.
[112] Evidence of Professor Ogden, T-227.

(b) that LI died at [redacted] Ferntree Gully, from *1a. mixed drug toxicity (codeine, morphine, tramadol, alprazolam and desmethylvenlafaxine)*;

(c) in the circumstances described above.

2. **Dr Le-Kim:** I find that the care provided to LI by his regular GP, Dr Le-Kim, was '*above and beyond what you'd expect of most general practitioners*'. At great personal cost, Dr Le-Kim continued to treat and care for LI, referred him to Turning Point to help manage his addictions and participated in his broader treatment plan with skill and compassion.[113] In addition, Dr Le-Kim commendably reflected on what has changed in her own practice since LI's passing, including a greater awareness about potential signs of drug misuse in her patients, and considerations relating to treating young people.

3. **Child Protection and LI's care team:** I find that the care provided to LI and his family by and on behalf of Child Protection, and within LI's care team, was comprehensive, effective and consistent with applicable statutory obligations, with a wide array of supports being provided to LI and his family. The Court's expert opined, and I agree, that LI's care team met regularly to co-ordinate and provide optimal care. Nevertheless, the experience of LI's family members and GP that was described at Inquest was that of frustration and disempowerment despite the level of care provided. A pertinent comment will follow.

4. **Use and operation of SafeScript:** The circumstances of LI's passing bring into sharp relief the importance of prescribers checking SafeScript to determine whether those seeking access to prescribed medications have a genuine therapeutic need, and who may otherwise be at risk of impulsive ingestion of medications that have been prescribed even on a one-off basis. As opined by Professor Ogden, the general practitioners who wrote prescriptions for benzodiazepines and opioids to meet LI's demands perpetuated the cycle of his 'doctor shopping'.[114]

[113] While not examined at Inquest, I found the statements provided by clinicians involved in LI's care very valuable (including but not limited to the statements of Dr Brett Stewart of CYMHS, Dr Michael Gardner, Child and Adolescent Psychiatrist at Eastern Health, Dr Matthew Frei of Turning Point, and Stephan Friedrich of Knightlamp). I have not made findings regarding the specific contributions of these persons or services to LI's care, given the narrow scope of Inquest, but consider the statements provided to collectively demonstrate the 'admiral effort' of the specialist services involved in LI's care and treatment.
[114] Ogden Report, CB, 309.

5. I find that the doctors who prescribed opioids and benzodiazepines to LI on a one-off or short-term basis, including those who stated they referred to the Prescription Shopping Program *after* LI had left with a prescription, missed an important opportunity to intervene in this cycle.

6. It was a cycle that ended in LI's death.

7. Therefore, despite the future-focused scope of the Inquest into LI's passing, I deem it necessary to notify each GP who prescribed to LI on a short-term or one-off basis of this finding in order to ensure they consider very carefully their future prescribing and referral practices, including to young people, who might present to them in a similar manner to LI, in a legal environment in which the checking of SafeScript is now mandatory.

8. As submitted to me by Counsel Assisting, it is clear that the implementation and mandatory[115] use of SafeScript for prescribers and pharmacists when prescribing or dispensing a monitored medicine has been a significant development since LI's death. The DoH are to be commended for the development and staged rollout of a system that, for the first time in real-time, allows for prescribing clinicians, especially busy GPs, to access a more complete patient high-risk monitored medication history.

9. I find that, had SafeScript been available then as it is today, and used effectively, the GPs who saw LI would have had crucial information pointing to LI's drug-seeking behaviours, and he would likely have been refused access to certain of the highly addictive medications that he was prescribed, and which led, tragically, to his death.

10. It is also commendable that, particularly since the death of Bradley Liefvoort, the DoH has commenced an active role in improving education and compliance with the checking of SafeScript, including through communications with practitioners who are behaving unlawfully and by referring a portion of these to AHPRA.

11. However, the evidence at Inquest demonstrated that, even in 2024, five years after LI's passing, there is still a long road to be travelled to achieve compliance with clinicians' mandatory obligations to check SafeScript. A compliance rate as low as 70

[115] SafeScript became mandatory for prescribers and pharmacists when prescribing or supplying a monitored medicine from 1 April 2020.

per cent is astonishing, given that the obligation to check SafeScript is a mandatory one, with concomitant penalties under *the Drugs, Poisons and Controlled Substances Act 1981* for failure to do so. The fact that the penalty has never been administered (with barriers identified in doing so, or at least easily doing so) demonstrates that the legislation as currently framed is wanting.

12. I accept the submission of Counsel for the DoH that DoH does not regulate medical practitioners in relation to how to prescribe or dispense medications, and that clinicians are required to adhere to their applicable professional codes of conduct.

13. However, while prescribers and dispensers bear the obligation to check SafeScript as a matter of law, the fact that only 10-30 clinicians are referred by DoH to AHPRA per month – which is conceded to be a mere drop in the ocean of the '*many, many thousands*' of clinicians who fail to check SafeScript, and that only a tiny proportion of those referrals appear to have resulted in any action in relation to practitioners acting unlawfully since SafeScript was made mandatory in April 2020 – is of grave concern.

14. Professor Ogden maintained in no uncertain terms that '*SafeScript cannot achieve its aims unless all practitioners including pharmacists use the software <u>every time</u> that they write or dispense a prescription for the [monitored] drugs*'.[116]

15. It is clear that more needs to be done – urgently – to improve compliance with SafeScript-checking obligations under *Drugs, Poisons and Controlled Substances Act 1981*.

16. **Improving compliance with SafeScript**: It may be the case that improved compliance strategies are addressed in the five-year review of SafeScript that is currently underway and due to be finalised this financial year.[117] Regardless, the Inquest has identified some concrete opportunities for improvement to ensure that clinicians are not only aware of the mandatory obligation to check SafeScript, but are cognisant of the value in doing so, and are in fact, doing so.

[116] Ogden Report, CB p. 310, underlined emphasis in original.
[117] This may also address the issue of the significant resources that are being invested in a Schedule 8 permit system that appears to be largely obsolete since the advent of a mandatory RTPM service in Victoria.

17. Doctors may indeed be understandably wary of government having an oversight role in individual prescribing decisions, but that is not the framework in which SafeScript operates. It is a tool that offers a more informed basis upon which to make clinical decisions and to promote patient safety. A clinician who has checked SafeScript in accordance with the legislation and who is notified of an alert may still, thereafter, prescribe or dispense monitored medications if believed to be clinically necessary. The legislation merely requires that check to be undertaken.[118]

18. **Intentionality regarding LI's death:** There is no presumption for or against a finding of suicide. Nevertheless, a finding that a person has deliberately taken his or her life can have long-lasting ramifications for families and friends of that person. Therefore, it should only be made when there is clear and cogent evidence.

19. In this case, there is evidence that LI had a history of intentional self-harm and previous attempts at suicide, including by way of drug overdose, which resulted in his hospitalisation. He was found upon death to have multiple linear scars on his left forearm with features suggestive of self-harm, though there was no evidence that these marks were inflicted immediately prior to his death. The evidence in the coronial brief includes text messages in which LI describes a history of suicidal ideation and ongoing challenges he was facing in life, including financial stressors, relationship rejection, and past experiences of violence.

20. On the other hand, LI's father was vehement that his son's death was accidental and that he just '*went a little bit too far*' in consuming the drugs that led to his death, noting that LI presented as very mature but lacked appreciation of risk, including in relation to his medications. LI's grandmother was also of the view that LI's death was accidental, noting that at the time he passed, he was hopeful for the future and looking forward to starting a new school. Dr Le-Kim noted the issue of LI's suicidality was '*hard to gauge*' and opined that his death was likely accidental, and that his ingestion of the drugs that led to his death was possibly an impulsive act based on having access to medications.

[118] Evidence of Professor Ogden, T-232 lines 23-30. Professor Ogden noted, '*in talking to practitioners they have a sort of paranoia about the Department generally and SafeScript and you know that somehow 'Big Brother is watching' […] I spent a lot of time sort of explaining [to clinicians] no it's not that way round. You know the Drugs and Poisons Regulation Unit is actually there to support your practice and make sure that patients are safe'.*

21. Having considered all of the evidence, I am satisfied that LI intended to ingest the medications that led to his death, and that he did so in the context of a number of significant life stressors. However, due to LI's youth and inexperience in life, and his diagnosis of BPD, which brought with it impulsivity and a degree of reactivity of mood and affect, I am unable to determine whether he was able to comprehend it was a final act. I find that it was likely an impulsive act based on access to prescribed medications rather than a considered attempt at suicide.

22. **Preventability of LI's death**: The roll-out of SafeScript occurred after LI's tragic passing. I consider that, given LI's vulnerabilities, including his mental health diagnoses, recklessness in relation to medication use, repeated hospitalisation, and chronic self-harm, he remained a high risk of death by overdose throughout 2018 and early 2019, despite the best efforts of his care team. It cannot now be known what the long-term outcome would have been for LI, had SafeScript been mandatory at the time he was seeking prescriptions to monitored medicines, and had he not been prescribed these medicines by GPs even on a one-off or short-term basis, given the complexity of the issues he faced and his access to non-prescribed medications.[119]

23. I therefore cannot find definitively that LI's death in January 2019 was preventable. However, it is my view that, given the tragic outcome, the potential for systemic improvement should be identified, considered, and pursued. This Inquest has revealed, through the dedicated assistance of the witnesses who came before the Court, and through the very useful questions and submissions of Counsel, a number of opportunities to improve the current systems to assist in preventing future deaths.

24. I will proceed to make a number of comments and recommendations that draw upon the evidence pointing to these systems improvements, with the recommendations required to be responded to within three months. This is the way in which the prevention role of the Court is advanced, and may also be a way for LI's loved ones to see to fruition the systems changes that they have strenuously advocated for since his tragic death.

[119] To this end, it is also noted that the one GP prescribing on a one-off basis who did check SafeScript on 27 January 2019 appears to have concluded LI was compliant with the 'one doctor one pharmacy' position despite the fact that there were certain alerts at this time for LI. The reasons for this cannot now be definitively discerned (and the conclusion may have been specific to the drug prescribed) but it may demonstrate the ongoing importance of seamless software integration and practitioner education in accessing and utilising SafeScript.

COMMENTS

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

1. Given: (i) the broader systemic issues involved in LI's death; (ii) the length of time since he died; (iii) the fact that SafeScript was in its infancy at the time of LI's passing; and (iv) the sheer number of doctors who prescribed medications to him, I elected to adopt an approach to the Inquest into LI's death that was future-focused, rather than calling, for example, evidence from each medical practitioner who prescribed opioids or benzodiazepines to this young man in the 2017-2019 period.

2. This decision to create a scope of Inquest that was forward-focused was also guided by the assessment by Professor Ogden in his expert report that the care provided to LI by and on behalf of Child Protection, along with the services that formed part of the care team, was comprehensive and of a high standard.

3. This was no doubt a difficult decision to bear on the part of LI's family, who strongly believed that those who prescribed and dispensed opioids and benzodiazepines to LI on a one-off basis, ought to have been brought before the Court to explain why. Further, their experience of the suite of services put in place by and on behalf of Child Protection was a complex one, with a sense of being '*bombarded*' by workers and appointments, with a perceived lack of continuation of care between workers and at times, a lack of particular forms of care (such as ongoing psychiatric treatment) when LI's family identified this as a priority for him.

4. I consider that the evidence of LI's father and grandmother, and Dr Le-Kim, offers a unique insight into the experience of family members and medical practitioners who are navigating aspects of the Child Protection system.

5. I am of the view that DFFH should consider the insights of LI's family and Dr Le-Kim in its future design of programs and training of staff, including where Child Protection is tasked with ensuring the safety and wellbeing of children and young people facing serious addiction and mental health issues and is required to: (i) make decisions and communicate care arrangements to family members, particularly in relation to kinship placements, and suitability therefor; (ii) coordinate a complex array

of services and service providers; and (iii) make decisions as to the membership of care teams and/or the frequency of communication between care teams and external health providers.

6. To aid this task, and as urged upon me by Counsel Assisting, a copy of the present findings may be provided to: (i) the DFFH/DoH working group that has recently convened to consider improving outcomes for adolescents with a mental illness who are Child Protection clients; and/or (ii) any other Child Protection units that DFFH considers might benefit.

7. For completeness, a copy of the present finding may also be provided to the team contracted by DoH to undertake the five-year review into the SafeScript system.

RECOMMENDATIONS

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

1. Following the expert evidence of Professor Ogden, I recommend that the **Australian Commission on Safety and Quality in Health Care** consider making compliance with real-time prescription monitoring a standard to be assessed under the National General Practice Accreditation Scheme.

2. I further recommend that the **Victorian Department of Health** develop, as a matter of priority, additional strategies to enhance its oversight and compliance role in relation to the checking of SafeScript, as well as to consider increasing the scope of application across the state, including by:

    a) Working with the **Royal Australian College of General Practitioners**, **Medical Board of Australia** and the **Pharmacy Board of Australia**, along with medical indemnity insurers and any other identified stakeholders, to develop education and training tools for clinicians that focus on and promote the positive benefits of SafeScript, reinforce its role as a clinical tool for the clinician's own decision-making, and address the perception among some clinicians that SafeScript usurps their clinical judgment;

b) Continuing to consider the ways in which to surmount technological barriers to implementing SafeScript throughout hospitals in Victoria; and

c) Continuing to work with the **Commonwealth Department of Health and Aged Care** to implement cross-border data-sharing of real-time prescription monitoring.

ACKNOWLEDGEMENTS

1. I convey my sincerest sympathy to LI's family and friends. I acknowledge the grief and devastation that you have endured as a result of your loss. I read and listened carefully to the coronial impact statements provided by LI's father and LI's grandmother and other family members, and was greatly assisted and moved by the personal reflections made in those statements. I thank the Family for their active participation and assistance in these proceedings and I acknowledge the great difficulty in undertaking this long after LI's passing, and within the narrow confines of the settled scope of Inquest. I also thank the Family Liaison Officers for supporting LI's family with dedication over the past five years.

2. I thank Counsel Assisting Ms Martin and the counsel and solicitors who represented the interested parties for their assistance, comprehensive submissions and collegial approach to these proceedings. I also acknowledge and thank Ms George Carrington and Ms Janet Lee at the Coroners Court for their invaluable assistance in this investigation. I also acknowledge and thank the CPU for its excellent ongoing assistance in these proceedings and Detective Senior Constable Jereme Virtue, my investigator, for his dedicated assistance both during the investigation and at Inquest.

ORDERS AND DIRECTIONS

I order that a de-identified copy of this finding be published on the Coroners Court of Victoria website in accordance with the *Coroners Court Rules 2019*.

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

LI's father

LI's grandmother

LI's mother

The general practitioners who prescribed monitored drugs to LI in 2018-2019

Dr Agnes Le-Kim, c/ Avant Law

Department of Health, c/ the Department's in-house counsel

Secretary of the Department of Health, Professor Euan Wallace

Department of Families, Fairness and Housing, c/ Lander & Rogers

Royal Australian College of General Practitioners

Medical Board of Australia

Pharmacy Board of Australia

Australian Commission on Safety and Quality in Health Care

Australian Health Practitioner Regulation Agency

Australian Government Department of Health and Aged Care

Eastern Health

Ambulance Victoria

Commission for Children and Young People

Detective Senior Constable Jereme Virtue, Coroner's Investigator

Signature:

INGRID GILES
Coroner

Date: 24 May 2024

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.