Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 35 /18

I, Sarah Helen Linton, Coroner, having investigated the death of ***Mark Leslie SACH*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***18 October 2018*** *find that the identity of the deceased was* ***Mark Leslie SACH*** *and that death occurred on* ***1 March 2016*** *at* ***Fiona Stanley Hospital*** *as a result of* ***combined drug toxicity*** *in the following circumstances:*

Counsel Appearing:

Mr T Bishop assisting the Coroner.
Mr E Fearis (State Solicitor's Office) appearing on behalf of the North Metropolitan Health Service.

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INTRODUCTION

1. Mark Sach (the deceased) worked as a full-time linesperson for Western Power. He lived with his wife and young daughter in Harrisdale and they had another child on the way. At the time of his death he was still a relatively young man of only 27 years of age.

2. Mr Sach was injured in a motor vehicle accident in 2012 and thereafter suffered from chronic pain. He saw a GP regularly and he had later seen a number of pain specialists who had tried to formulate a plan to help him reduce his pain and also to learn to manage it. Mr Sach had trialled various alternative therapies, attended a physiotherapist and followed a gym programme in an effort to control his pain in other ways than taking pain medication.

3. In late 2015 Mr Sach reported to a psychologist that he was struggling with flare-ups of his pain and that his prescribed medication was not helping. Mr Sach admitted to buying *'supplements'* that were not available in Australia and taking diazepam that was not prescribed to him. He was counselled about the dangers of this behaviour by the psychologist.

4. On 1 March 2016 Mr Sach admitted to his wife he had taken a drug that he had been purchasing over the internet. She noticed he had a 'lazy eye' but otherwise appeared fine. That evening Mr Sach went into the bedroom at about 6.30 pm. He was found by his wife approximately half an hour later lying unresponsive on the bed. She immediately called an ambulance and commenced CPR but he could not be resuscitated. He was declared deceased at Fiona Stanley Hospital just before 8.30 pm.

5. As part of the post mortem examination, toxicology analysis found various prescribed medications and also two 'new or novel psychoactive substances' (NPS), one being etizolam (which is about 10 times more potent than diazepam) and another known as U-47700 (which is roughly 7.5 times more potent than morphine). The cause of death was considered to be combined drug toxicity (including U-47700 and etizolam). Neither etizolam nor U-47700 are available on prescription in Australia.

6. I held an inquest at the Perth Coroner's Court on 18 October 2018 to explore the circumstances of Mr Sach's unexpected death. The evidence indicated the deceased purchased drugs over the internet and was self-medicating with these drugs as he was not satisfied with the pain management options being offered to him by his treating specialists. The inquest into Mr Sach's death highlighted the difficulties of managing patients with chronic pain and the increasing and concerning use of new psychoactive substances in Australia.

RELEVANT MEDICAL HISTORY

7. Mr Sach first experienced some back pain in 2010 after injuring his back through a combination of weights training and his work as a linesperson. He sought treatment from a chiropractor but it did not help with his pain. He then initiated his own strength training program, which succeeded in reducing his pain to a manageable level.[1]

8. Mr Sach was then involved in a motor vehicle crash on 23 August 2012. He was fatigued and fell asleep at the wheel and his vehicle collided with a tree. He suffered serious spinal fractures, which required hospitalisation and resulted in ongoing chronic spinal and neck pain thereafter.[2] This was in addition to the previous cervical and shoulder pain he had reported in the past.[3] From the time of the car accident the degree and intensity of Mr Sach's pain varied, but he was never completely free of pain and his baseline of pain increased over time.[4]

9. Mr Sach initially underwent rehabilitation through Royal Perth Hospital and was on oxycodone pain relief, although this was ceased on discharge. Mr Sach found that his ongoing back and neck pain significantly impacted upon his ability to continue with his active lifestyle and perform at work. He had found it very difficult to improve his exercise and functional capability, even after seeing a physiotherapist and chiropractor.[5] He had been forced to give up his mixed martial arts activities and adjusted his weights training to focus more on encouraging movement than his previous aim of gaining muscle mass. His loss of muscle mass and mobility affected his ability to perform at work, which affected his relationships with his managers and co-workers. Mr Sach had also lost a lot of his energy and stamina to socialise, which affected his personal life. His wife described him as a naturally sociable person who became increasingly depressed, anxious and withdrawn.[6]

10. Mr Sach's wife knew Consultant Pain Specialist Dr Chin-wern Chan through her work as a nurse at Hollywood Hospital. Dr Chan is a Consultant in Pain Medicine and Anaesthesia. He works privately at Hollywood Private Hospital and also sees public patients in the Pain Clinic at Sir Charles Gairdner Hospital. Dr Chan had a conversation with Mrs Sach about her husband's difficulties with his pain control and rehabilitation and she asked if Dr Chan could review him. Dr Chan agreed and suggested he see Mr Sach in his private consultation rooms at the Hollywood Medical Centre as at that time there was a much shorter wait than on the public waiting list. The difference in wait time was in the order of 6 to 7 months' at that time.[7]

[1] Exhibit 1, Tab 19.
[2] Exhibit 1, Tab 9B and Tab 19, Report of Dr Chin-Wern Chan dated 8.8.13.
[3] Exhibit 1, Tab 13.
[4] Exhibit 1, Tab 19.
[5] Exhibit 1, Tab 13.
[6] Exhibit 1, Tab 19.
[7] T 19; Exhibit 1, Tab 18, Report of Dr Chan 8.8.13.

11. Dr Chan saw Mr Sach shortly afterwards on 8 August 2013 at his private rooms.[8] Dr Chan saw Mr Sach together with Mrs Sach. Mr Sach described considerable pain related to the injuries he had sustained in the car crash. Dr Chan reviewed his imaging from Royal Perth Hospital, which made note of the multiple fractures Mr Sach had sustained and the belief that the fractures had healed, which Dr Chan later confirmed with a bone scan.[9] Dr Chan believed there was still a physical aspect to Mr Sach's pain as his muscles had weakened due to the healing fractures, which had resulted in poor posture. It was also possible there were some issues related to how the fractures had healed that were present but not detectable on scans.[10]

12. Dr Chan stated that most of his referrals from general practitioners and specialists are for patients whose pain arises post-accident and is difficult to treat. Dr Chan explained that in about half his patients there is a very clear cause for the pain but in the other half of cases the cause of the pain might be difficult to detect, as was the case with Mr Sach. Dr Chan felt Mr Sach fell into the category known as post-traumatic myofascial pain, with most of his pain located in the axial spine.[11]

13. Dr Chan found Mr Sach to be genuine and very motivated to reach the stage where he could return to work on a full-time basis and also return to his activities at the gym. He had already undergone evidence-based rehabilitation at RPH but, for someone like Mr Sach, Dr Chan believed he needed some more physiotherapy to improve the musculature that supports the spine as well as possibly some alternative, non-pharmacological, pain management strategies. Dr Chan proposed Mr Sach engage in a pain management program, which looks at occupational therapy, psychology and physiotherapy to complement any medications that are deemed fit. Dr Chan felt Mr Sach was very open to his plan of rehabilitation that extended beyond what he had attempted already.[12]

14. Dr Chan arranged for Mr Sach to be transferred to his care at the SCGH Pain Clinic as he would get better access to the complementary therapies such as physiotherapy, which was otherwise difficult due to Mr Sach's lack of private health care. Dr Chan stressed the importance of Mr Sach having access to this multi-disciplinary expert advice on the non-pharmacological management of his pain. Mr Sach's care was transferred on the basis of an introduction to pain management programme referral, with a trial of the medication Lyrica (pregabalin) for his nerve pain.[13] The Lyrica was in addition to the Panadeine Forte and Tramadol medications Mr Sach was already taking.[14]

15. Mr Sach was seen by Dr Chan for the first time at the Pain Clinic on 28 October 2013. Dr Chan considered Mr Sach had improved since Dr Chan last saw him a couple of months before. He noted Mr Sach was attending the gym five days a week and was taking the Lyrica morning and night, with a

[8] T 19; Exhibit 1, Tab 18, Report of Dr Chan 8.8.13.
[9] T 24.
[10] T 19 – 21.
[11] T 21 – 22.
[12] T 20.
[13] Exhibit 1, Tab 13.
[14] T 22.

larger dose in the evening. Mr Sach reported no adverse effects from the Lyrica but he did experience sedation from the greater dose at night. He also reported taking the Panadeine Forte and Tramadol sparingly.

16. Psychologically, Mr Sach reported feeling improved and happy and he was progressing with his physical therapy. There was some discussion about pain and discomfort in certain areas, which Dr Chan felt was more myofascial in nature, so he organised for Mr Sach to try trigger point injections and to have a physiotherapy assessment for advice on stretching and core muscle strengthening.[15]

17. Dr Chan saw Mr Sach for the second time at the SCGH Pain Clinic on 24 June 2014 and felt that Mr Sach was still very receptive to the proposed pain management program and was compliant with what Dr Chan had recommended in terms of attending the physiotherapist at the Pain Clinic. Dr Chan believed Mr Sach still seemed highly motivated to improve but he was concerned about the amount of physical activity Mr Sach was attempting. He talked to him about 'pacing' and the 'boom and bust cycle'. Dr Chan explained that some patients will try to recover too quickly and take on too much and exercise too vigorously. They end up experiencing more pain and then may not be able to continue to exercise, which impedes the whole rehabilitation process. Dr Chan was concerned that Mr Sach might fall into this trap as he was back at work full time and attending the gym regularly, so he spoke to him again about pacing himself. Nevertheless, he saw Mr Sach's increase in work hours and exercise as a significant improvement than when he first saw him.[16]

18. Dr Chan was aware that Mr Sach had been prescribed oxycodone previously after surgery but his impression was that Mr Sach and his wife were happy he had come off oxycodone and he did not make any requests to Dr Chan to be prescribed the medication.[17] Dr Chan added clonazepam to Mr Sach's medication regime at this appointment as his main pain was muscle spasms.[18]

19. Dr Chan did not see Mr Sach again for further reviews as he went on long service leave. Mr Sach's care was thereafter managed by various medical staff at the Pain Clinic, in conjunction with Mr Sach's GP, Dr Karis White, of the Canning Vale Medical Centre.

20. Mr Sach had first seen Dr White in early 2015 and he then attended appointments on average once a month over the following 14 months, predominantly for his chronic pain issues. Dr White was aware Mr Sach was also seeing the chronic pain team at SCGH and there was communication between her and the Pain Clinic staff, although the communication was often slow. Mr Sach told Dr White on many occasions that he was trying to come off his pain medications as he did not like relying on them. He also

[15] Exhibit 1, Tab 18, Report of Dr Chan 28.10.2013.
[16] T 23 - 25.
[17] T 25.
[18] Exhibit 1, Tab 18, Report of Dr Chan 24.6.2014.

said he had been undertaking a gym strengthening program given to him by a physiotherapist as part of his rehabilitation.[19]

21. It was clear to Dr White that Mr Sach was not satisfied with the pain management that he was receiving both from doctors at her practice and the pain management team at SCGH. Dr White recalled that Mr Sach felt his prescribed medications weren't working very well as he wasn't able to function as normal, which I take to mean he wasn't able to function at the level he had been able to prior to the accident. Mr Sach had a young daughter at the time and he also felt that he couldn't interact with her as well as he wanted to do.[20] Dr White understood from Mr Sach that he was concerned that his pain levels remained fairly high despite being compliant with his prescribed medication regime.[21]

22. It was noted that Mr Sach's work as a linesman made his management difficult as the job required a great deal of manual labour and significant leverage and force on the spine in regions.[22] In particular, his work placed strain on his axial spine. He reported stress at work due to workload and the pressures being placed on him to undertake tasks that aggravated his pain. Unfortunately, Mr Sach was unable to find alternative work that would be less likely to aggravate his spinal pain.[23]

23. Dr Chan went on extended leave so Mr Sach was next seen at the SCGH Pain Clinic on 24 March 2015 by Dr Stiofan O'Conghaile. Mrs Sach was present during the consultation. Dr O'Conghaile noted that Mr Sach was managing reasonably well at that time, but was bothered by an ache in the base of his neck, which was aggravated by duties at work. He also reported some low mood and dissatisfaction with his antidepressant, as well as impulse behaviour with regards to alcohol intake, which he was working on reducing. Mr Sach requested a prescription for immediate release oxycodone as he had recently been prescribed some, which had helped him with regard to his pain. He wanted to be able to take it after his work-out.[24]

24. Mr Sach's request for oxycodone was denied and a note was made that he was to be "not for oxycodone, morphine, hydromorphine, fentanyl, pethidine or methadone."[25] Instead of being given oxycodone or any other strong opioid Mr Sach was prescribed Palexia (tapentadol slow release) 50mg twice a day, which could be increased as required up to 100mg twice daily. Mr Sach was encouraged to see a psychologist and be reviewed by a psychiatrist in relation to his antidepressant medication. He was also encouraged to continue his physiotherapy exercises, stretches and range of movement exercises and to continue with his efforts to reduce his alcohol intake.[26]

25. Although Dr Chan was not present for these events, he was aware at the time of the inquest that Mr Sach had been prescribed tapentadol, which he

[19] Exhibit 1, Tab 15.
[20] T 8 – 9.
[21] T 9.
[22] Exhibit 1, Tab 14A, p. 1.
[23] Exhibit 1, Tab 14A, p. 2.
[24] Exhibit 1, Tab 13.
[25] Exhibit 1, Tab 18, Report of Dr O'Conghaile dated 24.3.15.
[26] Exhibit 1, Tab 13.

described as one of the newer opioids that is classified as a weak opioid. Dr Chan explained it is better suited to ongoing prescription as it has less abuse potential and carries less risk of tolerance, dependence and endocrinological adverse effects. Dr Chan agreed with the decision of Dr O'Conghaile to prescribe tapentadol to Mr Sach at this stage as his pain was persistent and had not improved. Dr Chan emphasised it was also important to note that the tapentadol was prescribed as part of a multidisciplinary program.[27]

26. On 28 July 2015 Mr Sach was reviewed at the Pain Clinic by a another Pain Medicine Consultant, Dr Phillip Kriel, as Dr Chan was still on extended leave. It was noted that following the steroid injections into his trigger points Mr Sach had experienced a flare-up and he also reported flare-ups from massage. Only dry needling appeared to have helped with his spasms. It was also noted that tapentadol was not suitable for his work, although it helped him at night. Mr Sach requested a psychology referral, which was provided for the Pain Clinic psychologist.

27. There were clearly some concerns expressed by Mr Sach at that stage about his treatment. Dr Kriel referred to some "unmet need expectation on diagnosis and management from him which I could not fill today." He noted Mr Sach seemed to have unanswered questions that Dr Kriel could not answer and Dr Kriel noted that other drivers were suspected or else he felt Mr Sach "was still having adjustment difficulties."[28] Dr Kriel recorded that he encouraged Mr Sach to focus on the positives and proven active strategies for his life and pain management.

28. The management plan set by Dr Kriel at the end of the consultation involved Mr Sach being started on the natural supplement curcumin 600mg daily as a trial and he was advised to stop the Panadeine and clonazepam he had previously been taking. He was also encouraged to try yoga and swimming. Dr Kriel made a note that it seemed reasonable for Mr Sach to continue working in his current capacity without escalation of medications and consider the plan fully, and if Mr Sach disagreed he could seek a second opinion privately or await the return of Dr Chan.[29] As I note later, Mr Sach did not appear to be happy with the outcome of this consultation.

29. Mr Sach saw Dr Su Chan, a clinical psychologist, at the Pain Clinic on 13 October 2015. Mr Sach was 30 minutes late for his hour long appointment so Dr Su Chan only saw him for half an hour. Mr Sach reported at that stage that he did not feel his current medications were helping him and so he had been "buying supplements(?) that are unavailable in Australia"[30] and at times used diazepam, which had not been prescribed to him Dr Su Chan emphasised the need for open communication with his treating medical practitioners and warned of the dangers of using medications that were not prescribed for him. Mr Sach indicated he understood the advice.[31]

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[27] T 27.
[28] Exhibit 1, Tab 18, Report of Dr Kriel dated 28.7.15.
[29] Exhibit 1, Tab 13 and Tab 14, p. 2 and Tab 18, Report of Dr Kriel dated 28.7.15.
[30] Exhibit 1, Tab 18, Report of Dr Su Chan dated 13.10.15.
[31] Exhibit 1, Tab 13 and Tab 18, Report of Dr Su Chan dated 13.10.15.

30. Mr Sach also reported struggling with his depression but did not indicate any current suicidal ideation or intent. He admitted to experiencing a lot of workplace stressors and some stress from personal issues at home. It was suggested that he might wish to see a private psychologist using the 'better access to mental health initiative' but Mr Sach reportedly seemed dismissive about getting further psychological input.[32] Dr Su Chan did not make any plans with Mr Sach for follow-up.

31. After the appointment the psychologist Dr Su Chan wrote to Dr Chan and Dr Kriel to inform them that Mr Sach had disclosed to her that he had been buying supplements and using diazepam which had not been prescribed for him.[33] It is assumed this information would have been followed up at his next appointment with a pain specialist, but that did not occur before Mr Sach's death.

32. Mr Sach's last appointment with his GP, Dr White, on 20 January 2016 was to review his medication. Mr Sach told Dr White he had been given a plan regarding his analgesia by the injury management doctor at work, and it had been suggested that he take regular tapentadol. He was given a new prescription for tapentadol on that basis. Dr White reported that Mr Sach's medication list at that time was as follows:

- Clonazepam 0.5mg BD
- Lyrica 150g mane, 300mg nocte
- Panadeine Forte 500mg/30mg 2 tabs 2-3x/day PRN
- Tapentadol 100 mg BD.

33. However, in the medical notes for 20 January 2016 Dr White also noted an added prescription for oxycodone hydrochloride 10mg 1 BD PRN.[34] Dr White gave evidence she had prescribed Mr Sach a few tablets of oxycodone a couple of times at his specific request when he was experiencing acute flare-ups of his pain, and this was one of those occasions.[35] Dr Chan agreed that was appropriate for management of Mr Sach's short term acute pain.[36]

34. In the past Mr Sach had also been prescribed the anti-depressant duloxetine for his depression, but he had weaned himself off this in June/July 2015 as he didn't like its effect and wanted to try manage his depression without medication. He had told Dr White his mood had not deteriorated as a result, although I note above he reported struggling with depression when he saw the clinical psychologist later in 2015. Mr Sach told Dr White he had been abstinent from alcohol in more recent times, which had led to an improvement in his mental health.[37]

35. In November 2015 Mr Sach had received a referral to a private clinical psychologist with an interest in pain management after he reported his mood

[32] Exhibit 1, Tab 13 and Tab 18, Report of Dr Su Chan dated 13.10.15.
[33] Exhibit 1, Tab 14B, p. 3.
[34] Exhibit 1, Tab 16.
[35] T 10 – 11, 17.
[36] T 31.
[37] Exhibit 1, Tab 15.

was again deteriorating, but Dr White was uncertain whether he ever followed up on this referral. Mr Sach reported work pressures and a fear that his employer was trying to force him to quit or find grounds to terminate his employment which had precipitated the deterioration in mood.[38] Dr White felt that otherwise Mr Sach was actually managing quite well from a psychological perspective.[39]

36. None of Mr Sach's doctors were aware that Mr Sach also purchased additional prescription-type medications off the internet, although as noted above he had mentioned to the psychologist buying 'supplements' and taking diazepam that was not prescribed to him. This information had been passed on to the Pain Clinic doctors but he was not reviewed again before his death. Mr Sach had told his GP that he was reluctant to take medications and so she had no reason to suspect he was self-medicating.[40] Mr Sach had no history of illicit drug use that might otherwise have triggered such a concern.[41] Dr White's evidence was that if Mr Sach had told her he was sourcing medications from overseas she would have tried to dissuade him from using them and to go back to the Pain Clinic for review of his regime.[42]

37. Dr White was aware that Mr Sach was unhappy about the lack of continuity of care at the Pain Clinic and had "butted heads" with one of the doctors at the Pain Clinic and had intimated that he did not speak with them openly as he didn't particularly like them. In comparison, Dr White felt that Mr Sach had generally been open with her, although she accepted in hindsight that was not the case given he had not disclosed to her his self-medicating behaviour.[43]

38. Mrs Sach recalled that her husband had found the lack of continuity of care from the Pain Clinic very frustrating and tiring as he was having to repeat his story every time he had an appointment at the Pain Clinic. He felt that he spent most of the appointment outlining his past treatment options without gaining any new information, advice or treatment. He also felt that the information he received often conflicted, depending upon which doctor he saw.[44] Mrs Sach believed Mr Sach received some benefits from the treatments he undertook on advice from the Pain Clinic, but more often than not he felt the responsibility lay with him to find a solution to his pain. This led him to research and trial various treatment options, some of which were simple treatments like anti-inflammatory gels and heat packs, but also involved research online for drug alternatives.[45]

39. Mrs Sach did not known a great deal about Mr Sach's internet searches for medication prior to his death, although she was aware that he had purchased a drug called etizolam. He had informed her that it was categorised as a "research chemical."[46] Mrs Sach says she wasn't happy with

[38] Exhibit 1, Tab 15.
[39] T 13.
[40] Exhibit 1, Tab 15.
[41] Exhibit 1, Tab 9B
[42] T 12.
[43] T 14.
[44] Exhibit 1, Tab 19.
[45] Exhibit 1, Tab 19.
[46] Exhibit 1, Tab 19.

him purchasing medications via the internet but initially she felt the improvements in his pain levels and mood after taking the unauthorised medications appeared to outweigh the risks. However, over time she noticed concerning changes in his behaviour and discovered other substances and implements in the house. These discoveries prompted Mrs Sach to ask Mr Sach to stop ordering and using the drugs but she believes he continued to order them and simply arranged to have them delivered to other people's houses. Her later enquiries led her to believe they were being shipped concealed in children's toys or make-up.[47]

40. Mrs Sach was unaware of the extent of Mr Sach's research on the drugs he was ordering, or what checks he did to ensure they were safe, but she did find internet search history to show he looked into the chemical properties and compounds of the drugs. She also believes the fact they were described as research chemicals gave him some reassurance. Mrs Sach attended most of her husband's medical appointments and noted he did not mention taking drugs purchased online during those appointments, although he did tell her he told a psychologist, which from the other evidence before me was likely to be Dr Su Chan.[48]

EVENTS PRIOR TO DEATH

41. Mr Sach's family relationships were generally good although he did report some relationship issues and personal stress from time to time. Mr Sach's primary stressor was his work. He believed he had not been treated well by his managers and colleagues following his injury and he was concerned he might get laid off due to the limitations imposed by his back pain.[49]

42. Mr Sach's wife left home at about 6.00 am on 1 March 2016. Mrs Sach is a nurse and she was going to work. Mr Sach had not been to work since Wednesday the previous week. At the time Mrs Sach left the house Mr Sach was still asleep in bed.[50]

43. When Mrs Sach returned home from her nursing shift at 2.30 pm Mr Sach was up and out of bed. Mrs Sach noticed that Mr Sach appeared to have a "lazy eye," which she said often occurred when Mr Sach had taken his full dose of medication.[51]

44. Mrs Sach got changed and then she and Mr Sach left the house to go and collect their daughter from day care. On the way home Mr Sach told his wife that he had taken one etizolam as some more had arrived in the post that day. Mr Sach said this was the reason for his lazy eye. He otherwise appeared fine at that time.[52]

[47] Exhibit 1, Tab 19.
[48] Exhibit 1, Tab 19.
[49] Exhibit 1, Tab 11 and Tab 15.
[50] Exhibit 1, Tab 9A, p. 2 and Tab 11.
[51] Exhibit 1, Tab 9A, p. 2 and Tab 11.
[52] Exhibit 1, Tab 9A, p. 2 and Tab 11.

45. The family arrived home at about 3.30 pm. Mrs Sach went outside to play with their daughter and Mr Sach remained in the house. At about 5.00 pm they all had dinner together. After dinner Mr Sach went and had a shower. After his shower he went into the lounge room to watch television, where he was joined by Mrs Sach and their daughter.[53]

46. At about 6.30 pm Mr Sach left the lounge room and went into the main bedroom. Mrs Sach thought Mr Sach appeared fine at the time that he left the lounge room.[54]

47. At about 7.00 pm Mrs Sach went into the bedroom with their daughter so that Mr Sach could say good night before their daughter went to bed. When she entered the room Mrs Sach saw Mr Sach lying on his back on the bed. He was towards the end of the bed and his feet were resting on the floor. She called out his name but he did not respond.[55]

48. When Mrs Sach got closer she noticed that Mr Sach's eyes were closed, his mouth was open and his lips appeared blue. She put down her daughter and checked his breathing. She could not discern any sign of breathing and he remained unresponsive.[56]

49. Mrs Sach called emergency services and requested an ambulance attend. She then moved Mr Sach to the floor and commenced CPR. When SJA paramedics arrived they took over resuscitation efforts. Upon their initial examination of Mr Sach it was noted he appeared to be in cardiac arrest. When his airway was checked the paramedics saw what appeared to be crushed tablets at the back of Mr Sach's mouth. His airway was cleared and resuscitation attempts continued while he was taken by ambulance to Fiona Stanley Hospital.[57]

50. Upon arrival at the hospital further attempts were made by medical staff to revive Mr Sach but he was unable to be revived. His death was certified at 8.23 pm.[58]

51. Police officers from the Coronial Investigation Squad were notified of the death by a doctor from Fiona Stanley Hospital. They attended the hospital and found a small glass smoking implement in Mr Sach's clothing, which appeared to have been recently used. The police seized the implement.[59]

52. The attending police officers established that Mr Sach's home was a secondary scene. They attended his home and conducted an examination. A number of items of interest were found.

53. In a small safe in Mr Sach's bedroom wardrobe police found:
    - 79 loose pills identified as Dantrium 25 mg (dantrolene, a medication used for muscle spasms);

[53] Exhibit 1, Tab 9A, p. 3 and Tab 11.
[54] Exhibit 1, Tab 9A, p. 3 and Tab 11.
[55] Exhibit 1, Tab 9A, p. 3 and Tab 11.
[56] Exhibit 1, Tab 9A, p. 3 and Tab 11.
[57] Exhibit 1, Tab 9A, p. 3 and Tab 11.
[58] Exhibit 1, Tab 2.
[59] Exhibit 1, Tab 9A, p. 2.

- 2 small clip seal bags containing a white powder (1.05 g);
- 1 large clip seal bag containing a white substance (9.5 g); and
- 1 large clip seal bag containing a white powder (11.5 g).

The substances found in the wardrobe were believed to be the drugs Mr Sach had purchased over the internet.

54. In the kitchen area of the house, above the fridge, police also located a number of prescribed drugs.

- 23 loose capsules of Lyrica 300mg (pregabalin);
- 20 capsules of Codalgin Forte (Panadeine Forte, a combination of paracetamol and codeine); and
- An empty container of Paxam 0.5mg (clonazepam).[60]

55. The various substances were chemically analysed. The substance U-47700 was tentatively identified as a component in two bags of powder, weighing 7.74 g and 0.44 g, but could not be identified unequivocally as there were no certified reference materials for the substance at the Chemistry Centre of WA laboratory at that time. Etizolam was identified as a component of a powder weighing 5.54 g.[61]

56. Mrs Sach was asked about the substances and she advised police that Mr Sach purchased non-prescribed medications off the internet, one of which Mrs Sach understood was etizolam. The source of Mr Sach's purchases was not identified.[62]

57. No notes or correspondence were found at the premises that would suggest Mr Sach had any suicidal thoughts. There was also no evidence to suggest any other person was involved in the death of Mr Sach.[63]

CAUSE OF DEATH

58. On 3 March 2016 a Forensic Pathologist, Dr V.B. Kueppers, made an external examination of Mr Sach's body. It showed a young adult male with medical intervention consistent with attempts at resuscitation. Dr Kueppers noted a smoking implement for amphetamines was found within Mr Sach's clothing.[64]

59. The following day Dr Kueppers performed an internal examination. The examination showed injury to the breastbone consistent with chest compressions (CPR attempts). The lungs were heavy, congested and fluid laden, which are non-specific findings, and microscopic examination showed

[60] Exhibit 1, Tab 9A, p. 2.
[61] Exhibit 1, Tab 8.
[62] Exhibit 1, Tab 9A, p. 3 and Tab 10 and Tab 11 [10] – [11].
[63] Exhibit 1, Tab 9A, p. 2.
[64] Exhibit 1, Tab 6.

focal early bronchopneumonia. There was no evidence of underlying natural disease.[65] Samples were sent away for toxicology analysis.

60. Toxicology analysis detected the new psychoactive substances U-47700 and etizolam.[66] Dr Kueppers advised that U-47700 (chemical name 3, 4-dichloro-N-[2-(dimethylamino) cyclohexy1-N-methylbenzamide) is a potent synthetic μ-opioid receptor agonist. It is reported as being 7.5 times more potent than morphine. Etizolam is a thienodiazepine, which is chemically related to benzodiazepines. It is considered to be approximately 10 times as potent as diazepam in producing hypnotic effects.[67]

61. Dr Kueppers noted that whilst the levels of U-47700 seen in this case are difficult to interpret, given the limited information available about the substance, she noted they do not appear inconsistent with the levels seen in the few reported fatalities associated with this drug.[68]

62. Dr Kueppers also found clear warnings on the internet in drug user forums advising against using the two substances in combination as it poses a significant risk. Dr Kueppers noted the two substances, etizolam and U-47700, may act synergistically, enhancing their central nervous system effects, with the potential to rapidly result in unconsciousness or even coma/death.[69] Codeine and the chronic pain mediation pregabalin (Lyrica), which were also found in the deceased's system and were consistent with the drugs he was prescribed, have additional sedating properties of their own.[70]

63. At the conclusion of all investigations Dr Kueppers formed the opinion that the cause of death was combined drug toxicity with the most significant contributors apparently being the new psychoactive substances U-47700 and etizolam.[71] I accept and adopt the conclusion of Dr Kueppers as to the cause of death.

MANNER OF DEATH

64. The evidence indicated Mr Sach had a long term chronic pain problem and efforts by doctors to reduce his reliance upon opiate and opioid medications had been unsuccessful. When he was unable to obtain prescriptions for the drugs he felt he needed, he self-medicated by sourcing other substances over the internet.

65. Mr Sach was open with his wife that he had taken one of these substances on the day he died and his behaviour was generally normal. There was no evidence to suggest that he had any intention to take his life when he took the various drugs that, in combination, killed him.

[65] Exhibit 1, Tab 6.
[66] Exhibit 1, Tab 7.
[67] Exhibit 1, Tab 6.
[68] Exhibit 1, Tab 6 and Tab 7.
[69] Exhibit 1, Tab 6.
[70] Exhibit 1, Tab 6.
[71] Exhibit 1, Tab 6.

66. I find that the manner of death was by way of accident.

DIFFICULTIES OF MANAGING CHRONIC PAIN PATIENTS

67. Mrs Sach raised a number of concerns in relation to Mr Sach's management at the Pain Clinic at SCGH. Her first concern was about the length of the waiting list for an initial consultation. Although Mr Sach managed to skip the lengthy waiting period by seeing Dr Chan initially at Hollywood Private Hospital before transferring to SCGH, Mrs Sach rightly pointed out that it is a great concern that patients generally have to wait so long to access the public health system.[72]

68. In a similar vein, due to the heavy patient list and limited resources, Mr Sach was only able to have appointments at the Pain Clinic every 6 to 9 months, which made getting advice and treatment very difficult. Mrs Sach also reiterated the problems that arose from the lack of continuity in the specialists Mr Sach saw at the clinic.

69. With regard to the treatment plans implemented, Mrs Sach noted that Mr Sach had requested on multiple occasions that he be prescribed stronger quicker acting (immediate release) opioids such as oxycodone to assist with his breakthrough pain. She recalled he had been told that the doctors at the Pain Clinic do not like to prescribe these medications to young male patients due to the risk of abuse and addiction. Mr Sach had suggested some ways to manage this risk, such as being able to receive the medications from only one nominated GP and at a regulated dose, but his proposals were dismissed.[73]

70. Mrs Sach also raised a concern that her husband was never referred to a psychologist at the Pain Clinic, although the evidence before me indicates that he did in fact see a psychologist, Dr Su Chan, and elected not to continue with psychological counselling, so that issue has been addressed.[74]

71. Mr Sach's usual treating pain physician, Dr Chan, advised that, in his experience, the majority of chronic pain patients are compliant with medications and management plans. However, he acknowledged that there are a minority of such patients who overuse medication and also self-medicate without disclosing this to their treating doctors or teams. Mr Sach would appear to fall within the second category.[75]

72. Dr Chan noted there have been cases where patients have been dishonest with regards to opioid medication, which has been diverted and on sold on the street or alternatively, used for recreational use. These patients usually have a history of illicit drug abuse, which was not the case with Mr Sach. Rather, Mr Sach fell into the category of chronic pain patient where standard

[72] Exhibit 1, Tab 19.
[73] Exhibit 1, Tab 19.
[74] Exhibit 1, Tab 19.
[75] Exhibit 1, Tab 14A, p. 2.

medications and alternative methods are not successful in managing their pain.

73. Dr Chan indicated that some of the difficulties probably arise from a change in policy with regards to opioid medication. In the last ten years the practise for prescribing opioid medications has changed. Pain specialists are no longer prepared to authorise such dangerous medications as OxyContin and MS Contin. These were previously prescribed routinely for chronic pain patients. Dr Chan explained that their policy now is to rationalise pharmacology, to minimise pharmacology and to promote self-control and management of pain through non-pharmacological mechanisms. Due to the corresponding reduction in opioid prescriptions, it may make a patient feel compelled to seek strong analgesia through other means, such as non-hospital sources.[76]

74. Dr Chan referred to immediate release OxyNorm as appropriate for exacerbations of pain and post-surgery for up to one month but then, in line with the current thinking and guidelines, it should be stopped.[77] Dr Chan explained that an immediate release opioid like OxyNorm is not appropriate for long-term use as it can be quite addictive. Therefore, if a patient requires an opioid for chronic pain (as compared to acute pain) the preference is to move the patient on to a sustained release preparation as quickly as possible as addiction can happen in patients prescribed the medication for longer than a week.[78] However, even sustained release opioids, such as OxyContin, carry a risk of addiction so they must be used with caution. Epidemiological studies have also shown that patients on long term opioids had significantly reduced outcomes (e.g. vitality, pain control, function) compared to patients who are not on opioid medication. The reliance on such medications also takes away from the importance of physical rehabilitation.[79]

75. Dr Chan acknowledged that this attitude towards opioid medications is a change in the way of thinking for pain management specialists. Originally there was a belief that patients with chronic pain were entitled to the same type of pain relief as a cancer patient would receive, which led to an increase in the prescription of opioids. However, this led to problems such as a risk of overdose deaths, the risk of criminal activity to obtain those medications and diversion. As a result, the approach now is to use opioids for acute pain and for cancer patients, but as a last resort in the suite of treatments for patients with chronic pain.[80] New milder forms of opioids, with less potential for abuse and less side-effects are also preferred in those circumstances.[81]

76. As for Mr Sach's expressed dissatisfaction with his pain management, Dr Chan acknowledged that it is often difficult to manage but his approach is to hear the patient's concerns and then try to explain his reasoning to them. Dr Chan believes that many misunderstandings exist because insufficient time is spent explaining to the patient the reason for what the

[76] Exhibit 1, Tab 14A, p. 3.
[77] T 22 – 23.
[78] T 25 – 26.
[79] T 26 – 27.
[80] T 26.
[81] T 27 - 28.

doctor is doing. For example, Dr Chan will have a very clear discussion with a patient about why he is not prescribing an opioid like oxycodone and show them the literature from around the world showing the death rates from oxycodone and similar opioids. Dr Chan expressed the view it is important to explain to a patient that the doctor is not trying to penalise them but has real concerns about the adverse effects of the medication.

77. Dr Chan also agreed that there can be situations where patients do not get along with a particular doctor or do not feel they have been given the right treatment. In those circumstances his clinic will offer the patient an opportunity to see another specialist for a second opinion. They try to arrange for the second opinion to come from a completely different group of pain specialists, such as a SCGH patient being offered an appointment with Royal Perth Hospital for the second opinion, even though generally patients are not allowed to move between different pain services within the public health system.[82]

78. Dr Chan observed that the problem is that generally patients would like their pain treated quickly, which is entirely understandable. However, the majority of chronic pain will take some time to manage and will also take repetitive efforts in terms of rehabilitation, physiotherapy and psychology. Some chronic pain patients lack motivation to engage in such multidisciplinary care.[83]

79. I note Mr Sach did show a willingness to engage, seeing a physiotherapist and psychologist as part of his treatment. However, he also appears to have sought more short term solutions in the form of sourcing alternative opioid medication when his requests for oxycodone prescriptions were declined. There is less difficulty when a patient is self-medicating with natural supplements, such as turmeric, which is appropriate and does not pose any significant adverse effects. However, where they are self-medicating with prescription medications, the effects are much more significant and the dangers much greater.[84]

80. Further, Dr Chan noted that many chronic pain patients present difficulties with management as they either do not turn up to appointments or they turn up considerably late, wasting the limited resources that are available. A case in point was when Mr Sach turned up to his appointment with the psychologist thirty minutes late. As the Pain Clinic has limited resources, these sorts of issues place excessive strain on the system and can make it difficult to adequately treat the patient who has presented late.[85]

81. Dr Chan noted other issues with chronic pain patients that were not directly related to the issues raised in this inquest so I will not address them further in this finding, although they were of interest from a general coronial perspective. The most important aspect, in respect of this inquest, was the self-medication. As Dr Chan noted, if patients are choosing to self-medicate with dangerous compounds imported from overseas, the sorts of strategies

[82] T 30.
[83] Exhibit 1, Tab 14A, p. 3.
[84] Exhibit 1, Tab 14A, p. 2.
[85] Exhibit 1, Tab 14A, p. 3.

that he suggests for improving the general functioning of the Pain Clinic would make little difference.

82. Dr Chan accepted that there are resourcing issues that cause delays in seeing new patients and in seeing current patients regularly. Dr Chan advised that he does the triaging for the SCGH Pain Clinic. They receive about 100 new referrals per week, which leads to about 4000 active referrals. This makes it very difficult to see new patients. Dr Chan advised the current public waiting list is about 9 months and even in his private clinic the wait is around 6 to 7 months now.[86]

83. As to Mr Sach's concern about a lack of continuity of medical care, Dr Chan appreciated that there can be a level of frustration for patients if they regularly see a new doctor and have to repeat their story but observed that this is the reality of the public health system. Dr Chan explained that usually even if he does not see the patient directly he tries to ensure that the treatment is discussed with him (as the Consultant in the clinic) so that there is always some level of continuity in the care. However, in the case of Mr Sach Dr Chan was on extended long service leave so this was not possible in his case.[87] Nevertheless, Dr Chan indicated that he was involved in training both Dr Kriel and Dr O'Conghaile, who saw Mr Sach, and they both had access to all of the medical records, so there was also a level of continuity in the type of care that would be expected to be provided by each doctor.

84. Between consultations at the Pain Clinic the model of care is that the patient is managed by his or her GP, who receives instructions from the Pain Clinic doctors.[88]

85. It was apparent that Mr Sach was unhappy with the advice of the last doctor he saw at the clinic, Dr Kriel. Dr Chan had reviewed Dr Kriel's documented approach and noted his plan was to concentrate more on rationalisation of medication and introduce turmeric, a safe supplement, and focus on physical activities such as yoga, all of which was in line with the previous treatment plans.[89] Dr Chan agreed with Dr Kriel's plan and felt the move away from medications was appropriate.[90]

86. Dr Chan indicated that the pain specialists at the clinic do explain to their patients that there comes a time when there is not much more that can be done for the pain in terms of medications and procedures. He estimated this would be the case in 50 per cent of the patients they see. With these patients they then have to concentrate on how best to help them cope with the pain, which is where the role of the clinic's psychologist is important.

87. Dr Chan noted that Mr Sach had seen the clinic's psychologist, whose role includes addressing issues such as a patient's frustration with the pain not improving. The psychologist can provide support and help to emphasise the

[86] T 19 – 20.
[87] T 45, 48
[88] Exhibit 1, Tab 14B, pp. 3 – 4.
[89] T 46.
[90] Exhibit 1, Tab 14A, p. 2.

need not to rely on medications so much in pain management. Unfortunately, in Mr Sach's case he did not want to continue with counselling with the psychologist.[91] He did appear willing to engage in counselling elsewhere, but it may not have provided the focus on understanding pain and the role of drugs in the management of chronic pain that could have been provided by the clinic psychologist.

88. Dr Chan explained that Mr Sach's case is not isolated in terms of patients exploring other options when the pain clinic's management does not meet their expectations. He indicated that some of his patients fly off to Mexico or get operations done in different countries because they are given hope that there are alternatives available outside Australia that will reduce their pain.[92] Many of Dr Chan's patients are trying to achieve a pain-free lifestyle, but from his perspective his role as a pain specialist is not always to cure people's pain, but in many cases to help them manage that pain and learn to live with it and still function.[93] The difficulty arises when patients do not accept that outcome.

89. I accept the concerns raised by Mrs Sach about some of the failings of the public health care system, which leaves pain patients with long gaps between appointments and a lack of continuity at times in their care. However, Mr Sach did have regular care from his GP, who believed they had established a good rapport, and yet he did not disclose to her what he was doing. He no doubt was aware Dr White would have disapproved and counselled him against continuing this behaviour.

90. The management of chronic pain is a difficult area and there are clearly no easy solutions. Advances in modern medicine in Australia have led many of us to believe that there should be a tablet or pill to solve most of our ailments but pain is a complex mix of physical and psychological components and medication is only one part of the solution. I accept that Mr Sach genuinely tried to explore the alternatives, but when life became too hard and his problems seemed too great, he fell back on the belief that drugs would provide the solution. Sadly, the outcome proved that the quick fix he sought was not the answer.

DANGERS OF NEW PSYCHOACTIVE SUBSTANCES

91. Dr Chan was advised after Mr Sach's death that he had been self-medicating with U-47700. Dr Chan expressed concern when provided with this information. Dr Chan advised Mr Sach's case is the first known case of this drug that he or his colleagues were aware of in Western Australia.[94] Dr Chan had seen no evidence of drug-seeking behaviour on Mr Sach's part in the times that he saw him and he felt there was no evidence of such behaviour in the medical notes or materials he had reviewed.[95]

[91] T 42.
[92] T 42.
[93] T 42 – 43.
[94] Exhibit 1, Tab 14A, p. 2.
[95] T 30 – 31.

92. Dr Chan gave evidence that all patients are asked about whether they are using any non-prescribed drugs. He believes when Mr Sach described using supplements, it is likely these were thought to be the kinds of natural supplements patients often source, such as natural anti-inflammatories like gingko biloba and turmeric. Dr Chan is aware that patients will often buy such products overseas as they can be obtained more cheaply than in Australia, so even hearing they came from overseas would not necessarily have set off alarm bells.[96] However, Dr Chan advised that since these events the staff at the Pain Clinic are more aware that the importation of substances may not be limited to supplements and can involve dangerous substances, so staff are encouraged to find out exactly what substances a patient is taking and to get the patient to bring in the medication and show them what it is. As part of their participation in the clinic patients agree to tell doctors what medications they are taking, so that gives the staff some ability to pursue the matter, although it still requires the patient to be honest and forthright.[97]

93. If Mr Sach's treating doctor or team at the Pain Clinic had been informed that Mr Sach was using this dangerous drug, Dr Chan felt it likely that they would have taken steps to have the drug destroyed or confiscated, through discussions with Mr Sach and his family and, if necessary, the police or customs.[98]

94. Although Dr Chan had no personal experience with U-47700, he is now aware of the medication from this case and through research and discussion he has become aware of the experiences of other addiction specialists within the USA with this drug. He noted it is a dangerous form of morphine and in the USA alone it has been responsible for approximately fifty to sixty recorded deaths. Its availability in the USA is due to the illegal and unregulated importation of the drug from laboratories in China.[99] In Dr Chan's opinion this drug should continue to be banned in Australia and confiscated immediately if found due to the significant dangers of overdose with this medication, as evidenced by the United States' experience.[100]

95. As to the etizolam, Dr Chan noted it is a sedative medication so it would likely have increased the effects of the clonazepam. Noting it is approximately six times more potent than diazepam, it would have impaired Mr Sach's judgment and likely have led to a decline in his function, rather than an improvement.[101] It demonstrates the dangers of people taking strong medications without expert medical and pharmaceutical advice.

96. Dr David Brown is a senior chemist and research officer at ChemCentre. Dr Brown was not involved in the analysis of the drugs seized from Mr Sach's home, as the analysis was done by the illicit drugs team, but he was aware of the results; namely, that etizolam and U-47700 were found.

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[96] T 32 – 35.
[97] T 36 – 37.
[98] T 37; Exhibit 1, Tab 14A, p. 2.
[99] T 33; Exhibit 1, Tab 14A, p. 2.
[100] Exhibit 1, Tab 14A, p. 2.
[101] T 37.

97. Dr Brown explained that one of the biggest challenges faced at ChemCentre is the speed with which the illicit drug market changes, which makes it difficult to make identifications of new drugs as they need some sort of reference material to compare it against. As a result, ChemCentre is always behind in the process of identifying new substances. The task is made easier where, as in this case, a substantial quantity of the substances is found so they can be tested and analysed to identify their fundamental chemical structure. After the drugs seized from Mr Sach's home were analysed, U-47700 was identified from analysis of the substance seized, although it was not in the ChemCentre library database at the time.[102] The toxicology analysis of the samples taken from Mr Sach were then able to be screened for the seized drugs and identified.

98. Dr Brown identified U-47700 as an illicit synthetic opioid and etizolam as a thienodiazepine derivative related to benzodiazepines.[103]

99. Illicit synthetic opioids fall within the category of new (or novel) psychoactive substances (NPS). Dr Brown referenced the United Nations Office of Drugs and Crime, which records the number of NPS known globally at the end of 2017 was in the order of 700 to 800, which is a significant increase from five years before, where there were very few. Dr Brown described there having been an explosion in the number of analogues in recent years.

100. Dr Brown indicated that illicit synthetic opioids form a relatively small component of the NPS market, in the range of 4%, and the number of detections of these substances at ChemCentre is low but has become more regular since 2015. The bulk are fentanyl analogues, with U-47700 falling into the other category. The synthetic opioids related to U-47700 are considered to be "medium dose" synthetic opioids, based on literature information.[104]

101. Dr Brown advised U-47700 was first manufactured or investigated in the 1970's by a pharmaceutical company looking for its analgesic properties. It reportedly never made it to clinical trials on humans so the only information comes from animal trials. From the literature, it is suggested that U-47700 is roughly 7 to 8 times more potent than morphine and about one tenth the potency of fentanyl.[105]

102. I am advised that in June 2017 the Therapeutic Goods Administration decided to include U-47700 in Schedule 9 of the Poisons Standard due to safety concerns raised that U-47700 had been abused overseas and posed a public health risk. Its abuse was said to have parallels with heroin, prescription opioids and other novel opioids and the drug was noted to have no legitimate medical use in Australia. Schedule 9 substances are classified as prohibited substances. They are substances which may be abused or misused, the manufacture, possession, sale or use of which should be prohibited by law except when required for medical or scientific research, or

[102] T 52 – 55.
[103] Exhibit 1, Tab 20, p. 2.
[104] Exhibit 1, Tab 20, p. 2.
[105] T 55 – 56.

for analytical, teaching or training purposes with approval of Commonwealth and/or State or Territory Health Authorities.[106] U-47700 has been included in the schedule since 1 October 2017.[107]

103. Dr Brown explained that etizolam is a derivative or a variety of benzodiazepine. It is prescribed in Italy, India and Japan as a sedative and also for its antidepressant and anti-anxiety properties but is not licensed for use in Australia. It is not a drug that traditionally has been seen in Australia. Dr Brown indicated it is a relatively recent detection within ChemCentre over the last couple of years.[108] Although not specifically named in the Poisons Standard, it is effectively included as a benzodiazepine derivative and it is illegal to possess it in Australia without a legal prescription, which would not be obtained from an Australian doctor.

104. Dr Chan noted that these drugs are often made in clandestine laboratories or in factories in countries that don't have the same quality control as in Australia. They may have impurities or their purity/percentages may vary.[109] Dr Brown agreed with Dr Chan that one problem with purchasing drugs through the illicit drug scene is that there is no guarantee what you are purchasing is what you are going to receive. There is also anecdotal evidence that on some occasions a purchaser will receive the drug they anticipate, but at much higher purity than anticipated. This is because, although sometimes the illicit substances are prepared in clandestine laboratories, typically they will be produced in pharmaceutical grade laboratories, which means the quality of these drugs can be very high, translating into high purity.

105. Dr Brown gave evidence that since the death of Mr Sach ChemCentre staff have identified U-47700 in multiple cases, all of which are also coronial matters, which serves perhaps to underscore the potency of the drug.[110] The literature indicates the same drug has been associated with deaths in both the United States and Europe.[111]

106. Etizolam, on the other hand, has been identified in post mortem toxicology reports but in the majority of these cases the death also involved other drugs that may have also contributed to toxicity.[112]

107. This case highlights the increasing and concerning use of new psychoactive substances and their devastating side-effects, including death. These drugs are freely available over the internet and there are likely to be an increasing number of deaths relating to their use in the future unless people are educated about the grave risks involved. It is very important for members of the public to understand the dangers of purchasing drugs over the internet that have not undergone the rigorous approval process that is required for prescription drugs within Australia. Further, taking any strong medications without medical supervision is fraught with danger and can be fatal.

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[106] Poisons Standard June 2018.
[107] https://www.tga.gov./au/book-page/21-n-alkylmamino-cyclohexylbenzamides-opioids-0.
[108] T 50.
[109] T 38 – 39.
[110] T 58.
[111] T 59.
[112] Exhibit 1, Tab 20, p.6.

CONCLUSION

108. Mr Sach had been suffering from chronic back pain for several years after a motor vehicle accident. He was reviewed by various doctors, including a pain specialist. Attempts were made to appropriately limit his use of strong opioid drugs. He had trialled psychological interventions and numerous alternative therapies in an effort to manage his pain in other ways.

109. However, it seems that Mr Sach was unsatisfied with the treatment offered to him and for some months prior to his death had been self-medicating with unlicensed drugs he sourced over the internet. He died unexpectedly at home one night as a result of taking a combination of these drugs.

110. Mr Sach is an example of the ultimate risk that such behaviour presents. He collapsed at home, in the presence of his wife, who could do nothing to save him. He left behind a daughter and unborn baby who will have to grow up without their father.

S H Linton
Coroner
6 December 2018