Coroners 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 ***Adrian Marcus Westlund****, with an Inquest held at Perth Coroners Court, CLC Building, 501 Hay Street, Perth, on 16-20 March 2015 find the identity of the deceased was* ***Adrian Marcus Westlund*** *and that death occurred on 2 March 2011 at Sir Charles Gairdner Hospital, and was consistent with Combined Drug Toxicity in the following circumstances:*

Counsel Appearing:

Ms K Ellson assisted the Deputy State Coroner
Ms J Hook (instructed by State Solicitors Office) appeared on behalf of the WA Department of Health
Mr D Bourke (instructed by MDA National) and with him Ms A de Villiers appeared for Dr Davies and Dr Buntine
Mr J Ley (instructed by Meridian Lawyers) appeared for Ms Jong, Mr Law and Mr Chim

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INTRODUCTION

Adrian Marcus Westlund (the deceased) died on 2 March 2011, the second day upon which he is recorded as taking an authorised methadone dose. Post mortem toxicology indicated he had also taken diazepam, oxazepam, alprazolam, dextromethorphan and ibuprofen, although these had not been prescribed on 28 February 2011 following the deceased informing his doctor he had already taken all his allocated benzodiazepine prescription.

He was 22 years of age.

Methadone is a Schedule 8 opioid of the Western Australian *Poisons Act 1964*, which incorporates the Standard for 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.

Diazepam and oxazepam are benzodiazepines listed in Schedule 4 of the *Western Australian Poisons Act 1964*, which incorporates SUSMP utilised by the TGA to promote standardised scheduling, packaging and labelling for a variety of medications available across Australia.

Alprazolam is a fast acting potent benzodiazepine which has now (February 2014) been reclassified as a Schedule 8 medicine, one of only two benzodiazepines currently having that status.

<u>SUSMP Schedule 8</u>

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, supply, distribution, possession and use to reduce use, 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 (CEO WAH).[3]

2. If the person to whom a medical practitioner wishes to prescribe 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 CEO WAH.

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

[2] WA *Poisons Act 1964* shortly to be replaced by WA *Medicines and Poisons Act* (assented to 2 July 2014, yet to be proclaimed)

[3] Ex 10, tab13, p3

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 for 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 opioid addiction the medical practitioner must be an authorised prescriber.[5]

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 28 February 2011 for participation in CPOP. He had also been a registered drug addict from 13 May 2008 – 12 May 2010 and so understood the regulations around the prescribing of Schedule 8 medicines. In the case of his registration for 28 February 2011 he signed an acknowledgement of his obligations on 25 February 2011.[8]

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

[4] Ex 8, tab 1, p2
[5] Ex 8, tab 1, p3
[6] Ex 11, tab A1
[7] Ex 8, tab 1, p2
[8] Ex 5, tab 5D in expectation of registration

for the drug, 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)[9] and the WA Department of Health have developed strategies aimed at assisting prescribers with their decision making when considering prescription of a Schedule 8 drug 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 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 benefit scheme (PBS) medications and does not provide information for drugs prescribed off PBS (privately).[10] 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 a 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 upon 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

[9] Ex 10, tab 1
[10] It is restricted in the information it can share with inquiring doctors

February 2014 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/calmant in the elderly and those with chronic ill health.

They are often co-prescribed with Schedule 8 medicines for their calming effect, and are 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 drugs 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[11] 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 drugs 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 enquiry, 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,[12] where previously registered drug addicts

[11] Ex 1, tab 1
[12] Daniel James HALL and Shane Andrew BERRY

obtained drugs which contributed to their death, 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.

While the deceased in this case was not a registered drug addict at the time he obtained multiple scripts for benzodiazepines, real time dispensing information with respect to benzodiazepines would have identified his drug seeking behaviour.

In all three cases the Commonwealth Prescription Shopping Information and Alert Service advice line (doctor shopping 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 arouse the practitioners suspicion of the need to make further enquiry.

This case related to issues around prescribing for 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 doctor over the application for registration. In this case the issue was more to do with benzodiazepine prescribing than Schedule 8 medicines.

The oral evidence in each case was very 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 the specific amounts and combinations of drug levels at which these deceased died in defined circumstances. It is enough 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[13]

The Deceased

The deceased was born on 11 May 1988 in East Perth. He was the youngest of three children with two older sisters. His parents separated when he was five years old and the children remained with their mother with access by their father. While a teenager the deceased did very well in boxing and trained hard to excel in Muay Thai boxing. He maintained an interest in this type of boxing throughout his life.

The deceased had behavioural issues at high school and frequently ran into problems with the police while missing school. This resulted in an extensive juvenile criminal record.[14]

The deceased's first record with the Next Step (CPOP provider) Drug and Alcohol Services (Next Step) was for an assessment after being referred by the juvenile justice psychological services on 29 June 2005 when he was 17 years of age. He self-reported injecting amphetamines and

[13] 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.
[14] Ex 4, tab 7

smoking cannabis commencing at the age of 16. He did not continue with participation in the program.[15] Following that assessment the deceased became involved in a general lifestyle of drug use including heroin and abuse of prescription medications.

In April 2008 the deceased was assessed for the buprenorphine program at Next Step to control his heroin use recorded as occurring every two days over an 18 month period. He had been involved in a Mission Australia detoxification program prior to that assessment and on 13 May 2008 Dr Peter Schrader was authorised to prescribe the deceased Suboxone on CPOP with the 777 Pharmacy at Mount Hawthorn as the dispensing pharmacist.[16]

The deceased did not remain on the CPOP program for more than a week or two and his last recorded dose of Suboxone was on 22 May 2008 when he complained of side effects and was advised to return to Next Step for alternative medication.[17]

The deceased had a number of referrals to various hospitals for accidents which involved him being prescribed analgesics and medication for stress and anxiety, often benzodiazepines.

In January 2009 the deceased was recorded as reporting he injected heroin and drank alcohol daily. He claimed he had used drugs since he was 14 years of age and also reported using amphetamines, benzodiazepines and cannabis. He completed a program with respect to that referral in September 2009 and was reported to be improved.[18]

In April 2009 the deceased presented to the Sir Charles Gairdner Hospital Emergency Department following a partial seizure after intravenous injections including heroin and diazepam. He was diagnosed with aspiration pneumonia and substance abuse. He was on life support

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[15] Ex 5, tab 6D
[16] Ex 5, tab 6C, E & F
[17] Ex 5, tab 6I
[18] Ex 5, tab 6A

for four days and in hospital for 10.[19] He did not attend any of the outpatient clinics following his discharge but did experience ongoing seizures which later led to the loss of his employment as a roof carpenter due to the fact he could no longer work at height.[20] The deceased's father described the deceased as becoming more depressed and anxious as a result of these events.

In May 2009 the deceased presented to Fremantle Emergency Department after a seizure and gave a history of substance abuse including Subutex, LSD, heroin, ecstasy and opioids. The history notes the deceased was "*benzodiazepine dependent and required withdrawal management*". Both a CT scan of his brain and an EEG produced normal or equivocal results.[21]

Prior to the commencement of this downward spiral the deceased had been an aspiring boxer but was eventually unable to continue with the sport professionally as a result of his seizures.

2010

Review of the deceased's medical records with two general practices indicate the Gemini Medical Centre (now known as the Kenetic Health Clinic-(Kinetic)) in West Perth was generally the deceased's family practice. Records indicate as far back as 2001 the deceased was seeing Dr Beinart who was aware of the deceased's behavioural problems and issues to do with his anxiety and stress.

When Dr Beinart left the practice Dr Peter Lacey took over the deceased's general care as a representative of Kinetic. The Kinetic records indicate the deceased mostly saw Dr Peter Lacey from early 2010 onward.[22]

On 4 March 2010 the deceased attended at Kinetic and saw Dr Lacey for the first time. Dr Lacey had the deceased's

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[19] Ex 4, tab 7.25
[20] Ex 4, tab 7.7
[21] Ex 4, tab 7.26
[22] Ex 5, tab 4

general medical history with that practice and so was aware of the historical issues which had faced the deceased.[23]

The deceased told Dr Lacey he had an addiction to benzodiazepines and Dr Lacey assessed him as being a very troubled and agitated young man. The deceased nominated Xanax (alprazolam) as his addiction benzodiazepine but did not inform Dr Lacey of where he had first obtained the drug or how.[24]

The deceased was still attempting to maintain his fitness for boxing which he did competitively. He advised Dr Lacey he had been sleeping very badly and was anxious about an upcoming boxing event. Dr Lacey spent some time trying to persuade the deceased to see a psychiatrist but this was unsuccessful as he never kept any arranged appointments. There were also attempts by hospitals to continue monitoring the deceased by way of outpatient clinics which were unsuccessful.

Dr Lacey prescribed the deceased temazepam as an alternative to alprazolam in an attempt to wean him off what is now accepted to be an extremely potent benzodiazepine.

In May 2010 the deceased's registration with Next Step as a registered drug addict from May 2008 ceased, although he had not been following the Suboxone program. He had not informed Dr Lacey he was a registered drug addict for Schedule 8 medicines. There is a well-known interaction between opioids and benzodiazepines.

In May 2010 the deceased started seeing doctors at the Subiaco Station Medical Group (Subiaco) where he initially saw Dr Foley. He complained of back pain and a CT of his lumber spine was ordered prior to the commencement of any prescription medication.

On 16 May 2010 the deceased was seen at Sir Charles Gairdner Hospital requesting antibiotics and sleeping

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[23] Ex 5, tab 3
[24] Ex 4, tab 7.16

tablets. He was told to see a general practitioner to assess his anxiety and insomnia, and informed that if temazepam had not been effective when last prescribed it was unlikely to assist him now.

The deceased returned to Dr Lacey at Kinetic on 25 May 2010 to advise him temazepam wasn't assisting him with his anxiety and that he was experiencing panic attacks. Dr Lacey prescribed the deceased with alprazolam, because the deceased claimed to have positive outcomes with alprazolam, although it was a drug he had told Dr Lacey he was trying to avoid. This script was not on PBS but was a relatively low dose. Dr Lacey requested to see the deceased the following day and the deceased attended for that review and advised Dr Lacey the Xanax was helpful.[25]

The deceased continued seeing Dr Foley at Subiaco but neither Dr Lacey or Dr Foley were aware of the others' involvement with the deceased's medical and mental health care.

On 29 May 2010 the deceased presented, this time to Royal Perth Hospital (RPH), requesting Xanax. He informed the Emergency Department doctor he had been taking Xanax for the past 2-3 months for anxiety and that he had lost his GP script. RPH declined his request for Xanax and gave him diazepam instead. He was advised to follow up with his GP as soon as possible for appropriate medication.[26]

Between June and November 2010 the deceased continued to see Dr Foley at Subiaco as well as doctors at Kinetic Health. He was prescribed Xanax by both practices without either practice becoming aware of the other. None of the prescriptions over this period appear on his PBS record from Subiaco for Dr Foley.

In August 2010 Dr Foley (Subiaco) referred the deceased for counselling hopeful this would enable him to overcome his addiction. While the deceased was seen by mental health

[25] Ex 5, tab 4, page 6
[26] Ex 5, tab 2, Ex 4, tab 7.26

workers no real progress was made with him accepting practically he had a problem.[27]

Dr Foley also recorded the deceased asking for opioids in the form of oxycodone after a fall. Dr Foley declined this and instead prescribed Panadeine Forte. Dr Foley confronted the deceased with his benzodiazepine addiction and the deceased told him he was using amphetamines. Dr Foley did not recall ever being told the deceased used heroin.

The Next Step records indicate telephone contact between Metro Community Drug Service and the deceased on 28 August 2010 where the deceased reported he had been on the Suboxone program 2 ½ years earlier and was currently using heroin every day. He advised Metro Community Drug Service contact he had been using $300-350 worth of heroin daily for the past 8 months. He advised them prior to that he had only used occasionally, but had been using heroin on and off for over 5 years. He claimed to have last used heroin two days prior to 28 August 2010. He also reported using benzodiazepines, including oxazepam and Xanax daily, and self-reported larger doses than had been prescribed to him by either Dr Foley (Subiaco) or Dr Lacey (Kinetic) together.[28]

The deceased was requesting he be admitted to the methadone program. He had not been referred by either of his current GPs. The deceased was offered an appointment for assessment for 9 September 2010, however failed to attend on that date at the specified doctor and when contacted advised Next Step he no longer required their support or services.[29] The deceased reported he was working full time as a roof carpenter.

On 3 September 2010 the deceased suffered a convulsive seizure at work, possibly relating to his excessive benzodiazepine use and withdrawal.[30] He was still receiving

[27] Ex 5, tab 7.17
[28] Ex 5, tab 6J
[29] Ex 5, tab 6K
[30] Ex 4, tab 7.26

benzodiazepines from both Dr Foley at Subiaco and Dr Lacey at Kinetic, without knowledge of each other.

By September 2010 Dr Foley had made it clear he recognised the deceased had a problem with benzodiazepines. When Dr Foley left Subiaco he encouraged the deceased to visit him at his new practice to assist the deceased with his problems. Dr Foley did not see him again.[31]

On the date the deceased was supposed to be seeing the Next Step doctor (9 September) he returned to Kinetic and saw Dr Andrew Fairhurst for blood tests. When he next saw Dr Fairhurst on 13 September he requested Xanax for his anxiety. Dr Fairhurst refused his request and instead attempted to increase his dose of Avanza. Dr Fairhurst stated:-

> *"I do not prescribe anxiolytics, sedative or opiate analgesia, which can be used as drugs of abuse, without good reason and particularly not to patients who I don't know very well. I am aware of the 'doctor shopping' help line and have used this periodically. I was not his usual treating doctor in this clinic and I never prescribed medication of addiction to him."*[32]

The deceased did not return to Kinetic then, but instead returned to Subiaco where he saw Dr Victoria Buntine for the first time (21 September). He reported his seizure of the 3rd of September to her and said it was as a result of him trying to stop benzodiazepines too quickly. He reported he had increased his mirtazapine and was only taking 5 Valium (diazepam) in an attempt to reduce his benzodiazepines.

Dr Buntine recorded her impression the deceased *"really wants to be off benzos"* and planned to reduce his Valium by half a tablet a week. Dr Buntine called the Doctor Shopper hotline (Commonwealth) and confirmed the deceased was not known to them.

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[31] Ex 4, tab 7.16
[32] Ex 4, tab 7.15

Dr Buntine ceased the majority of the deceased's different benzodiazepines and opioids and instead provided him with a PBS prescription for Antenex (diazepam). She considered the dose to be high but necessary to prevent withdrawal seizures.[33] Dr Buntine asked the deceased to return to her in a week for review, but he did not attend.

There are no Medicare or PBS records for the deceased for October 2010 and it is unclear whether he did not see any doctors or saw doctors privately, used medication from the black market, or used medication he had stock piled when visiting two separate unrelated practices for off PBS prescriptions for benzodiazepines.

Involvement of Dr Davies (Subiaco)

On 4 November 2010 the deceased saw Dr Andrew Davies at Subiaco for the first time. Dr Davies had only commenced at Subiaco in February 2010 and had not had interaction with the deceased before. Dr Davies was an authorised prescriber under the CPOP program.

Dr Davies reported the deceased saw him for advice in *"coming off"* benzodiazepines. He had developed a large addiction to these medications as a result of his anxiety, insomnia, alcohol withdrawal, benzodiazepine dependence and seizure disorders.

The deceased informed Dr Davies he was using approximately 20x5mg Valium (diazepam) tablets per day in addition to benzodiazepines sourced from the black market.[34] He stated he was also using mirtazapine.

Dr Davies stated he used the Australian Therapeutic Guideline; Psychotropic Version 6 Benzodiazepine Conversion chart when converting from one benzodiazepine to another.[35] Dr Davies formulated *"a graduated plan to reduce his benzodiazepine dependence"* and issued him with

[33] Ex 4, tab 7.21, t 16.03.15, p437
[34] t 16.03.15, p456
[35] Ex 4, tab 7.20

a script for a six day period being diazepam 50x5mgs to be taken 2 in the morning, 2 at midday and 4 at night with Serepax (oxazepam) to be taken one in the morning, one at midday and two at night. Dr Davies equated this to the equivalent of 16x5mg Valium tablets or 80mgs of diazepam per day which would have been a reduction in his alleged use of the 20x5mg Valium (100mg of diazepam) a day.[36]

The deceased did not advise Dr Davies he had previously been on a Suboxone program to cope with heroin dependency or that he had ever been addicted to opioids in any way. Dr Davies did not provide the deceased with any repeat prescriptions because he wished to review the deceased in six days time to assess the effect of the slight decrease in Valium on the deceased's condition.

On 5 November 2010, the day following his first visit with Dr Davies, the deceased was found in his car in his father's drive way unconscious. The ambulance patient care record indicates the deceased admitted to taking 1/8 point of heroin intravenously, but there was some query as to whether this was accurate. The deceased refused to be transported to hospital.[37]

The deceased was due to return to Dr Davies on 10 November 2010.

On 8 November 2010 he visited Dr Lacey at Kinetic. The deceased advised Dr Lacey he was using 45mg a day of mirtazapine and felt fine. It was Dr Lacey's impression the deceased was doing well and getting himself together. Impressed with the deceased's presentation Dr Lacey provided him with 50x2mg alprazolam (Xanax tablets) off PBS.[38]

The very next day, and a day early for his review the deceased presented again to Dr Davies at Subiaco. He advised Dr Davies he was feeling edgy with the reduced dose of benzodiazepines, but was settling, and Dr Davies made a

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[36] Ex 4, tab 7.20
[37] Ex 4, tab 11 & 7.7
[38] Ex 5, tab 4 & Ex 4, tab 7.16

note he should be able to start reducing the prescription further within a week. He provided the deceased with scripts for Serepax (oxazepam) and Antenex (diazepam) on PBS and a prescription for Panadeine Forte. Neither of these were filled. The deceased was due to have new scripts written on 15 November 2010.

On the same date (9 November) the deceased returned to Dr Lacey at Kinetic and obtained a prescription for Panadeine Forte because he had had an accident and hit his head.[39]

Having been provided by both Dr Davies (Subiaco) and Dr Lacey (Kinetic) with scripts for Panadeine Forte on 9 November 2010 the deceased returned to Dr Lacey (Kinetic) on 10 November with pain in his knee and asked for more pain relief. He admitted to Dr Lacey he had taken the whole box of Panadeine Forte prescribed by Dr Lacey the previous day. As a result Dr Lacey recorded *"I simply cannot trust him with addictive drugs"* and refused to supply him with any prescriptions at all.[40]

Dr Lacey and Dr Davies remained unaware of each other's interactions with the deceased.

Two days later the deceased was admitted to Sir Charles Gairdner Hospital with a lacerated right arm requiring medication. The deceased caused problems among the nursing staff when they discovered him attempting to use a tourniquet during the admission for an intravenous injection.[41]

On 13 November 2010 the deceased discharged himself from hospital, against medical advice and then attended a different doctor at Kinetic, Dr Eugene Mattes. The deceased reported his admission to (SCGH) to have glass removed from his arm and advised the doctor someone had stolen his Xanax. He advised Dr Mattes he was taking up to 8 Xanax (alprazolam) per day and had discharged himself from

[39] Ex 4, tab 7.14, 7.20: Ex 5, tab 3I, tab 4
[40] Ex 5, tab 4, page 6
[41] Ex 5, tab 1

hospital because he was not being appropriately attended to. He said he would see Dr Lacey on Monday and Dr Mattes made an appointment for him for Dr Lacey.

Meanwhile Dr Mattes offered to provide the deceased with 20 Panadeine Forte but the deceased requested 50. Dr Mattes made a note querying this drug seeking behaviour, but provided the prescriptions along with 30 Brufen and 16 Xanax tablets to last until he saw Dr Lacey on the Monday. The deceased did not attend his follow up appointment with Dr Lacey on Monday 15 November 2010.[42]

On 16 November 2010 the deceased returned to Dr Davies at Subiaco and stated he had ceased his benzodiazepine suddenly which resulted in severe withdrawals. He then increased his benzodiazepine use and had run out of his prescription. As a result of running out of his prescription he felt severe withdrawals and had a panic attack which caused him to put his arm through a window lacerating his arm. He said he had attended an emergency department for treatment but was frustrated with the long wait and left against medical advice.

When Dr Davies examined the deceased he believed he was in withdrawal. He was pale, sweaty and tachycardic. Dr Davies discussed a return to the original reduction plan with the deceased, and emphasised the importance of being monitored and withdrawing from the benzodiazepines gradually rather than dramatically.[43]

The deceased assured Dr Davies he was still serious in his commitment to resolve his addiction and now understood Dr Davies' preference he stabilise his benzodiazepine use and then reduce gradually. Dr Davies felt the deceased was genuine in his assurance and as a result provided him with a script for Atenex (diazepam) and Serepax (oxazepam).

Dr Davies emphasised to the deceased that if he again used medications outside Dr Davies' agreed management plan

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[42] Ex 5, tab 4
[43] Ex 4, tab 7.20

Dr Davies would review his future prescriptions and limit the amount, possibly to daily scripting. Dr Davies also provided the deceased with a prescription for Augmentin to be taken for the infection that had developed in the wound on his arm laceration. The deceased was to return to Dr Davies in six days for review and further scripts.

The deceased did not return to Dr Davies for his review appointment.

Instead the deceased returned to Dr Lacey at Kinetic on 22 November 2010 and requested a prescription for Xanax (alprazolam). As a result of Dr Lacey's previous experience with the deceased and the fact he had given an undertaking he would cease taking such potent benzodiazepines, Dr Lacey refused to prescribe him with further Xanax and warned him to keep his next appointment with Dr Lacey or Dr Lacey would request the deceased use another practice.[44]

Dr Lacey never saw the deceased again.

Unlike other doctors who found the deceased charming and apparently believable, Dr Lacey advised he found the deceased's body language and language threatening in the context of knowing he was a boxer. He felt obliged as a medical practitioner to try and help the deceased but found him to be unreliable. His plan had been to stabilise the deceased's benzodiazepine use and then generally reduce it but could not rely on the deceased to cooperate.[45]

2011

There are no medical records for the deceased for December 2010 or January 2011 but his father reported his son became more and more depressed as he worked less and less as a casual labourer. Mr Westlund also reported finding syringes around the house but it is not clear when exactly Mr Westlund is referring to.

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[44] Ex 5, tab 4, page 6
[45] Ex 4, tab 7.16

The deceased's reported use of heroin was by smoking it. Dr Davies was not aware of the deceased having any *"track"* marks.[46] It is clear the deceased's behaviour was a source of friction between himself and his father.[47]

On 25 January 2011 the deceased met Ms Yaelle Cutler in Leederville. Ms Cutler advised the court she and the deceased seemed to *"get along really well"*[48] and as a result the two of them spent a lot of time together, usually every day. While it was not immediately obvious the deceased was a regular drug user it soon became apparent to Ms Cutler the deceased had a drug habit. As far as she was aware it was mainly prescription drugs. The deceased told her he took too many and he was trying to stop taking so many, but it would be dangerous for him to stop altogether and he might die. It was her belief his drugs of choice were Xanax (alprazolam) and Valium (diazepam). They never spoke about any use of heroin or amphetamines.

The deceased advised Ms Cutler he was able to get any drugs he wanted from the doctors he saw by lying to them.[49] She did not believe the deceased needed to buy drugs on the black market because he obtained enough from doctors. He obtained so many he did not need to use them all but kept them in a bucket or bag in his room. Although he intended to on sell them he never bothered, just used the drugs he wanted from his own stock pile.

In the three weeks in which she had known the deceased she thought he was *"drugged up"* most days with his speech almost always slurred. He always seemed clumsy and tripping on things. He told her he told his doctors he was anxious and felt impending doom. He wasn't sure why he lied to the doctors. She believed he had lied to the doctor he was also using as a counsellor within the last week of his life, and that he had lied to that doctor about using heroin so he could obtain methadone.[50]

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[46] t 16.03.15, p471
[47] Ex 4, tab 7.7
[48] t 16.03.15, p344
[49] t 16.03.15, p346
[50] t 16.03.15, p347

Ms Cutler stated this happened at about the time the deceased was talking about moving house with his father. The deceased's father hoped the move would prove a fresh start for his son.[51]

On 3 February 2011 the deceased returned to Subiaco and saw Dr Victoria Buntine for the second time. He attended at the practice wanting to see Dr Davies for counselling because he was now using large quantities of Serepax (oxazepam) and Valium (diazepam). He advised he was off heroin and wanted a structured program for drug withdrawal. He said he was on a wait list for Next Step and the Next Step records indicate the deceased self-referred to the Metro Community Drug Service Drug and Alcohol Youth Service twice between May 2010 and the 22 February 2011. The records indicate on both occasions the deceased did not continue with his self-referral.[52]

Dr Buntine recommended the deceased continued to see Dr Davies and meanwhile prescribed him, on PBS, Antenex (diazepam) and Serepax (oxazepam) as well as Avanza for depression. She directed he was only to take the medication as she prescribed and the deceased agreed he would see Dr Davies the following day. She prescribed as she did because of the deceased's very high reported use and her concern to stabilise him until he could see Dr Davies. She was not comfortable continuing with his program herself.[53]

The deceased's medical records indicate Dr Buntine then discussed the deceased's presentation with Dr Davies and recounted the amount of benzodiazepines he had told her he was using. She did not discuss with Dr Davies his comment about *"no longer using opiates"* because she was under the impression it was no longer relevant to a discussion of his drug use. The medications prescribed by Dr Buntine on PBS on 3 February 2011 were the last PBS prescriptions issued for the deceased prior to his death.

[51] Ex 4, tab 7.7
[52] Ex 5, tab 5
[53] t 16.03.15, p432, p444

The deceased returned to see Dr Davies on 4 February 2011 and he reported to Dr Davies he was taking Valium (diazepam) and Serepax (oxazepam), equivalent to 350mg of diazepam per day. He advised Dr Davies he was sourcing these on the black market.

Dr Davies was concerned these were "*huge doses of benzodiazepines*"[54] and he asked the deceased to attend Next Step for assistance with his benzodiazepine withdrawals. The deceased refused to attend Next Step and said he wanted Dr Davies to help him. Dr Davies agreed but said it was his preference the deceased move to daily or even second day dispensing from a chemist, however, the deceased stated he would not engage with Dr Davies in a management plan if Dr Davies intended to restrict his prescriptions in that way.[55]

The deceased convinced Dr Davies he was committed to withdrawing from his benzodiazepine use and had taken a number of steps to assist him with his new mind set. He had removed himself from his associates, bought a new telephone and was trying to get back into the gym and boxing.

Dr Davies had already lost the deceased as a patient before from his planned reduction management. He was concerned if he did not assist the deceased he would return to the black market. Dr Davies agreed to continue attempting to structure a plan for the deceased to firstly stabilise him and then reduce his benzodiazepine use. Dr Davies provided the deceased with off PBS scripts for Valpam (diazepam) and Murelax (oxazepam). The prescription provided a reduction in his alleged diazepam equivalent consumption.

The deceased took the script to the Chemist Warehouse in North Perth for dispensing. The amounts prescribed were higher than the recommended doses for diazepam and the pharmacist, Mr Woei Chim, phoned Dr Davies to verify the

[54] Ex 5, tab 3F
[55] t 16.03.15, p465

prescription because he thought it was an error.[56] On speaking with Dr Davies Mr Chim understood the prescription was part of a plan for the deceased and Dr Davies intended the amounts prescribed. Mr Chim then dispensed the medication as prescribed. Records suggest this was the first time medication had been dispensed to the deceased by Chemist Warehouse, North Perth.[57] Mr Chim made a note in the computer record that he had verified the prescription with the prescribing doctor. Mr Chim also believed he made a note of the conversation in the written diary.

The deceased returned to Dr Davies on 10 February 2011 and presented with signs of acute withdrawal. He looked very unwell, was suffering tachycardia, and was pale and sweating. The deceased advised Dr Davies he had made a mistake in his previous reporting of the drugs he was taking and that he had been buying Xanax (alprazolam) on the black market, not Serepax. Xanax is a much stronger benzodiazepine than oxazepam and he believed the amount he had been prescribed by Dr Davies was not holding him. Dr Davies understood that was why the deceased was suffering from such clear withdrawal signs.[58]

In an attempt to restabilise the deceased Dr Davies revised his script in an attempt to substitute the alprazolam with a less potent benzodiazepine. He prescribed the deceased Alprax (alprazolam) at a reduced rate, and Valpam (diazepam). This prescription equated to 500mg of diazepam a day. All are agreed this was an extreme prescription and, in evidence, Dr Davies agreed it was at that time the highest dose of diazepam he had ever prescribed daily.[59] Dr Davies stated he prescribed in that way because he believed the deceased was telling him the truth, he needed to stabilise the deceased from withdrawal symptoms, and then continue with a planned reduction of 10% every 2-4 weeks. Dr Davies agreed that if he could have registered the deceased as a drug addict for the use of

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[56] t 16.03.15, p388
[57] t 16.03.15, p394-396
[58] t 16.03.15, p467
[59] t 16.03.15, p468

benzodiazepines he would certainly have registered him as addicted to benzodiazepines.[60]

The deceased again took this script to the Chemist Warehouse in North Perth. Mr Chim was again the pharmacist on call, although Mr Chim has no independent recollection of that interaction other than his initials against the computer entry for the transaction. In evidence, Mr Chim indicated he believed he would have rung the prescribing doctor again because there was a change in medication in the script. He cannot recall doing so and the pharmacy diary no longer exists.[61]

Dr Davies confirmed he had a discussion with a pharmacist about one of the prescriptions for the deceased but could not remember if it related to that for 4 or 10 February 2011. He certainly recalled indicating it was a deliberate prescription to help the deceased reduce his overall drug intake.[62] Mr Chim also understood the deceased was aware of the plan and understood how to implement it safely.

Seven days later, on 17 February 2011, the deceased returned to Dr Davies for review. Initially Dr Davies was impressed the deceased had actually maintained the correct review time, however, when the deceased spoke with Dr Davies he informed him his scripts had run out the previous day and he had counteracted any withdrawals by smoking heroin. Dr Davies was surprised at this information. He did not know the deceased had ever used heroin. He was concerned the deceased was now using it because his prescription wasn't lasting him the time agreed on their plan.

Dr Davies spent a considerable amount of time discussing the need for the deceased to be completely honest with him about his drug use. While there are urine screens available to test whether a person has used heroin, they are not usually used to verify a statement someone has taken heroin, rather to test if someone had been taking illicit

[60] t 16.03.15, p464
[61] t 16.03.15, p403
[62] t 16.03.15, p469

drugs when they should not. They are not considered a tool to determine whether someone has taken heroin, when they say they have.[63]

Dr Davies reiterated his preference the deceased commence daily dispensing for his benzodiazepine prescriptions. Dr Davies discussed the deceased's need for counselling and the deceased requested his counselling be with Dr Davies initially, and perhaps a private psychologist later, due to the deceased's resistance to being referred to Next Step. Dr Davies re-prescribed the deceased's benzodiazepines of alprazolam and diazepam, with a consultation for the following week.

The deceased again took the script to Chemist Warehouse in North Perth where he was seen by Ms Jong Shuin Ning. Ms Jong was as concerned as Mr Chim had been about the script. However, she was reassured the veracity of the prescribing had already been checked by Mr Chim, who had noted the doctor had discussed a plan for the deceased. In addition, Ms Jong went out onto the pharmacy floor to speak with the deceased herself. One of her reasons for doing this was to assess how the deceased was behaving with a script he had apparently already been using for over a week. Ms Jong's conversation with the deceased and the questions she asked him satisfied her he was coping with the prescription she believed he was already taking.

In evidence, Ms Jong advised the court *"If I see someone like that on the street, I would not be able to tell that he was on such medications. He appeared to be fine, and just like a normal person"*.[64] After satisfying herself the script was a valid prescription, and the deceased understood the prescription, she dispensed it to him. She was satisfied he had a high tolerance to benzodiazepines.

The deceased returned to Dr Davies on the correct day, 24 February 2011, for review. The deceased advised Dr Davies he had been thinking about the need for honesty and considered he needed to be completely open with Dr Davies.

[63] t 16.03.15, p470, t 19.03.15, p623
[64] t 16.03.15, p409

He advised Dr Davies he had regularly smoked 1-3g of heroin per day over the preceding few months. This was in addition to his benzodiazepines, which he said he had taken as prescribed successfully.

Dr Davies thought it was important the deceased's heroin use be dealt with before addressing his benzodiazepine use further. On discussing the options available the deceased stated he would like to go on the methadone program. This necessitated the use of CPOP and Dr Davies, as an authorised prescriber, filled out the necessary documentation to have the deceased registered as a Schedule 8 medicine user. This would list him as a registered drug addict on the State register and ensure a consistent amount of legitimate opioid medication.

It did not occur to Dr Davies the deceased may be alleging heroin use as a means of seeking Schedule 8 medication.[65] According to Ms Cutler that is precisely what the deceased was doing.[66]

Dr Davies explained he would become the deceased's authorised prescriber for the purpose of any methadone prescription and the deceased would need to obtain his methadone from the same pharmacy. He also arranged to see the deceased twice a week, once for counselling and once for the purposes of reviewing his prescriptions. While waiting for the methadone authorisation to be approved, Dr Davies prescribed the deceased his usual script for benzodiazepines, without reduction in view of his issues with heroin.

The deceased took the benzodiazepine script to Chemist Warehouse North Perth and was seen by Mr Zeng Law.

Mr Law was very concerned about the prescription, but when he reviewed the pharmacy history for the deceased he found the prescription was consistent with those for the previous two weeks, and that one of the earlier pharmacists had queried the fact of the prescription with the prescribing

[65] t 16.03.15, p472
[66] t 16.03.15, p347

doctor notwithstanding there was a different benzodiazepine. Mr Law believed the deceased had a high tolerance to benzodiazepine medication, however, he still attempted to ring the doctor to confirm the script was accurate. Unfortunately, Dr Davies was not available. Mr Law discussed the prescription with both the deceased and Ms Jong.[67] Ms Jong confirmed her conversation with Mr Law in evidence.[68]

The deceased returned to Dr Davies at Subiaco the following day hoping the authorisation for commencement of the methadone program had come through. It had not and the deceased requested medication for the weekend to prevent him from using heroin and Dr Davies provided him with a script for a pain killer only.[69]

The deceased returned to Dr Davies on Monday 28 February 2011 hoping the authorisation for his methadone had been received. Dr Davies had received it that morning, following discussions with the duty doctor from Next Step as to the appropriate starting amount for the deceased in view of his drug history. It does not appear from the evidence Dr Davies was advised the deceased had been a participant in community programs before.

The agreement between the deceased and Dr Davies was that the deceased would receive counselling on Mondays, and repeat prescriptions on Thursdays. Dr Davies wrote the deceased a prescription for his methadone treatment; the specified pharmacy was Pharmacy 777 in Glendalough. Dr Davies assumed that having written the deceased his prescription for methadone he had gone away and had the methadone dispensed prior to his consultation with the deceased later in the afternoon. This would allow Dr Davies to assess how the deceased was coping with the commencement of methadone.

When the deceased returned that afternoon he was, in Dr Davies' view, exhibiting signs of mild withdrawal. He

[67] t 16.03.15, p374
[68] t 16.03.15, p414
[69] Ex 4, tab 7.20

was lucid and not overly sedated. Dr Davies believed this presentation confirmed the deceased had been using heroin, that the methadone prescription was a substitute, and that he appeared to be dealing well with the substitution with the assistance of benzodiazepines. As a result Dr Davies commenced his counselling session with the deceased and spent a considerable amount of time discussing his background.

At the conclusion of the consultation Dr Davies advised the deceased he needed to be careful with his benzodiazepine medications because of their interaction with methadone. He advised the deceased to only use a small amount and to withhold them if he was becoming sedated. It was at this point the deceased said he had used all his benzodiazepines over the weekend to stop him from taking heroin, along with the prescribed pain killers. The deceased asked Dr Davies for a new script.

Dr Davies refused to provide the deceased with additional benzodiazepines.

Dr Davies reiterated they had a plan and the prescribed amount of benzodiazepines, as high as it was, was to be taken according to their plan and he would not write a script outside the plan without switching the deceased to daily dispensing. The deceased did not wish to have a daily script for benzodiazepines. He was not provided with any prescription for benzodiazepines or pain killers.

The deceased was due to return to Dr Davies on the Thursday, 3 March 2011 for a prescription review. In the meantime Dr Davies expected the deceased to go without any benzodiazepines in view of his rejecting Dr Davies' offer of daily dispensation.[70]

The deceased's ability to hold a coherent conversation with Dr Davies for a counselling session on the afternoon of 28 February 2011, when Dr Davies assumed the deceased had had his first methadone dose, convinced Dr Davies he did

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[70] t 16.03.15, p475

have a problem with heroin, and the methadone prescription was holding that addiction, but not overly sedating.

Methadone Prescription

There is a difficulty with the documentation for the deceased's methadone dispensing.

It was Dr Davies' understanding the deceased had a dose on the morning of 28 February 2011, following which Dr Davies had reviewed him during a counselling session which gave Dr Davies the ability to observe the deceased' s behaviour having commenced methadone.

It is far from clear the deceased took his methadone dose on 28 February 2011.

The documentation from 777 Pharmacy Glendalough does not record the deceased as receiving his starting dose of methadone on 28 February 2011. Rather the pharmacy records indicate the deceased had his first authorised dose of methadone on the CPOP program from Pharmacy 777 Glendalough at 8:50am on 1 March 2011.[71] This was the day after the deceased had seen Dr Davies implying he had already had his first dose and requesting additional benzodiazepines which were declined. This means the presentation to Dr Davies on the afternoon of 28 February 2011 was flawed and verifies Ms Cutler's view the deceased told Dr Davies he was a heroin addict solely for the purpose of obtaining legal methadone.

Further on the same date, 1 March 2011, the deceased is recorded as having another dose of his methadone at 8:52am. Unfortunately the dispensing pharmacist has no recollection as to why this may have occurred. There is speculation the deceased may have vomited the first dose and needed to be redosed.[72] There is an alternative explanation that the pharmacy and health department records, derived from the pharmacy records, are wrong and

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[71] Ex 5, tab 5E
[72] Ex 18

the doses recorded for 1 March 2011 should have actually been separated into 28 February 2011 and 1 March 2011. However, there is no evidence before the court that is what occurred.

Both the health department record and the pharmacy record indicate two doses for 1 March 2011 and one for 2 March 2011. If this is accurate it means Dr Davies did not have the opportunity to observe the deceased following his first methadone dose. In addition, if the deceased did vomit his first dose of methadone it may indicate he was not as tolerant to opioids as he would have Dr Davies believe.[73]

The deceased was not due to return to Dr Davies until 3 March 2011.

There is no evidence as to the deceased's behaviour and presentation following his first dose of methadone on 1 March 2011.

2 MARCH 2011

The deceased's father stated he left the house at approximately 7:30am on Wednesday 2 March 2011 to go to work. He saw the deceased that morning and believed him to be fairly dopey. They had a brief conversation about the day to come.[74]

Mr Westlund then left the house.

Ms Cutler was working a split shift in Subiaco. It was her evidence she collected the deceased from his home and took him to the pharmacy at Glendalough for his methadone. She believed she picked him up at approximately 8am although the pharmacy record indicates he had his dose at 9:08am on 2 March 2011. She then returned the deceased home and went to work in Subiaco.

[73] t 19.03.15, p613
[74] Ex 4, tab 7.7

Mr Westlund rang his son at approximately midday to discuss a problem with his car. It was a brief conversation and Mr Westlund believed his son seemed his usual self.

Ms Cutler returned to the deceased's home just after 1pm and on that occasion she advised the court *"then I saw him again between 1-4pm and that was when he was a lot more slurry and spilling things and stuff like that"*.[75]

Ms Cutler said no one else was home with him during that time. She advised that when she had left him at approximately 4pm he had been coherent and on the computer, although slurred. She then left and returned to work for the rest of her shift. She finished work at 7:30pm and tried to call the deceased as previously arranged but was not able to contact him again.

Mr Westlund returned home at approximately 6pm on 2 March 2011 and checked his son's room to find the deceased lying face down on his bed asleep. He was snoring, which was not unusual, and seemed to be fine.

Mr Westlund went to the shops, came home and cooked some dinner. At about 8:30pm he went to check on the deceased. On this occasion the deceased was still face down on the bed but was no longer breathing and had vomited.

Mr Westlund cleared his son's airways, turned him over and started doing CPR, compressions only, while he contacted emergency services. Mr Westlund continued attempting to resuscitate his son until the ambulance officers arrived approximately 10 minutes later and continued the resuscitation effort.

The ambulance took the deceased to Sir Charles Gairdner Hospital and Mr Westlund followed by car. It was while he was in the car driving to hospital he was advised by telephone from a doctor at the hospital his son was dead.

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[75] t 16.03.15, p346

Following his son's death Mr Westlund believed the deceased appeared to have made an attempt to clean his room. It was his view the deceased had put all his medication packets and rubbish in a bag. Mr Westlund added some items to the bag.

Ms Cutler's evidence was the deceased kept an assortment of medication from his various prescriptions in a bucket or bag in his room during the times she was visiting him.

A box of alprazolam dated 17 February 2011 was seized from the deceased's room following his death.[76]

POST MORTEM EXAMINATION

The post mortem examination of the deceased was undertaken by Dr G A Cadden on 4 March 2011 at the PathWest Laboratory of Medicine WA.[77] It was an external examination only due to an objection to post mortem examination lodged by the deceased's parents.

The difficulty with an external examination in a case involving concern with toxicology is it restricts the reliability of the toxicological analysis by restricting the information to blood samples only.

On understanding the cause of death was likely to involve a drug overdose permission was sought for a restricted abdominal examination to allow the collection of samples of specific tissues which are known to clarify blood toxicology results. Specified samples were collected on 9 March 2011 to assist in clarifying the toxicology.

The external examination of the deceased revealed little of concern with respect to a likely cause of death. For the purpose of coming to a conclusion as to the deceased's cause of death Dr Cadden referred to the Chemistry Centre toxicological analysis for the deceased dated 11 April 2011[78]

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[76] Ex 4, tab 12
[77] Ex 4, tab 13
[78] Ex 4, tab 14

which identified a number of drugs. Alcohol was not detected in the deceased's blood or urine.

Alprazolam was located in the deceased's blood and liver at levels indicative of toxicity. The level of methadone was within the range of both maintenance and fatality levels seen in drug related deaths. Other medications in the blood were diazepam, desmethyldiazepam, oxazepam, dextromethorphan, all at therapeutic or sub therapeutic levels.

Dr Cadden also noted medical reports from Fremantle Hospital and Royal Perth Hospital which referred to prior seizure activity, without investigations demonstrating any central nervous system abnormality, and the possibility the seizures related to benzodiazepine withdrawals. Dr Cadden noted the deceased had not been witnessed to be fitting at the time of death although that would not exclude a seizure having occurred prior to him being found unresponsive.

Dr Cadden was of the opinion the deceased's death was consistent with combined drug toxicity, however he was unable to determine whether aspiration or other factors had been present due to the limited post mortem authority. At the time of the deceased's death it had not been clear an inquest would be warranted and consequently the parents' wishes in not conducting a full post mortem examination were respected.

PBS PRESCRIPTIONS BEFORE DEATH[79]

There is no dispute from Dr Davies his prescriptions for the deceased's benzodiazepines during 2011 were off PBS. The last PBS entry for benzodiazepines for the deceased were prescribed by Dr Buntine in February 2011 as a holding mechanism until the deceased could recommence his visits with Dr Davies.

The fact the deceased was prescribed off PBS medication and it was generally not for Schedule 8 medication accounts

[79] Ex 4, tab 16

for his lack of record on the doctor shopping advice line. He did not fit the criteria necessary for him to be identified as a person at risk of doctor shopping. It is for this reason Dr Buntine's enquiry with the advice line to verify his reliability in requesting high prescription for benzodiazepines produced no results.

The fact the deceased was dependent on benzodiazepines would make telephone calls to the State Health Department with respect to his drug registration status prior to 28 February 2011 irrelevant. He was no longer a registered drug addict at the time he started seeing Dr Davies and his earlier registration as a drug addict, which ended in May 2010, was not considered by the doctors at Kinetic Health because they believed his opiate difficulties were a thing of the past. Benzodiazepine dependence is not registerable currently in the same way as opiate or Schedule 8 medicine dependencies.

EXPERT EVIDENCE

Professor David Joyce

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. He provided the court with expert evidence to assist with analysis of the deceased's post mortem toxicology and the contribution of various drugs to the death of the deceased.

Professor Joyce reviewed the available medical information with respect to the deceased. He noted the deceased had a history of anxiety and depression with a reference to the use of *"speed"* in August 2010. In September 2010 he was alleged to have had a convulsive seizure which at the time was attributed to benzodiazepine withdrawal and had self-reported a long use of both heroin and benzodiazepines. Professor Joyce also noted the deceased had an abnormally high number of hospital and GP attendances for accidents and injuries requiring analgesic medication.

Professor Joyce then went on to analyse the medication history for the deceased in the months directly before his death as being most relevant to the toxicological analysis at the time of death.

In general terms Professor Joyce indicated benzodiazepines are sedating drugs, but some are more potent than others. It is usual when treating a benzodiazepine dependency to convert all the different forms to a diazepam equivalent and use that as a starting point for the level of dependency, and then gradually reduce the amount used over a period of time.

Those dependent on benzodiazepines develop a tolerance to high levels very quickly and those patients will seek higher levels in an attempt to recapture the original euphoric effect. Once dependent on a high level of benzodiazepines rapid withdrawal of the drug can lead to extreme distress including convulsions and death.[80] It is necessary to stabilise a patient on a known level first and then reduce the amount. Professor Joyce believed the equivalent of 80mg of diazepam per day would be the usual starting point for a high level of dependency, from which reduction then occurred.[81] This was the methodology used by Dr Davies in the deceased's initial attempted treatment in 2010.

The amount of an equivalent to 350mg of diazepam daily reported by the deceased to Dr Davies on 4 February 2011 on his return to Dr Davies was outside Professor Joyce's range of practice, but a reduction to the equivalent of 300mg per day for stabilisation was in accordance with the theory of stabilisation, to be followed by reduction.

The apparent withdrawal symptoms observed on 10 February 2011 following this dose, because of the deceased's alleged mistake in identifying alprazolam would imply, in theory, the deceased needed a higher dose for stabilisation before reduction. Hence the new dose equivalent to 500mg diazepam daily. However, Professor

[80] t 19.03.15, p615
[81] t 19.03.15, p617

Joyce indicated from his specialised perspective, the daily amounts alleged by the deceased were incredible.[82]

Literature supplied to the court and Professor Joyce references patients on high doses of benzodiazepines, using equivalents of diazepam medication and successfully reducing over time with control over their own medication.[83] Professor Joyce did not see the reference as controversial[84] but both he, and Dr Alan Quigley, Director of Clinical Services at Next Step, indicated the preference would be to treat this type of extraordinary dependency in an inpatient setting.[85] The deceased had refused Dr Davies attempts to have him referred to Next Step.

The introduction of methadone to counteract the deceased's alleged heroin use, in addition to the benzodiazepine dependency created the perfect trap for Dr Davies.[86] Dr Davies either treated the deceased by accepting what the deceased said or Dr Davies refused to treat him and ran the risk of the deceased returning to the black market which is how he alleged he was in the situation he was in. There was no reliable method by which Dr Davies could test the veracity of the deceased's reported use, and the deceased's presentation to him was consistent with the deceased's alleged use. It was Professor Joyce's specific area of expertise in pharmacology which allowed him to conclude the deceased must have been untruthful.[87]

Professor Joyce outlined a tolerance to benzodiazepines would not provide a tolerance to opioids (methadone)[88] and the introduction of methadone to a person with a benzodiazepine dependency, without the regular heroin use claimed by the deceased, was an additional difficulty caused by the deceased's drug seeking behaviour.

Professor Joyce was under the impression the deceased had not had methadone on the day of his death and believed the

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[82] t 10.03.15, p630
[83] Ex 20
[84] t 19.03.15, p616 & 629
[85] t 19.03.15, p618, t 20.03.15, p736
[86] t 19.03.15, p629
[87] t 19.03.15, p630
[88] t 19.03.15, p618

levels in the toxicology post mortem examination to be high for the given dose, but explicable by the interreaction of the various drugs in the deceased's system. It is also explained by the fact the deceased had taken a dose on the morning of 2 March 2011.

Similarly the level of diazepam was not as high in the toxicology post mortem report as one would expect on the amounts Dr Davies prescribed.[89] This is consistent with the deceased exaggerating his dependency in order to gain an oversupply of benzodiazepines.

The deceased had told Dr Davies he had no benzodiazepines left from his previous prescription and Dr Davies had declined to prescribe more on 28 February 2011. Yet the deceased still had high levels of alprazolam post mortem indicating he must have either obtained more from another source or was consistently lying about his level of use in order to obtain enough drugs for use as and when he desired.

The fact the deceased was not as tolerant as he claimed would make him especially vulnerable to the possibility of overdose. The level of alprazolam was consistent with the prescription[90] which only made up a portion of the benzodiazepine amount overall. The amount however could be lethal in a person without the tolerance claimed by the deceased. The deceased must have had access to an oversupply and lied about having used all of his previous prescription.

The post mortem toxicology also reveals the deceased was using excessive amounts of over the counter cough suppressant containing a weak opioid, dextromethorphan. This would have an added sedating effect in a person who was already over sedated by the use of benzodiazepines and opioids.

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[89] t 19.03.15, p620
[90] t 19.03.15, p621

In Professor Joyce's view the alprazolam, methadone, diazepam and dextromethorphan were all contributors to the deceased's death by way of:-

> *"….suppression of breathing and the over relaxation of the muscles that normally protect the upper airway when people are unconscious, so the people who have taken overdoses of these sorts of drugs will go off to sleep, they will slow down their breathing and the power of breathing will drop, so the muscles around the top of their airways relax too much, they won't be able to provide enough motive force to pull the air past it and will asphyxiate as a result."*[91]

Methadone has the same capacity to suppress breathing and its effects are long lasting. The 30mg supply of methadone to the deceased was an intermediate dose in itself and would be sedating, but not fatal, unless it caused vomiting which would lead to aspiration and death if a person was overly sedated as in this case.[92]

Professor Joyce suspected the most likely risk of death in the deceased's case would have been vomiting while overly sedated and insensitive to vomiting. The deceased would have been incapable of the reflex response, and conscious responses, which would normally wake him and protect him from vomit and aspiration. The high level of sedation is explained by the mixture of drugs increasing the effects of sedation as Professor Joyce explains:-

> *"….the pathway to the death in these instances is not instantaneous. The aspiration impairs oxygenation and allows accumulation of carbon dioxide. These would normally wake a person. A well sedated person will not wake. The damage done to the brain and other tissues by the impaired oxygenation and carbon dioxide accumulation progressively degrade brain and circulatory performance to the point of death."* [93]

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[91] t 19.03.15, p613
[92] Ex 4, tab 7.22
[93] Ex 4, tab 7.22

The fact the deceased claimed to have a high tolerance to benzodiazepines would have implied the addition of methadone shortly before death was a contributing factor. However, it is likely the deceased had misrepresented his benzodiazepine use and did not have the tolerance alleged. Methadone was then added and increased the likelihood he would be susceptible to death as a result of the mixture of drugs.

There is no support for the proposition the deceased mistakenly took an excessive amount of drugs because the post mortem toxicology and death is explicable on the prescriptions given.

The prescriptions are lethal for a benzodiazepine and/or opioid naïve person, and carry the risk of sudden death, even for those who are tolerant to the amounts described. However, leaving a person who is truly dependent to the extent alleged by the deceased, unmedicated, also carries the risk of death.

The prescriber is left in the perfect trap, especially where there is outright refusal to submit to inpatient management.

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 Royal Perth Hospital (RPH), and establishing a pain clinic at Fiona Stanley Hospital (FSH).

Professor Schug advised he does not prescribe benzodiazepines in his area of pain management, and his knowledge with respect to this death would be mainly over the prescription of methadone, which is a preferred opioid for the treatment of chronic pain. His need to prescribe methadone meant he understood the basics of the undesirability of prescribing benzodiazepines and opioids in the same patient concurrently.

It was Professor Schug's understanding benzodiazepines were rarely fatal in and of themselves, however, in combination with other respiratory depressants, such as opioids, which stop the respiratory drive of the brain, then the combination could lead to lethality.

Professor Schug advised that in principle one would always advise against co-prescribing, but in reality it is often required because benzodiazepines can reduce the withdrawal effect of restricted levels of opioids and thus creates a co-dependency.[94] In a pain clinic they are not involved with opioid substitution, only distinguishing between chronic pain and opioid abuse.

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.[95]

The situation which arose for Dr Davies with respect to treating the deceased was not really something about which Professor Schug wished to comment, however, he did believe a real-time dispensing information system, inclusive of benzodiazepines would be useful to all medical practitioners. As far as Professor Schug was concerned the biggest risk to a patient from a prescriber's perspective was how much of the drug he had at home, not how many prescriptions he had collected.

[94] t 23.03.15, p723
[95] Ex 9

Professor Peter Winterton

Professor Winterton is a Clinical Associate Professor in Paediatrics and Community Practice. He is on the board for the Royal Australian College of GP's to advise in areas affecting general practice. He was asked to comment upon Dr Davies' care of the deceased.

It was Professor Winterton's view that Dr Davies' aim of managed reduction for benzodiazepine dependency was correct, however, Professor Winterton did not believe that aim was evidenced by Dr Davies' prescribing in the last few weeks of the deceased's life. In Professor Winterton's view the only options for Dr Davies were to refuse to treat the deceased, write daily prescriptions with conditions if necessary, or refer him to an inpatient facility, if one could be found, which would cope with his situation.

The addition of methadone to the prescribing for benzodiazepines emphasised the need for Dr Davies to be very wary in agreeing to deal with the deceased at all.[96]

Professor Winterton argued general practice was not equipped to handle the sort of medical emergency the deceased was describing when he added his alleged heroin addiction to the benzodiazepine dependency. There was no doubt in Professor Winterton's mind that circumstance necessitated inpatient management to prevent a fatal outcome even in the process of reducing the dependency.[97]

Professor Winterton agreed one could not physically enforce a particular regime on a patient and there were no grounds for use of the *Mental Health Act 1996* in the circumstances of the deceased.

Professor Winterton agreed the prospect of quantitative testing to support the reliability of a patient's assertions as to their drug use was not economically viable.[98] He was satisfied Dr Davies had at all times attempted to act in the

[96] t 18.03.15, p525, 563
[97] t 18.03.15, p565
[98] t 18.03.15, p571

deceased's best interest, but the difficulty was he trusted the deceased too much.[99]

Professor Winterton did not dispute Dr Davies' intentions as far as the deceased was concerned, but believed it was not in Dr Davies' best interest to prescribe to the deceased the level of medication he was seeking when there was no way of assessing the reliability of the deceased's self-reporting.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 22 year old male who lived at home with his father and had a serious drug issue. It is not clear to me how or why the deceased developed such a strong drug seeking trait, or even if there were any triggering factors.

The deceased grew up with the support of his parents, although they separated when he was quite young, and at the time of his death he was living with, and supported by his father, through what must have been difficult issues to manage between them.

Despite behavioural issues at school and antisocial behaviour, the deceased remained loved and supported by his family. He had a skill he was anxious to develop with Thai boxing, a skill which is enhanced by a fit mind and fit body.

The deceased was also skilled at charming people and able to manipulate situations to achieve outcomes he desired for himself. These were not always outcomes which were in his best interest.

Following the deceased's involvement with illicit drugs which caused him trouble while still a teenager, he moved to prescription medication following treatment programs imposed by juvenile justice conditions aimed at trying to prevent his continuing drug abuse. He learned very quickly that he could substitute prescription medicines for illicit

[99] t 18.03.15, p577/8

drugs. These may not have been as effective in achieving the outcomes he required, but they were legal, and if he misused them he could achieve some of his desired benefits.

The deceased gave the impression of attempting to overcome his drug seeking behaviours by self-reporting to community treatment options like Next Step, and engaging with doctors. I am not satisfied he was ever genuine in a realistic attempt to overcome his drug use. It became more about obtaining concerning amounts of prescription medication legally, so he could determine his own use. His engagement with doctors appeared almost an intellectual challenge he could not resist, to see for how long he could provoke sympathy to his situation, and attempts to assist him. He was clearly an intelligent man and it is a tragedy he misused his abilities to do harm to himself.

On any occasion a doctor appeared to attempt to exert control over his requested treatment he disengaged and moved to another. On occasion I am satisfied he caused injury for which a hospital would provide short term medication.

The way in which the deceased operated, by moving between known doctors long term, always acknowledging part of his drug problem but not the whole picture, kept the doctors concerned to assist him with his issues. The deceased paid for private scripts of benzodiazepines and these provided him with a source of prescription medication to use when he was having difficulty sourcing whatever he wanted.

While it is clear the deceased had a serious problem with drugs generally, I am not satisfied he was as tolerant to opioids or benzodiazepines as he alleged. I am satisfied he overstated his tolerance to obtain higher amounts of medicine than he needed. He did this to ensure he always had prescription medication to hand whenever his ability to source whatever drugs he wanted was disrupted.

His charm, his acknowledged drug use and his perceived self-knowledge of drug interactions made him impossible to treat.

Whether the deceased wanted treatment is a very vexed issue, but he certainly never told enough of the truth to allow treatment to occur. Even on his last consultation with Dr Davies (28 February 2011), who was undeniably trying to salvage a treatment program for the deceased which he would accept, the deceased both by word and implication told untruths designed to thwart any reduction in his drug consumption by way of compliance with a withdrawal program.

- The deceased implied he had taken methadone when we know he had not, thus presenting Dr Davies with an entirely false picture of his response to his first dose of methadone.

- The deceased stated he had no benzodiazepines left when he attempted to persuade Dr Davies to write him another prescription. This was clearly untrue when looking at his post mortem toxicology and the presence of the prescribed benzodiazepines in that analysis.

I accept the evidence of Professor Joyce and Dr Quigley the accepted method of reducing a high benzodiazepine dependency is to stabilise a patient at 80mg per day of diazepam equivalent, and then reduce the amount progressively over a few weeks. However, note in cases where a patient such as the deceased claims to be tolerant to much higher amounts of benzodiazepines, that method would be destined to fail in practice due to the withdrawal effects, which can include death. It is for this reason dependencies of 80mg per day diazepam equivalent or higher are recommended to occur in an inpatient setting. An option the deceased consistently and emphatically refused.

In his original engagement with Dr Davies in 2010 the deceased was provided with 80mg per day diazepam equivalent, but he stopped seeing Dr Davies when Dr Davies

refused to provide prescriptions outside a weekly plan. The deceased at no time told Dr Davies about using another general practice to source benzodiazepines during that time.

On the deceased's return to Dr Davies in February 2011 he alleged he had considerably elevated his level of tolerance to benzodiazepines due to his need to source drugs from the black market because he was no longer being provided with prescriptions for them. This at a time when he was telling Ms Cutler he could obtain whatever he wanted from doctors by lying without needing the black market. He just kept his own supply in a bucket to use when he wanted them.

Dr Davies' original attempt to stabilise the deceased at 80mg per day equivalent diazepam was thus effectively thwarted. If Dr Davies wanted to help the deceased, and protect him from the unknowns of the black market, he now had to attempt a much higher starting point.

The method was conventional, and there is support from an established facility in the literature for an individualised starting point. The issue is only the commitment of the patient to abide by the program. Something Dr Davies hoped the deceased now had, although he was still refusing to engage with Next Step at Dr Davies request he do so. It does not appear the deceased ever told Dr Davies he had participated in a community program when younger, but referred instead to friends advising him community treatment centres were very rigid and uncompromising.

Dr Davies provided the deceased with a reduced prescription for stabilisation at 300mg equivalent diazepam, instead of the calculated 350mg per day equivalent diazepam. A dose Dr Davies referred to as "*a huge amount*" and it was rightly queried by the dispensing pharmacy.

On the assumption the deceased had taken that amount as prescribed, Dr Davies was naturally concerned when the deceased returned exhibiting acute withdrawal signs and alleging he had previously been taking a much higher dose of benzodiazepines, sourced from the black market. How the deceased achieved the withdrawal symptoms is a matter

for speculation, but Dr Davies reported observing classic withdrawal phenomena. Dr Davies believed he had no option but to elevate the prescription amount faced with a very unwell deceased who was still refusing Next Step and daily scripting. He did not have the option of registering the deceased as addicted to benzodiazepines.

Having obtained benzodiazepines to this level I am suspicious the deceased was actually using at that level. It seems more likely he was using less but ensuring an oversupply for any future time when Dr Davies would eventually refuse to prescribe, as he undoubtedly would.

The evidence of Ms Jong as to the deceased's presentation on 17 February 2011 would appear to support the deceased was not taking such high doses because he seemed fine when he saw Ms Jong, but was adversely affected when he did take the drugs, presumably later in the day as observed by Ms Cutler and his father.

I am satisfied the deceased's plan was then to obtain legitimate opioids. He now had a supply of benzodiazepines to counteract any failure of supply of opioid drugs and legitimate opioids, misused, were less likely to cause him a problem legally. I doubt he used heroin to the extent he alleged if at all, and I am satisfied he used the ploy of smoking heroin to counteract benzodiazepine withdrawal, to initiate a legitimate supply of opioids and explain a lack of *"track"* marks.[100]

On the pretext of being frank with Dr Davies the deceased disclosed serious heroin use for Dr Davies to deal with, in addition to the benzodiazepine dependency. Dr Davies agreed in evidence he no longer is as naïve when dealing with patients,[101] but he liked the deceased and believed he was genuine. He discussed options with the deceased and the methadone program was chosen.

This was a well-recognised community program and Dr Davies had the benefit of being able to discuss the

[100] t 16.03.15, p471
[101] t 16.06.15, p465

treatment with Next Step duty doctors. Once registered the deceased was ensured a consistent supply of acceptable Schedule 8 medication and Dr Davies could then continue to address his benzodiazepine dependency.

The expert evidence at inquest confirmed the level of methadone, although high, was not of concern alone and survivable. Dr Davies had discussed the level with the duty doctor in the process of authorisation for the application. The application form also requires the authorised doctor to provide information on other drugs being used, although not the amounts. Benzodiazepines are accepted drugs to be prescribed with drug reduction programs due to their ability to ameliorate the reduction/substitution process, despite the risk of adverse effects if not used appropriately.

Dr Davies advised the deceased of this, and it was this very issue which caused Dr Davies to refuse the deceased a benzodiazepine prescription on the deceased's last consultation with him on 28 February 2011. As far as Dr Davies was aware on that date the deceased had no prescribed benzodiazepines to misuse, had successfully taken his first dose of methadone, and had a constructive consultation with Dr Davies where his presentation had appeared entirely appropriate.

Dr Davies had no reason to suspect the deceased was going to go home and, over the following two days take benzodiazepines Dr Davies had refused to prescribe, as well as commence his methadone, and take excessive amounts of cough suppressants.

That is precisely what the deceased did.

And he died.

The evidence is it is most likely he died as a result of the effects of the high amount of drugs making him vomit, and the effects of the opioids and benzodiazepines together sedating him to the extent he had no way of protecting himself from the effects of vomiting and the resulting

inability to breath effectively exacerbated by aspiration. There is no evidence he intended to die.

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 well known patient's medical problems, without appropriate real time information to assist them in acting in their patient's best interest. The fact the 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.

Most of the medical practitioners coming into contact with the deceased liked him. He was generally well presented, appeared genuine, was enthusiastic, well-mannered, and generally an engaging 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 uncompliant with management strategies the deceased managed to persuade doctors he was ready to try again. Invariably, the doctors who wanted to help him, would try again.

The evidence suggests the deceased obtained whatever prescription medication he could persuade medical practitioners he needed, often by over-reporting his daily use, but then used that medication recreationally, at will. In this way he created a stock-pile he could use when he wished, but more relevantly did not build for himself the tolerances to opioids or benzodiazepine medications he portrayed. It is doubtful even the deceased understood his actual level of tolerance to these medications at any point in time due to his numerous seizures and periods of unconsciousness after the alleged use of various substances, or periods of alleged abstinence.

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

The desire to continue to try and manage a patient exposes a doctor to the risk of being manipulated. In this case Dr Lacey understood far more quickly than Dr Davies the unreliability of the deceased as an historian. This was, however, with the advantage of Dr Lacey's practice's long term association with the deceased, something the practitioners at Subiaco did not have.

All the deceased's doctors would have been much better able to prescribe in his best interests if they had real time access to information about all prescription medication dispensed to him at the times they were prescribing him with benzodiazepines. With proper knowledge of the deceased's prescription history a better understanding of his use of alternate practices and escalating amounts may have outlined the deceased's problems more clearly, but whether he would have tolerated more control is a matter for conjecture.

While he 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 case it is unclear as to the deceased's actual level of dependency on either benzodiazepines or opioids. He seems to have been able to control his medication use to allow him to appear coherent when necessary, but exhibited signs of withdrawal when useful in the quest for higher amounts of prescription medication. He was clearly not as tolerant as he believed to the mixture of alprazolam, methadone and cough mixture he took, if he ever had been that tolerant. His post mortem toxicology indicates he was obtaining medications and then using them at levels which do not support his belief in his tolerance.

Communication of his drug seeking behaviours would have:-

1. Alerted practitioners at Kinetic and Subiaco he was obtaining prescription medication from two sources concurrently;
2. Alerted Dr Davies to the fact none of those prescriptions equated the levels he was alleging as his dependency to benzodiazepines, unless sourcing the black market; and
3. Would have revealed extreme reliability/credibility issue surrounding any history from the deceased.

Unfortunately, that knowledge and a refusal to treat would probably have pushed this particular deceased well and truly into the illicit drug market because it is not clear he ever had the commitment to truly adhere to a management plan. This is precisely what Dr Davies was seeking to avoid.

<u>Current Prescribing</u>

The drugs sought by those with prescription medication dependency are those prescribed as analgesics (Schedule 8 opioids) or for their calming/sedative effect (Schedule 4 benzodiazepines). They are also medications to aid those with an illicit drug dependency (opioid) overcome that dependency (methadone, naloxone) and assist with withdrawal affects (benzodiazepines), by providing the patient with an alternative but less intense, effect. Prescription anti-depressants and anti-psychotics are also often misused.

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 assessed. As short term pain relief they are effective.[102] Doctors need to treat pain and so will use opioids for appropriate patients. Inevitably there will be some overlap between

[102] 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.

appropriate and inappropriate, especially with changing medical practice. It is because of the seriousness of the outcomes of over medicating 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 drug use and the dispensing of the drugs prescribed.

Benzodiazepines, as sedatives, are very effective in treating a number of difficulties in the elderly and the 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.

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 shortcomings 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 notified 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 oversupply can be misused, used as a 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 and 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 Alan 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 GP's and community pharmacists in their provision of pharmacotherapy, largely methadone or buprenorphine treatment to opioid dependent patients.[103]

Medical practitioners need to be accredited, following training, to prescribe pharmacotherapy, patient's needs 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.[104]

Any doctor prescribing medication with a view to controlling a dependency needs to be able to ascertain what drugs his patient is actually taking. There is no reliable way of determining whether information provided is reliable. It is a

[103] t 20.03.15, p730
[104] t 20.03.15, p732

matter of trust. It is essential a treating doctor know the amounts and descriptions of drugs being misused so that useful alternative dosage regimes can be implemented. While quick drug screens may pick up the fact a drug's use screens will not pick up the quantities to verify the amounts a 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 a patient is telling the truth, the doctor needs to assess an alternative dosage which is then prescribed for a period of time to stabilize 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 a degree of trust between the doctor and the patient for this to be effective.

Doctors have no way of verifying the use of 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. Both practitioners at Kinetic and Subiaco believed they had some background with the deceased when he approached them for high level prescription medication and did not view him as a "walk in" about whom they would have had a level of suspicion, as did Dr Buntine when she checked the doctor shopping hotline for the deceased on first meeting him.

Currently, a pharmacist in WA is not in a position to access drug addict register information.[105] 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 prescription may ring the prescribing doctor, or if really concerned can refuse to dispense, but is not in a position to access the drug addict register themselves. If more of a Schedule 8 medicine is dispensed than the 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 dependency via an authorised prescriber, it is reasonably easy to circumvent without real time information to the prescriber or dispenser as to the patients actual access to prescription medicines.

The 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 people identified as a prescription shopper.[106] The criteria for a prescription shopper are set by legislation, regulation 20(a), of the *Human Services (Medicare) Regulation 1975* and not all patients who are potentially drug seeking are captured.

The PBS data for the deceased in this case did not identify him as a prescription doctor shopper despite the fact he was clearly seeking both opioid and benzodiazepine medications. 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.[107] 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 all controlled drugs, but not private dispensing.

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[105] t 19.03.15, p640-641
[106] Exhibit "10", tab 1 and t. 17.03.15, p.495
[107] t 17.03.15, p498

The doctor shopping hotline is available to pharmacists 24/7 but does not provide information off PBS, and if the 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 did fit the prescription 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 the State/Territory.[108] That is all dispensed events relating to controlled drugs and any other drugs of interest for which information can be collected according to relevant state and territory legislation.[109] This is ERRCD.

The evidence at the 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 information.[110] Currently Western Australia has finalised a sub-license 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.[111]

[108] t 23.03.15, p678
[109] Ex 10, tab 2 – Fact Sheet 8 May 2013
[110] t 23.03.15, p677
[111] t 19.03.15, p640

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 available Australia wide, unless there is an 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[112]. 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 recently passed the legislation (*Medicines and Poisons Act 2014*) to achieve that outcome, the regulations have not yet been finalised as to how that outcome will occur.[113] 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 in the control of dispensing controlled medicines. Similarly, because it is based on pharmacy records, and the legislation requires a record be kept of prescribing and dispensing drugs of addiction it could be extended to benzodiazepines, not just Schedule 8 medicines, as drugs of addiction. The State legislation has also re-worded 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

[112] t 19.03.15, p638
[113] t 19.03.15, p641 & 648

on a register is entered. The intention would be to prevent the writing of a prohibited script at the source.[114] That 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. While the writing of prohibited Schedule 8 scripts was not an issue in this case the access to the real time dispensing data for benzodiazepines would have alerted both Dr Lacey and Dr Davies to the fact they were both prescribing benzodiazepines for the deceased. This would have put the deceased's credibility clearly in issue when relating to Dr Davies enormous amounts of prescription of benzodiazepine.

This clearly raises the issue for a decision to be made as to whether other drugs/medicines, such as benzodiazepines, are being used inappropriately and should be considered for stricter control. These could include medicines of concern, benzodiazepines and some anti-psychotics (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 for them at that moment.[115]

Should benzodiazepines be controlled like Schedule 8 medicines

This is a vexed issue. A surprising number of doctors heard at inquest believed benzodiazepines should be controlled in the same way as Schedule 8 medicines despite the additional paperwork this would involve.[116] Others were very concerned this would lead to a number of elderly patients being labelled as "drug addicts" and great

[114] t 19.03.15, p643
[115] t 19.03.15, p665
[116] t 12.03.15, p269 (Wilkinson)

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 that the term "drug addict" can be prejudicial.[117]

Labelling is not a 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 large practices of those needing benzodiazepines (nursing homes) but choose not to be an authorised for Schedule 8 pharmacotherapy programs (CPOP) and can refer those to suitably accredited clinicians.

Interestingly, the doctors who believe 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 of 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.[118]

Professor Schug was of the view long term prescribing of benzodiazepines was undesirable, even in the elderly.[119]

<u>Challenges for Prescribers</u>

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.

[117] t 18.03.15, p540-41 (Winston)
[118] t 19.03.15, p590
[119] t 23.03.15, p710-11

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 – as a GP in these 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 really want the drugs are clever, and unfortunately, sometimes can be quite aggressive and persuasive."*[120]

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 overprescribing to some extent. This can occur when 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 opioids 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.

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

[120] t 12.03.15, p267

> *"One of the oppressive parts of medical practice is dealing with patient's whose relationship with you is entirely based on deceit and manipulation and to have those better controlled in practice will improve the medical practitioners capacity to enjoy the quality of professional life."*[121]

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 when Dr Davies finally realised the deceased was continuing to abuse his benzodiazepine prescription concurrently with his methadone authorisation he refused to prescribe further benzodiazepines outside the agreed plan, or substitution for a daily dispensing regime. Unfortunately it was too late and the deceased had already stock piled quantities of the drugs he was requesting.

The deceased took his methadone, benzodiazepines from previous scripts or other sources, supplemented it with cough mixture and died.

Dr Davies did harm where he had only ever wanted to assist the deceased with his drug issues. 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 Davies been alerted to the deceased's prescriptions for benzodiazepines from Kinetic in late 2010 he would have had a much clearer understanding of the deceased's unreliability as an historian.

Every practitioner appearing in the course of the three inquests was strongly in favour of the implementation of an

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[121] t. 19.03.15, p.591

electronic information system which would provide them with real time dispensing information for Schedule 8 drugs.[122] 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 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 inquiries of the previously prescribing doctor. In his view dispensing information was predominately the useful information.

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

It is the dispensing information which is available from ERRCD.

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 numbers of doctors willing to expose themselves

[122] 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

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.

In this case I reject the family's submission the deceased was genuinely trying to address his drug issues due to his continued lack of honesty and manipulation of the one doctor still prepared to try and assist him. I accept Dr Davies was foolish to continue to try and assist the deceased when there was no ability to properly supervise his compliance with any plan. In both his interest and that of the deceased there should have been a refusal to prescribe benzodiazepines at the levels requested without daily dispensing at a much earlier time.

It would have been preferable Dr Davies refused to prescribe at all with the levels requested on the deceased's return to his practice in 2011. However, I accept Dr Davies' intention was to reduce the deceased's dependency on drugs by using known reduction methodologies for which he accepted the deceased's self-reporting of extreme levels.

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.[123]

[123] 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.[124]

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[125] 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

[124] 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.
[125] 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