lCoroners Act, 1996
[Section 26(1)]

Western ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 9/15

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Daniel James HALL****, with an Inquest held at Perth Coroners Court, CLC Building, 501 Hay Street, Perth, on 9-11 & 17-20 March 2015 find the identity of the deceased was* ***Daniel James HALL*** *and that death occurred on 31 July 2010 at 35 Colonial Drive, Bibra Lake, as a result of Multiple Drug Toxicity and Bronchopneumonia in the following circumstances:*

Counsel Appearing:

Ms K Ellson assisted the Deputy State Coroner
Ms J Hook (State Solicitors Office) appeared on behalf of the Department of Health
Mr G Bourhill (instructed by MDA National) appeared on behalf of Drs Wolman, Mahon and Rodoreda
Mr D Bourke (instructed by MDA National) and with him Ms A de Villiers appeared for Mr Miller
Ms F Vernon appeared for Dr Bradford

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INTRODUCTION

Daniel James Hall (the deceased) died on 31 July 2010 after he had ingested a number of OxyContin tablets prescribed to him as analgesics following a day surgery procedure on his nose, contrary to the prescriber's instructions.

He was 26 years of age.

OxyContin is the slow release form of the Schedule 8 opioid, oxycodone, of the Western Australian *Poisons Act 1964,* which incorporates the standard for the Uniform Scheduling of Medicines and Poisons (SUSMP) utilised by the Commonwealth Therapeutic Goods Administration (TGA) to promote standardised scheduling, packaging and labelling for a variety of medicines available across Australia.

SUSMP Schedule 8

Schedule 8 medicines are often referred to as controlled drugs[1] which are defined as *"substances which should be available for use but require restriction of manufacture,*

[1] Schedule 8 drugs are referred to by a number of names, controlled medicine, drug of addiction, S8 poisons, controlled drug, narcotic substance, drug of dependence, s8 substance.

supply, distribution, possession and use to reduce abuse, misuse and physical and psychological dependence."

Opioid drugs such as morphine, fentanyl and oxycodone are Schedule 8 medicines often used as pain killers (analgesics). Opioid drugs such as buprenorphine, naloxone and methadone are Schedule 8 medicines often also used as substitution for the illicit use of opioids with a view to decreasing dependency. They are also pain killers in their own right.

There are restrictions imposed by legislation[2] and regulation on the prescription of Schedule 8 medicines:-

1. Where a medical practitioner wishes to prescribe a Schedule 8 medicine for more than 60 days in any 12 month period, that medical practitioner must apply for authorisation from the Chief Executive Officer of the Western Australian Department of Health (CEOWAH).[3]

2. If the person to whom a medical practitioner wishes to prescribe a Schedule 8 medicine is a *"notified or registered drug addict"* under the *Drugs of Addiction Notification Regulations 1980* (WA) then the medical practitioner must apply for an authorisation from the CEOWAH.

3. Where a medical practitioner believes or suspects a person is addicted to Schedule 8 drugs they are required to notify the Executive Director, Public Health within 48 hours. A register is kept of all notifications in the WA Department of Health.[4]

4. Where a medical practitioner wishes to treat a person with pharmacotherapy (usually methadone or buprenorphine) for an opiate addiction the medical practitioner must be an authorised prescriber.[5]

[2] WA *Poisons Act 1964* shortly to be replaced by WA *Medicines and Poisons Act* (assented to on 2 July 2014 not yet proclaimed.)
[3] Ex 10, tab 13, p3
[4] Ex 8, tab 1, p2
[5] Ex 8, tab 1, p3

5. In Western Australia treatment is available through the Community Program for Opioid Pharmacotherapy (CPOP) and a CPOP prescriber must be trained and approved by the WA Department of Health.[6]

6. A pharmacy must also be authorised to dispense pharmacotherapy.[7]

7. A person listed as a registered drug addict is required to disclose that fact to any medical practitioner from whom they seek to obtain relevant drugs (Schedule 8 opioid medicines and the benzodiazepines, alprazolam and flunitrazepam.).

The deceased was listed as a registered drug addict on 23 December 2009 for participation in CPOP. His authorised prescriber was Dr Alan Wilson,[8] for the prescription of Suboxone (buprenorphine and naloxone). The deceased signed an acknowledgement he understood he was a registered notified drug addict on that date.[9]

Despite regulation of the prescribing of Schedule 8 medicines, those wishing to abuse Schedule 8 medicines appear to have little difficulty in obtaining sufficient quantities to allow such abuse due to the tension for prescribers in distinguishing those patients with a real need for the drugs, and those who have developed an addiction to the effects of the drugs.

Both the Commonwealth Department of Health (through the Department of Human Services)[10]and the WA Department of Health have developed strategies aimed at assisting prescribers with their decision making when considering the prescription of a Schedule 8 medicine or alternative. However, both systems require the prescriber to have a level of suspicion about the patient, and actively seek information which is highly confidential, controlled and frequently

[6] Ex 11, tab A1
[7] Ex 8, tab 1, p2
[8] Ex 1, tab 10
[9] Ex 1, tab 4, p6
[10] Ex 10, tab 1

impossible to access at the time needed for good decision making around prescribing.

The Commonwealth system is a *"real time"* information service but is restricted to pharmaceutical benefits scheme (PBS) medications and does not provide information for drugs prescribed off-PBS (privately).[11] It is a 24 hour service but will only provide specific information on prescriptions where there is a recent, defined history of multiple prescribers.

The WA system cannot provide information in real time because it relies on collation (partly manual) from pharmacies before it becomes available. It only operates in regular business hours and only provides information on enquiry as to drug addict registration. It covers both PBS and off-PBS Schedule 8 medicines. If a patient is not a registered drug addict it does not provide enquiring doctors with any information.

SUSMP Schedule 4

SUSMP also lists drugs under a Schedule 4. These include *"substances, the use or supply of which should be by, or on the order of, persons permitted to prescribe and available from a pharmacist on a prescription"*. Schedule 4 drugs include benzodiazepines (diazepam, temazepam, oxazepam) often used to treat anxiety and insomnia. From February 2014 the benzodiazepine, alprazolam, was removed from Schedule 4 and listed in Schedule 8.

Schedule 4 drugs are prescription only but, now excluding alprazolam and flunitrazepam, do not need specific training for prescription long term, and do not attract registration for drug addiction. They are widely used for the treatment of anxiety and used as a sedative/calmative in the elderly and those with chronic ill health.

They are often co-prescribed with Schedule 8 medicines for their calming effect, and are

[11] It is restricted in the information it can share with enquiring doctors.

sought after by those with a drug habit to ameliorate a disruption of supply. They are therefore very commercial.

The "Doctor Shopping" Inquests

Both Schedule 4 and Schedule 8 medicines can be prescribed using Pharmaceutical Benefits Scheme (PBS) prescriptions or non-PBS (private) prescriptions (no PBS benefit). Only PBS prescriptions are monitored by the Commonwealth via Medicare. WA Health collates information on both PBS and off PBS medication[12] but is very delayed (sometimes months) in its ability to track prescriptions.

This means a person can still be a registered drug addict (or whatever name is used in that state or territory) but attend a number of prescribers seeking Schedule 8 medicines in a short period of time. These will probably be provided if the registered drug addict does not inform the prescriber they are a registered drug addict and the prescriber has no reason to believe, or is not in a position to make the necessary inquiry, there may be a reason not to prescribe.

Obviously this is a technique which can also be used by non-registered drug addicts and others with drug seeking behaviours.

The death of the deceased was examined at inquest, along with two others,[13] where previously registered drug addicts obtained drugs which contributed to their deaths, despite the controls imposed by legislation. The three cases are quite different, but all demonstrate the difficulties facing prescribers in attempting to treat patients sympathetically, without the ability to verify information in real time, and still maintain a relationship with their patient which allows them to prescribe in the patient's best interest.

In all three cases the Commonwealth Prescription Shopping Information and Alert Service advice line (doctor shopping

[12] Ex 8, tab 1
[13] Adrian Marcus WESTLUND & Shane Andrew BERRY

hotline) would not have assisted an enquiring medical practitioner despite it being a *"real time"* monitoring tool due to the fact none of the deceased fulfilled the statutory criteria for "doctor shopping" status, although clearly demonstrating drug seeking behaviour.

The State drug addict register would have provided information to an enquiring medical practitioner about that registration in two of the cases, but in both of those the deceased had advised the currently prescribing doctors of a prior problem with drug addiction. An enquiry may have alerted the doctors to a credibility/reliability issue, but in both cases the drug seeking behaviour leading to death appeared to be a one off request for pain relief and did not cause the practitioners suspicion of the need to make further enquiry.

The third case related to issues around prescribing for a CPOP registration and enquiry of either the Commonwealth or State would not have taken the matter further for the prescriber than did his discussion with the Next Step doctors over the application for registration. In that case the issue was more to do with benzodiazepine prescribing, than Schedule 8 medicines.

The oral evidence in each case was fairly specific with respect to drugs and dosages out of necessity for the facts of each case. I have intentionally avoided reproducing all the specifics in the written findings, with knowledge these are public documents and accessible via the internet. Those interested in misusing prescription medications are generally well informed and I have no desire to add to their knowledge with specific amounts and combinations of drug levels at which these deceased died in defined circumstances. It is enough that they died as a direct result of the misuse of prescription medication.

The drugs in question were Schedule 8 (opioids) and Schedule 4 (benzodiazepines) and the issue of tolerance in individuals is always a relevant factor.

BACKGROUND[14]

The Deceased

The deceased was born in Melbourne on 18 May 1984. His family moved to Western Australia in 1985 and the deceased became the oldest of three boys. He always had an interest in sport of various kinds and withdrew from a TAFE accounting course to focus fulltime on cycling whilst still in his teens. He was involved with the WA Institute of Sport and trained for national championships, often for up to 5-6 hours a day.[15]

In November 2000, when only 16 years old, the deceased broke his right collar bone when he fell from a bicycle. He had surgery and returned to training, but overtrained and needed another operation before he could go to Melbourne to further his cycling career.[16] He started using amphetamines and anabolic steroids. He continued to suffer from his injury until he eventually gave up cycling and returned to Perth. He did not return to TAFE but worked for his father and trained at a gym for fitness. He described ongoing pain from his prior injury.[17]

The deceased became very introverted with mood swings and his mother found needles in his work overalls. She confronted him about his drug use and he sought help from his general practitioner (GP), who referred him to a private psychiatrist, Dr Rigg. The deceased was provisionally diagnosed with bipolar disorder after having a drug induced psychotic episode. The deceased did not respond to anti-depressant and mood stabilizing medications and Dr Rigg suspected he was involved in substance abuse.[18] Dr Rigg last saw the deceased in March 2002 when he was still only 17 years old.

[14] I need to acknowledge the submissions of Counsel Assisting, Ms K Ellson, as the basis of the summary of fact, in conjunction with my understanding of the evidence led at inquest, any mistakes will be mine.
[15] Ex 1, tabs 4 & 5
[16] Ex 3, tab 1
[17] Ex 1, tabs 4 & 5
[18] Ex 1, tab 28

On 1 April 2002 the deceased was seen at Fremantle Hospital with insomnia. He advised he was seeing a private psychiatrist. He was provided some medication and referred back to his psychiatrist.[19] He started to see Dr de Jong who considered he had a mood disorder and gave a provisional diagnosis of bipolar disorder. Dr de Jong did not provide the deceased with diazepam, as requested, and on the next visit suggested the deceased trial clonazepam and Seroquel. The deceased chose not to see Dr de Jong again.[20]

On 30 April 2002 the deceased sought help from Dr Chris Newall at Quarry Adolescent Centre in Fremantle. Dr Newall encouraged him to continue with his medication and be reviewed by a psychiatrist. Dr Newall then discovered the deceased was abusing anabolic steroids, was reluctant to take prescribed medication or submit himself for review by a psychiatrist.[21]

Dr Newall changed the deceased's medication to Efexor XR (antidepressants) and Seroquel and continued to review him. The deceased appeared to improve.

In August 2002 the deceased was charged with forging a prescription for diazepam and Sustanon on one of Dr Newall's prescriptions. Following serious discussion with Dr Newall the deceased attempted to change his lifestyle.

The deceased's father helped him to find work in the oil industry and initially he worked in Western Australia, on land, earning a good income. He was screened for drug use by his employer which restricted his exposure to drugs.[22]

The deceased progressed to off-shore oil rigs and bought himself a unit in South Perth in his early 20's.[23] While the deceased appeared to be very focused on his work, during his off rotation periods his mother now suspects he had problems with drugs, which caused problems with his

[19] Ex 1, tab 22
[20] Ex 1, tab 25
[21] Ex 1, tab 6
[22] Ex 1, tab 5
[23] Ex 1, tab 5

employers, and may account for why he seemed to change employer very frequently.[24]

In addition, it now appears the deceased was obtaining prescriptions from doctors which would enable him to *"stockpile"* medication by claiming he was working overseas for periods of time. While he did travel with his work he did not travel to many of the places for which he was asking for large prescriptions.[25] He had numerous hospital admissions for accidents which would provide him with medication for pain relief. In hindsight, the regularity of these may have been of concern.

In May 2005 the deceased returned to Dr Newall, now at Cottesloe Medical Centre (Cottesloe), with personal problems. He denied drug use and Dr Newall restarted him on Efexor XR and trialled him with Zyprexa. Despite this the deceased appeared to drink heavily and was admitted to hospital on various occasions for self-harm, and overdose episodes.[26]

The deceased was often non-compliant with medication and was resistant to psychiatric review. The deceased attended at different medical practices and saw a range of doctors.

In May 2007 he was reviewed by psychiatrist, Dr Wu, referred by a doctor at Bibra Lake Medical Centre. Dr Wu recommended hospital admission in an attempt to clarify some of the deceased's issues around agitation and mood stabilisation.[27] The deceased was not prepared to follow Dr Wu's advice and returned to Dr Newall at Cottesloe stating he was under Dr Wu's care and had been prescribed Efexor XR, Epilim and diazepam.[28]

In 2008 the deceased formed a close relationship and became a father in early 2009. His son became a protective

[24] Ex 1, tab 5
[25] t 10.03.15, p49-50
[26] Ex 2, tab 1-3, Ex 1, tab 6
[27] Ex 1, tab 7
[28] Ex 1, tab 6

influence for the deceased during his life despite his separation from his son's mother.[29]

The deceased continued to be accident prone and require strong analgesics and steroids for pain. In January 2009 he was again found to have altered a prescription for opioids in an attempt to gain more drugs than prescribed.[30]

It became clear, even to the deceased, he was dependent on oxycodone and he also started to use fentanyl patches. He attempted to seek help with his problem and again used different medical practices without fully informing the doctors he was seeing about his treatment from other practices.

As well as returning to Dr Newall at Cottesloe, he continued with doctors at Central City Medical Centre (Central), where he had been a patient since September 2001.[31] They were familiar with his injury issues and so were accepting of a need for pain relief. Dr Mahon gave evidence as to his prescription preferences for the control of chronic and breakthrough pain in the mid 2000's.[32]

The doctors at Central had attempted to wean the deceased off his opiate dependency and between them tried different combinations of weaker long acting opiates, unsuccessfully. The deceased needed to keep returning for repeat or stronger prescriptions to control his withdrawals, and eventually Dr Mahon (Central) received a letter from the CEOWAH advising him he had prescribed the deceased Schedule 8 medications over a period of greater than 60 days in 12 months.[33]

The letter advised Dr Mahon to make an application to register the deceased with the drug register if he wished to continue prescribing the deceased with opioids. Dr Mahon did not wish to become registered as a provider for the deceased and therefore did not issue him with further

[29] Ex 3, tab 1
[30] Ex 1, tab 23, 24
[31] Ex 1, tab 6, 20
[32] t 11.03.15, p168
[33] Ex 3, tab 3D

prescriptions for Schedule 8 medicines.[34] Others in the practice had also begun to refuse the deceased Schedule 8 medicines, and provided him with clear warnings about his drug seeking behaviour.[35]

Registration as a Drug Addict

On 22 December 2009 the deceased returned to Dr Newall at Cottesloe asking him for help. He admitted he was dependent on opiates and that he was taking Subutex (buprenorphine) and venlafaxine (Efexor). Dr Newall did not wish to be a recognised prescriber for the deceased and referred him to Dr Wilson, at the same practice, who was authorised for CPOP.

The deceased was seen by Dr Wilson the following day and he entered into an agreement on 23 December 2009 to become a registered drug addict and to participate in CPOP using Suboxone (buprenorphine) with Dr Wilson as his authorised prescriber. The agreement also required the deceased to obtain his prescriptions from 777 Pharmacy in Applecross. The history he gave Dr Wilson differed from that provided to Dr Newall[36] with respect to his employment plans overseas. The deceased informed Dr Wilson he needed the CPOP plan to enable him to obtain prescriptions to attend a job overseas in January 2010. Successful compliance with the plan would enable multiple scripting of drugs approved on the plan.

The date of the letter to Dr Mahon (Central) advising him he had over prescribed Schedule 8 medication to the deceased was 23 December 2009. The same date as Dr Wilson's (Cottesloe) application to become a registered prescriber for the deceased. Dr Mahon does not recall receiving the letter in 2009, but believed he may have received it sometime later, in 2010.[37] It had been sent to a practice he had not

[34] Ex 1, tab 17, 18
[35] Ex 1, tab 20
[36] Ex 1, tab 19
[37] t 11.03.15, p172

worked at for over 20 years, and even that was an incorrect address.[38]

The information about the deceased's drug addict status was not shared in any way between practices and doctors, which meant each practice remained unaware of the extent of the deceased's drug seeking behaviour. The only organisation aware of his contemporaneous use of different prescribers would have been the CEOWAH and then only after a time lapse of some months. It would seem Dr Wilson's application for authorisation triggered the letter to Dr Mahon, but Dr Wilson was not advised of Dr Mahon's prior prescribing, and Dr Mahon was not advised there was now an application to prescribe on behalf of Dr Wilson. This is due to legislative privacy requirements.

By 23 December 2009 Dr Mahon (Central) and his colleagues had already attempted to alter the deceased's medication management and had simply stopped prescribing Schedule 8 medicines to the deceased, other than for specific short term pain management, possibly one of the deceased's reasons for returning to Dr Newall.[39] The last Schedule 8 prescription Dr Mahon had provided to the deceased was on 16 October 2009 for fentanyl patches.[40] Other doctors at Central prescribed short term fentanyl patches after 23 December 2009 without knowledge of his drug addict status.

In evidence all doctors described the deceased as an apparently genuine patient in his desire to break his drug dependency and deal with his pain. They had no reason to believe they should make further enquiries as to his medical history, as provided by the deceased.[41]

Dr Mahon also explained that on the occasions he may have had concerns about the deceased, he refrained from discussing registering him as a drug addict because he felt

[38] t 11.03.15, p172
[39] t 11.03.15, p168-169
[40] t 11.03.15, p190
[41] t 10.03.15, p184 Wilson, t 11.03.15, p67 Mahon

he might then never see him again, and so not be in a position to assist him.[42]

On receipt of his authorisation to prescribe pharmacotherapy for the deceased, Dr Wilson (Cottesloe) provided him with a script for Suboxone for a seven day period.[43] He was able to review the deceased again on 29 December 2009 and began to reduce his dose in accordance with the CPOP plan. On the next review, 31 December 2009, the deceased complained the reduced dose had resulted in severe withdrawals. Dr Wilson prescribed completely different medication for the deceased (diazepam and Clonidine) but the deceased did not return for review with respect to those drugs.[44]

The deceased did not re-attend Dr Wilson until 3 February 2010 when he stated he had lost his job, had some personal issues related to the breakdown of his long term relationship and had restarted taking OxyContin after buying it on the street. He had returned to live with his mother and wished to sort out his life. Dr Wilson offered to restart the CPOP program with the deceased (he was still registered) because his version of events seemed plausible.

Dr Wilson provided the deceased with a two day script for low dose Suboxone and asked he obtain counselling from Next Step. The deceased returned after the two days saying he felt well and was given a script for three days. He advised Dr Wilson he wished to return to work offshore and did not re-attend for review or low dose Suboxone prescriptions. The deceased did ring the surgery on 15 February 2010 to ask for a script for diazepam to be posted to him at home in preparation for going overseas. Dr Wilson declined.

Dr Wilson did not hear from the deceased again.[45]

[42] t 11.03.15, p170
[43] Ex 1, tab 19
[44] t 10.03.15, p87
[45] t 10.03.15, p88

Dr Wilson later received letters advising him the deceased had received Schedule 8 medicines from two other doctors, unknown to Dr Wilson, during the time he had been prescribing and was registered as the deceased's authorised prescriber. The letters were not received until May and November 2010.[46] Dr Wilson noted that information in his records, should the deceased return to him.

It is apparent from the evidence the deceased continued to see doctors from Central for fentanyl patches and other Schedule 8 medicines, while he was registered with Dr Wilson at Cottesloe. While Drs Bradford and Wolman (Central) were not prescribing the deceased with Schedule 8 medicines, long term, following their colleague, Dr Mahon's experience with the deceased, they did continue to provide him with intermittent Schedule 8 pain relief, not realising he was in breach of his drug addict status, since 23 December 2009, with another doctor/practice.

These prescriptions would have adversely affected the deceased's CPOP program with Dr Wilson, as well as being in breach of the regulations.

Dr Bradford and Dr Wolman (Central) both received letters from the WA Acting Chief Pharmacist on 19 May 2010 advising them the deceased was a 'notified drug addict' under the care of Dr Wilson, unknown to either doctor.

The letter from the Chief Pharmacist advised the doctors to annotate their records for the deceased to ensure no doctor at that practice (Central) inadvertently prescribed Schedule 8 medicines to the deceased in future. Both doctors had prescribed the deceased OxyContin as short term pain relief for his shoulder.[47] They had continued with that prescribing from time to time not knowing he was now registered as a drug addict with another doctor/practice. Some of Dr Wolman's prescriptions (Central) were off PBS, due to the deceased claiming he needed prescriptions for OxyContin to take with him for his overseas employment.[48]

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[46] t 10.03.15, p90
[47] t 10.03.15, p57 (Bradford) t 10.03.15 (Wolman)
[48] t 10.03.15, p57

The deceased had also been prescribed fentanyl patches with a view to ceasing his OxyContin dependency, and benzodiazepines to assist with his travel, anxiety and withdrawal from oxycodone. The fact the deceased had been with the practice for a long time and seemed compliant with the management plan the doctors put in place for him, had satisfied those doctors the deceased was compliant with treatment and did not raise a suspicion they should check his drug status with either the Commonwealth (doctor shopping) or State (registered drug addict) information lines.[49]

The doctors continued to prescribe until receipt of the letter, dated 19 May 2010, advising them of his drug registration.[50] The letters were received by those doctors on 21 May 2010. The doctors then advised the deceased they could no longer prescribe him Schedule 8 medicines.

The letter from the Chief Pharmacist advising the Central doctors of the deceased status as a registered drug addict in May 2010 was scanned and attached to the deceased's notes. At that time Central's record system had no facility to raise an alert of this type without the doctors specifically looking for it in the system.[51] In order to find these alerts the doctors had to both know it was on the record and remember it was there.[52]

At the end of May 2010 the deceased was admitted to Fremantle Hospital as the result of a drug induced episode. He was admitted to psychiatry and placed on the ward where he continued to request IV fentanyl and other opioids. The deceased's mother advised the nurses she was aware of her son visiting two separate GP practices which gave him access to prescriptions for diazepam and zolpidem. When the nurses attempted to find the prescriptions the deceased claimed he had given them to his brother, but that

[49] t 10.03.15, p60
[50] Ex 3, tab E
[51] Ex 1, tab 17
[52] t 11.03.15, p174

he had wanted them because he was worried about *"coming off"* benzodiazepines.

The deceased was informed this was unacceptable behaviour and the tablets collected and returned to his mother to provide to the deceased as he needed them. Following discharge from Fremantle Hospital on 3 June 2010 he was provided with outpatient appointments for Fremantle Hospital to monitor his progress.[53] The discharge summary was sent to Central, but not Cottesloe.

EVENTS LEADING TO DEATH

Following release from Fremantle Hospital the deceased attended Central and saw Dr Mahon about a problem with his nose. On 28 June 2010 Dr Mahon referred the deceased to an Ear, Nose and Throat (ENT) Specialist, Mr Stuart Miller, and wrote the referral to Mr Miller in the deceased's presence.[54]

Dr Mahon did not advise Mr Miller of any concerns the deceased had a Schedule 8 and benzodiazepine dependency or the fact he was a registered drug addict. While that information would have been available on Central's file by June 2010, Dr Mahon did not remember it as he was writing the referral due to the fact he had not provided the deceased with Schedule 8 medicines since October 2009, and he was not expecting the deceased to be requiring an operation, or procedure which would need strong analgesics.[55]

In hindsight, Dr Mahon agreed he should have provided that information to Mr Miller. Dr Mahon did provide Mr Miller with a list of prescription medications Central was prescribing to the deceased at the time of the referral, chlorpromazine, Efexor (venlafaxine), diazepam and fluticasone nasal spray.[56]

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[53] Ex 2, tab 2
[54] t 11.03.15, p178 Ex 1, Tab 17C
[55] t 11.03.15, p178
[56] Ex 1, tab 17

The deceased also returned to Dr Newall at Cottesloe on 19 July 2010 and advised him he had been admitted to Fremantle Hospital following an episode of acute mania. Dr Newall provided the deceased with repeat prescriptions for his medication for his bipolar affective disorder, diazepam, olanzapine and venlafaxine and the deceased told Dr Newell he did not want to follow up with Fremantle Hospital, but to remain with Dr Newall.

On 23 July 2010 the deceased was reviewed by Mr Miller who diagnosed a sessile lesion on his anterior superior left nasal septum (nasal polyp) of unknown pathology. [57] Mr Miller decided it would be necessary for the deceased to have the lesion biopsied and this was scheduled for 29 July 2010 as a day procedure under general anaesthetic.

Prior to the procedure the deceased needed to contact the specialist anaesthetist, Dr Paul Rodoreda, to discuss anaesthesia and post-operative analgesics. The deceased advised Dr Rodoreda of his usual medications for bipolar disorder[58] and the fact he had a high tolerance to usual analgesics. Dr Rodoreda was impressed with the deceased's presentation in view of his medications and believed him to be in control of his medication management. The deceased understood he would be provided with a general anaesthetic, rather than a local anaesthetic, and that he would be provided with post-operative 80mg OxyContin because he advised Dr Rodoreda this was the only analgesic which worked for him.

The deceased rang his local pharmacy to ensure they would be able to provide the prescribed post-operative medication.[59]

On the morning of 29 July 2010 the deceased was reviewed by Dr Rodoreda and he advised the anaesthetist he used Efexor, Largactil, diazepam, alprazolam and Zyprexa for his

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[57] Ex 1, tab 12
[58] Dr Rodoreda's evidence was the deceased's bipolar medication would have interfered with his hepatic function and affect his metabolism of anaesthesia and analgesics. t 11.03.15, p135
[59] Ex 1, tab 5

bipolar disorder. He advised Dr Rodoreda he had a past history of drug abuse, but that it was no longer a problem due to his work as an offshore rigger. He presented very well to Dr Rodoreda who had no reason to suspect the deceased was not a reliable historian. Consequently he saw no reason to check the deceased's drug registration status or the doctor shopping help line and the deceased did not tell Dr Rodoreda he was currently a registered drug addict, or that he was being prescribed diazepam by two separate practices for his bipolar disorder.

The deceased explained he needed strong analgesics because experience had taught him usual analgesics were ineffective in controlling his pain. This was supported during the course of the procedure when Dr Rodoreda found he had to consistently give the deceased 50% more anaesthetic and analgesic medication to control his unconscious responses to allow the procedure to continue uninterrupted.[60]

Following the procedure, during recovery, the deceased advised Dr Rodoreda he was experiencing severe pain and needed additional analgesia. He was given pethidine. His reactions were consistent with his response to intraoperative anaesthesia and analgesia when he was unconscious, and did not cause Dr Rodoreda any concern. All the deceased's responses indicated he had a high tolerance to these drugs and needed more to achieve the desired result from a medical perspective.

In view of his experience with the deceased in the operation and the history provided to him by the deceased, Dr Rodoreda believed the deceased needed a high level of analgesic relief post operation, and that the deceased was competent to manage his medication. Without knowing he was a registered drug addict Dr Rodoreda was comfortable providing the deceased with a script for five days supply of OxyContin tablets, 80mg. A high dose, but consistent with Dr Rodoreda's experience with the deceased and his stated tolerance to analgesic medication.

[60] t 11.03.15, p141

There was nothing about the deceased's presentation to alert Dr Rodoreda, or Mr Miller, there was any cause for concern with prescribing him with a high level of pain relief in one prescription, post operation. Information about his drug registration status would have presented a different picture and necessitated a different management plan.

Post-Surgery

The deceased told his mother, prior to the procedure, he would be given high doses of OxyContin (slow release oxycodone) post-surgery. His mother simply did not believe it would happen.[61] She believed that because he was a registered drug addict it could not happen.

Mrs Hall was shocked when the deceased appeared with a prescription for 20x80mg OxyContin tablets to be dispensed in one supply. In evidence, Mrs Hall advised the court that while she was concerned about the prescription she:-

> *"….believed he had been well for quite some time"… "I trusted him as a grown man that he knew what he was doing."*[62]

The deceased asked to be taken to the pharmacy immediately so he could collect the tablets and when his mother asked to have custody of them so she could give them to him as prescribed, they argued, and he would not give his mother the tablets. He was very excited.

That night Mrs Hall saw the deceased take one OxyContin tablet as prescribed (1 tablet every 12 hours).[63] When she went to work the following day on Friday 30 July 2010, the deceased appeared to be well and Mrs Hall was not concerned he had misused his medication. He was expecting a female friend to visit and seemed to be behaving appropriately.

[61] t 10.03.15, p48
[62] t 10.03.15, p51
[63] Ex 1, tab 4, tab 5

Mrs Hall returned home at about 11:30pm and the deceased was there with his friend. They were outside and it was cold so Mrs Hall asked them to go inside because the deceased had not been well. She then went to bed.

The deceased's friend provided police with her account of events after Mrs Hall went to bed. Essentially, she observed the deceased taking at least 8 OxyContin tablets during the course of the night at different times. Following this the deceased's breathing became a concern and she put him in the shower at about 2am. She then:-

> *"….observed the deceased to dissolve and consume what she stated was one non-prescription tablet and 20mls of cough syrup."*[64]

The next morning, Saturday 31 July 2010, the deceased drove his friend home. He was supposed to collect his son for an access visit but when his ex-partner spoke to him on the phone he was obviously unwell. She was very angry at the state he was in and telephoned his mother complaining he should not be looking after their son when he was not fit to drive. Mrs Hall had not seen the deceased that morning and he arrived home as she was talking to the mother of his son,[65] at about 10:30am.

The deceased was obviously unwell.

The deceased was barely able to stand, was breathing heavily and slurring his words. He told his mother he was hungover but she could not smell any alcohol and did not believe him. When she asked him directly how many tablets he had taken he evaded the issue and just said it was all good. Mrs Hall helped him to bed at about 11:15am and went to ring his ex-partner and confirm the deceased was in no fit state to be around their son.

At 12:35pm the deceased's father rang him but the phone was not answered.

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[64] Ex 1, tab 4, p9
[65] Ex 1, tab 5

The deceased's brother arrived home at about 1:15pm and Mrs Hall walked past the deceased's room shortly thereafter, but could not hear him breathing, so she went to investigate. He was unresponsive but warm. She and the deceased's brother tried to resuscitate the deceased and called emergency services. An ambulance arrived at 1:36pm but the deceased could not be revived.

It was early afternoon on Saturday 31 July 2010.

Of the original 20 OxyContin tablets, only 2 were left. While it was probable the deceased's friend had some, it appears the deceased consumed at least 10 tablets in the 24 hours before his death. The prescribed dose was 1 tablet per twelve hours.

POST MORTEM EXAMINATION

The post mortem examination of the deceased was undertaken by Dr Judith McCreath on 3 August 2010 at the PathWest Laboratory of Medicine WA.[66]

Dr McCreath noted at initial examination the deceased was of a muscular build with scarring to his left arm and right thigh. On internal examination she noted he had severe atherosclerosis of the left anterior descending artery, to the extent there was almost complete occlusion of the lumen. This type of pathology can affect the efficient beating of the heart and is a known side effect of anabolic steroid abuse.

There was some evidence of bronchopneumonia consistent with the deceased's mother's observation the deceased had symptoms of a cold on the day before he died, but there was no evidence of aspiration, sometimes seen in cases of drug overdose.

Toxicology[67] revealed oxycodone, vanlafaxine, desmethylvenlafaxine, diazepam, zolpidem,

[66] Ex 1, tab 13
[67] Ex 1, tab 14

chloropromazine, olanzapine, propoxyphene, pethidine, pholcodine, quinine, alprazolam, and sildenafil in the blood. Oxycodone, vanlafaxine, chloropromazine, olanzapine, propoxyphene, pethidine, codeine and lignocaine were located in the urine, which also tested positive for benzodiazepines. Liver showed oxycodone and the stomach contents still contained oxycodone residue.

Dr McCreath formed the opinion death was as a result of multiple drug toxicity and bronchopneumonia.

PBS PRESCRIPTIONS BEFORE DEATH[68]

In the 3 months leading up to the deceased's death he had been dispensed with temazepam and diazepam from the Bibra Lake Pharmacy on 28 May 2010, chlorpromazine and diazepam from the City Railway Pharmacy on 23 June 2010, amoxycillin and clavulanic acid from the City Railway Pharmacy on 5 July 2010, diazepam from the Bibra Lake Pharmacy on 12 July 2010, diazepam and olanzapine from the Cottesloe Centre Pharmacy, and then venlafaxine from Beaufort Street 24hour Chemist on 19 July 2010, and oxycodone from the Bibra Lake Pharmacy on 29 July 2010.

The prescriptions up until 12 July 2010 were all from doctors at Central, while those for 19 July 2010 were from Cottesloe. That for oxycodone on 29 July 2010 was from Dr Rodoreda. (See figure 1)

[68] Ex 1, tab 16

Figure 1:- PBS medications dispensed in 3 months pre death of deceased on 31 July 2010 (31 April 2010/31 July 2010)

Date Dispensed 2010	Pharmacy	Drug	Medical Practice
28 May	Bibra Lake	Temazepam Diazepam	Central
23 June	Railway City Pharmacy	Chloropromazine Diazepam	Central
5 July	Railway City Pharmacy	Amoxycillin & Clavulanic Acid	Central
12 July	Bibra Lake	Diazepam	Central
19 July	Cottesloe Centre Pharmacy Beaufort 24/7	Diazepam Olanzapine Vanlafaxine	Cottesloe
29 July	Bibra Lake	Oxycodone	Dr Rodoreda

- Three months is relevant to Commonwealth Prescription Shopping Information and Alert Service ("doctor shopping" hotline - 6 different prescribers).
- Deceased's registration as drug addict was 23 December 2009 (opioid only) to 22 December 2011.
- 777 Applecross Pharmacy was his authorised pharmacotherapy dispenser so would have recognised the 29 July 2010 prescription as unauthorised. Bibra Lake would not without a reason to suspect the prescription.

EXPERT EVIDENCE

Professor David Joyce[69]

Professor Joyce is a Professor of Clinical Pharmacology and Toxicology at the University of Western Australia and also has a clinical practice at Sir Charles Gairdner Hospital (SCGH). He provided the court with expert evidence to assist with analysis of the post mortem toxicology report and the contribution of those drugs to the death of the deceased.

Professor Joyce reviewed the available medical information for the deceased. He observed the medical history was notable for drug use, several psychiatric illnesses including bipolar affective disorder and methylamphetamine induced hypomanic state, and a surprising number of injuries which would warrant the use of analgesic medications. He noted there was a reference in the deceased's mother's evidence of the use of anabolic steroids when the deceased was younger and involved in cycling and gym training.

Professor Joyce was not of the understanding any of the deceased's known conditions would have altered his drug metabolism or made him any more susceptible to drug toxicity.[70] Professor Joyce was also aware of the deceased being treated with Suboxone in December 2009/January 2010, but noted it appeared to have stopped by June 2010. It was clear the deceased had been obtaining opioid drugs outside the CPOP program. His high tolerance to opioid medicines, as observed by Dr Rodoreda, is not accounted for by his PBS prescriptions in the month immediately before 31 July 2010.

The deceased's medical history included self-reporting high levels of prescription opioid drugs, including extraction from fentanyl patches. Professor Joyce noted this indicated the deceased was an accustomed opioid user, but did not give good quantitative information for the period immediately

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[69] Ex 1, tab 26
[70] t 19.03.15, p593

preceding his death. Opioid tolerance fluctuates with the intensity of recent use.

Of the drugs located in the deceased's system post mortem, Professor Joyce noted alprazolam is a potent member of the benzodiazepine family and was not on any of his lists of prescribed drugs immediately before death, however Professor Joyce did not believe alprazolam was a significant contributor to his death. All the other drugs, barring oxycodone, located in the deceased's system post mortem were consistent with his prescriptions.

In Professor Joyce's view the combination of drugs located in the deceased's system post mortem would have been entirely safe, without the concentration of oxycodone located.[71]

Oxycodone is an opioid drug which is a potent pain killer and is restricted to the management of severe pain, such as that Dr Rodoreda believed the deceased would experience as a result of his nasal polyp procedure on 29 July 2010. Professor Joyce noted:-

> *"….it is attractive to people who are addicted to opiate drugs and has a high abuse potential."*[72]

He noted its concentration in the deceased's system post mortem was approximately five times higher than would be expected with a prescription of 80mg of OxyContin twice daily as outlined by Dr Rodoreda.[73]

Despite this, Professor Joyce noted opioid tolerance greatly modifies an individual's toxic response to an opioid and continued exposure to high doses can create a situation where a person is able to survive doses many times higher than the lethal dose for a person naïve to opioids. However, a high degree of tolerance would probably be needed to survive the deceased's blood concentration of 0.8mg/L, especially if his recent exposure to opioids had been less

[71] t 19.03.15, p595
[72] Ex 1, tab 26
[73] t 19.03.15, p598

intense. While Professor Joyce did not believe the other sedating drugs present in the deceased at post mortem were significant in themselves, they did add to the sedating and respiratory depressant effects of the oxycodone, so likely made some contribution towards the timing of the death.[74]

The amount of oxycodone still present in the deceased's stomach contents indicated he had taken a recent dose orally, and would have been able to continue absorbing that into his system until a lethal concentration was achieved in his blood. Professor Joyce was unable to comment on the effect of bronchopneumonia in the death however, did note that any other impairment of the lungs, irrespective of how it occurred, would increase the risk of a lethal outcome from opioid toxicity.

While Professor Joyce noted the prescription on 29 July 2010 for 80mg of OxyContin twice daily was high, the amount in the deceased's system was not reflective of the deceased taking his oxycodone in accordance with the prescribed amount. It indicated a much higher consumption of oxycodone than Dr Rodoreda envisaged.[75]

In evidence Dr Rodoreda explained his basis for the prescription of 80mg OxyContin twice daily. It seems to be entirely reasonable on the evidence of the deceased's tolerance to analgesics as reported by him by way of history, and as evidenced by his responses during the surgical procedure, when he was unconscious and not in a position to fabricate his responses.

If the oxycodone had been taken as prescribed by Dr Rodoreda, that is 1x80mg OxyContin every 12 hours for five days to control pain from the deceased's nasal procedure, it is unlikely any harm would have come to the deceased.[76] The amount in his system post mortem made it clear the deceased had not taken the oxycodone as prescribed by Dr Rodoreda.

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[74] t 19.03.15, p596-7
[75] t 19.03.15, p598
[76] t 19.03.15, p599

In addition, if the deceased's exposure to oxycodone in the three months leading to his death was as reflected by his PBS prescription history, his tolerance is unlikely to have been as high as his responses intraoperatively indicated. It seems likely he was obtaining opioids illicitly despite his attempts to control his dependency and his mother's attempts to supervise him.

In evidence Dr Joyce explained the desirable medical effects of opioids such as OxyContin (slow release oxycodone) are that they alleviate pain and improve mood in the short term[77] however, people quickly lose that response, in a matter of days, and so need to increase the dose or frequency in order to maintain the desirable effects. In reality it should only be used short term, while it has the desired effect, and increasing a patient's exposure to it does not assist with the desired effect, but does produce tolerance and encourage addiction.

In the same way, an acquired tolerance to opioids disappears very quickly, and can take habitual users by surprise if they have been unable to obtain drugs for a period of time and start to reuse at their prior levels. Many heroin overdoses occur in this context.[78]

Professor Joyce was clear the most significant aspect of death in the case of this deceased was the overdose of oxycodone. While the other drugs in his system, and the severe narrowing of his left anterior descending artery[79] may have contributed to the timing of his death, the fact there was still unused oxycodone in the stomach contents indicated there was enough oxycodone alone to account for his death at some point. Benzodiazepines, in particular, can enhance the risk of lethal outcomes for excessive doses of opioids[80].

The benzodiazepines in this case were diazepam, (its metabolite desmethyldiazepam) and the very potent

[77] t 19.03.15, p592
[78] t 19.03.15, p593
[79] t 19.03.15, p600
[80] t 19.03.15, p596

alprazolam. There is no PBS record of any practitioner prescribing the deceased alprazolam which implies it was either a private script or obtained illicitly.

Professor Stephen Schug

The inquest also heard evidence from Professor Schug, an anaesthesiologist who has specialised in pain management, and is currently director of pain management with the WA Department of Health at RPH, and establishing a pain clinic at Fiona Stanley Hospital (FSH). The approach to chronic pain management currently is to use techniques other than ongoing medication.

Professor Schug was strongly against the use of opioids for anything other than very short term strong pain relief, outside the treatment of terminally ill cancer patients.[81]

Professor Schug pointed out the incidence of the prescribing of opioids for chronic pain, which is not cancer related, is fairly recent. It arose due to the success of pain management for cancer sufferers with opioids, and was extended to non-cancer pain without there being appropriate scientifically based evidence for its efficacy. Professor Schug stated the little evidence that is available indicates most chronic non-cancer pain does not respond very well to opioids, especially long term treatment.[82] While opioids reduce the level of pain, they do not improve a patient's functionality or quality of life. Patients develop tolerance and may even become increasingly sensitive to pain. Professor Schug indicated the increased prescribing of opioids has led to an increase in its availability for illicit use. They are highly commercial.

Post-operative pain is acute pain and appropriately treated with opioids, short term, to allow recovery from surgery. However, once the immediate pain (acute) has subsided continued treatment with opioids for residual pain (chronic) can actually limit recovery because continued sensitivity is

[81] t 20.03.15, p702-705
[82] t 20.03.15, p702

not identified, which may be a disease or issue in its own right.[83]

Professor Schug believed all three deceased in these cases died from opioid-induced ventilatory impairment (OIVI) as a consequence of a combined use of benzodiazepines and opioids. He described OIVI as a more correct description of the consequences of opioids on ventilation in humans, where both the depression of the respiratory centre in the brain and the impairment of maintenance of airways was affected by the use of opioids. He described the addition of benzodiazepines to opioids as resulting in an additional effect on the respiratory centre, but more importantly in muscle relaxation and the consequence of loss of airway maintenance.[84]

Thus the prescription for the deceased of 2 x 80mg tablets of OxyContin daily for five days was reasonable to a patient presenting in the way the deceased presented to Dr Rodoreda, without knowledge of his drug addict registration and tendency to misuse prescription medication.[85] Had Dr Rodoreda known of the deceased's drug addict status there were a number of options available for the deceased's acute pain relief. The most significant being whoever prescribed opioids, if opioids were the only option, be it the anaesthetist with authorisation, or the authorised prescriber, specify daily dispensing as opposed to the whole quantity dispensed at once.[86]

The fact of the deceased's tolerance to such high doses may have alerted a practitioner to his drug seeking behaviour, but consistently the deceased's open and easy manner reassured medical practitioners he could manage his medication appropriately and his abuse potential was a thing of the past.

[83] t 20.03.15, p704
[84] Ex 9
[85] t 20.03.15, p716
[86] t 20.03.15, p713, and 717

Professor Peter Winterton

Professor Winterton is a clinical associate professor in paediatrics and community practise. He is on the board of the Royal Australian College of GPs to advise in areas affecting general practice. He was asked to comment upon the GP care of the deceased.

Professor Winterton considered that generally the care of the deceased by Central was excellent. A patient like the deceased, who was very demanding, is often difficult for one practitioner to deal with alone. The Central notes communicated well between practitioners caring for the deceased. They could not overcome the discrepancies which arise when a patient does not obtain all his input from one practitioner, however, and the records system in place in Central, at time of the deceased's management, did not allow practitioners within the same practice to be alert to all prior problems.

This was without the complication of the deceased dealing with more than one general practice, without knowledge of his history with other practices.

Dr Mahon (Central) indicated that since the deceased's death Central's recording system had been improved to allow alerts with respect to a patient to appear on the opening screen for that patient, with any doctor in that practice. In this way Dr Mahon would have been alerted to the fact the deceased was a registered drug addict when he wrote his referral to Mr Miller for review of the deceased's nasal polyp. In their current practice that fact would have been automatically added to the referral letter. Dr Mahon acknowledges he had access to the knowledge, and he should have provided that information to Mr Miller, but he did not remember it at the time of writing the referral and at that time it was not an automatic function of their software.

This would have overcome a problem about which Professor Winterton was concerned, the fact the referring GP did not advise Mr Miller of the deceased's drug addict status. Had

that been done Professor Winterton believed the deceased would not have been prescribed the post-operative amounts of 2 x 80mg OxyContin daily, in one pick up script, or even that type of prescription.

Professor Winterton also believed a script of 2x80mg of OxyContin to be excessive for a opioid naïve patient, a fact with which Professor Joyce agreed. However, the deceased did not claim to be opiate naïve and neither Professor Winterton nor Professor Joyce had heard Dr Rodoreda's evidence that the deceased had advised Dr Rodoreda of his high threshold to analgesics, and the apparent proof of that history in his responses during surgery to both anaesthesia and analgesia.

The fact of such a high dosage should indicate some suspicion as to the acquisition and currency of such a high tolerance.[87]

Professor Schug was not as concerned at the prescription circumstances, but all three experts called were cautious of that sort of dosage being provided for one collection in any circumstance.

The simple fact is that with knowledge of the deceased's drug addict status that prescription and dispensing should not have occurred. That is a risk minimisation strategy introduced by legislation, because the real issue was the deceased taking so much medication, approximately five times the prescribed dose, in 24 hours.

Without knowledge of the deceased's drug addict registration a practitioner would not have expected the deceased to so abuse his medication.

Even Dr Mahon, who was aware of the deceased's past difficulties, did not remember when writing his referral because in his dealing with the deceased he always presented as genuine. More recently Dr Mahon had not

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[87] t 19.03.15, p591

had any indication the abuse of opioids and benzodiazepines was a continuing problem.

Professor Winterton also believed the deceased's anabolic steroid history was a significant factor in his ability to withstand significant respiratory distress.[88] Professor Winterton pointed out the use of day procedures, as opposed to appropriately monitored recovery time in an inpatient facility, was a new problem in caring for patients.[89]

Professor Winterton was also concerned the labelling of patients as "*registered drug addicts*", especially when the patient presented well and appeared genuine may create subconscious discrimination. He did not believe that was desirable in a doctor/patient relationship, despite it being an extremely important fact for a GP to communicate to external specialists.[90]

Overall, all three experts considered the prescription of 20x80mg OxyContin over five days to be an extremely high dose in itself. There were safer alternatives. However, all conceded patients using opioids do develop a tolerance, and if that was the level needed to control his acute pain post-operatively, the script in itself was not of concern without knowledge of the deceased's drug addict status or his dependency on prescription medication.

It was the deceased's dependency which was the real problem. This was the reason for him taking in excess of his prescription, and is the reason legislation has attempted to risk minimize by regulation the prescription of Schedule 8 opioids and the more potent benzodiazepines.

The difficulty remains the timely communication of this protective information to practitioners who may come into contact with a relevant patient. Not one of the practitioners coming into contact with the deceased saw him as presenting as other than a genuine, charming and reliable

[88] t 18.03.15, p537
[89] t 18.03.15, p533
[90] t 18.03.15, p540-541

historian, even where there may have developed an underlying unease as to his credibility. The deceased did not present in such a way that a medical practitioner meeting him for the first time would automatically believe he or she should be checking with one of the prescription information lines as to his prescription history or drug addict status.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 26 year old male who had developed benzodiazepine and opiate dependences following the premature conclusion of his aspirations to become an elite cyclist due to physical injury.

The deceased's late teen years had been devoted to his attempts to recover from injury experienced while training with great determination and focus to become a competitive cyclist. The injury he received when 16 years old, when he fell from a bicycle and broke his collar bone, caused a chain of events which saw the deceased's goals in life seriously disrupted. During his attempts to maintain his chosen career path he became exposed to anabolic steroids and analgesic medication, which exacerbated mood and anxiety swings later diagnosed as bipolar disorder.

Central's records of the deceased go back to 2001 when he was in the process of attempting to recover from his shoulder injury. From that event as a 16 year old Central practitioners remained one of the medical practices responsible for the deceased's ongoing care, but always with the understanding he had battled to overcome his changed circumstances as the result of a shoulder injury whilst in his teens.

In those early years the deceased also became aware of the ways to use anabolic steroids in an attempt to boost his endurance, and this along with analgesics, around his surgery, would have taught him medications could be manipulated to achieve certain outcomes. He became accustomed to taking benzodiazepines and antidepressants

as part of his readjustment to life without a specific goal and focus and an anticipation of the euphoria of achievement.

The deceased became adept at manipulating events to achieve prescription medications he believed would assist him with his life.

The deceased presented very well to doctors and, without exception, all doctors heard in the course of the inquest referred to the deceased as a very disarming and credible individual. As Dr Mahon stated:-

> *"He was a very charming confident young man who I took pleasure in seeing and treating as a GP. Very straight forward and I didn't have, at least initially, concerns about his potential for drug misuse. I liked him. He was charming."*[91]

Dr Mahon knew of the deceased's history and indicated it wasn't until 2009 he began to be concerned there may be difficulties with the deceased's drug dependency:-

> *"….and there were often stories of prescriptions being lost or travel plans which I took at face value, but I was starting to worry, as alarm bells always go off when you're prescribing Schedule 8 drugs and high dose benzodiazepines drugs when people are asking for higher quantities than we would expect they need and prescriptions getting lost."*[92]

However, Dr Mahon went on to balance those concerns by his knowledge of the history of the deceased:-

> *"….but equally he had a genuine-seemingly to me, a genuine shoulder pain that he had for many years, he had an operation on it, he had several shoulder injections from myself, if not others which favoured his case as being genuine. We see a lot of patients asking for drugs and it is very rare they forward the*

[91] t 11.03.15, p166
[92] t 11.03.15, p166

> *procedures that the doctors recommend"...."but (the deceased) was always very compliant with our recommendations and happy to try them and come back for more, for example intra articular shoulder injections. So that weighed in his favour as being in genuine pain, which I believe he was."*[93]

It was the deceased's presentation, supported by his history, which persuaded most doctors his requests for Schedule 8 medicines and benzodiazepines were legitimate.

Although his father and mother supported and encouraged the deceased in obtaining new goals he appears to have remained surreptitiously dependant on medication. While his parents understood his troubles, I do not believe they were necessarily aware of the full extent of the deceased's use of medication to assist him with his life style endeavours. At a very young age the deceased did very well in the employment area and was able to buy himself a unit in South Perth and maintain a reasonable relationship. It appears as though the somewhat erratic life style of working on and off rotations may have exacerbated his tendency to rely on medication recreationally.

Certainly the argument he required medication for periods away from the metropolitan area allowed him to manipulate doctors and prescriptions with respect to his known difficulties with bipolar disorder and pain from his various injuries. It would appear the deceased had developed a chronic pain situation, possibly exacerbated by the ongoing use of opiate medication as outlined by Professor Schug.[94]

This ability to obtain prescription medication from different practices where the deceased was registered with a genuine basis for the prescription of medications, enabled him to obtain more prescription medication than had he received all his management from one practitioner, with knowledge of the extent of his drug seeking tendencies.

[93] t 11.03.15, p166-167
[94] t 20.03.15, p702

During the early 2000's the deceased was able to obtain prescriptions for a range of opiates and benzodiazepines as a result of his known conditions. It seems even the use of two practices may not have been sufficient due to the fact in both 2002 and 2008 the deceased was charged with fraudulently obtaining prescription medication by altering genuine prescriptions from his doctors.

While Dr Newall at Cottesloe knew of the deceased's tendency to fabricate prescriptions it is not clear the doctors at Central were ever aware of the deceased's difficulties to that extent.

Certainly the doctors at Central in 2008 and 2009 became aware the deceased appeared to have become dependent on his prescription medication and made efforts to wean him off his dependencies by using alternative management techniques, with which the deceased appeared to comply. Despite the deceased expressing a wish to help himself, and the medical practitioners with whom he came into contact attempting to help him, he was able to circumvent their management plans and remained dependent on his personal medication regime by alternating practices without their knowledge.

By the end of 2009 the deceased recognised he had a problem and returned to Dr Newall, who had been somewhat more strict with him, with an apparently full confession about his drug dependencies. Dr Newall recognised the deceased needed to have a plan for his prescription drug reduction and referred him to Dr Wilson at the same practice who was an authorised CPOP prescriber.

The deceased became a registered drug addict on the 23 December 2009, with Dr Wilson as his authorised prescriber, and the 777 Pharmacy in Applecross as his pharmacy for Subutex. He still required medication for his bipolar disorder and that occurred through Fremantle Hospital where he attended with various psychiatric issues, Dr Newall when he sought Dr Newall's assistance, and the doctors at Central.

The doctors at Central were not made aware of the deceased's registration as a registered drug addict with Cottesloe and the deceased did not advise Central of his status when he attended that practice seeking opiate medication for his chronic pain. Those doctors continued to prescribe short term pain relief to assist him with his pain, although they attempted to change the medication regime in view of his suspected dependency. Without knowledge of his status those prescriptions were in breach of the WA *Poisons Act 1964*. Notification of that fact did not occur for five months after his registration with Dr Wilson, by which time he was no longer seeing Dr Wilson, having not been successful with Dr Wilson's attempts to reduce his dependency.

By that time the doctors at Central had largely stopped prescribing him opiate medication and so did not appreciate the deceased had a continuing problem.

I accept the reason for the legislation surrounding the prescription of Schedule 8 and Schedule 4 drugs is an attempt to protect those misusing drugs from themselves, but note that while it recognises many people with the status of *"addict"* or *"dependant"* cannot help themselves, it fails to adequately enable doctors to also assist in protecting patients from themselves.

None of the doctors with whom the deceased came into contact considered ringing either the Commonwealth doctor shopping hotline or the state drug addict registration line to query the deceased's status. He did not give them any reason to believe he intended to be non-compliant and encouraged a concern that having treated the deceased for so long, he would cease to avail himself of their input and so be exposed to the street supply of medication. This is obviously undesirable because no doctor then has the opportunity to attempt to intervene in a patient's best interest.

In May 2010 all the doctors routinely involved with the deceased and his medical problems were made aware of his

drug addict status. By that time most of them had stopped prescribing medication of concern to the deceased so were not concerned with their ongoing management of the deceased's routine health issues.

I am satisfied it was for this reason Dr Mahon, in June 2010, failed to recall the deceased's prior dependency on prescription medication. He saw the deceased routinely for a nasal polyp for which he referred the deceased to an Ear, Nose and Throat specialist, Mr Miller, for his consideration of the options for the deceased.

The referral letter by Dr Mahon on 28 June 2010 contained a list of the deceased's medication for his bipolar disorder, but did not mention the fact the deceased was a registered drug addict because that information was not immediately available to Dr Mahon at the time he wrote the referral for the deceased, in his presence.

Dr Mahon indicated he would not normally check a patient, while they were sitting in front of him, by ringing either of the advice lines, nor did the deceased's presentation with respect to his nasal polyp remind him the deceased had a tendency to drug seek. The affliction appeared genuine, which it was, and Dr Mahon, as the deceased's general practitioner with responsibility for his general health, referred the deceased to the appropriate specialist.

It is common ground Dr Mahon regrets he did not inform Mr Miller of the deceased's prior history, and since the deceased's death the Central practice records software program has been updated to allow information that may affect a patient's management to be immediately available to doctors on screen, at the time they write referrals or prescriptions for patients.

Mr Miller's opinion was the deceased required a procedure to remove the nasal polyp for biopsy, and that was arranged for the 29 July 2010.

The anaesthetist for the procedure was Dr Rodoreda. Dr Rodoreda was not provided with information the

deceased was a registered drug addict independently of the deceased. The deceased did not advise Dr Rodoreda of his current drug addict registration. He advised Dr Rodoreda of a past problem which was no longer an issue.

The deceased specifically discussed anaesthesia and analgesia with Dr Rodoreda. His self-reported experience was his pain was only sufficiently managed by use of 80mg OxyContin analgesia. The deceased was required, as part of his CPOP agreement, to advise medical practitioners likely to prescribe him opiates of his registration. He did not, but instead requested prescription of 80mg OxyContin tablets.

Dr Rodoreda offered the deceased Panadeine Forte with some oxycodone support, but the deceased indicated this would be ineffective.

The deceased's mother was appalled when the deceased informed her he would be provided with 80mg tablets of OxyContin. The deceased's mother did not understand it would be possible for a medical practitioner to provide the deceased with that type of medication while he was a registered drug addict.

During the course of the procedure Dr Rodoreda discovered he needed 50% more anaesthesia to control the deceased's responses to the operative procedure. This satisfied Dr Rodoreda the deceased was genuine in his assertion he had a high tolerance to anaesthesia and analgesia.

When the deceased was in the recovery room and expressed severe pain Dr Rodoreda, taking into account the situation during the procedure, understood the deceased to be genuine in his request for high level analgesics. While the deceased was given pethidine in the recovery room he was provided with a script for 20x80mg OxyContin tablets with the intention the deceased take one tablet every 12 hours. OxyContin as a slow release form of the opiate oxycodone, should have provided good coverage to the deceased despite his high tolerance. Dr Rodoreda had no doubts, on the deceased's presentation, he would manage his medication appropriately.

On the day of the procedure the deceased's mother both dropped off and picked the deceased up from hospital.

The deceased's mother was shocked when the deceased did obtain a script for 20x80mg table of OxyContin. She took the deceased to the Bibra Lake pharmacy where he obtained the medication and they argued about custody of the tablets. It is often the case those recovering from a drug dependency have issues with trust. The deceased's mother clearly believed if the deceased had been given such a script by a specialist there must have been some understanding of the deceased's issues and she left the tablets with the deceased, against her concern for his ability to manage the medication alone.

That night the deceased's mother observed him take one tablet in accordance with his prescription and he appeared well that evening and the following morning which led her to believe he was indeed taking the medication as prescribed and seemed to be behaving appropriately, without ill effects from those doses.

The following day the deceased's mother had to go to work in the afternoon and was aware the deceased was expecting a visitor about whom he was excited. On her return home that evening the deceased was there with a female friend and the deceased's mother, aware of the fact the deceased seemed to be developing a cold, asked them to come inside when she went to bed. At that stage she was not particularly concerned.

The evidence supplied to the police by that female friend indicated that between herself and the deceased a number of the OxyContin tablets were consumed during the course of the night.

In the morning the deceased took his friend home and at approximately 10:30am returned home. His mother observed him to be extremely unwell. When she asked him directly how many of his tablets he had taken he was evasive but said everything was fine.

The deceased's mother helped him into bed at approximately 11:15am and continued with her chores around the house.

The deceased's father rang him at approximately 12:35pm but received no answer. That message was not noted until later in the day.

At approximately 1:15pm the deceased's brother returned home and the deceased's mother had a reason to pass the deceased's door where she became concerned she could no longer hear him breathing. On checking the deceased she found him unresponsive and she and the deceased's brother commenced resuscitation pending arrival of an ambulance.

On the arrival of emergency services the deceased could not be resuscitated and it was confirmed he had died. Of the twenty OxyContin tablets only 2 remained.

The post mortem examination of the deceased revealed his death had been caused by a lethal quantity of oxycodone. Levels which were considerably in excess of the deceased's compliance with his prescription.

I am satisfied the deceased took a minimum of 10 oxycodone tablets in the 24 hours preceding his death and died as a result of that overdose, exacerbated possibly by bronchopneumonia and the sedating effect of other drugs located in his system, which on their own would have been safe.

I do not believe the deceased had any intention of dying and his death was as a result of his inability to control his desire for the effects of an opiate overdose.

I find death arose by way of Misadventure.

PUBLIC HEALTH ISSUES IDENTIFIED AS A RESULT OF THE DEATH OF THE DECEASED

The death of the deceased illustrates the difficulty for medical practitioners in attempting to manage a well-liked patient's known medical problems, without appropriate real time information to assist them in acting in their patient's best interest. The fact a patient's best interest may not be consistent with the patient's desires, exacerbates the whole concept of a therapeutic relationship and the trust a doctor needs to treat a patient in their best interest.

Every single medical practitioner coming into contact with the deceased liked him. He was a well presented, apparently genuine, enthusiastic, well mannered, charming young man. He was confident and knowledgeable and able to persuade doctors he had insight into his problems and would be compliant with management plans. Even when known to be non-compliant with management strategies the deceased managed to persuade doctors he would try again. Invariably, the doctors, who wanted to help him, would try again.

All doctors expressed how difficult it is to manage the treatment regime of a patient with whom they were very familiar. Dr Newall, at Cottesloe had experienced the deceased's ability to deceive by providing fraudulent prescriptions, but after discussion with the deceased had still attempted to assist him.

Similarly Dr Wilson (Cottesloe) had attempted to restart the deceased on a CPOP program after his initial failure in an effort to help the deceased and keep him from the black market, to which the deceased had admitted.

That probably best identifies the difficulty for doctors. When a patient such as the deceased, with known medical difficulties, proves to be non-compliant with a management plan, the concern is the patient reject them and be exposed to the dangers of a black market supply.

The desire to continue to try and manage a patient exposes a doctor to the risk of being manipulated. I accept if Dr Mahon had indicated to Mr Miller the deceased had an opiate dependency and that had been communicated to Dr Rodoreda, the deceased's management post operation would have been different. But there was no tool to assist Dr Mahon with that referral and Dr Mahon had at no stage had direct involvement with the deceased's drug addict registration.

Dr Rodoreda is adamant his assessment of the deceased was that his OxyContin prescription, if used as prescribed, was appropriate for someone in the deceased's circumstances. Dr Joyce confirmed that had the deceased taken his OxyContin, as prescribed, and not supplemented it with other medications not prescribed, he was unlikely to have come to harm, despite it being a high dose.

The deceased was able to function on a prescription of 80mg of OxyContin twice daily. It was the overwhelming amount of oxycodone in his system, inconsistent with his prescription, and still available to his system by way of his stomach contents, which caused his death.

The issue is doctors cannot rely on people with drug dependencies to be truthful, nor do doctors see it as beneficial to their practice of medicine, to continually question, apparently genuine patient's description of symptoms, which may be alleviated with appropriate medication.

The deceased's ongoing pain as a result of his injuries when young was something his doctors were anxious to address. Professor Schug indicated in the 2000s, before the real danger of over prescription of opiate medication was apparent, it was common practice to prescribe opiates long term for pain relief. By 2009 the deceased's regular doctors had restricted their prescriptions to short term pain relief. All the deceased's doctors believed they were acting in the deceased's best interest by continuing to attempt to manage

him rather than expose him to the black market trade and the dangers of no management at all.

All the deceased's doctors would have been much better able to prescribe in his best interest if they had real time access to information about all prescription medication dispensed to him, and knowledge of his drug addict registration at the times they sought to prescribe him opioid medication, and to some extent the benzodiazepines he was also using. With proper knowledge of the deceased's prescription history his dependency may have been controlled. While the deceased was able to access prescription medication from different sources at the same time any attempt to reduce his dependency was unlikely to succeed.

In this particular case I suspect the deceased's consumption of prescription medication had to some extent been curtailed by his doctors' management. He was clearly no longer as tolerant as he believed to the dose of oxycodone he took, if he had ever been that tolerant. His post mortem toxicology indicates he was still obtaining some medications from other sources but not at levels which would support his belief in his tolerance for such high level exposure. That other medication would not have contributed to his death had he not consumed multiples of his oxycodone prescription in a short period.

Communication of his drug seeking behaviours would have:-

1. Prevented the issue of an oxycodone script to be dispensed in one amount; and
2. Alerted the pharmacy dispensing the medication it was an unauthorised script due to his drug addict status.

This would have prevented his death.

Current Prescribing

The drugs sought by those with a prescription medication dependency are those prescribed as analgesics (Schedule 8 opioids) or for their calming/sedative effect (benzodiazepines). They are also medications used to aid those with an illicit drug dependency (opioid) overcome that dependency (methadone, naloxone) and assist with withdrawal effects (benzodiazepines), by providing the patient with an alternative, but less intense, effect. This reduces the craving.

Opioids as analgesics are legitimately prescribed for acute pain but the benefits of prescription long term (chronic pain) for non-cancer patients is currently being reassessed. As short term relief they are effective.[95] Doctors need to treat pain and so will use opioids for appropriate patients. Inevitably there will be some overlap between appropriate and inappropriate, especially with changing medical practice. It is because of the seriousness of the outcomes of overmedicating with opioids, their prescription has become controlled by use of legislation. While accepted as necessary, it adds a layer of difficulty for medical practitioners, without good information as to the reality of prescription use and the dispensing of the drugs prescribed.

Benzodiazepines, as sedatives, are very effective in treating a number of difficulties in the elderly and chronically unwell. Some, such as alprazolam and flunitrazepam, are so potent they have been rescheduled into Schedule 8 medicines in an attempt to control their prescription. The rest remain in Schedule 4 where they need prescription, but are not as strictly controlled as the Schedule 8 medicines. This does not alter the fact the misuse of benzodiazepines is equally as concerning as the misuse of opioids, and can cause toxicity and death due to their effect on suppression of respiratory effort.

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[95] It should be noted that OxyContin and other slow release forms of oxycodone are not currently PBS listed for use in acute pain. Australian Government PBS Website: TGA Product Information for OxyContin.

Both opioids and benzodiazepines induce individual tolerance which brings with it a misguided perception of a patient's ability to tolerate high levels, and addiction.

Recognition of these problems has led to the introduction of both the Commonwealth Prescription Shopping Information and Alert Service telephone advice line and the State Drug Addict Register information line. Both systems have serious short comings in reality despite being of benefit where a practitioner has reason to believe there may be an issue and has the ability to act upon it in a timely manner.

The WA Drug Addict Register

There is a State register of authorised drug addicts for those recorded as addicted to Schedule 8 medicines. To be treated once recorded as a registered drug addict a patient has to agree to only seek Schedule 8 medicines from a specific doctor and pharmacy.

The system can be abused in the short term because by the time evidence emerges the patient has obtained Schedule 8 medicines from another doctor or pharmacy there may already have been an oversupply. This over supply can be misused, used as bank or sold on the black market.

Community Program for Opioid Pharmacotherapy (CPOP)

The WA community program for opioid pharmacotherapy (CPOP) and its ability to monitor registered opioid dispensing can only provide information on opioid prescriptions (PBS & off PBS) because it relies on information collected from pharmacies on a monthly basis which needs to be collated. The fact a person is a registered drug addict can be obtained by an enquiring medical practitioner, but with no details of any current medication plan.

The inquests heard evidence from Dr Allan Quigley, Director of Clinical Services branch (Next Step) of the WA Drug and Alcohol Office. Next Step provides treatment services to people with drug and alcohol problems with a focus on prevention and education. It developed CPOP, introduced in 1997, to support GPs and community pharmacists in their provision of pharmacotherapy, largely methadone or buprenorphine treatment, to opiate dependent patients.[96]

Medical practitioners need to be accredited, following training, to prescribe pharmacotherapy, patients need to be registered, and there is the availability of advice and assistance from Next Step practitioners for any treatment regime. Although it focuses on opioids, the prescribing of benzodiazepines and the co-prescribing of those classes of medicines is, of necessity emphasised. This is for outpatient treatment. There are also available various inpatient treatment facilities in the private sector.[97]

As seen in the current case the deceased was registered on 23 December 2009 by Dr Wilson (Cottesloe), but other doctors (Central) providing the deceased with prescriptions for opioids as short term analgesics were not notified of their breaches of his registration, of which they were not aware, until receipt of the relevant letters, some months after the event.

In the case of Dr Rodoreda, who inadvertently prescribed the prescription which led directly to the deceased's death two days later, a letter advising him of the deceased's registration was not received until four months after the deceased's death. Advising practitioners of a breach four months after a death helps no one.

An authorised doctor needs to ascertain what drugs his patient is misusing. There is no reliable way of ascertaining whether the information provided is reliable. It is a matter of trust. It is essential a treating doctor know the amounts and description of the drugs being misused so that a useful alternative dosage plan can be implimented. While quick

[96] t 20.03.15, p730
[97] t 20.03.15, p732

drug screens may pick up the fact of a drug's use, screens will not pick up the quantities to verify the amounts the patient is alleging. Thus one of the ways a plan may be abused is by a drug seeker alleging their intake of certain drugs is higher than it is in reality.

On the assumption the patient is telling the truth, the doctor needs to assess an alternative dose which is then prescribed for a period of time to stabilise the patient. With regular review and counselling the amounts of the alternative drug are gradually reduced to decrease a patient's dependency. There has to be a therapeutic relationship and degree of trust between the doctor and the patient for this to be effective.

Doctors have no way of verifying the use of the alternative medication, other than by their interaction and engagement with their patient in counselling and reviews. The alternative drugs tend to have a less intense desired effect but reduce the craving for the drug of dependency. This can also be ameliorated by the use of benzodiazepines, as calmants and stabilisers.

Once a patient is registered, any medical practitioner asked for Schedule 8 drugs can ring the relevant advice line for information about the fact of registration, but to do so is an indication of a lack of trust, and many doctors will not ring an advice line if they are not suspicious about the patient with whom they are dealing. In the case of the deceased the doctors with whom he dealt regularly were aware of his injuries and history and did not believe there was a necessity to ring either of the drug information lines to check on a patient they felt they knew well.

Currently, a pharmacist in WA is not in a position to access drug addict register information.[98] This is despite the fact a pharmacist may be in a better position than a general practitioner to suspect the prescription they are asked to dispense may be used inappropriately. Currently a pharmacist, if concerned about a script, may ring the

[98] t 19.03.15, p640-641

dispensing doctor, or if really concerned can refuse to supply, but is not in a position to access the drug addict register themselves. If more of a Schedule 8 medicine is dispensed than that patient uses, it provides an immediate oversupply for the black market, or for the use of that patient.

Thus while there is a WA Community Program to assist patients with their wish to reduce their drug dependency via an authorised prescriber, it is reasonably easy to circumvent without real time information to the prescriber or dispenser as to a patient's actual access to prescription medicines.

Commonwealth Prescription Shopping Information and Alert Service advice line (doctor shopping hotline)

The "doctor shopping" hotline provides up to date information to medical practitioners on PBS only prescriptions for a person identified as a prescription shopper.[99] The criteria for a prescription shopper are set by legislation, Regulation 20(a), of the Human Services (Medicare) Regulations 1975 and not all patients who are potentially drug seeking are captured.

The PBS data for the deceased in this case would not have identified him as a prescription doctor shopper despite the fact he was clearly seeking analgesic and benzodiazepine medications, apparently for his pain and bipolar conditions. Even under the Commonwealth system there can be a significant delay before the fact of the prescription shopper has been established to the extent the shopper and the prescribers are notified.[100] This is despite the fact the collection of PBS data is in real time from the online pharmacy dispensing data. It captures all PBS dispensing of controlled medicines, but not private dispensing.

The doctor shopping hotline is available to pharmacists 24/7 but does not provide information off PBS, and if the

[99] Ex 10, tab 1 & t. 17.03.15, p495
[100] t 17.03.15, p498

person about whom an enquiry is made does not fit the criteria then no information is available.

None of the deceased in these three cases would have fit the doctor shopper criteria.

They all died as a result of the misuse of prescription medication.

ELECTRONIC RECORDING AND REPORTING OF CONTROLLED DRUGS (ERRCD)

Following a Tasmanian initiative (DORA) the Commonwealth Government developed a system for the real time monitoring of dispensed prescriptions for Schedule 8 medicines based on the online dispensing data from pharmacies Australia wide. It is a software system which will enable State/Territory regulators and medical practitioners to have real time access to that data for their State/Territory.[101] That is all dispensed events related to controlled drugs and any other drugs of interest for which information can be collected according to relevant State and Territory legislation.[102] This is ERRCD.

The evidence at inquest from the Commonwealth is that this data is available and operational on a server host and will be provided to all states and territories once each individual state or territory has finalised a licencing agreement for the exchange of the information.[103] Currently Western Australia has finalised a sublicence agreement with the Commonwealth which allows access to the database and is examining the ways in which that system will need to be modified to work at the State level.[104]

Each state or territory interface with the Commonwealth system will differ in line with the individual state legislation and regulation. This means dispensing data will still not be

[101] t 20.03.15, p678
[102] Ex 10, tab 2 - fact sheet 8 May 2013
[103] t 20.03.15, p677
[104] t 19.03.15, p640

available Australia wide, unless there is agreement and modification to achieve consent to the sharing of information across jurisdictions.

The WA Health Department, as the State regulator, collects all pharmacy data on all dispensed Schedule 8 medicines.[105] Once WA has implemented its interface with the Commonwealth system, it will be possible for WA pharmacies to provide all their medicine dispensing data into a secure WA system. It would then be possible to construct an access point for WA prescribers to access WA information in real time, using the pharmacy data for both on and off PBS medicines.

While WA has recently passed legislation (*Medicines and Poisons Act* 2014) to achieve that outcome, the regulations have not yet been finalised as to how that outcome will occur.[106] One of the desirable outcomes would be pharmacy access to the information sharing system, especially that which relates to the drug addict register, as an additional aid to the control of dispensing controlled medicines. Similarly, because it is based on pharmacy records, and the legislation requires a record to be kept of prescribing and dispensing of drugs of addiction it could be extended to benzodiazepines, not just Schedule 8 medicines, as drugs of addiction. The State legislation has also reworded the terms used around 'dependency' and 'addiction' which will make the sharing of relevant information less prejudicial.

The State data will need to be compatible with the commercial software used in the majority of medical practices so that information received from pharmacies can be accessed via the State held database in real time. Because the State holds the equivalent of the drug addict (user, dependent etc.) register it would be possible for software to be implemented which would provide alerts from the database to the prescriber when the name of a person on the register is entered. The intention would be to prevent the writing of a prohibited script at the source.[107] That

[105] t 19/03/15, p638
[106] t 19.03.15, p641 & 648
[107] t 19.03.15, p643

information, available in pharmacies as well as medical practices, would ensure pharmacists would not dispense unauthorised prescriptions to users from an unrecognised prescriber.

A prescriber would still need to log into the system but it would be open to commercial software providers to develop automatic links to State drug registers and real time dispensing data.

In the current case that would have prevented all Schedule 8 prescriptions, following the deceased's 23 December 2009 registration, from being written for the deceased without reference to Dr Wilson. It has the potential to stop it at the prescription level for electronically produced prescriptions for registered drug addicts, and at the pharmacy level for dispensing wherever handwritten prescriptions are still in use. The pharmacy at Bibra Lake would not have been in a position to provide the deceased with 20x80mg OxyContin tablets without interrogation of Dr Wilson, as the authorised prescriber of the deceased's Schedule 8 medicines, as to the appropriateness of the script for oxycodone for a registered drug addict.

There is also potential for a decision to be made as to whether other drugs/medicines are being used inappropriately and should be considered for stricter control. These could include medicines of concern, benzodiazepines and some antipsychotics (Schedule 4).

Prescribers logging onto the system would be able to view a real time dispensing history before making a decision as to the appropriateness of any prescription before them at that moment.[108]

<u>Should benzodiazepines be controlled like Schedule 8 medicines</u>

This is a vexed issue. A surprising number of doctors heard from at inquest believed benzodiazepines should be

[108] t 19.03.15, p665

controlled in the same way as Schedule 8 medicines despite the additional paperwork this would involve.[109] Others were very concerned this would lead to a number of elderly patients being labelled as *"drug addicts"* and great reluctance by doctors to then be involved in prescribing benzodiazepines to elderly or needy patients. There is no doubt in the minds of those treating patients the term *"drug addict"* can be prejudicial.[110]

Labelling is not of major concern because different terms can be used such as 'authorised drug user' but the additional paperwork may be a difficulty for busy clinicians who have a large practice of those needing benzodiazepines (nursing homes) but choose not to be authorised for Schedule 8 pharmacotherapy programs (CPOP) and can refer those to suitably accredited clinicians.

Interestingly, the doctors who believed benzodiazepines should be controlled in the same way as Schedule 8 medicines tended to be those who were authorised pharmacotherapy prescribers, or had been, due to the extent of misuse they see of those drugs. The doctors who did not believe benzodiazepines should be controlled like Schedule 8 medicines were those who did not wish to be involved in CPOP prescribing, and referred those of their patients requiring it to other practitioners.

Professor Joyce believed there were some arguments for further control of benzodiazepines. He reminded the court many of the falls seen of the elderly, in nursing homes, which often led directly to death could be avoided if those patients were more alert, and not as sedated with benzodiazepines.[111]

Professor Schug was of the view long term prescribing of benzodiazepines was undesirable, even in the elderly.[112]

[109] t 12.03.15, p269 (Wilkinson)
[110] t 18.03.15, p540-41 (Winterton)
[111] t 19.03.15, p590
[112] t 20.03.15, p710-11

Challenges for Prescribers

The intention for the regulation of Schedule 8 medicines is to provide adequate medication to those who are in need of it, but to try and prevent its misuse by controlling prescriptions for medication which is not necessary. Medical practitioners desire to treat patients with a medical problem in the most effective way possible without doing harm. Lack of knowledge of a patient's real need for medication puts a prescribing medical practitioner at a great disadvantage when trying to determine the potential harm of a prescription. As one medical practitioner said:-

> "*There's all these people that have died because – as a GP in those situations, you try – none of us are malicious. We try and do our best, we try and judge the situation. But people who are addicts and who really want the drugs are clever and, unfortunately, sometimes can be quite aggressive and quite persuasive.*"[113]

The capacity of opioids and benzodiazepines, to induce tolerance in a patient, which similarly can diminish quite quickly, adds another layer of complication for a prescriber. Both groups of drugs can cause respiratory depression, which has its own challenges, and if prescribed together can cause additional issues. The black market also relies on over prescribing to some extent. This can occur where a patient no longer requires a high level of medication, but does not inform their prescriber or exchanges one drug for others.

Aside from tolerance to controlled medicines there is also the aspect of addiction to drugs which elevates a desire for the psychological outcome. Addiction to a drug can cause many undesirable outcomes, not the least of which is an addict's propensity to lie to obtain the drug, and indulge in drug seeking behaviour (violence or intimidation) where access to the drug of choice is restricted.

[113] t 12.03.15, p267

Throughout the inquest doctors related very frightening and threatening interchanges they had experienced with patients seeking drugs which the doctor had questioned. This was quite separate from the issue of continually being concerned a patient may not be reliable in their medication history:-

> "*One of the oppressive parts of medical practice is dealing with patients whose relationship with you is entirely based on deceit and manipulation and to have those better controlled in practice will improve the medical practitioner's capacity to enjoy the quality of professional life.*"[114]

None of the deceased in the three inquests chosen for these "doctor shopping" matters were in the intimidating or threatening category. They all appeared to the prescribing doctors to be genuine in the need for pain relief medication or their desire to overcome a dependency by use of controlled prescribing. The doctors concerned consistently took them to be both credible and reliable as to their medication history when dealing with them.

In the current case the doctors at Central knew the deceased had medical problems which warranted Schedule 8 medicines from time to time and prescribed them. By 2009 the doctors at Central were changing his medication regime to try and avoid ongoing Schedule 8 prescription. The misuse of fentanyl patches was not as prolific in 2009 as 2015. The Central doctors were not as aware of the extent of the deceased's drug use as was Dr Newall at Cottesloe, as the deceased had apparently not altered any of Central's prescriptions.

Dr Newall at Cottesloe became aware of the deceased's misuse of prescription medication, but still attempted to help the deceased when he believed his wish to address his problem was genuine. It was, to a doctor, a medical problem which could be treated. While Dr Newall was not prepared to undertake pharmacotherapy with the deceased

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[114] t 19.03.15, p591

himself, he did refer him to a doctor who was authorised to treat him at that practice, Dr Wilson. When Dr Wilson did not prescribe as the deceased wished, he stopped seeing Dr Wilson and did not continue with the program.

There is nothing a medical practitioner, complying with the regulations can do where medical information is so strictly confidential. The deceased remained on the register, but doctors at Central did not know for many months they had breached the regulations unwittingly by prescribing Schedule 8 medication when he was a registered drug addict at another practice.

By the time Dr Mahon wrote the relevant referral for the deceased's nasal polyps review to an ENT specialist he had forgotten the deceased had a history of drug dependency, and the deceased genuinely needed to be reviewed and treated for his nasal problem. Without knowledge of the deceased's drug history, Mr Miller, the ENT surgeon, had no reason to question the referral letter, and Dr Rodoreda had no reason to disbelieve the deceased when he appeared to give the anaesthetist a full and frank disclosure of his past issues to account for his high level opioid tolerance, born out while under anaesthetic.

The deceased:-

1. did not disclose his drug addict status;
2. was able to access all the drugs at one supply through a pharmacy where he was not known as a registered drug addict;
3. would not allow his mother to have custody of the drugs; and
4. did not comply with the prescription and took more of the OxyContin than he could tolerate.

He died.

His medical practitioners did harm where they had only ever wanted to treat him for his known medical difficulties. This is simply not fair on doctors where there is available a method which could minimise the ability for drug seekers to

obtain drugs by misrepresenting themselves to prescribers. Had Dr Mahon's software provided an alert the deceased was a registered drug addict following his registration, it would not have been necessary Dr Mahon remembered to include it in his referral to Mr Miller, and had the pharmacy at Bibra Lake been alerted to the fact the deceased was a registered drug addict, they would not have supplied the complete script in one dose without consulting with either prescriber. If either of those things had happened the deceased's death may have been prevented despite himself.

Every practitioner appearing in the course of the three inquests was strongly in favour of the implementation of an electronic information system which would provide them with real time dispensing information for Schedule 8 drugs.[115] The majority of them would also appreciate up to date information on the dispensing of benzodiazepines as an information system as opposed to a regulation system. Schedule 8 opioids, and Schedule 4 benzodiazepines, are often used in conjunction in areas of drug dependency and as they both operate as respiratory depressants information or access to their dispensing history would be appropriate.

Dr Quigley, on behalf of Next Step, was of the view dispensing information was the most important factor in attempting to assist those with a dependency. Access to dispensing information would also provide information about the last prescription which would enable the receiving doctor to make enquiries of the previously prescribing doctor. In his view dispensing information was predominantly the useful information.

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[115] t 10.03.15, p71 Bradford
t 10.03.15, p96 Wilson
t 10.03.15, p118 Wolman
t 11.03.15, p153 Rodoreda
t 11.03.15, p183 Mahon
t 12.03.15, p245 Kumar
t 12.03.15, p267 Wilkinson
t 13.03.15, p310 Myburgh
t 13.03.15, p334 Drummond
t 16.03.15, p370 Foley
t 16.03.15, p445 Buntine
t 16.03.15, p483 Davies
t 18.03.15, p528 Winterton
t 19.03.15, p590 Joyce
t 20.03.15, p710 Schug
t 20.03.15, p748 Quigley

Similarly, Professor Schug was of the view the dispensing data outweighed prescription data.

It is the dispensing information which is available from ERRCD. One of the significant similarities of two of the three matters is the fact none of the prescriptions issued would have been fatal had the recipient used the drugs as prescribed. Even in the matter of the deceased Berry the expert view was he could have taken both prescriptions obtained on the same day without a fatal outcome had he taken both as prescribed. He didn't, he used multiples of the prescriptions intravenously, serious abuse, which caused toxicity, sedation, aspiration and death.

It is because drug abusers misuse prescription medicines legislative restrictions have been put in place in an attempt to save them from themselves. Blaming prescribers when drug abusers circumvent those restrictions is destined to reduce the number of doctors willing to expose themselves to the risks of attempting to assist those with dependencies. It is more constructive to provide prescribers with a tool which will better enable them to treat patients effectively, than chastise them for providing apparently competent medical prescriptions because they have the potential to be misused.

Recent research by the Victorian Coroners Court Prevention Unit on the outcomes of the use of the real time prescription monitoring system developed in Tasmania suggests that the frequency of overdose deaths in Tasmania has not decreased overall, but there has been a notable decrease in overdose deaths involving the prescription medications that are monitored by the system. A particularly pronounced decrease was observed following the Tasmanian implementation, in the frequency of Tasmanian overdose deaths involving pharmaceutical opioids. It was emphasised it was important to ensure those prescribing or supplying relevant medication used the system.[116]

[116] Presentation: Tasmanian overdose deaths before and after the DAPIS implementation: Dr Jeremy Dwyer (et al), Coroners Court of Victoria: Asia Pacific Coroners Society Conference 12 November 2015, Hobart, Tasmania.

Recommendations

I wish to acknowledge the assistance of the Chief Pharmacist and Next Step in commenting on the proposed recommendations. Where I have deviated from that input it was as a result of my intended deviation.

Secure Database

1. WA prioritise the real time collection of dispensing data from all pharmacies for all Schedule 8 and reportable Schedule 4 poisons.[117]

2. All WA real time dispensed medicine data be held in a secure regulated database held by the WA government regulator.

3. WA regulate to ensure the supply or dispensation of all Schedule 8 and reportable Schedule 4 poisons are recorded in the secure regulated database held by the WA Government regulator.

4. WA regulate to provide both prescribers, registered pharmacists[118] and authorised suppliers access to that secure data via secure software links to facilitate real time decision making around both prescribing, supplying and dispensing of Schedule 8 and reportable Schedule 4 poisons.

5. The current Schedule 8 (controlled drug) dependency register be part of that secure database and provide that information along with real time information about medicines dispensed on enquiry by a prescriber, registered pharmacist or authorised supplier.

6. The information from any register regulated (e.g. reportable Schedule 4 poisons) as part of the secure

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[117] The phrase 'reportable Schedule 4 poisons' is adapted from definitions contained in Part 6, *Medicines and Poisons Act* 2014 (WA), assented to on 2 July 2014, not yet proclaimed.
[118] Those pharmacists registered under the *Health Practitioners Regulation National Law (WA)* in the pharmacy profession.

database, be similarly available on enquiry for dispensed medicines.

7. Once real time WA dispensing data is available for use there be a regulated time period to allow commercial practice case management software to be developed to facilitate real time access. Once that period is over it be regulated that prescribers access the available data prior to completing any prescription or supply for Schedule 8 or reportable Schedule 4 poisons. The intention is to ensure those with drug seeking behaviour understand prescribers must comply with regulation to enable a prescription to be written.

Benzodiazepines

8. All benzodiazepines be included as reportable Schedule 4 poisons.

9. There be a method implemented to assist prescribers and dispensers with decision making around benzodiazepine dependency, and restrictions imposed on recognised unsafe prescribing or supply. How that is achieved is up to the regulator. Again the concern is not with policing but providing prescribers with a mechanism with which to decline to prescribe in the face of undue pressure from drug seekers.

CPOP

10. CPOP prescribers be given information about a patient's prior CPOP programs and prescribers when seeking authorisation to commence a new program.

11. CPOP prescribers to provide advice when seeking authorisation as to other medications to be prescribed in conjunction with the authorised program medicine. This is to include reportable Schedule 4 poisons and amounts with intended reduction regime, if that is applicable.

Australia Wide Dispensing Information

12. The ultimate aim for the secure regulated database held by the WA Government regulator be for all prescription medicines to be captured. If medication warrants a prescription, it warrants monitoring.

13. The ultimate aim for real time ERCCD data should be for Australia wide access to dispensing data for medical practitioners, registered pharmacists and authorised suppliers.

E F Vicker
Deputy State Coroner
10 February 2016