STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the deaths of Christopher SALIB, Nathan ATTARD and Shamsad AKHTAR
Hearing dates:	14-18 October, 28 October-1 November, 25-29 November 2013, 6-7 March 2014.
Date of findings:	27 June 2014
Place of findings:	State Coroners Court, Glebe
Findings of:	Deputy State Coroner C. Forbes
Catchwords:	Coronial Law-Cause and manner of death-Drug toxicity-Prescription drugs-"Dr shopping"-Whether doctors appropriately prescribed-Recommendations for real time prescribing
File number:	2011/388711, 2012/949956, 2011/389656
Representation:	Dr K. Stern SC, Counsel Assisting with Ms K. Edwards instructed by Ms J Geddes, Crown Solicitors Office Mr M. Lynch and Ms R Mathur (representing Dr Chan, Dr Alexander, Dr Tan, Dr Ng, Dr.Nijhawan, Dr D'Silva, Dr Shields, Dr Wassif, Dr Brown) Mr M. Walsh (representing Dr Small, Dr Wan, Dr Saxena) Mr G. Gemmell (representing Dr Lee, Dr Li, Dr Oo) Mr G. Gregg (representing Dr Kolta) Mr G. Doherty (representing Dr Kiel, South East Sydney Local Health District) Mr Hewson (representing Dr Sim) Mr P. Rooney (representing Sterns Pharmacy, Gold Cross Pharmacy)

	Ms M. Moody (representing Terry White Pharmacy) Mr S. Thornton (representing the Salib family) Mr S. Woods (representing the NSW Ministry of Health)
Findings:	I find that Christopher Salib died on 6 February 2011 at 517/18 Maloney Street, Eastlakes, NSW. I am satisfied the cause of his death was ischaemic heart disease with multiple prescription drug toxicity as a condition contributing to the cause. The manner of his death was natural causes. I find that Nathan Attard died on or about 20 March 2012 at 4/32 Morehead Street, Redfern, NSW. I am satisfied the cause of his death was the unintentional consequences of ingesting a lethal combination of prescription drugs. The manner of his death was misadventure. I find that Shamsad Akhtar died on 6 June 2011 at 6 Alvis Place, Plumpton, NSW. I am satisfied the cause of her death was the unintentional consequence of ingesting a lethal combination of prescription drugs. The manner of her death was misadventure.
Recommendations:	**To the Secretary of the Australian Government Department of Health and Aging** 1. I recommend that all benzodiazepines should be moved to Schedule 8 of the Standards for the Uniform Scheduling of Medicines and Poisons. **To the NSW Minister for Health** 1. I recommend that the New South Wales Department of Health consider steps to be taken to implement a real-time web based prescription monitoring program available to, at least, pharmacists and general practitioners within 12 months, that: a. records the dispensing of all Schedule 8 poisons in New South Wales; b. provides real-time prescription information to all prescribers and dispensers throughout New South Wales; and c. facilitates the New South Wales Department of Health to monitor the dispensing of these medications and

identify behaviours of concern, with an expected completion date of 36 months.

2. I recommend that the New South Wales Department of Health consider including all benzodiazepines within the program set out above.

3. I recommend that the New South Wales Department of Health consider what if any additional steps can be taken to educate pharmacists and general practitioners on the ability to report inappropriate prescribing to the Pharmaceutical Services Unit, Ministry of Health (NSW), on means of identification of inappropriate prescribing, and on the authority requirements when prescribing schedule 8 drugs.

3A. I recommend that New South Wales Department of Health consider:

a. imposing a requirement that a doctor should not commence prescribing a schedule 8 drug or a benzodiazepine to a patient without making enquiries to verify the patient's prescribing history, or if not practicable, such supply should be limited to that which is necessary until the prescribing history can be obtained; and

b. expanding the restrictions on the prescribing of schedule 8 drugs in sections 27 to 29 of the *Poisons and Therapeutic Goods Act 1966* to also cover a list of restricted drugs of dependence.

To the CEO of the Pharmacy Guild of Australia

1. I recommend that the Pharmacy Guild of Australia consider preparing de-identified case studies involving misuse of prescription medications with a view to providing continuing education to pharmacists in identifying and responding to prescription shopping and/or drug dependency.

2. I recommend that the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Royal Australian College of General Practitioners liaise with a view to:

a. promoting the use of staged supply and other means to reduce the risk of the misuse of prescription medication;

b. promoting the use of supervised administration of medication in a pharmacy; and

c. developing education modules on lawful options available to respond to suspected misuse of prescription medications.

To the President of the Royal Australian College of General Practitioners

1. I recommend that the Royal Australian College of General Practitioners consider developing a short 1-2 page clinical guideline for use by general practitioners regarding:

   a. The management of chronic non-cancer pain;

   b. The prescription of benzodiazepines;

   c. The prescription of opioids;

   d. The circumstances in which the use of private and/or repeat prescriptions may be appropriate; and

   e. Available resources including the Drug and Alcohol Specialist Advisory Service and the form to authorise the release of personal Medicare and Pharmaceutical Benefits Scheme claims information to a third party.

2. I recommend that the Royal Australian College of General Practitioners consider developing a clinical governance framework for General Practices and General Practitioners to address the rising problem of prescription drug abuse in Australia.

3. I recommend that the Royal Australian College of General Practitioners and the National Coronial Information System (NCIS) liaise to consider how to facilitate sharing of information on the NCIS database in relation to deaths linked to the abuse of prescription medication.

4. I recommend that the Royal Australian College of General Practitioners consider including within its continuing professional development requirements for general practitioners:

   a. A requirement that all general practitioners who prescribe Schedule 8 poisons and/or benzodiazepines, be required to attend an unit of skills training within 3 years (or within 3 years of qualification) dealing with pain management, drug dependency and the proper prescribing of opioids and benzodiazepines, and including, once it is completed, the guideline referred to above; and

   b. An education module which addresses sharing of information about patients, including the legal constraints upon this; and

   c. Use of de-identified case studies in these education modules, and liaise with the Pharmacy Guild of Australia in relation to these.

5. I recommend that the Royal Australian College of General Practitioners and the Australian Medicare Local Alliance (with those entities seeking to involve such national bodies as they consider appropriate in the circumstances)consider establishing a program, available on a non-mandatory basis for members of the Royal Australian College of General Practitioners, for establishing local forums to be attended by general practitioners, and to invite also pharmacists and other specialists or hospital services, to identify problems of doctor shopping within that area and to establish channels of communication to deal with the problem.

To the Minister for the Australian Government Department of Health and Aging

1. I recommend that the Minister together with the Chief Executive Officer of Medicare:

   a. consider working with the Pharmaceutical Society of Australia, the Pharmacy Guild and other relevant peak bodies to facilitate access to the prescription hotline by pharmacists and to promote the use of the

	prescription hotline by pharmacists; b. consider adopting mechanisms to make it compulsory for all medical prescribers to be registered under the Prescription Shopping Program(administered by the Department of Human Services on behalf of the Department of Health (Cth)); c. consider the efficacy of the Prescription Shopping Program (administered by the Department of Human Services on behalf of the Department of Health (Cth)) and consider what, if any, means might be adopted to assist in ensuring that the system is used by practitioners and that it enables prompt identification of the abuse of prescription medications having regard to the issues arising in these matters. **To the Secretary Australian Government Department of Health and Aging and the Minister of the New South Wales Department of Health** 1. I recommend that the Commonwealth Department of Health and Aging and the New South Wales Department of Health (through the PBS) consider imposing a requirement that a general practitioner should not, other than in exceptional circumstances, prescribe long term anti-depressant and/or anti-psychotic medication to a patient without seeking advice and/or input from a psychiatrist, who should if relevant, be the patient's treating psychiatrist.

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IN THE STATE CORONER'S COURT
GLEBE
SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

The Hippocratic Oath
(Excerpt)

"…I will follow that system of conduct and treatment which according to my ability and judgement I consider for the benefit of my patients and will abstain from whatever is deleterious and mischievous

I will give no deadly drug…"

Introduction

1. This inquest concerns the deaths of three unrelated persons who at the time of their death were found to have dangerous quantities of addictive prescription medication in their system. Their treating doctors had prescribed the medication. There is no clear evidence that any of the deceased intended to take their own life.

2. The medications that had been prescribed ranged from analgesics to benzodiazepines and opioids. The Victorian Coroners Prevention Unit [1]have developed and maintained a Drug Overdose Deaths Register.[2] There is no similar Register in NSW. That data shows that deaths from drug overdoses are on the rise in Victoria. In 2010 there were 349 overdose deaths which rose to 374 in 2013. Prescription drugs caused or contributed to 83% of the overdose deaths last year.

3. This inquest heard evidence that a number of types of prescription drugs were of concern. Dr Wodak, an independent expert specialist in addiction medicine, gave

[1]The Victorian Coroners prevention Unit was established in 2008 to strengthen the prevention role of the Coroner. It researches matters related to public health and safety and in relation to formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations.
[2]Annexure 1.

evidence of statistics involving just opioid deaths. He stated that opioid prescription medication overdoses have been rising rapidly in Australia. In 2007 there were 360 deaths and that figure rose to 705 deaths in 2010. [3] He stated that the increase in Australia is following a similar trend in the United States. Dr Wodak gave evidence that there were about 17,000 prescription opioid deaths in the United Stated in 2012, and that every year since 2000 prescription opioid overdose deaths in the United States have outnumbered deaths from heroin and cocaine together. He also gave evidence that last year there were more deaths in the United States from prescription opioid overdose than there were from motorcar accidents.

4. The three deaths subject of this Inquest involved a spectrum of prescription drugs not only opioids. The Victorian Drug Overdose Register showed that Diazepam (which is a benzodiazepine and not an opioid) was the drug that caused or contributed to the highest number of overdose deaths last year.

5. There is little doubt that the misuse and abuse of addictive prescription medication is a serious public health issue. Community concern with drug overdose has been focussed on illicit drugs. This Inquest has illustrated that all manner of unfortunate people are getting caught up with addictive prescription medication.

6. The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:

   (a) the identity of the deceased;

   (b) the date and place of the person's death;

   (c) the physical or medical cause of death; and

   (d) the manner of death, in other words, the circumstances surrounding the death.

   Section 82 of the *Act* also permits a Coroner to make recommendations that are considered necessary or desirable in relation to any matter connected with a death that relates to issues of public health and safety. In this Inquest the focus has primarily been on Section 82 and whether there are changes that should be made in the prescribing of addictive medication that might prevent similar deaths.

[3] Ex 3 Tab 1 p 25

7. This Inquest has been assisted by the expert evidence of the following independent experts:

- Dr Alex Wodak AM is a specialist in addiction medicine. He is Emeritus Consultant for the Alcohol and Drug Service at St. Vincent's Hospital, Sydney. He gives medical care to inpatients and outpatients with complications of drug and alcohol dependence. He lectures medical students from the hospital and the University of NSW and Masters of Public Health students from the University of NSW and University of Sydney on alcohol, drugs and drug overdose. He attended a number of annual meetings of the Drug Policy Foundation in Washington DC and took part in the establishment of the Australian Parliamentary Group for Drug Law Reform and the subsequent formation of the Australian Drug Law Reform Foundation. In 1995, he co-authored a book for UNSV/ Press on drug policy reform. In 1996 he becamePresident of the Australian Drug Law Reform Foundation. He is a member of the Royal Australasian College of Physicians (RACP), The Australian Professional Society on Alcohol and Drugs (APSAD), The Public Health Association of Australia (PHA), The Australasian Society of HIV Medicine (ASHM), The International AIDS Society (IAS), The Alcohol and other Drugs Council of Australia (ADCA), The Australian Drug Law Reform Foundation. His report and complete curriculum vitae can be found at Ex 3 Tab 1.

- Dr Hester Wilson is a general practitioner and staff specialist in addiction. She is a clinician with over 20 years clinical experience in general practice. She currently works in a mixed billing general practice in the Inner West suburbs of Sydney and as a Staff Specialist in Addiction in Surry Hills. She has the following qualifications; Bachelor of Medicine with Honours, Diploma of Family Planning, Graduate Diploma of Mental Health, a Fellowship of the Royal Australian College of General Practitioners and a Fellowship of the Chapter of Addiction Medicine in the Royal Australian College of Physicians. She undertakes regular training to maintain current knowledge of general practice, mental health and addiction. Her reports appear at Ex 3 Tab 1 and 1A.

- Dr Ross MacPherson is a pain specialist. He is a senior staff specialist and Clinical Associate Professor at the Department of Anaesthesia and Pain Management at Royal North Shore Hospital, Sydney. He is also a Clinical Associate Professor in the Department of Anaesthesia at the University of Sydney. He is a Fellow of the Australian and New Zealand College of Anaesthetists, Fellow of the Society of Hospital Pharmacists of Australia, Fellow of the Royal Society of Medicine (London), Member of the Pharmaceutical Society of Australia, Memberof the Australian Medical Association Member of the European Society of Anaesthetists. His report and complete curriculum vitae can be found at Ex 5 tab 2.

- Dr Christopher Ryan is a Senior Staff Specialist Psychiatrist at Westmead Hospital and Senior Lecturer at the Westmead Clinical School and University of Sydney. As a Senior Staff Specialist he is daily involved in the clinical care of patients with acute mental illness including and especially the assessment and management of patients who abuse substances in the context of psychiatric illness. As a senior lecturer he teaches for the University and is the author or co-author of over 50 academic papers, including several on risk assessment. His reports and complete curriculum vita appear at Ex 3 Tab 3A and 3B.

- Mr. M. O'Donnell has worked as a pharmacist for 35 years. He has managed and owned pharmacies over that period and currently works as a locum pharmacist. His report and complete curriculum vitae can be found at Ex 3 Tab 2.

8. Each independent expert reviewed the voluminous medical, hospital and pharmaceutical records that were obtained in relation to each of the deceased. They wrote lengthy reports expressing their opinions upon the care and treatment of each deceased with a particular view as to the relevant prescribing and dispensing of medication and whether any lessons could be learned to improve the present system.

9. The present systems in NSW that attempt to deal with the regulations of prescription medication are;

a) The Prescription Shopping Program[4],

b) Restrictions on prescribing Schedule 4 and Schedule 8 drugs[5], and

c) The Pharmaceutical Benefits Scheme (PBS)[6],

10. Notwithstanding that these systems were in place, they had no real impact on the prescribing to any of the deceased. One of the striking features of this inquest is that friends and families of the deceased describe them as obviously misusing prescription medications, yet many of the prescribing doctors and dispensing pharmacists describe the deceased as not appearing to have any such problem.

11. The three deaths that are being examined in this Inquest are the deaths of Christopher Salib, Nathan Attard and ShamsadAkhtar.

CHRISTOPHER SALIB

Introduction

12. Mr Salib died on 6 February 2011 when he was just 24 years old. At the time of his death he was found with thirty packets of prescription medication amongst his belongings and toxic levels of Codeine, Oxycodone and Paroxetine in his blood.

13. He died at his home in Eastlakes, Sydney. He shared his unit with his girlfriend Sydney Burgess and his friend Peter Morris. His parents, brother and his grandmother survive him and miss him dearly.

14. In his youth Mr Salib was a talented school student, achieving places in selective primary and high schools.

15. When he left school he worked as an apprentice mechanic and was awarded the BMW apprentice of the year in both 2004 and 2005.

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[4] see Annexure 2 for details

[5] see Annexure 3 for details

[6] see Annexure 4 for details

Prescription drug use

16. Three weeks before he died, on 18 January 2011, Mr Salib returned home appearing extremely drug affected, slurring his words and dribbling. He had with him a box of 50 Xanax with 30 tablets missing, along with a prescription and a repeat prescription for Xanax. An ambulance was called and the ambulance records dated 19 January 2011 noted, Mr Salib "did not intend to kill himself [with] tablets, just bored."[7]He was taken to Prince of Wales Hospital and a note was made on the records that he was misusing prescribed medication.[8]

17. Mr Salib's mother gave moving evidence about her struggles to assist her son. After the overdose she rang the family doctor requesting that he stop prescribing further medication to Mr Salib. She also gave evidence that she contacted the local pharmacist requesting that her son be given no more prescription medication.

18. Mr Salib's flatmate, Mr Morris, was also concerned about the amount of prescription medication he was taking. Mr Morris says that there were "several" occasions when he would come home to find Mr Salib totally "out of it" because of an overdose of Xanax.[9] He says it was normal for Mr Salib to pass out when he was in the toilet or in the shower. He describes one occasion during the week prior to Mr Salib's death when he found him snoring and making a gargling sound and he was lying in bed on his back with greeny fluid around his mouth.

19. On 5 February 2011, the day before his death, Mr Salib went to the Prince of Wales Emergency Department complaining of back pain and he was prescribed Panadeine Forte and Oxycodone.

20. Later that night he attended the Kensington Pharmacy and filled both the Panadeine and Oxycodone prescriptions. He returned to his unit and watched movies before falling asleep on the sofa. He was noted to be snoring heavily and very loudly. At one point during the night he was observed to wake with froth coming from his mouth.

[7]Vol1 Tab 17
[8]Vol 2 page 12, 217
[9]Vol 1 Tab 11

21. During the morning of 6 February 2011 Mr Salib stopped snoring and appeared to be gulping for air. His lips began to turn blue. Mr Salib's flatmate Peter Morris commenced CPR whilst Ms Burgess called 000. The 000 transcript records that 000 was informed that he had taken medication. The ambulance arrived at 8.09 am but attempts at resuscitation were unsuccessful. Life was pronounced extinct at 8.39 am on 6 February 2011.

22. Police attended the premises at 8.56 am. All medications located were seized and entered into exhibits. All of the Oxycodone tablets he had been prescribed the night before were missing from the packet.

23. Large quantities of prescription medicine were found near his bed, including:

    a) 4 boxes of Paroxetine (a schedule 4 selective serotonin reuptake inhibitor, antidepressant) 20 mg, 30 tablets prescribed by Dr Liber, filled on 22 September 2009 by Eastlakes Pharmacy

    b) 3 boxes of Paroxetine 20 mg, 30 tablets prescribed by Dr Shields, filled on 31 January 2011 by Serafim Chemists

    c) 1 box of Paroxetine 20 mg, 30 tablets prescribed by Dr Kolta, filled on 8 January 2011 by Eastlakes Pharmacy with an instruction to take 2 ½ tablets daily, empty

    d) 1 box of Alprax 1 (Alprazolam, schedule 4 benzodiazepine, anti-anxiolitic), 1 mg 50 tablets, filled on 31 January 2011, with a recommendation of one tablet daily when required, empty

    e) 1 box of Zeldox (Ziprasidone) (a schedule 4 antipsychotic and Neuroleptic), 80 mg, 60 capsules, filled by Chemist by Mail, Maroubra – empty

    f) 1 box of Zydol (Tramadol – analgesic), 50 mg, 20 capsules, prescribed by Dr Freedman and filled on 1 February 2011 by Chemist by Mail, Maroubra with an instruction to take 2 capsules 3 times a day when required – empty

    g) 1 box of Panamax (Paracetamol) 500 mg, 100 tablets

h) 1 box of Maxamox (Amoxicillin Trihydrate) 1 g, prescribed by Dr Freedman, filled on 30 January 2011 by Chemist by Mail, Maroubra, with an instruction to take 1 tablet twice a day

i) 1 box of Paracetamol/Codeine 500/30, 20 tablets, prescribed by Dr Kiel and filled on 5 February 2011 by Kensington Pharmacy with an instruction to take 2 tablets 4 times a day when required - empty

j) 1 box of Endone (Oxycodone - a schedule 8 narcotic analgesic), 5 mg, 30 tablets (or possibly 20, although the blister pack in the photograph at tab 7 shows 30 empty blisters seemingly from two different sources, and Dr Kiel says she prescribed only 20), prescribed by Dr Kiel and filled on 5 February 2011 by Kensington Pharmacy, with an instruction to take one to two tablets 4 times a day when required – empty

k) 1 box of Cialis, Tadalafil (for the treatment of erectile dysfunction) 5 mg, 28 tablets, prescribed by Dr Lowy for oral once a day use and filled by Chemist by Mail, Maroubra, with some missing

l) 1 prescription for Aropax 20 mg, 90 tablets (a schedule 4 selective serotonin reuptake inhibitor, antidepressant) (possibly with 4 repeats, difficult to see from photograph at tab 7)

m) 1 prescription for Zyprasidone Hydrochloride 80 mg, 60 tablets, with 5 repeats dated 31 January 2011 from Dr Shields.

n) 1 empty box of Advil (Ibuprofin based pain relief)

Cause of death

24. The Post Mortem Report described Mr Salib's cause of death as ischaemic heart disease with obesity listed as a significant underlying condition. This was based upon the findings of 97% stenosis of the left circumflex coronary artery over a length of about 8 mm and 50% stenosis of the left anterior descending artery.

25. Toxicological testing also identified Alprazolam, Codeine, Oxycodone, Paracetamol, Paroxetine and Tramadol in Mr Salib's blood. Codeine, Oxycodone and Paroxetine were within the toxic range.

26. The forensic pathologist, Dr Szentmariay, who supervised the autopsy, gave evidence that while ischaemic heart disease was noted as the cause of death, people can survive with the level of heart damage found and that the cause of death may also have been the drug toxicity.

27. There was divergence amongst the independent expert witnesses as to the cause of death. In particular:

    a) Dr Wodak expressed the view that the death was "almost certainly" the result of the result of a drug overdose rather than ischaemic heart disease;

    b) Dr MacPherson stated that multiple drug toxicity was a possible cause of death - although it could not be stated definitively just on the toxicological results - and agreed that multiple drug toxicity could have been a contributory factor to a death caused by ischaemic heart disease; and

    c) Dr Wilson did not dispute the cause of death given in the post mortem report but noted the contributory role played by Mr Salib's excessive consumption of prescription drugs.

28. Having considered the weight of the expert evidence together with Mr Salib's history and the temporal nature of him having just taken medications prior to his death I am satisfied on balance that the drug consumption should be noted as a significant factor contributing to his death. Accordingly, I am of the view that the most appropriate finding as to cause of death is that Mr Salib died as a result of ischaemic heart disease with multiple drug toxicity as a condition contributing to the cause.

29. Most importantly, for the purpose of this inquest there is no doubt that prior to his death Mr Salib obtained dangerous quantities of prescription medication. The question for this Inquest is how that came about?

Medical attendances

30. Mr Salib attended a number of different medical professionals in the period leading up to his death. During the course of this inquest it has become clear that he was in genuine severe back pain. It has also become clear that he was addicted to and abusing prescription medication.

31. The history of medication prescriptions and supply in the period leading up to his death is telling. Of particular note are the following:

Alprazolam/Xanax

Date prescribed	Date dispensed	Prescription	Prescriber	Dispenser
22 June 2010	10 August 2010	50 x 1 mg x 2 repeats 150 tablets	Dr Kolta	Eastlakes Pharmacy (Ung statement at 42)
19 October 20u0	19 October 2010	50 x 1 mg x 1 repeat 100 tablets	Dr Kolta	Eastlakes Pharmacy (Ung statement at 42)
19 October 2010	14 November 2010	50 x 1 mg 50 tablets	Dr Kolta	Gardeners Road D&N Chemist (Wu statement at 38)
22 December 2010	22 December 2010	50 x 1mg x 1 repeat 100 tablets	Dr Kolta	Eastlakes Pharmacy (Ung statement at 42)
22 December 2010	18 January 2011	50 x 1 mg 50 tablets	Dr Kolta	Malabar Pharmacy (Abraham statement at 39)

31 January 2011	31 January 2011	50 x 1 mg 50 tablets	Dr Shields	Serafims Bourke Street Pharmacy (Serafim statement at 40)

Paroxetine – Schedule 4. Prescribed 2.5 tablets daily

28 August 2009	10 August 2010	20 mg x 90 x 5 repeats	Dr Liber	Eastlakes Pharmacy
22 September 2010	22 September 2010	20 mg x 90 x 4 repeats	Dr Kolta	Eastlakes Pharmacy (Ung statement at 42)
22 September 2010	25 October 2010	20 mg x 90	Dr Kolta	Eastlakes Pharmacy (Ung statement at 42)
22 September 2010	27 November 2010	20 mg x 90	Dr Kolta	Eastlakes Pharmacy (Ung statement at 42)
22 December 2010	22 December 2010	20 mg x 30 x 0 repeats	Dr Kolta	Eastlakes Pharmacy (Ung statement at 42)
22 September 2010	8 January 2011	20 mg x 90	Dr Kolta	Eastlakes Pharmacy (Ung statement at

				42)
Not known	31 January 2011	20mg x 90 x 4 repeats. Paid for by PBS.	Dr Shields	Serafims Bourke Street Pharmacy (Serafim statement at [40])

Ziprasidone Hydrochloride/Zeldox – antipsychotic and neuroleptic. Schedule 4, Appendix A.

Prescribed 1 in morning, 2 at night (Dr Liber)/1 twice daily (Dr Nijhawan)

20 November 2009	31 August 2010	80 mg x 120 x 4 repeats	Dr Liber	Eastlakes Pharmacy
20 November 2009	25 October 2010	80 mg x 120	Dr Liber	Eastlakes Pharmacy
16 January 2011	16 January 2011	80mg x 60 x 5 repeats	Dr Nijhawan	Chemist by mail Maroubra

Analgesia/anti-inflammatory

16 January 2011	16 January 2011	Meloxicam 15 mg x 30 x 0 repeats	Dr Nijhawan	Chemist by mail Maroubra (Youssef statement at 43)
30 January 2011	30 January 2011	Tramadol hydrochloride 50 mg x 20 x 2 repeats (2 capsules 3 x daily)	Dr Freedman	Chemist by mail Maroubra (Youssef statement at 43)

30 January 2011	1 February 2011	Tramadol hydrochloride 50 mg x 20	Dr Freedman	Chemist by mail Maroubra (Youssef statement at 43)
2 February 2011	2 February 2011	Diclofenac 50 mg	Prince of Wales Hospital	Prince of Wales Hospital
2 February 2011	2 February 2011	Oxycodone 5 mg	Prince of Wales Hospital	Prince of Wales Hospital
2 February 2011	2 February 2011	Paracetamol	Prince of Wales Hospital	Prince of Wales Hospital
3 February 2011	3 February 2011	Codeine phosphate with paracetamol x 20 x 0 repeats	Dr Shen - Prince of Wales Hospital	Rosebery Pharmacy (Morgan statement at 41)
3 February 2011	3 February 2011	Ibuprofen	Dr Shen - Prince of Wales Hospital	
3 February 2011	3 February 2011	Paracetamol	Dr Shen - Prince of Wales Hospital	
4 February 2011	4 February 2011	Codeine phosphate with paracetamol x 20	Dr Wassif	Chemist by mail, Maroubra (Youssef statement at 43)
30 January 2011	4 February 2011	Tramadol hydrochloride x 50 mg x 20	Dr Freedman	Chemist by mail, Maroubra (Youssef statement at 43)

	5 February 2011	Codeine phosphate with paracetamol x 20	Dr Kiel - Prince of Wales Hospital	Kensington Pharmacy
	5 February 2011	Oxycodone x 5 mg x 20	Dr Kiel - Prince of Wales Hospital	Kensington Pharmacy

32. Mr Salib had been supplied little by way of analgesia up until the end of January 2011. However in the period between 30 January 2011 and his death on 6 February 2011 (8 days) he was supplied:

    a) 60 capsules of Tramadol Hydrochloride, with the daily dose of 6 capsules;

    b) 60 tablets of Codeine phosphate with Paracetamol with a daily dose of a maximum of 8 tablets prescribed by three different doctors, Dr Shen, Dr Wassif and Dr Kiel (both Dr Shen and Dr Kiel were at the POWH); and

    c) 20 Oxycodone with a daily dose of 4-8 tablets a day.

33. Mr Salib'sattendances at doctors in the last 5 months of his life was as follows:

    a) Dr Kolta on 18 September 2010, 22 September 2010, 19 October 2010, 2 November 2010, 2 December 2010, 9 December 2010, 22 December 2010

    b) Dr Lowy on 20 September 2010

    c) Dr Wassif on 9 October 2010 & 4 February 2011

    d) Dr Abeywickrema for a long consultation on 21 December 2010

    e) Dr Nijhawan for an afterhours consultation on 16 January 2011

    f) Dr Freedman for a long consultation on 30 January 2011

    g) Dr Shields on 31 January 2011

    h) POWH on 19 January, 2-3 February and 5 February.

Expert opinions of Mr Salib's treatment and lessons that can be learned

34. The experts agree that Mr Salib was a difficult person for health care professionals to manage. Dr Wodak thought that Mr Salib was the most challenging of the deceased with which these inquests were concerned, and that he was the most at risk of a tragic outcome. A challenging feature of the Mr Salib's case was his frequent experiences of severe and apparently genuine pain.

35. Whilst the experts acknowledged difficulties associated with treating Mr Salib, criticisms were also made of some his care. I will now address those criticisms with a view to seeing if any lessons can be learnt for future patients.

Dr Kolta

36. Dr Kolta was the GP Mr Salib attended most frequently. (Vol 1 Tabs 22 & 23) His practice was at the Advance Eastlakes Medical Centre. He was the family doctor.

37. The criticisms of Dr Kolta relate to his long term prescribing of Xanax and the prescribing of psychiatric medication with no communication with Mr Salib's psychiatrist.

38. Dr Kolta first saw Mr Salib on 10 April 2007. He began prescribing psychiatric medication on that occasion as Mr Salib told him that he was taking Zeldox for schizophrenia and Paroxetine for depression. Dr Kolta made no record of any psychiatric symptons and did not communicate with Mr Salib's treating psychiatrist, Dr Liber. He continued prescribing psychiatric medication.

39. The first of Dr Kolta's records that relate specifically to psychiatric symptoms is three years later, on 10 March 2010 when Mr Salib complained of anxiety and recklessness and said that alcohol was the only thing that would calm him down.

40. Dr Kolta prescribed Xanax. Dr Kolta said that he checked with the PBS that a prescription for Xanax 1 mg with one tablet to be given twice daily as a trial, with two repeats was appropriate. Dr Kolta suggests that he took it from thePBS authorization that Mr Salib had not recently been prescribed Xanax by other doctors (Vol1 Tab

23[112]).

41. The PBS does not provide advice to doctors as to the appropriateness of prescribing medication. It authorizes prescribing at the PBS's concessional rate if certain known criteria are met. Those criteria are readily available to prescribing doctors and can be consulted prior to obtaining an authority.

42. Dr Kolta should have known that obtaining an authority from the PBS was not the same as a clinical endorsement. He should have known that the authority could not be used as a substitute for his own clinical judgment. Dr Kolta does not suggest he was asked any questions about Mr Salib's background, possible contra-indications or risk of drug abuse. He does not suggest he faxed Mr Salib's medical file. There was no basis upon which anyone at the end of a phone could have made a better clinical decision about the appropriateness of the prescription. Further, Dr Kolta does not state he was told anything about Mr Salib or his recent prescriptions – he simply made an assumption that Xanaxwas not being prescribed elsewhere. This misconception of Dr Kolta's is not shared by any of the other multitude of doctors in this inquest. It is not suggestive of a systematic problem or misunderstanding held by anyone other than Dr Kolta.

43. According to the expert evidence there are few justifications for prescribing Xanax. It is a dangerous and dangerously addictive drug contra-indicated for long term use and with limited short-term benefit.

44. Xanax was initially prescribed by Dr Kolta as "a trial". There is no evidence that the trial had any time parameters, any benchmarks for success or that it was ever reviewed (Dr Wilson p18 and Dr Ryan p23). Dr Kolta said he asked Mr Salib to return in two weeks time for a review however, Dr Kolta's consultation on 23 March 2010 makes no mention of Xanax or Mr Salib's mental state. Once commenced, Dr Kolta prescribed Xanax on a regular basis throughout 2010 without any analysis of whether or not he should continue to prescribe this particular medication. The long-term prescription of Xanax is not consistent with the PBS restrictions on use, nor is it consistent with the product information.

45. Dr Ryan, independent expert psychiatrist, expressed his concern about the prescription. His report states that Xanax is strongly contra-indicated in patients who might suffer from alcohol dependence. (p.7) The consultation where Dr Kolta first prescribed Xanax includes a note that "alcohol is the only thing calm him down". Dr Ryan states

> *"no case for panic disorder is made out in the notes and the symptoms described might also be consistent with another anxiety disorder, or depression, or anxiety related to alcohol dependence"* p29

If the prescription was for panic disorder Xanax is not recommended as first line therapy (Dr Ryan p29 and others). There is no evidence that any other therapy for the panic attacks was attempted or even considered by Dr Kolta. Dr Kolta did not consult with any psychiatrist about other, more effective ways, to treat panic disorder or panic attacks such as cognitive behavioural therapy. Dr Kolta would have been aware of the contra-indications for Xanax if he had consulted MIMs and he was well aware of Mr Salib's use of alcohol. If Dr Kolta had consulted MIMs he would have known that Xanax is not appropriate for long-term use. There has been no expert evidence presented to the inquest, which supported long-term use of Xanax.

46. The evidence suggests that Mr Salib was addicted to Xanax and that Mr Salib was abusing Xanax. In early December 2010, after he was admitted to hospital having overdosed on Xanax, his mother contacted Dr Kolta and asked him to stop giving Xanax to her son. Ms Salib said Dr Kolta assured her that he would include a file note to stop doctors prescribing Xanax to Mr Salib while he was on leave. Ms Salib also said Dr Kolta told her that he would ask the Maroubra Mental Health Crisis Team to follow up with her son. There is no evidence Dr Kolta complied with his offer and did anything to contact the Crisis Team.

47. Dr Kolta had a different version of the call. He stated that on 24 December 2010 Mr Salib's mother told him that Mr Salib had been agitated after he had taken his Xanax and the police had been involved. Dr Kolta said he "advised" Ms Salib that her son should stop taking Xanax. Dr Kolta does not suggest he did anything to ensure that

matter was followed up or made any specific arrangements about Mr Salib's care while he was overseas until February 2011.

48. Dr Kolta's note in Mr Salib's file that relates to this time is dated 24.12.2010 and reads "*agitated due to xanax. No more xanax until I come back*". Dr Ryan describes this note as "cryptic" (p23).

49. There was also a lack of some form of communication or advice from a psychiatrist. Dr Kolta was Mr Salib's primary prescriber of psychiatric medication.

50. Dr Ryan, independent expert psychiatrist, states that Dr Kolta was escalating the dose of Paroxetine to a dose at the upper end of the scale without any clear documentation.

51. Dr Wilson, independent expert GP, suggests that Mr Salib's instability and overdose in January 2011 may have been caused by the apparent cessation of Zeldox from 25 October 2010 (p14).

52. The notes of Mr Salib's admission to Prince of Wales Hospital on 18 January 2011 suggest Mr Salib may have had a number of unresolved mental health issues at that time. Those notes state that the day before presentation he had been wandering outside naked in an intoxicated and delirious state and that the previous week he had contact with an axe at his grandmother's house and that he had been in possession of a knife when the ambulance attended his house (Dr Ryan report at p12).

53. There is no evidence that suggests that Dr Kolta ever turned his mind to the possibility that Mr Salib's apparent mental health problems were connected to his abuse of prescription medication, or that the prescriptions he was giving may have been exacerbating Mr Salib's problems. This question may have been resolved if Dr Kolta had determined to undertake a proper review of Mr Salib's diagnoses, medication and treatment in consultation with a psychiatrist, or had communicated directly with Dr Liber, who had been Mr Salib's treating psychiatrist. The fact that Dr Kolta was not even aware that Mr Salib had been discharged from further care by Dr Liber was itself indicative of the dangers of the lack of communication in this case.

Dr Wassif

54. On 25 April 2010 Mr Salib saw Dr Wassif at the Maroubra Medical and Dental Centre. He had seen Dr Wassif previously on two occasions. He told Dr Wassif that another doctor had given him a prescription for Endone. Dr Wassif gave Mr Salib a repeat prescription for Endone (Oxycontin – 80 mg) for lower back pain. Dr Wassif decided that Mr Salib's pain was genuine and that less powerful drugs would not treat the pain.

55. On 25 June 2010 Dr Wassif saw Mr Salib again. Mr Salib requested a repeat script for Panadeine forte or Endone but Dr Wassif refused, informing Mr Salib that he would not provide another script for pain medication as he needed to see a specialist first (Vol 3 Tab 5 page 5).

56. Dr Wassif saw Mr Salib on a total of 9 occasions. In evidence during this inquest he accepted that in hindsight Mr Salib displayed some warning signs of drug seeking behaviour and that he should have contacted Mr Salib's regular GP to ensure he was not "doubling up" medication. Dr Wassif's evidence illustrates the challenges facing doctors when presented with dual signs of drug seeking behaviour and genuine pain and the benefits of conferring with a patient's regular doctor before prescribing addictive medication.

Dr Shields

57. After Dr Kolta's conversation with Mr Salib's mother at the end of December 2010, Mr Salib was able to continue to obtain Xanax elsewhere. On 31 January 2011 Mr Salib obtained a box of 50 tablets prescribed at a one-off consultation with Dr Shields at Taylor Square Clinic, after telling Dr Shields he was regularly prescribed Xanax.

58. Six days after this appointment, Mr Salib died. There were 50 Xanax tablets missing from the packet prescribed by Dr Shields and Xanax was present in Mr Salib's blood.

59. Dr Shields gave evidence that he did not choose to prescribe Xanax because it was clinically the most appropriate treatment for Mr Salib's condition. He agreed that Xanax was a dangerous drug because of the risk of addiction and said he personally did not

endorse its use for schizophrenia. Dr Shields said he prescribed it on the understanding that it was being prescribedby Mr Salib's regular GP and that Mr Salib had lost his prescriptions. Dr Shields vigorously defended his prescription as appropriate in the context in which Mr Salib presented namely:

- in apparent crisis, and possibly danger, after a fight with his brothers about his sexuality leading to being thrown out of home and the loss of his prescription medication;
- after 8:00pm when his regular doctor could not be contacted by phone;
- in company with a known patient of the Taylor Square clinic; and
- saying he had a formal diagnosis of schizophrenia and claiming that Xanax was being regularly prescribed to him by his psychiatrist with two psychotropic medications (Paroxetine and Ziprasidone) known to be used with Xanax to treat schizophrenia.

Dr Shields said he did not suspect doctor shopping, partly because he was convinced Mr Salib was in genuine crisis and partly because the request was in combination with other drugs used for schizophrenia and for a lower dosage than usually requested by doctor shoppers. Dr Shields agreed he did not contact the prescription hotline but felt he exercised caution by giving one script without a repeat. He also stated that he provided a private prescription because it was more expensive than a PBS script and would act as a deterrent to drug seeking.

60. Dr Wilson, independent expert GP described his decision to prescribe Xanax to this unknown patient as "unwise". It was striking how much the scenario facing Dr Shields matched Dr Wilson's description in her evidence of a classic suspicious case – namely patients attending very late out of hours, claiming to hold a regular prescription and asking for Xanax.

61. With the benefit of hindsight, Dr Shields, like a number of doctors in these inquests, relied too heavily on his clinical judgment and experience. He did so at the expense of more cautious prescribing practices. His decision to prescribe the volume of

medication to an unknown patient who was attending outside of normal surgery hours was unsupportable. There was no need to provide Mr Salib with 50 Xanax tablets. To quote Dr Wilson in evidence "nobody needs 50, if you don't know them".

62. If Mr Salib's regular doctor could not be contacted it would have been more prudent to provide a limited number of tablets. Dr Wilson in her evidence suggested 5 or 10 tablets would have been suitable until he returned to his normal GP or until he could obtain an appointment to commence treatment with a new GP (see also Dr Wilson at p18).

63. Dr Shields acknowledged in evidence that he could have provided 10 tablets – when asked why not he replied "that's a good question". Dr Shields did say that pharmacists disliked breaking packets but agreed this consideration was insignificant compared to patient safety issues. Dr Shields did not suggest he based his decision on pharmacy preferences. He said he believed Mr Salib was not at risk.

64. Dr Shields denied prescribing privately to avoid contacting the PBS for an authority to prescribe Xanax or because Mr Salib did not meet the PBS requirements for an authority (panic disorder when other treatments have failed or are inappropriate). His reason was that a patient paying the higher cost of a private prescription would be deterred from misusing it. This approach must be queried. According to Mr O'Donnell, independent expert pharmacist, if a generic brand is selected from a cheaper pharmacy a private prescription may even be cheaper than a PBS one.

65. Providing a limited number of drugs would have been a better deterrent and reduced the risk of overdose and the risk of sale on the black market.

66. Concern was also held towards Dr Shield's decision to provide five repeats of Paroxetine andZiprasidone. It is difficult to comprehend why Dr Shields thought it necessary or appropriate to supply 6 months of medication to a person he thought was a diagnosed schizophrenic. Dr Shields repeatedly stated it was common practice to provide 5 repeats "ask any GP".

67. It was not unreasonable to accept Mr Salib had lost his supply or ensure he had some supply until he could see his regular doctor. But a 6 month supply undermined the need for monitoring and review in circumstances where Mr Salib was expressing dissatisfaction with the care of his treating GP and in an apparent crisis. If Dr Shields could not contact Mr Salib's GP or psychiatrist it would have been appropriate to provide a limited dose until his long term mental health needs could be adequately assessed.

Prince of Wales Hospital

68. A discharge letter dated 2 February 2011 from Prince of Wales Hospital [10]notes that Mr Salib had a severe reaction to opioid analgesia, setting out that upon administration of opioid analgesia he became difficult to rouse and required Naloxone to reverse the opioid.

69. Three days later on 5 February, Dr Kiel at the Emergency Department of Prince of Wales hospital prescribed Mr Salib 20 Oxycodone and 20 Panadeine Forte tablets.

70. Mr Salib went away and filled and apparently consumed the Oxycodone hours before his death. As previously stated there was a toxic range of Oxycodone in his blood.

71. During her evidence Dr Kiel offered condolences to the Salib family. She was clearly deeply affected by the death of her patient.Dr Kiel gave evidence that she did not have access to all of Mr Salib's notes from the Hospital when she saw him in the Emergency Department. She said that as a consequence she did not know that Mr Salib was opiate naïve. Dr Kiel was not also aware of the notes from Mr Salib's 18-19 January 2011 visit to Prince of Wales Hospital that included a "consensus view" that Mr Salib was misusing prescription medication and that Mr Salib may have admitted involvement in the distribution of drugs.

[10]Vol 1 Tab 11,Dr Shen at Vol 3 Tab 3 page 49

72. Dr Kiel's stood by her prescribing on the 5 February in the circumstances of not having access to all of Mr Salib's notes. In her view, she was required to ensure that Mr Salib was not left without adequate pain relief upon his discharge until he could see his regular doctor. Her actions were consistent with the guidance from the Prince of Wales Hospital as to pain management. Erring on the side of treating pain even in cases of suspicion of drug seeking behaviour is supported by the evidence of Dr Wilson and an independent expert Emergency Specialist Dr Day, and by guidance for the profession.

73. I have been informed that the Prince of Wales Hospital has now made changes to facilitate Emergency Doctors having full access to patient's medical record and notes from across the hospital including any mental health admissions. This case highlighted the need for this more complete approach to patient care.

74. Following his attendance at the Emergency Department a Discharge Summary was prepared[11] but it does not appear that it was sent to Mr Salib's general practitioner. This may have been because Mr Salib died on the evening of discharge. It had been noted in the hospital records that MrSalib was specifically requesting Oxycodone at his attendance: *"pt requesting analgesia, re Oxycontin"*. There was nothing in the discharge summary/letter which indicated any suspicion of drug seeking behaviour. This is another example of the lack of communication between medical practitioners. Information of this nature is highly important and would assist a treating doctor in becoming aware that their patient may be addicted to the drugs they are prescribing.

Conclusion

75. Mr Salib attended numerous doctors and obtained many prescriptions. His case illustrates the fragmentation of care inherent in our medical system.It highlights the real and urgent need for a real-time prescribing system.

76. His case highlights the need for a GP seeing an unknown patient to communicate with a treating doctor before prescribing addictive medication.

[11] tab 31

77. His case highlights the need for a GP to obtain psychiatric input, (especially when there is a treating psychiatrist), for long term prescribing of psychiatric medication.

78. His case highlights the need for Emergency Departments to have access to a patients full history and upon discharge to communicate with the patient's treating practitioners.

79. His case highlights the dangers of long term prescribing of benzodiazepines and the importance of improving education in relation to prescribing potentially addictive prescription medication. Dr Wilson recommended that before starting a medication with the potential to lead to dependency there should be a time limited trial with clear goals to allow a change in therapy as appropriate

80. Dr Wodak identified that one measure which may have been of assistance in this case may have been the identification of a single clinician with overall responsibility for the case, with ready identification of other clinicians who also have a significant responsibility (Ex 5 Tab 1 p 11). That recommendation has particular resonance in this matter given the number of GPs, the psychiatrist, the Emergency Department and the lack of communication between them.

NATHAN ATTARD

Introduction

81. Mr Attard died some time shortly before 24 March 2012. On that date police found his body in his unit in Redfern. They were conducting a welfare check after neighbours had raised concerns. A neighbour had last seen him on 20 March 2012.

82. He was 34 years old at the time of his death. A large amount of medication was found in his unit including empty packets of Morphine, Diazepam and Mirtazapine and he had toxic levels of Mirtazapine and Codeine in samples taken from his liver.

83. His parents and a sister survive him. His mother says that he began partaking of cannabis and alcohol from about age 16. This activity increased over time. From around the age of 22 years his behaviour changed. He gave up work as a carpenter. His hygiene

levels dropped and he had developed paranoia. He had regular psychotic episodes. The family spoke with him about every two weeks and had a good relationship with him. Mrs Attard said he was regularly using alcohol, cannabis and prescription medications.

84. Mrs Attard spoke with him on 15 March 2012 and he told her that there were demons within the unit. This was the last time she spoke with him.

Prescription drug use

85. Since March 2011, approximately 12 months prior to his death, he was prescribed medication by the following GPs: Dr Brenner, Dr Alexander, Dr Kumar, Dr Ravi, Dr Salgo, Dr Liebhold, Dr Tan, Dr Rothonis, Dr Brown, Dr Senior, Dr Wang, Dr Chan, Dr O'Young, Dr Truong, Dr Ng, Dr Fuzes, Dr Kumardeva, Dr Small, Dr Su, Dr Alexandrou, Dr Banik and Dr Wan.

86. In these three inquests, Mr Attard was the person who most fit the description of "doctor shopper". Mr Attard sought out prescriptions from doctors with frequency and determination. His efforts were sustained and systematic. According to PBSrecords Mr Attard was treated by at least 44 medical practitioners in his lifetime and saw 22 different doctors in the 12 months before his death. Dr Wilson, independent expert GP, [12]said during her oral evidence:

> *"he had worked out a system that allowed him to obtain the medicines that he was looking for, without actually triggering alarm bells for anyone".*

Cause of death

87. The post mortem investigations were hampered by the decomposition of Mr Attard's body.

88. Written submissions have been made by Ms Mathur, representative for Dr Chan, Dr Alexander, Dr Tan, Dr Ng, Dr Brown, on this issue. I have read and considered all of those submissions. It is submitted that as a result of the state of decomposition it is simply not possible to make a finding as to cause of death. That it may have been by

[12] Ex 3 Tab 1

way of physical injury from a fall or an assault, resulting in, for example, a fatal cerebral haemorrhage, and that in those circumstances an open finding should be made.

89. It is not submitted that evidence of an assault on Mr Attard about a week prior to his death or evidence he had arguments with his neighbours were evidence that in some way was causal or contributed to his death. It is submitted that this history of assaults and arguments leads to a finding that one could not exclude the possibility that he may have been the victim of a violent assault on the day of his death. It is further submitted that despite Mr Attard being in possession of large quantities of prescription medication that there is the possibility, and some evidence, it may not have all been for his personal use.

90. While I take into account all of those matters I am not persuaded by the submission that an open finding should be made on the cause of death for the following reasons;

- Dr Schwartz conducted an autopsy on Mr Attard. She found no evidence of any injury or pathology that may explain the death. She found no broken bones, no injuries to the trunk of his body or arms and legs, no skull fracture or abnormality to his dura. She saw no subdural haematoma or any bleeding outside or underneath the dura. She reported that cardiac and respiratory causes were excluded.

- When the police attended Mr Attard's unit they formed the view there were no suspicious circumstances in the unit. They found no blood, no evidence of disturbance or intrusion, and his body was found on his bed.

- The police found two empty blister packs of Mirtazapine (Axit), two empty blister packs of Morphine Sulphate; and an empty packet of 50 Diazepam tablets in the unit.

- While decomposition meant the usual toxicological tests could not be conducted, toxic quantities of Mirtazapine and Codeine were found in samples taken from Mr Attard's liver along with unquantifiable levels of morphine. (Dr Wodak gave evidence that in the presence of multiple drugs that lower levels are required to have a fatal outcome.)

- Mr Attard was prescribed morphine for the first time just before his death and the prescribing of opioids escalated before his death.

- Dr MacPherson, independent expert pain specialist, noted that Mr Attard had been dispensed over 100 tablets of Morphine Sulphate, Mirtazapine and Benzodiazepine in the days leading up to his death and that he was " in possession of a lethal amount of those various drugs" (Ex 5 Tab 2)

- Mr Attard was known to use prescription medication excessively and was seen by neighbours clearly to be drug affected on many occasions.

- Mr Attard had at least one previous overdose on prescription drugs. On 19 April 2009 he was admitted to St Vincent's Hospital after consuming 20 Valium tablets, 6 Xanax tablets and an unknown amount of Endep.

91. Taking into account his history, all of the circumstances surrounding his death and the expert opinion and I am satisfied that there is evidence on the balance of probabilities to make a finding on the cause of Mr Attard's death. I find that on balance he died as a result of multi-drug toxicity.

Medical attendances

92. Over the twelve months before his death Mr Attard was prescribed vast amounts of medication by a range of different doctors. An excel spreadsheet of all medications supplied on the PBS or recorded in pharmacy records isat Vol 1A Tab 31.It is possible that further private prescriptions were also filled.

93. The Prescription Shopping Program, the Restrictions on prescribing Schedule 4 and Schedule 8 drugs and The Pharmaceutical Benefits Scheme had no significant impact on his ability to obtain large quantities of prescription medication.

94. Several of the treating doctors who gave evidence in the inquest were under the mistaken impression for several years that they were Mr Attard's main or sole GP.

95. Dr Wilson observed:

> *"In the last 6 months of his life, from l September 2011, he attended 59 consultations with 19 general practitioners, one medical specialist and a*

psychologist. He obtained 75 scripts, 38 of which were for various benzodiazepines while 46 were for opioid containing medicines. His use of opioids escalated in the final weeks of his life and he was prescribed morphine for the first time. His consultation pattern was such that it would have appeared to each prescriber that his use was under control (p28)."

96. The following table indicates the supply of diazepam to Mr Attard in the last year of his life.

Diazepam (Schedule 4)

2 March 2011	2 March 2011	50 x 5 mg x 0 repeats	Dr Brenner	Crown Street Pharmacy - PBS
3 March 2011	6 March 2011	25 x 5 mg x 0 repeats	Dr Alexander	Chemist Warehouse - PBS
	14 March 2011	50 x 5 mg x 0 repeats	Dr Liebhold	The Club Pharmacy – private
	16 March 2011	50 x 5 mg	Dr Tan	Sterns Pharmacy – private
31 March 2011	1 April 2011	25 x 5 mg x 0 repeats	Dr Alexander	Chemist Warehouse – PBS
	4 April 2011	50	Dr Tan	The Club Pharmacy – private
5 April 2011	5 April 2011	50 x 5 mg x 0 repeats	Dr Brenner	Eastpoint Pharmacy – PBS
5 April 2011	5 April 2011	50 x 5 mg x 0 repeats	Dr Senior	Sterns Pharmacy – PBS
26 April 2011	26 April 2011	25 x 5 mg x 0 repeats	Dr Alexander	The Club Pharmacy – PBS

	9 May 2011	50 x 5 mg x 0 repeats	Dr Chan	Blooms the Chemist Surry Hills – private
	10 May 2011	50 x 5 mg x 0 repeats	Dr Tan	The Club Pharmacy – Private
13 May 2011	13 May 2011	50 x 5 mg x 0 repeats	Dr Brenner	Edgecliff Medical Centre Pharmacy – PBS
16 May 2011	20 May 2011	50 x 5 mg x 0 repeats	Dr LIebhold	Blooms the Chemist Surry Hills - PBS
27 May 2011	27 May 2011	25 v 5 mg x 0 repeats	Dr Kumar	Sterns Pharmacy – PBS
	16 June 2011	50 x 5 mg x 0 repeats	Dr Tan	Sterns Pharmacy - private
17 June 2011	17 June 2011	50 x 5 mg x 0 repeats	Dr Chan	Blooms the Chemist Surry Hills – PBS
29 June 2011	29 June 2011	25 x 5 mg x 0 repeats	Dr Alexander	Poets Corner Pharmacy – PBS
21 July 2011	21 July 2011	50 x 5 mg x 0 repeats	Dr Chan	Chemist Warehouse Darlinghurst – PBS
12 July 2011	23 July 2011	50 x 5 mg x 0 repeats	Dr Senior	Redmond-Fuss Pharmacy – PBS
	26 July 2011	50 x 5 mg x 0 repeats	Dr Tan	Sterns Pharmacy – private
21 July 2011	27 July 2011	50 x 5 mg x 0 repeats	Dr Fuzes	Edgecliff Medical Centre Pharmacy - PBS

3 August 2011	3 August 2011	25 x 5 mg x 0 repeats	Dr Alexander	Poets Corner Pharmacy – PBS
	23 August 2011	20 x 5 mg x 0 repeats	Dr Tan	Gold Cross Pharmacy – private
29 August 2011	29 August 2011	50 x 5 mg x 0 repeats	Dr Brenner	Sterns Pharmacy – PBS
	30 August 2011	45 x 5 mg x 0 repeats	Dr Chan	The Club Pharmacy – private
1 September 2011	1 September 2011	25 x 5 mg x 0 repeats	Dr Alexander	Stevens Pharmacy – PBS
14 September 2011	14 September 2011	25 x 5 mg x 0 repeats	Dr Alexandrou	SerafimsBourke Street Pharamcy – PBS
	17 September 2011	45 x 5 mg x 0 repeats	Dr Chan	Blooms the Chemist Surry Hills – private
	29 September 2011	50 x 5 mg x 0 repeats	Dr Tan	Florence Pharmacy – private
6 October 2011	6 October 2011	50 x 5 mg x 0 repeats	Dr Brenner	Sterns Pharmacy - PBS
14 October 2011	14 October 2011	25 x 5 mg x 0 repeats	Dr Kumar	Poets Corner Pharmacy – PBS
25 October 2011	25 October 2011	50 x 5 mg x 0 repeats	Dr Tan	Chemist Warehouse – PBS
	31 October 2011	45 x 5 mg x 0 repeats	Dr Chan	Poets Corner Pharmacy – private
7 November 2011	7 November 2011	50 x 5 mg x 0 repeats	Dr Brenner	Edgecliff Medical Centre

				Pharmacy - PBS
	21 November 2011	50 x 5 mg x 0 repeats	Dr Tan	Sterns Pharmacy – private
5 December 2011	5 December 2011	45 x 5 mg x 0 repeats	Dr Chan	Florence Pharmacy – PBS
8 December 2011	8 December 2011	25 x 5 mg x 0 repeats	Dr Alexander	Poets Corner Pharmacy – PBS
	20 December 2011	50 x 5 mg x 0 repeats	Dr Tan	Florence Pharmacy – private
6 January 2012	6 January 2012	50 x 5 mg x 0 repeats	Dr Brenner	Poets Corner Pharmacy - PBS
	20 January 2012	50 x 5 mg x 0 repeats	Dr Tan	Poets Corner Pharmacy – private
	7 February 2012	45 x 5 mg x 0 repeats	Dr Small[13]	Poets Corner Pharmacy – private
9 February 2012	9 February 2012	50 x 5 mg x 0 repeats	Dr Brenner	Crown Street Pharmacy – PBS
	21 February 2012	50 x 5 mg x 0 repeats	Dr Tan	Florence Pharmacy – private
22 February 2012	23 February 2012	25 x 5 mg x 0 repeats	Dr Alexander	Crown Street Pharmacy – PBS
12 March 2012	12 March 2012	50 x 5 mg x 0 repeats	Dr Liebhold	Chemist Warehouse Darlinghurst – PBS

[13] The entry in the table comes from the pharmacy records. Dr Small gave unchallenged evidence that he did not prescribe benzodiazepines to Mr Attard or see this patient in 2012. The 2012 record is a dispensing and not a prescribing date. In the circumstances, the provenance of the prescription remains uncertain.

	13 March 2012	45 x 5 mg x 0 repeats	Dr Chan	Blooms the Chemist Surry Hills - private

97. In addition, throughout this period, Dr Tan was injecting Mr Attard with Diazepam on regular occasions.

98. In the period from August 2011 until his death, Mr Attard was also being prescribed and supplied Oxazepam, Morphine sulphate (Schedule 8 – Appendix A), Mirtrazapine,Codeine Phosphate with Paracetamol, Tramadol, Quetiapine, Temazepam, Alprazolam, and Buprenorphine in a Transdermal patch.

99. As Morphine sulphate is a type C drug of addiction (as defined in the Poisons and Therapeutic Goods Act 1966 (NSW)), its supply is prohibited if the prescriber is of the opinion that the patient is a drug dependent person.

100. Morphine sulphate was prescribed as follows:

Morphine sulphate

23 February 2012	23 February 2012	20 x 10 mg x 0 repeats	Dr Chan	Poets Corner Pharmacy – PBS
	13 March 2012	20 x 15 mg x 0 repeats	Dr Chan	Blooms the Chemist Surry Hills – private
16 March 2012	16 March 2012	20 x 15 mg x 0 repeats	Dr Chan	Poets Corner Pharmacy – PBS

Expert opinions of Mr Attard's treatment and lessons that can be learned

101. Dr Wodak, independent expert addiction specialist, [14]said in his report that the individual GPs could not be faulted. He observed that Mr Attard received too many prescriptions for opioids and benzodiazepines in the last weeks of his life, and that

[14]Ex 5 Tab 1

some of the doses were too high. But Dr Wodak stated in his report and evidence that the GPs were doing their best without knowing the full clinical picture.

102. Dr Wilson by and large agreed and said Mr Attard "slipped under the radar" because he spread his attendances evenly amongst medical services, in other words by a system of doctor shopping.

103. Mr Attard's story highlights the need for a real time prescribing system that would enable a doctor to determine whether a patient had recently been prescribed an addictive drug. Access to this information would mean health professionals could make informed and better decisions. None of the doctors who gave evidence said they would have prescribed in the same way if they were aware of the true clinical picture. Mr Attard's prescribing history highlights the need for the real time prescribing system to include all benzodiazepines .

Diazepam

104. A number of treating doctors were prescribing monthly doses of daily diazepam. Some of the treatment lasted for years. The doctors thought the long-term prescription was keeping Mr Attard's symptoms under control.

105. It is apparent from the expert evidence that there is no safe level of long term prescribing of diazepam. The efficacy declines to the extent that the prescribing is no more than feeding dependence. Long-term use risks the patient developing insomnia and anxiety, two of the symptoms doctors were treating in Mr Attard. He had been prescribed diazepam for ten years and there was no attempt to implement a long-term plan to reduce his intake and deal with his addiction.

106. Dr Tan also periodically injected Mr Attard with Valium. Dr Wilson stated clearly in her evidence that there is no proper clinical justification for injecting benzodiazepines for chronic pain. Dr Wilson could not conceive of any good reason for the injections administered by Dr Tan. Dr Tan's notes were not of assistance. They either included no clinical reason for the injection or curious notes such as "*with a walking stick*",

"*grandmother passed away two weeks ago, the patient depressed for two weeks now better*" and "*almost bitten by dog*".

107. Dr Tan also continually prescribed or injected Diazepam despite an awareness of Mr Attard's problems with alcohol and a diagnosis of alcohol abuse. On 24 October 2011 she injected Valium despite noting he had been drinking excessively. On 21 November 2011 she prescribed Valium despite being aware Mr Attard was drinking again and had been taking twice the recommended dose of Diazepam.

108. Dr Tan was aware of Mr Attard's Diazepam use when he first attended her on 8 May 2007 and commenced a monthly dose for years from 6 February 2008 without documenting a clinical reason beyond the death of Mr Attard's grandmother and his dissatisfaction with Endep. It does not appear Dr Tan obtained any medical history from Mr Attard (beyond his claim he had already been prescribed Valium). She did not consult his previous GP, or contact the hotline and there is no evidence she considered other treatments.

Psychiatric Medication

109. Dr Ryan, independent expert psychiatrist, [15]speculates that Mr Attard's primary, perhaps only, problem may have been substance dependence. He states that many of the consultations resulted in prescriptions of benzodiazepines or Zolpidem or Quetiapine or sedating antidepressants for the treatment of anxiety, insomnia, bipolar disorder or depression and these medications may have done nothing but feed his addiction.

110. Dr Ryan noted that Mr Attard was never seen by a psychiatrist and was diagnosed by various general practitioners for a range of conditions including depression, anxiety, insomnia, schizophrenia and bipolar disorder. Dr Ryan says that he is unable to be confident that any of these diagnoses were accurate.

[15] Ex 3 Tab 3

111. He is particularly concerned as many of those diagnoses resulted in long term prescriptions for psychiatric medication.

112. He was concerned that on a number of occasions GPs simultaneously prescribed both Tramadol and a serotonergic antidepressant without any reference to the potential of the combination causing serotonin syndrome.

113. Dr Ryan says that Dr Senior's notes are so poor it was difficult to determine what treatment he prescribed and he was concerned that it appeared that on a number of occasions he prescribed Diazepam and possibly chlorpromazine intramuscularly. He said that if that is true that it would represent "bizarre practice". The administration of these medications intramuscularly would be associated with a range of potentially serious side effects, such as severe drops in blood pressure and abscess formation. Dr Ryan says that these prescribing choices together with his abysmal documentation raise serious concerns about Dr Senior's competency in the practice of medicine.

114. Dr Ryan states that Dr Brown repeatedly prescribed 30mg tablets of Serapax to be dispensed as 50 tablets. He says that this prescription can only be made with PBS authority and only for a number of approved indications, which Mr Attard failed to meet.

115. Dr Ryan's concerns confirm that there is a real need for GPs to communicate with and receive input from psychiatrists when diagnosing and treating patients with long-term psychiatric medication.

Opioids

116. It is possible that opioids played a contributory role in Mr Attard's death.

117. Dr Senior prescribed Norspan patches and Mirtazapine (Axit) with 5 repeats to Mr Attard on 21 February 2012 about one month before he died.

118. Norspan is used to treat opioid addiction and to treat chronic pain. There is no evidence to suggest that Mr Attard was addicted to opioids or genuinely suffering from chronic pain in early 2012. It does not appear that Dr Senior recorded any reason for the prescription. Dr Senior could not provide any notes of the consultation to the inquest. In his third statement of 26 July 2013 Dr Senior stated he had a "vague memory" of prescribing it but did not say why he did prescribe it.

119. The Norspan patches are significant because Dr MacPherson gave evidence to the effect that the patches can diminish the effects of other opioids. As outlined below Mr Attard was prescribed Morphine Sulphate, apparently, for ankle pain, two days after the patches were prescribed on 23 February 2012. Dr MacPherson agreed that there is a risk that a patient taking opioids and wearing a patch could overdose on medication. This could occur if the opioids did not have the expected effect because of the antagonistic (blocking) reaction with the patch. The patient might take an increased dose to obtain the desired effect and then overdose when the effect of the patch declined.

120. The statements of Dr Senior show that by 2012 he believed Mr Attard to be drug dependent, a doctor shopper, and an abuser of drugs. On 24 January 2012 Dr Senior had been alerted to the possibility that Mr Attard had tried to forge a prescription by Blooms Chemist. In light of the risk noted by Dr MacPherson it would have been important for Dr Senior to check what medications Mr Attard was being prescribed and to warn Mr Attard of the risk if he were to consume opioids.

121. Dr Chan added morphine sulphate (Schedule 8 drug of addiction) – to Mr Attard's medication in February and March 2012. Dr Chan prescribed morphine sulphate three times in the course of the month.

122. Dr Chan said he prescribed the morphine to treat Mr Attard's pain from an ankle fracture, which Dr Chan believed had occurred in April 2011 (ie 10 months earlier). While Dr Wodak said this was not an egregious error he said that he did not support the use of morphine for old fracture pain. Dr Chan was aware that Mr Attard was a regular user of valium. He prescribed valium to Mr Attard on nine occasions including

monthly from 9/5/2011-5/12/2011. Dr Chan denied that he considered Mr Attard drug dependent when he prescribed morphine sulphate. Dr Chan did not contact the hotline or make any other checks about Mr Attard's current medication before prescribing a Schedule 8 opioid of addiction. Dr Chan made no notes of any clinical assessment for the two consultations. It is hard to see the basis for his confidence. According to Dr Chan's statement, he had already prescribed Panadeine Forte from September 2011 to February 2011 to Mr Attard for his apparent ankle pain and said he stopped because it had not worked. This is not recorded in his notes or reflected in the PBS summary.

123. Dr Chan also prescribed morphine sulphate to Mr Attard on 23 February 2012. If it worked on that occasion he did not record it. Dr Chan agreed in his evidence that, if Mr Attard had a substance abuse problem, the introduction of an opioid to his medication regime was more likely to hurt Mr Attard than help him. He accepted that, in retrospect, this may have been the case.

124. It is particularly hard, to appreciate the rationale for the 16 March 2012 morphine sulphate prescription. This prescription was given just 3 days after the first prescription on 13 March. Both prescriptions were for 20 tablets to be taken daily. Both were for 15mg of morphine. According to Dr Chan, on 16 March 2012 Mr Attard was still in pain.

125. Dr Chan seemed unable to answer how the identical 16 March prescription could possibly have assisted Mr Attard if the first prescription had failed to address his pain. The prescription placed a dangerous quantity of morphine in the hands of a patient with substance abuse problems without any apparent rationale and without any checks having taken place to ensure that Mr Attard was not being prescribed medication elsewhere. The sudden escalation in prescribing, for which Dr Chan was responsible, must also be seen against the backdrop that Mr Attard was largely opioid naïve.

Medical Records

126. A number of the GPs involved in the care of Mr Attard wrote notes that were inadequate. A number of the doctors failed to meet what the experts considered were minimum professional standards.

127. Dr Ryan singled out Dr Senior and Dr Brown for severe criticism for their extremely scant and barely legible notes. The notes failed to document assessment, diagnosis, rationales for prescribing or management plans. He said their notes failed to meet "what I would regard as basic levels of competence for a general practitioner practicing in Australia" (pp78-79). Dr Wilson was also critical of the doctors' record keeping and failure to document (see p27). There is no evidence from either doctor that they have changed their practice or have any insight into the deficiency. Dr Brown states Mr Attard's death has not changed the way in which he provides medical services [16]Dr Ryan suggests that Dr Brown and Dr Senior's combined failures in management were so serious that the public may be in ongoing danger.

Conclusion

128. Mr Attard's case demonstrates the vital contribution that real time prescribing would make to the protection of individuals and society against the harms and costs of the abuse of prescription medication. None of the doctors who gave evidence said they would have prescribed in the same way if they were aware of the true clinical picture.

129. Mr Attard's case illustrates the importance of improving education and standards of care in relation to the prescribing of potentially addictive prescription medication. In particular the prescribing of all benzodiazepines.

130. It highlights the need for greater communication and coordination of care between GPs especially those within the one practice. Had there been greater communication about Mr Attard, or a higher index of suspicion from his treating doctors, it is certainly possible that his pattern of drug seeking would have been identified

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131. It highlights the need for GPs to obtain specialist Psychiatric input when diagnosing and/or long term prescribing psychiatric medication long term.

132. It demonstrated that the existing regime of the Prescription Shopping Program, Restrictions on prescribing Schedule 4 and Schedule 8 drugs and the PBS scheme had no real impact on Mr Attard's ability to obtain prescription medication despite the fact that nine different doctors prescribed him medication on the PBS within a three month period.

Positive Change

133. This Inquest has been informed of the following positive changes that have emerged as a direct result of Mr Attard's death.

- Dr Small gave evidence to the effect that he and his colleagues now regularly meet to discuss issues arising from patient management. Dr Small has also undertaken a typing course to improve his notes and has worked on his computer skills.

- Dr Alexander had never had a team meeting with her colleagues when she was caring for Mr Attard but states that her practice has now introduced them every 2-3 weeks. She said in her evidence that she finds them very helpful towards having a complete picture of a patient..

- Dr Kumaradeva has committed to improved note taking, a higher index of suspicion towards patients who request drugs of dependence and has even devised a questionnaire for every patient suspected of drug dependence.

- Dr Brenner, Dr Chan and Dr Ng all gave evidence to the effect that Mr Attard's death had caused them to reflect on their prescribing practices.

SHAMSAD AKHTAR

Introduction

134. Ms Shamsad Akhtar died on 6 June 2011 in her home in Plumpton. She was 35 years old. She was married and a devoted mother to three young children aged 11, 10 and 7, who tragically were present at home when she died.

135. On 6 June the children had become concerned about their mother and called her good friend Ms Shazia Hussain. Ms Hussain was one of a group of close knit and supportive friends from Pakistan.

136. Ms Hussain came to the house and found Ms Akhtar on the couch, she was making an unusual snoring sound and her lips were blue and swollen. Ms Hussain had previously found Ms Akhtar in a similar state from taking excessive amounts of medication. She made sure Ms Akhtar was breathing and returned home.

137. A short time later, Ms Hussain received another call from one of the children who said they were unable to rouse their mother even after throwing water on her. Ms Hussain returned to the house with another friend of Ms Akhtar. They called 000 and commenced resuscitation. The ambulance attended however Ms Akhtar could not be revived.

138. The following medication, which had been prescribed in the last 11 days of Ms Akhtar's life, was found on top of the microwave;

- Amitriptyline (an anti-depressant also known as Endep, 26 May 2011, Dr Lee, pack of 50 to be taken one daily, 31 remaining),
- Metoclopramide (an anti-nausea medication 26 May 2011, pack of 25 to be taken three times daily, empty),
- Amitriptyline (31 May 2011, Dr Lee, pack of 50 to be taken one daily, full),
- Zolpidem (a medication for insomnia also known as Ambien, 2 June 2011, Dr Lee, pack of 14 to be taken ½ to 1 at night, 7 remaining),
- Temazepam (another medication to treat insomnia 5 June 2011, Dr Li, pack of 25 to be taken as directed, 16 remaining),

- Antenex (Valium 5 June 2011, Dr Li, pack of 50 to be taken as directed, 40 left), an unopened pack of
- Alodorm (nitrazepam a benzodiazepine used to treat insomnia) unopened,
- Erythromycin Ethyl Succinate (a bacterial treatment, 5 June 2011, Dr Saxena, pack of 25 to be taken 3 times a day, 16 remaining),
- Mersyndol Forte (a pain killer containing Paracetamol, Codeine phosphate with Doxylamine succinate, full pack).

Prescription drug use

139. Ms Akhtar's husband said that she suffered from migraines and depression since about 2008.

140. In March 2009 Ms Akhtar was admitted to Bungarribee House, a psychiatric facility. She had taken an overdose and was noted to have a mood disorder-depression. She was discharged into the care of the Blacktown Community Mental Health Team.

141. Ms Akhtar's friend, Ms Hussain, described her as having a "big history" of taking lots of medicine. She gave evidence of Ms Akhtar suffering blackouts and episodes of reduced consciousness after overdosing on her medication.

142. Ms Hussain gave very moving evidence describing Ms Akhtar's life becoming increasingly dominated by her pursuit and consumption of medication. She also described attempts made by the family and friends to prevent her obtaining the medications.

143. Medical and pharmacy records reveal that Ms Akhtar had large quantities of drugs prescribed to her in the last year of her life, which escalated in the month before her death.

144. In the year before her death Ms Akhtar attended just one medical centre, the Plumpton Market Medical Centre ("PMC"), and one pharmacy, the Plumpton Terry White

Pharmacy ("TWP"). Her attendances were extremely frequent. She visited both the PMC and TWP at least once a week in 2011.

145. Records show that the prescription medications dispensed to Ms Ahktar from January to June 2011- include the following:

Amitriptyline – schedule 4 All from the PMC and all supplied by Terry White Chemists Plumpton. Found in lethal levels at post-mortem.

30/12/10	3/01/11	2429W	50	50mg	2	1 tablet at night	John K Lee	
14/01/11	16/01/11	2429W	50	50mg	2	as directed by doctor	John K Lee	
14/01/11	23/01/11	2429W	50	50mg	2	as directed by doctor	John K Lee	
14/01/11	31/01/11	2429W	50	50mg	2	Use as directed by doctor	John K Lee	
23/01/11	12/02/11	2429W	50	50mg	2	2 tablets twice daily as directed	Alan Sim	PBS;
18/02/11	20/02/11	2429W	50	50mg	2	2 tablets at night as directed	John K Lee	PBS;
23/01/11	8/03/11	2429W	50	50mg	2	2 tablets twice daily as directed	Alan Sim	PBS;
18/02/11	22/03/11	2429W	50	50mg	2	2 tablets at night as directed	John K Lee	PBS;
28/03/11	30/03/11	2429W	50	50mg	2	1 tablet at night	John K Lee	PBS;
18/02/11	12/04/11	2429W	50	50mg	2	2 tablets at night as directed	John K Lee	PBS;
28/03/11	23/04/11	2429W	50	50mg	2	1 tablet at night	John K Lee	PBS;
28/04/11	30/04/11	2429W	50	50mg	2	1 tablet at night	John K Lee	PBS;
28/03/11	6/05/11	2429W	50	50mg	2	1 tablet at night	John K Lee	PBS;
28/04/11	13/05/11	2429W	50	50mg	2	1 tablet at night	John K Lee	PBS;
28/04/11	21/05/11	2429W	50	50mg	2	1 tablet at night	John K Lee	PBS;
12/05/11	26/05/11	2429W	50	50mg	0	1 tablet daily	John K Lee	PBS;
31/05/11	31/05/11	2417F	50	10mg	2	1 tablet at night	John K Lee	PBS;
Total			850					

Amitriptyline was prescribed and supplied when the records should readily have indicated that the supply would not have run out. In total, in that period of 156 days, 850 Amitriptyline tablets were supplied to Ms Akhtar.

Tramadol – Schedule 4 – appendix A. All from the Plumpton Marketplace Medical Centre. All supplied by Terry White Chemists Plumpton. Found in lethal levels at post-mortem. Available on PBS as restricted benefit up to 20 per script – "for dosage titration in chronic pain where aspirin and/or paracetamol alone are inappropriate or have failed."

3/01/11	5/01/11	10	200mg	1 tablet when required	John K Lee	
14/01/11	16/01/11	10	200mg	1 tablet twice daily when required	John K Lee	
20/11/10	23/01/11	10	200mg	1 tablet daily when required	John K Lee	
2/02/11	6/02/11	10	200mg	1 tablet daily as directed	John K Lee	PBS
9/02/11	15/02/11	10	200mg	1 tablet when required	John K Lee	
16/02/11	20/02/11	10	200mg	1 tablet daily as directed	John K Lee	
23/02/11	27/02/11	10	200mg	1 tablet daily as directed	John K Lee	PBS
4/03/11	8/03/11	10	200mg	1 tablet daily as directed	John K Lee	PBS
16/03/11	18/03/11	10	200mg	1 tablet daily when required	John K Lee	
22/03/11	22/03/11	10	200mg	1 tablet daily when required	John K Lee	PBS
1/04/11	4/04/11	10	200mg	1 tablet daily when required	John K Lee	PBS
12/04/11	12/04/11	10	200mg	1 tablet when required as directed	John K Lee	PBS
18/04/11	18/04/11	10	200mg	1 tablet daily when required	John K Lee	PBS

28/04/11	30/04/11	10	200mg	1 tablet daily when required	John K Lee	PBS
4/05/11	6/05/11	10	200mg	1 tablet daily when required	John K Lee	PBS
9/05/11	13/05/11	10	200mg	as directed by doctor	**Daryl Li**	PBS
17/05/11	21/05/11	10	200mg	1 tablet daily when required	Daryl Li	PBS
23/05/11	2/06/11	10	200mg	1 tablet daily	John K Lee	PBS
Total		180				

Paracetamol and Codeine and Doxylamine (or other combinations of these medications) Schedule 4 – Codeine found in a lethal level and Doxylamine found in a toxic level at post-mortem. Doxylamine not available on PBS.

2/01/11	2/01/11	Paracetamol + codeine phosphate + doxylamine succinate	20	450mg-30mg-5mg	1-2 tablets four times daily	ThandaTun	
3/01/10	3/01/11	dextropropoxyphene hydrochloride with paracetamol	20	32.5mg/325mg	1-2 tablets three times daily PRN	John K Lee	
6/01/11	6/01/11	Paracetamol + codeine phosphate + doxylamine succinate	40	450mg-30mg-5mg	1 tablet twice daily	John K Lee	
3/01/11	13/01/11	dextropropoxyphene hydrochloride with paracetamol	20	32.5mg/325mg	1-2 tablets three times daily PRN	John K Lee	
14/01/11	16/01/11	Paracetamol + codeine phosphate + doxylamine succinate	20	450mg-30mg-5mg	1 tablet three times daily	John K Lee	
19/01/11	19/01/11	Paracetamol + codeine phosphate + doxylamine succinate	40	450mg-30mg-5mg	1-2 tablets three times daily PRN	John K Lee	
25/01/11	27/01/11	Paracetamol + codeine phosphate + doxylamine succinate	40	450mg-30mg-5mg	2 tablets when required as directed	Zaw Win Oo	
3/02/11	3/02/11	Codeine phosphate with paracetamol	20	30mg-500mg	1-2 tablets three times daily PRN	John K Lee	PBS
~~2/02/11~~	~~6/02/11~~	~~Paracetamol + codeine phosphate + doxylamine succinate~~	~~20~~	~~450mg-30mg-5mg~~	~~1 tablet PRN~~	~~John K Lee~~	
2/02/11	7/02/11	Paracetamol + codeine phosphate + doxylamine succinate	40	450mg-30mg-5mg	1 tablet PRN	John K Lee	

9/02/11	15/02/11	Paracetamol + codeine phosphate + doxylamine succinate	20	450mg-30mg-5mg	1 tablet twice daily PRN	John K Lee	PBS
16/02/11	22/02/11	Paracetamol + codeine phosphate + doxylamine succinate	40	450mg-30mg-5mg	1 tablet twice daily PRN	John K Lee	
~~2/02/11~~	~~2/03/11~~	~~Paracetamol + codeine phosphate + doxylamine succinate~~	~~40~~	~~450mg-30mg-5mg~~	~~1 tablet twice daily PRN~~	~~John K Lee~~	
2/02/11	8/03/11	Paracetamol + codeine phosphate + doxylamine succinate	40	450mg-30mg-5mg	1 tablet twice daily PRN	John K Lee	
16/03/11	18/03/11	Paracetamol + codeine phosphate + doxylamine succinate	20	450mg-30mg-5mg	1 tablet twice daily PRN	John K Lee	PBS
28/03/11	30/03/11	Paracetamol + codeine phosphate + doxylamine succinate	14	450mg-30mg-5mg	2 tablets daily PRN	John K Lee	
1/04/11	4/04/11	Paracetamol + codeine phosphate + doxylamine succinate	40	450mg-30mg-5mg	1 tablet twice daily PRN	John K Lee	
14/04/11	16/04/11	Paracetamol + codeine phosphate + doxylamine succinate	40	450mg-30mg-5mg	1-2 tablets every four hours PRN	Daryl Li	
18/04/11	18/04/11	Codeine phosphate with paracetamol	20	30mg-500mg	1-2 tablets every four hours	John K Lee	PBS
23/04/11	28/04/11	Paracetamol + codeine phosphate + doxylamine succinate	40	200mg	2 tablets three times a day	ShaliniSaxena	
26/04/11	6/05/11	Paracetamol + codeine phosphate + doxylamine succinate	40	450mg-30mg-5mg	1 tablet three times daily PRN	John K Lee	
~~9/05/11~~	~~13/05/11~~	~~Paracetamol + codeine phosphate + doxylamine succinate~~	~~40~~	~~450mg-30mg-5mg~~	~~1-2 tablets every four hours PRN~~	~~**Daryl Li**~~	
9/05/11	16/05/11	Paracetamol + codeine phosphate + doxylamine succinate	40	450mg-30mg-5mg	1-2 tablets every four hours PRN	**Daryl Li**	
~~17/05/11~~	~~21/05/11~~	~~Paracetamol + codeine phosphate + doxylamine succinate~~	~~40~~	~~450mg-30mg-5mg~~	~~1-2 tablets every four hours PRN~~	~~Daryl Li~~	
17/05/11	23/05/11	Paracetamol + codeine phosphate + doxylamine succinate	40	450mg-30mg-5mg	1-2 tablets every four hours PRN	Daryl Li	
8/05/11	30/05/11	Paracetamol + codeine phosphate + doxylamine succinate	20	450mg-30mg-5mg	1-2 tablets four times daily PRN	ThandaTun	
23/05/11	5/06/11	Paracetamol + codeine phosphate + doxylamine succinate	40	450mg-30mg-5mg	1 tablet three times daily PRN	**John K Lee** ~~ShaliniSaxena~~	
Total			**714**				

Diazepam – Schedule 4 Appendix A &D.All from the Plumpton Marketplace Medical Centre. All supplied by Terry White Chemists Plumpton.

18/01/11	18/01/11	50	5mg	1 tablet daily	TeofistaDevera	
25/01/11	27/01/11	50	5mg	1 tablet daily as directed	Zaw Win Oo	
10/02/11	10/02/11	50	5mg	1 tablet daily	Aye A Bartlett	PBS
23/02/11	27/02/11	25	2mg	1-2 tablets at night as directed	John K Lee	PBS
9/03/11	10/03/11	50	5mg	1 tablet twice daily when required	John K Lee	PBS
6/04/11	6/04/11	50	5mg	0.5-1 tablets twice daily when required	John K Lee	PBS
30/04/11	3/05/11	50	5mg	as directed by doctor	Daryl Li	PBS
12/05/11	16/05/11	50	5mg	1 tablet twice daily when required	John K Lee	PBS
31/05/11	31/05/11	30	5mg	1 tablet twice daily when required	John K Lee	PBS
2/06/11	5/06/11	50	5mg	as directed by doctor	Daryl Li	PBS
Total		455				

146. These tables are extracted from spreadsheets that can be found in Ex 2 Vol 1 Tab 15 and were provided by way of submission. The spreadsheets were prepared from records kept by TWP and from PBS records. Dr Lee and Dr Li from PMC dispute the accuracy of the items marked with yellow highlighter. [17]The items that have been struck through have been accepted as not dispensed on the date referred to but deferred. The doctor's names in bold print have been changed as requested. I do not propose to resolve the remaining disputed items as the PMC medical records are

[17]Ex 10

neither clear nor complete and even if the entries in dispute had not been prescribed by the particular doctor it would not have changed the conclusions that I make. The disputed items do not amount to a significant difference to the prescribing to Ms Akhtar. For example, even if the challenged script in relation to Amitriptyline were accepted, the total dispensed in the period of 156 days would be 800 Amitriptyline rather than 850 tablets.

Cause of death

147. Dr Saxena from the Plumpton Medical Centre wrote a Death Certificate on 7 June 2011 identifying Ms Akhtar's cause of death as "respiratory tract infection" of a 48 hour duration, with other significant conditions contributing to the death identified as severe depression, severe migraine and thyroidectomy.

148. At autopsy on 8 June 2011 Ms Akhtar was found to have prominent tonsils with focal collections of pus. Microbiological culture did not identify any significant bacterial or viral pathogens. Toxicological analysis found lethal levels of Tramadol, Codeine and Amitriptyline, toxic levels of Paracetamol and Doxylamine (a sedating antihistamine) and non-toxic levels of benzodiazepines (page 3). The pathologist Dr Kendall Bailey described the cause of death as "multiple drug toxicity".

149. Professor Macdonald Christie, states that the toxicological results indicated the presence of medication in levels capable of causing death. The drugs found in toxic concentrations (Tramadol, codeine and Amitriptyline) all act to produce sedation and/or respiratory depression.

150. The description of Ms Akhtar's final hours including the blue lips and snoring are also consistent with a person suffering from respiratory depression.

151. Dr Wodak described the cause of death on the death certificate given by Dr Saxena as wrong and that it should not have been provided.

152. Dr Saxena gave an unsatisfactory explanation in saying that she wrote the certificate under a degree of urgency as the family wished to take the body home to Pakistan for a funeral. As Dr Wodak pointed out, if there was any degree of uncertainty a cause of death should not have been indicated.

153. Having considered the expert evidence together with the circumstances surrounding Ms Akthar's death, I am satisfied on the balance of probabilities that the cause of her death was multiple drug toxicity and there is no clear evidence that the overdose was intentional.

Medical attendances

154. The PMC was managed by Dr Li. He described it as a busy centre with 19 doctors seeing about 500 patients a day.

155. Ms Akhtar's attendances escalated in the last six months of her life. There are 163 entries in Ms Akhtar's notes between 6 December 2010 and 5 June 2011. Ms Akhtar was seen 42 times by seven different doctors from 2 February 2011 until 5 June 2011. She attended the PMC on 14 occasions in the month before her death. Dr Wodak notes that in the 19 days before Ms Akhtar died four doctors issued 18 different prescriptions.

156. In the month before her death she attended PMC on 4 May, 8 May, 9 May (twice), 12 May, 16 May, 17 May, 23 May, 24 May, 26 May, 31 May, 2 June, 4 June and 5 June 2011. (14 times)

157. In his report, Dr Ryan notes the cluster of attendances between 25 January and 17 February 2011 during which Ms Akhtar appeared every few days requesting opioids and sedative hypnotics (p107).

158. In his recorded interview, one of the treating doctors, Dr Sim, commented on the number of times Ms Akhtar attended the PMC between 19.11.2010 and 12.12.2010 stating "*You can see there's a lot of consults. She virtually lives off the surgery*" .

159. The fact she was obtaining her medication from different doctors at the one practice, or the Prescription Shopping Program, or the Restrictions on Schedule 4 and 8 drugs or the PBS had any impact on her continuing to attend for medical appointments and receive prescription medication.

160. The records at the PMC show that concerns about Ms Akhtar's drug consumption were being recorded from around late 2008. On 19 December 2008 a doctor at the PMC refused to supply Ms Akhtar with Valium after she had obtained prescriptions for Valium from 3 different doctors in the preceding 11 days. That refusal had no impact on two further prescriptions for Valium from two different doctors on 28 and 29 December 2008.

161. On 8 September 2010 the notes state "unable to write more scripts" and "Dr shop". On 21 October 2010 there were more notes about "Dr shopping". These notes and concerns intensified in the six months before her death. Despite the notes prescriptions for the medication continued and without any evidence of detailed discussions and case-planning as between the various doctors at the PMC.

162. Ms Akhtar was regularly obtaining medication at a rate that exceeded her prescribed dosage.

163. Ms Akhtar repeatedly made requests for extra medication because she was going on "trips" which never eventuated.

164. The doctors at PMC would have known that the trips did not occur because Ms Akhtar continued to attend the PMC.

165. On 5 January 2009 Ms Akhtar obtained 100 Mersyndol forte tablets because she said she was travelling overseas "for a while" but she attended the practice regularly over the coming month.

166. On 27 October 2010 Ms Akhtar told Dr Lee she was going to Pakistan for 2-3 months but her regular visits continued without interruption for the rest of the year.

167. On 19 December 2010 Ms Akhtar told Dr Li she was going to Pakistan but continued to attend the practice seeking medication.

168. On 18 April 2011 she again claimed she needed additional supplies for a trip to Pakistan. On that occasion Dr Lee stated "*I was pretty tough, I only gave her the usual, I didn't give her the request for two or three months' supply*" (record of interview Tab 20 pages 78-79).

169. On 31 May 2011, after a series of attendances demonstrated that she had not gone to Pakistan as she claimed to Dr Li and Dr Lee, Ms Akhtar told Dr Lee she was visiting her brother in law in Bankstown for two weeks and requested extra medication.

170. Such an obvious sign of drug seeking behaviour, against the background of the concerns expressed in the medical records and the frequency of Ms Akhtar's attendance should have provoked a practice wide case management plan, and attempts to address Ms Akhtar's dependence upon prescription medication.

171. Ms Akhtar also regularly claimed she needed more medication because she had lost scripts or medication. These claims were made on 17 January 2009, 25 January 2009, 20 July 2009, 3 August 2009, 4 August 2009, 10 August 2009, 13 August 2009, 12 October 2009, 7 November 2009, 7 December 2009, 26 December 2009, 5 June 2010, 10 June 2010, 16 June 2010, 23 June 2010, 26 August 2010, 18 September 2010, 20 September 2010, 25 October 2010, 22 November 2010, 30 December 2010, 2 February, 6 February 2011 and 9 February 2011.

172. On 10 August 2009 the records show a large and clearly legible notation "*LAST TIME. No more scripts given for lost scripts". Once again, despite this entry in the notes prescriptions continued.

173. On 10 June 2010 after noting a lost script for Diazepam Dr Saxena wrote in the notes "CAN'T give any more Valium after this". At the next appointment on 12 June 2010, Dr Li prescribed Mersyndol forte, Amitriptyline and Valium.

174. There were so many claims for lost scripts or medications that most doctors had experienced a number of claims. There is only evidence that on one occasion a doctor contacted TWP where Ms Akhtar obtained all her medication to verify her claim. That was on 6 February 2011 and apparently, Ms Akhtar quickly made an excuse and left the surgery.

175. The notes contained numerous warnings and concerns recorded by doctors about her dependence, addiction and drug seeking behaviour.

176. While the notes are difficult to read, at least some of the warnings must have been legible to doctors treating Ms Akhtar in 2011. On 24 November 2010 Dr Saxena recorded a long note about her discussions with Ms Akhtar about her use of multiple medication, claims of lost scripts and the side effects about medication interactions. The note includes "assessment: ?withdrawal of medication"

177. On 6 December 2010 Dr Lee created a "medication watch list" because, he said, Ms Akhtar was obtaining so much medication from so many different doctors at the PMC. Dr Lee said in evidence he alerted his colleagues to the existence of the watch list but he could not persuade them to use it.

178. On 2 January 2011 Dr Tun recorded that Ms Akhtar was a "frequent doctor shopper" and appeared drowsy, but he prescribed Mersyndol forte and Zolpidem.

179. On 5 January 2011 Dr Saxena warned Ms Akhtar against her use of "excessive medication". On 23 January 2011 Dr Sim refused requests for Tramadol, sleeping tablets and Mersyndol forte and wrote "*watch script requests for valium, aladorm and mersyndol forte*".

180. On 6 February 2011 Dr Sim wrote a detailed and legible note detailing his concerns about Ms Akhtar's prescription drug dependence. On 15 February 2011 he wrote "*I feel she is addicted*" and recorded "*no more consults with me*". This note had little apparent effect on the other doctors at PMC. Dr Lee prescribed Mersyndol forte to Ms Akhtar the next day (Dr Lee said in his evidence that he was alarmed by Dr Sim's note but prescribed after Ms Akhtar made promises to reduce her medication p37 – however he also accepted that warnings were going to be ineffective if Ms Akhtar was addicted p36).

181. On 23 May 2011 Dr Lee was sufficiently concerned about Ms Akhtar presenting for more medication that he recorded a note to the effect that there should be no prescription of Mersyndol Forte until 23/06/11, Durotram 200mg until 03/06/11 and Zolpidem until 06/06/11 (Vol 3 Tab 3 page 4)[18].

182. On 2 June 2011 Dr Li stated he had a discussion with Ms Akhtar about the addictive nature of the benzodiazipines Diazepam, Temazepam and Nitrazepam (Vol 2 Tab 23 page 5). Dr Li then prescribed all three benzodiazpeines to Ms Akhtar without recorded explanation. (Dr Lee had already prescribed 30 diazepam and 25 Nitrazepam tablets to Ms Akhtar 2 days earlier on 31 May 2011 but failed to record this prescription in the consultation notes). Two days later on 4 June 2011 Dr Li prescribed Tramadol, Zolpidem and Mersyndol Forte. That prescription was contrary to Dr Lee's recorded instructions from 23 May 2011.

183. In addition to the medical notes there is some evidence that the doctors had discussed Ms Akhtar's drug seeking behaviour with each other. According to Dr Lee's recorded interview, Dr Sim and Dr Saxena had warned him to be careful with Ms Akhtar (page 67) and Dr Saxena had told him that Ms Akhtar took large amounts of medication, ignored advice and doctor shopped for more medication (p32) (see below).

184. There may have been issues communicating with Ms Akhtar because of language barriers and, perhaps, her cultural background and her gender.

185. However, that is no answer to the volume of medication prescribed to Ms Akhtar, the lack of attention paid to her addiction issues and the deficiencies in her care. The doctors were aware of their limitations. Those limitations should not have been allowed to triumph over the effective provision of care to a patient in real need of help.

Expert opinion of Ms Akhtar's treatment and lessons that can be learnt

186. After reviewing all of the medical records, Dr Wilson and Dr Ryan formed the opinion that Ms Akthar was dependent on opioids and benzodiazepine medication. Dr Ryan felt that it was likely that Ms Akhtar's opioid and sedative hynoptic dependence had existed since early 2009 (p8). Professor MacPherson felt that Ms Akhtar was addicted to opioid medication and showed clear signs of that addiction (p7).

187. Ms Akhtar's main presenting problems were headache, insomnia, anxiety and depression. Dr Ryan's opinion is that it is very likely these symptoms might have been part of her dependence, he said

> " *I am critical of the care Ms Akhtar received at this medical centre on a number of grounds: a poverty of warnings of possible dependence of the drugs prescribed; inappropriate assessment and management of Ms Akthars insomnia, headaches, depression, anxiety and prescription drug dependence; illegible or incomplete documentation; and failure to take account of earlier documentation made by other general practitioners" (p.9)*

188. Dr Ryan raised the possibility that that there were social reasons for Ms Akthar's depression in which case antidepressants would not have been appropriate. He stated that the anti depressants that were given were often sub- therapeutic or "chaotically delivered" with medication changes without sufficient dosage or time for adequate trial.

189. He also criticised the lack of any clear plan to tackle Ms Akhtar's dependence.

190. Dr Wodak agreed. He described it as "astonishing" that no action was taken other than writing more scripts. He says that it is difficult to defend the large number of prescriptions for potentially dangerous medications. (p 24)

191. Dr Wilson described the attempts to assist Ms Akhtar as fragmented and that no one doctor at the practice took on the role of regular treating doctor or responsibility for Ms Akhtar's care.

192. Professor MacPherson noted, Ms Akhtar was co-prescribed Amitriptyline and Tramadol – drugs with a known risk of serotonin syndrome. Professor MacPherson stated that headaches are a major symptom of serotonin syndrome.

193. Ms Akhtar was not a typical doctor shopper. She did not attend numerous different medical centres to disguise the true level of her consumption. Any doctor at the PMC could have gained an understanding of Ms Akhtar's medication history simply by reading her file (albeit that that was, of itself, not an accurate record of the prescribing) or by speaking to the other doctors at the practice.

194. The doctors also failed to use the TWP as a resource for information and assistance. It is plain that options such as staged supply or supervised prescriptions were not considered by the doctors at PMC. When asked about supervised dosing in his recorded interview Dr Sim stated that he thought it was unfair and too "communist", presumably meaning too coercive (p28).

195. The failure to record any pharmacy checks in the medical file is extraordinary in light of the number of times that Ms Akhtar claimed to have lost prescriptions (see above). Doctors Lee, Sim and Saxena acknowledged they were sometimes skeptical of these claims but they could easily have confirmed if the claims were false. The doctors could also have obtained information on the pattern of Ms Akhtar's medication consumption from the pharmacy.

196. Whilst it is clear that there was one conversation between Dr Saxena and Mr Alexander of the Terry White Pharmacy on 22 November 2010, there is a conflict as to the content

of that discussion. It is plain, however, that it arose from a refusal to supply medication to Ms Akhtar by the pharmacy, and an intervention by Dr Saxena to enable that supply to be continued. Whilst Dr Saxena asserts that she asked the pharmacist to regulate supply, there is no documentary evidence to support this and there is no evidence of any follow up communication by Dr Saxena in this regard. On balance, in these circumstances and in the light of any failure by Dr Saxena to document or follow up such an important request Mr Alexander's account is preferable. In any event, the occasion of this conversation was a missed opportunity for the PMC to develop a plan to assist Ms Akhtar including involvement of the pharmacist.

197. Dr Wodak described the prescribing by the prescribing GP's as "excessively generous" (at p 26).Dr Wilson stated there was no evidence of any attempt by the doctors at the PMC to manage Ms Akhtar's care or to change their behaviour to change her use (tx p 91).

Dr Lee

198. Dr Lee was Ms Akhtar's main prescribing doctor in 2011. By early 2011 Dr Lee was aware of a number of warning signs suggesting that Ms Akhtar was addicted to her medication including notes by other doctors, repeated claims of lost scripts, false claims of trips away, clusters of attendances and repeated requests for addictive medications when her supplies should not have been exhausted if she was taking them as prescribed.

199. Dr Lee effectively accepted this in his recorded interview and his evidence. He agreed that Ms Akhtar was a high-risk patient, was dependent on her medication and displayed a number of signs of drug seeking behaviour. In Dr Lee's recorded interview he stated "100% she is addicted" although he qualified that by saying it was a "light addiction" because she did not suffer "big withdrawal symptoms". His evidence at the inquest was to the effect that Ms Akhtar was still functioning in her daily life and did not display physical signs of being drug affected. Dr Lee said Ms Akhtar had a "dependence addiction" rather than an "abusive addiction" (p172 18.10).

200. There is no evidence that Dr Lee made inquiries or obtained information about Ms Akhtar's daily life that would support his assumption about her functioning. His consultations appeared to be brief with few notes, particularly about Ms Akhtar's presentation or her personal and home life. The notes that do exist in the medical file suggest Ms Akhtar was not sleeping, happy or coping well.

201. Dr Lee had been told by Ms Akhtar that her husband had flushed her medication down the toilet or thrown it out the window because he thought she was taking too much (p223).

202. Dr Lee's distinction between a good and a bad addict seems to have led to Ms Akhtar's presenting problem being given less attention. This displays a lack of knowledge and understanding of the problem of drug dependence.

203. Dr Lee said communication was difficult with Ms Akhtar because of her limited language skills and he suspected she was unlikely to open up to a male doctor because of her cultural background. Dr Lee should not have made any assumptions in these circumstances about an obviously high-risk patient. The objective evidence clearly demonstrated that Ms Akhtar was dependent and addicted. If he found that communication was difficult then it was incumbent upon him to take additional care with his patient. It did not excuse prescribing without taking such care.

204. Dr Lee prescribed dangerous amounts of addictive medication to Ms Akhtar in increasing quantities. There was no documented clinical rationale for prescribing this volume of benzodiazepines, particularly when they were not indicated for Ms Akhtar's presenting conditions and not recommended for long-term use. Dr Lee knew benzodiazipines could be dangerous if used long term. They were particularly unsuitable for a patient he accepted he knew was at least drug dependent. Dr Lee did not refer Ms Akhtar to a specialist for her insomnia or to a pain clinic despite her long-term complaints of insomnia and lower back pain.

205. Between 1 April 2011 and 5 June 2011 Dr Lee prescribed diazepam tablets, Nitrazepam tablets, Temazepam tablets, Panadeine forte and Mersyndol forte. Whilst there may be

disputes as to the precise volume there can be no dispute that the volumes were excessive bearing in mind the recommended doses and Ms Akhtar's ongoing substance dependence issues. Between 26 and 31 May 2011 he prescribed three different benzodiazepines (Diazepam, Nitrazepam, Temezapam) to Ms Akhtar within days without any documented rationale. These prescriptions were concurrent with the dangerous co-prescription of Tramadol and Relpax.

206. Dr Lee regularly prescribed opioids to Ms Akhtar, namely Panadeine Forte and Mersyndol Forte. These medications are not recommended for the treatment of drug-addicted patients and Dr Lee was aware that Ms Akhtar was addicted to prescription medication when he issued these prescriptions.

207. Dr Lee made an attempt to reduce Ms Akhtar's drug usage when he introduced the medication watch list. But Dr Lee's attempts were chaotic and doomed to fail because of inadequate documentation and failure to follow through.

208. Dr Lee repeatedly prescribed medication when Ms Akhtar should have had ample supplies if taking medication as directed. Dr Lee also ignored or undermined the attempts of other doctors to deal Ms Akhtar's addiction, by prescribing notwithstanding indications to the contrary in the medical notes.

209. Dr Lee failed to liaise with the Blacktown Community Mental Health Team in relation to Ms Akhtar's presentation and her drug dependence, and failed to ensure that he followed their recommendations as to appropriate medication.

210. He also failed to seek an appropriate referral to a drug and alcohol service and/or to seek advice or guidance in relation to the treatment of drug dependent patients.

211. Professor MacPherson commented that Ms Akhtar was simultaneously being prescribed anti-depressants (particularly Endep) and analgesia (particularly Tramadol) capable of causing serotonin syndrome and those drugs may have been the cause of Ms Akhtar's headaches. Dr Lee also prescribed Relpax (Eliptipran) on 24 May 2011, the day after he prescribed Tramadol. There was expert evidence that these

drugs have a known severe interaction. There is no evidence that Dr Lee provided any warning to Ms Akhtar about the potential for dangerous interaction or told her not to take them together. The effect of those medications on Ms Akhtar is unknown.

212. Dr Lee states that he saw no signs of serotonin syndrome and regularly documented "NANS" (no abnormal neurological signs) in the medical records. Those notations appear but they sit uncomfortably with the evidence suggesting that Ms Akhtar was regularly complaining of insomnia and crippling headaches (a major symptom of serotonin syndrome). Dr Lee said in evidence that he did not think those complaints suggested that Ms Akhtar was adversely affected by medication because she had been complaining of headaches for years.

213. In her report Dr Wilson stated that the prescription of large amounts of Amitriptyline prescribed by Dr Lee in the month before Ms Akhtar's death, in combination with benzodiazepines and opioids increased the risk of death (p36).

Dr Saxena

214. Dr ShaliniSaxena was probably Ms Akhtar's principal treating GP at the PMC until 2011. Dr Saxena was from India and spoke Hindi. Ms Akhtar was from Pakistan and spoke Urdu. Because of the similarity of these two languages, communication was enhanced.

215. Dr Saxena's notes in her early treatment of Ms Akhtar are more thorough and detailed than many of the doctors at the PMC. In 2011 Dr Saxena only saw Ms Akhtar on five occasions. The notes suggest that Dr Saxena started to encourage Ms Akhtar to see Dr Lee towards the end of 2010.

216. Dr Saxena saw Ms Akhtar on a sporadic but regular basis from 2008 to 2010. Dr Saxena identified a series of medical concerns but it is very difficult to identify any long treatment plan for Ms Akhtar. In her report Dr Wilson noted that Dr Saxena had claimed for medicare items for management plans, team care arrangements and identifying and documenting treatment plans and review dates. There is no

documentary evidence to suggest that these plans and review dates were ever followed through and acted upon.[19]

217. From 2008-2010 Dr Saxena regularly prescribed Valium, Merysndol Forte and Panadeine Forte primarily for headaches and insomnia. These prescriptions continued without any evidence that Ms Akhtar had attended a neurologist to investigate the cause of those headaches or of the outcome of any such referral. On 12 April 2010 Ms Akhtar told Dr Saxena that Mersyndol Forte was not helping with her headaches. There is no evidence to suggest Dr Saxena alerted other doctors at the PMC about this development and she continued to prescribe Mersyndol Forte.

218. Dr Saxena regularly prescribed Valium to Ms Akhtar despite its contra-indication for long term use. Dr Saxena also prescribed Valium alongside opioid medication to treat Ms Akhtar's headaches. In her interview Dr Saxena said that she co-prescribed Panadeine Forte (an opioid and mild central nervous system depressant) with Valium (a benzodiazipine and central nervous system depressant) on the assumption that Ms Akhtar would heed her warning not to take all the medication and not to take the medications together (p21).

219. Dr Saxena continued to prescribe opioids and benzodiazepines to Ms Akhtar despite obvious signs of drug seeking behaviour (including the cluster of claims of lost scripts in 2009), after she had herself recorded "dr shop" in Ms Akhtar's notes and long after it must have been apparent that any warning to Ms Akhtar about her medication consumption was ineffective without taking active steps to reduce her consumption.

220. Dr Saxena said in her interview that her consultations with Ms Akhtar in 2009 became 20 minute lectures warning against excessive consumption and the need to see specialists (p15). But at no stage did Dr Saxena take steps to implement a plan for staged reduction, or supervised dosing or supply. It must have been clear that these "lectures" were not effectively dealing with the problem. Moreover, as set out above, Dr

[19]Dr Wilson at p32-33

Saxena failed to take advantage of an opportunity to rethink Ms Akhtar's plan of care (if indeed there was one) when the pharmacy refused supply and she had to intervene.

221. Instead of taking active steps herself, Dr Saxena encouraged Ms Akhtar to see Dr Lee and said she told Dr Li she did not want to prescribe medication to Ms Akhtar. If this conversation with Dr Li did take place, it was another missed opportunity for the PMC to put in place a coherent plan to manage Ms Akhtar's treatment and medication (p58). It also evinces a failure by Dr Saxena to take steps to protect the patient as opposed to a desire to extricate herself from a difficult therapeutic relationship.

222. Dr Saxena failed to liaise with Blacktown Mental Health Services in relation to Ms Akhtar's drug dependence. There is no evidence that she wrote to the mental health team about her concerns about Ms Akhtar's medication consumption and dependence or otherwise shared that information with them. Again, this prevented coordinated care being provided.

223. Dr Saxena claimed in her interview that she checked with other doctors and the pharmacy if Ms Akhtar had filled prescriptions she claimed to have lost. The pharmacy did not support this claim and there is no written evidence to support it.

224. Some of Dr Saxena's claims regarding her efforts to assist Ms Akhtar are not supported by the medical records. For example, in her interview Dr Saxena said that she checked that Ms Akhtar had run out of medication before prescribing 25 tablets of 5mg Valium (to be taken 3 times a day) on 26 December 2010 (p27). However, the medical records show a clear notation from Dr Lee that he had prescribed 50 tablets to Ms Akhtar just 20 days earlier on 6 December 2010 (3/3/16). According to the pharmacy records, the dosage instructions were ".5 to 1 tablets a day". Ms Akhtar could not have finished her Valium supplies if she was taking them as prescribed. Moreover, Dr Saxena's notes do not record the reason for tripling the prescribed dosage of Valium.

225. In Dr Saxena's interview she stated:

> *"So I thought I'd get her to see Dr Cheung who is a gastro endocrinologist at the same time also get somebody to do drug and alcohol also so if she sees all the list of*

medication then Dr Cheung will be able to either refer her further or you know look after that part." (p. 11)

226. There is no evidence in Dr Cheung's reports which suggests that he had been asked to address Ms Akhtar's issues with medication in addition to her thyroid issues[20]. There is no indication that Dr Saxena expressly raised Ms Akhtar's drug dependence issues with Dr Cheung.

227. Dr Saxena said in her interview that she had referred Ms Akhtar to a pain management specialist, or a psychologist at a pain clinic (Dr Gardiner), due to concern about Ms Akhtar's medication consumption in the hope that he would implement a "full management thing" (p47). Again there is no letter in the notes to ascertain the basis of the referral. There is a report in the PMC file from Dr Gardiner, a psychologist apparently specializing in adolescent adult & couples therapy, dated 24 April 2008. [21] That letter makes no reference to medication or addiction. It diagnoses Ms Akhtar with Adjustment Disorder with Mixed Anxiety and Depressed Mood and refers to future discussions about "long term methods" to address her concerns in future appointments. It appears that no long term plan was ever implemented and Dr Saxena believed Ms Akhtar had stopped attending Dr Gardiner after a couple of sessions (p24-25). Again, this does not reflect any reliable element in a plan to address drug dependence.

228. It is also clear that Dr Saxena continued to prescribe pain medication and sedatives in the absence of any pain management or medication plan when she knew Ms Akhtar was not visiting Dr Gardiner (see also p24-25).

229. Dr Saxena could have refused to prescribe sedative medication unless a plan was in place. Notably, Dr Saxena said in her interview, in effect, that she did not prescribe Schedule 8 medication unless she received confirmation that her patient had seen a pain management specialist and had a letter that it was appropriate to prescribe the

[20]Vol3 Tab 3 pages 88, 98
[21]Vol 3 Tab 3 page 91

medication to the patient (p61). It is by no means clear why a similarly pro-active approach was not taken to Ms Akhtar.

Dr Li

230. Dr Darrell Liwas the manager of Plumpton Medical Centre and, with Doctors Lee and Saxena, one of the principal prescribers to Ms Akhtar. Dr Li prescribed numerous short acting benzodiazepines to Ms Akhtar when he was aware that she had been taking the medications for years without any discernible improvement in her symptoms and when they are not indicated for long term use or for drug dependent patients. Dr Li failed to consider, like his colleagues, whether Ms Akhtar's symptoms related to her medication consumption and periods of withdrawal, and thus if her treatment was the primary source of her symptoms.

231. Dr Li was aware of numerous warning signs that Ms Akhtar was addicted to medication including the frequency with which she attended the practice, the volume of medication that Ms Akhtar was consuming (which if consumed would exceed her directed dose), the numerous claims of lost scripts, failure to follow up on referrals and the false claims of future trips. Dr Li accepted in his interview that Ms Akhtar was "possibly" addicted to Panadeine Forte or Mersyndol Forte (p41). Dr Li did not introduce any plan to manage Ms Aktar's consumption or gradually reduce her consumption. He displayed no apparent index of suspicion towards the frequent claims of lost scripts or provably false claims of upcoming trips.

232. Dr Li did not provide any satisfactory explanation in his statements or interviews as to why he failed to refer Ms Akhtar to a neurologist, pain management specialist, sleep specialist or drug and alcohol specialist. Dr Li was aware Ms Akhtar received psychiatric treatment but prescribed and changed psychiatric medication without a clearly documented clinical rationale and without any consultation with a psychiatrist.

233. The last medication collected by Ms Akhtar on 5 June 2011 included three different benzodiazepine medications – Temazepam, Diazepam and Nitrazepam – prescribed by Dr Li. This prescription was dangerous. It was made after Ms Akhtar had been

prescribed large amounts of sedative and opioids in May and had ample supplies if taking her medication as directed. There was no evidence in the inquest capable of supporting the prescription of three different benzodiazepine medications to any patient, let alone to Ms Akhtar.

234. Dr Li said in his interview that he discouraged his doctors from prescribing benzodiazepines or opioids (including codeine based opioids) (p17). He did not outline the steps he took to deter the doctors or why he had taken no such steps in the case of Ms Akhtar. There is no evidence to suggest Dr Li did anything to support or promote Dr Lee's watch list with the PMC doctors. Dr Li undermined Dr Lee's attempts to regulate Ms Akhtar's use on 4 June 2011 when he prescribed three medications contrary to Dr Lee's recorded request on 23 May as to the next prescription date. Dr Li was either unaware of the note recorded just days before in the file, did not understand the notation or just decided not to comply.

Dr Sim

235. Dr Sim terminated his relationship with Ms Akhtar when he decided that she was addicted to prescription medication. It was apparent from a review of Ms Akhtar's file (and Dr Sim stated that he did review the file) that she was a vulnerable patient with fragile mental health and a young family. Dr Sim did not think Ms Akhtar was exaggerating her suffering to obtain medication, he said in his interview "*I could sense that she was suffering. I think she's a victim of her own sort of medical problems. I don't think she was putting it on, no*." (p. 26)

236. Dr Sim took no action to talk to other doctors in the centre to ensure that Ms Akhtar received assistance with her addiction or received proper monitoring. He made no offer of a referral to a drug and alcohol specialist or pain clinic and did not seek to communicate directly with others with a view to addressing Ms Akhtar's drug dependence issues. His solution was merely to remove himself from the problem. This flies in the face of guidance to doctors not to terminate a therapeutic relationship without ensuring that steps are in place to ensure appropriate ongoing care for a patient (eg Medical Board of Australia Good Medical Practice guidance at 3.13).

Terry White Pharmacy

237. The report of expert pharmacist Michael O'Donnell was critical of Terry White Pharmacy. In his report Mr O'Donnell stated

> *"I believe the pharmacists at Terry White Chemist Plumpton should have had concerns about over-utilisation of medications especially with regard to the number of prescribing doctors and the nature of the medication prescribed"*[22]

238. Mr O'Donnell observed that a patient taking 608 prescriptions in 4 years would be at the top end of prescription customers in volume and would warrant extra care to be paid to dose frequency and interactions. Mr O'Donnell stated that the bunching and escalation of medication dispensed to Ms Akhtar should have alerted the TWP to an increasing risk of underlying problems and triggered alarm bells.

239. Mr O'Donnell expressed surprise at the absence of any recorded communication between the PMC and the TWP.

240. Much of the criticism by the experts, especially Mr O'Donnell, was based on the premise that the pharmacists had not consulted with the PMC before dispensing medication. However, the manager of the pharmacy, Mr Michael Alexander, gave statements and evidence to the effect that he and his employed pharmacists routinely consulted, clarified and queried prescriptions provided to Ms Akhtar. In his statement of 31 July 2013 Mr Alexander said he was told "time and again" that Ms Akhtar's medication usage was being monitored by the doctors in the surgery and the doctors were aware of how much medication she was receiving. Mr Alexander asserted that contact was made with the PMC in relation to approximately 50% of Ms Akhtar's prescriptions. At the inquest Mr O'Donnell gave evidence to the effect that he would not press much of his criticism of the pharmacy if this communication took place.

[22]Ex 3 Tab 2 p21

241. The doctors at the PMC contested Mr Alexander's claims. Dr Lee, Ms Akhtar's principal prescribing doctor in 2010 and 2011 said in evidence that he had never spoken to Mr Alexander or TWP employees about Ms Akhtar.

242. The pharmacy kept a computerized patient file in relation to Ms Akhtar and a "screen dump" of this file was provided to the inquest. That screen, which was displayed each time Ms Akhtar visited the pharmacy, had four entries. None of the entries recounted contact with the PMC doctors. Mr Alexander gave evidence to the effect that there was no other paper file relating to Ms Akhtar. The file did not record any clarification of medication instructions which Mr Alexander stated occurred frequently. There was no record even of the decision to cease all supply which Mr Alexander said occurred towards the end of 2010 or the reasons for resuming supply. There was no evidence that any other entries relating to Ms Akhtar had been deleted and no reason to suppose some entries would be deleted when others, dating back to 2009, remained on screen.

243. Mr Alexander could not recall any specific conversation with a PMC doctor with the exception of the conversations with Dr Saxena discussed above. The only doctor mentioned in Mr Alexander's statement was Dr Virginia Tomayo, a doctor whom had not prescribed any medication to Ms Akhtar for at least 18 months. If Mr Alexander was making frequent calls to the PMC in 2011 it is striking that he did not mention Dr John Lee in his statement or recall any specific conversation with him. Dr Lee firmly denied under oath that any contact was made by the TWP in relation to Ms Akhtar.

244. Mr Alexander provided telephone records to the inquest to demonstrate the frequency with which his pharmacy contacted the PMC. He was aware the inquest had not obtained the records and could not obtain them in time. Of course, those records do not demonstrate which patient was being discussed but the calls are extremely frequent and many coincide with the dates of Ms Akhtar's visits to the pharmacy. It appears likely that at least some of the calls relate to Ms Akhtar.

245. In the absence of notes I could not be confident as to the content of any call or conversation between the doctors and the pharmacists. The absence of proper notes

has proved a real impediment to resolving important factual issues in this inquest but more importantly precluded any pharmacist at the TWP from relying or learning from the content of those notes. The TWP is a high volume pharmacy with a number of employed pharmacists. Proper notes are critical to ensure patients are provided with adequate continuity of care, particularly when a pharmacist has warned a patient about a potentially dangerous drug interaction, clarified dosage instructions or refused supply to a patient. There is a real risk that informal interactions between pharmacists will not protect a patient in these circumstances if information 'falls between the cracks' between different pharmacists.

246. Mr Alexander agreed that patient notes can serve to warn pharmacists about drug seeking behaviour by clients including repeated requests for medications outside appropriate intervals, false excuses for obtaining extra supplies and fraudulent behaviour.

247. Mr Alexander accepted in his evidence that notes were important to ensure continuity of care in high volume pharmacy settings. He agreed that the ability of trained pharmacists to provide continuity of care was one justification for the statutory privilege granted to pharmacists to dispense medication. He also accepted that adequate note taking was required by the Prescription Dispensing Guidelines issued by the Pharmaceutical Society of Australia. Mr Alexander said it was not "overly difficult" to record notes on a patient's file.

248. The TWP failed to record

- clarification of dosage instructions for Endep and Valium which, according to Mr Alexander, were frequently inconsistent between prescribing doctors;
- individual occasions when supply was refused (according to Mr Alexander's statement he refused to supply Endep to Ms Akhtar many times;
- conversations pharmacists had engaged in with prescribing doctors;

- the dispensation of Relpax despite the risk of dangerous interactions with other medications and the reason for dispensing the medication (the phone records suggest calls were made to the PMC on dates when Relpax was dispensed);

- the decision to cease all supply and the reasons why that decision was reversed.

249. The notes that did exist did not prove effective. On 3 January 2011 Mr Alexander recorded a note stating that Ms Akhtar had been provided with Endep and Zolpidem (Stilnox) because she said she was going to Melbourne and "please make sure she doesn't come back for more". On 6 January 2011 another pharmacist recorded a note stating "she is not going to Melbourne any more, please be careful of the interval in between the repeats of her pain relieves". Mr O'Donnell noted that these warnings had little effect (p22). Ms Akhtar was dispensed Endep and Zolpidem, with Tramdol and Mersyndol Forte (ie pain relief, sedatives and opioids) just 10 days later on 16 January. Ms Akhtar was then dispensed Mersyndol Forte and Zolpidem on 19 January, Endep and Zolpidem again on 23 January (with Tramadol), Valium and Mersyndol Forte on 27 January and Endep again on 31 January 2011. The only recorded call to the PMC during this period was on 27 January 2011.

250. Mr Alexander said in his statement that he refused supply to Ms Akhtar on several occasions when he saw no overriding therapeutic need for the medication. He agreed in his evidence that pharmacists have an independent duty of care to their patients and sufficient training in medication to exercise that duty. He agreed that they can and should exercise independent judgment and are not bound by prescriptions issued by doctors. He agreed with the statement in the Prescription Guidelines that supply can be refused even if the prescriber does not accept the concerns and advice of the pharmacist "in exceptional circumstances" (Mr O'Donnell p20).

251. At no point did the TWP pharmacists exercise that independent judgment and refuse medication particularly in May and June 2011 when Ms Akhtar appeared to be stockpiling large amount of sedative medication (benzodiazepines and opioids) and was being dispensed medication (Tramadol and Endep/Amitriptyline) with a real risk of dangerous interaction.

252. On 5 June 2011 Ms Akhtar visited the TWP for the last time. She was dispensed an opioid, Mersyndol Forte, and three different benzodiazepines (Nitrazepam (25 tablets), Temazepam (25 tablets) and Diazepam (50 tablets)) prescribed by two different doctors, Dr Li and Dr Lee. Ms Akhtar had no immediate need for the medication if she was taking it as directed. She had been dispensed 30 Diazepam (twice daily when required) and 25 Nitrazepam (daily as required) a week earlier on 31 May 2011. She had received 25 Temazepam (daily) on 26 May 2011. As noted above, she had been dispensed significant amounts of opioid and benzodiazepine medication throughout May 2011.

253. Given the volume of medication dispensed, and the dates of dispensing, the dispensing itself reflects a failure to take adequate care for Ms Akhtar's safety.

Conclusion

254. Ms Akhtar obtained the escalating quantities of prescription medication from one medical centre and one pharmacy. Her case highlighted the need for education and training of GPs and pharmacists on identifying and appropriately treating patients with addiction to the medication which they are being prescribed.

255. It highlighted the need for greater communication between GPs and pharmacies when a patient is obtaining medications in excess of prescribed dosages.

256. It highlighted the need for pharmacies to keep notes on a patient's file.

257. It highlighted the need for greater communication and continuity of care between GPs within the one practice. Consideration needs to be given to the allocation of one GP as the responsible treating practitioner.

258. It highlighted the need for GPs to communicate with treating psychiatrists and treating mental health teams.

259. It highlighted the need for improved education to GPs on prescribing potentially addictive medication.

Positive Change

260. This Inquest has been informed of the following changes that have emerged as a direct result of Ms Ahktar's death.

- Dr Lee gave evidence that he has attended courses on anxiety disorders, mental health, the relationship between pharmacology, insomnia and chronic pain and strategies to deal with problematic patients. He now provides written instructions and handouts to patients on multiple medications and educates patients and families regarding medication intake. He attends weekly group meetings at the PMC in relation to patients that need to be monitored closely. He is also working with the community pharmacy to supervise two of his patients.

- Dr Li gave evidence that he has implemented the computerisation of all PMC records using Medical Director software for patient notes, issuing of prescriptions, looking up drug interactions, referral letters etc. He has organised a weekly group meeting at the PMC to discuss difficult patients. He has also implemented the use of Home Medicine Review Program into the practice.

CONCLUSION

Present system

261. One of the main focuses of this inquest has been to find out why none of the present systems of prescription regulation resulted in any of the deceased coming to the attention of the doctors, pharmacists or authorities as being such extreme prescription drug abusers. The main objective of the inquest is to see if any improvements would result in other prescription drug abusers being detected before they lost their lives to addiction. To these ends I will make recommendations with a view to improving the present regime. At all times I acknowledge that the primary function of the health care system is to provide care to patients. The balance must be struck between the degree of regulation to control abuse of prescription medication and the right of patients to have access to the drugs they need.

262. The Prescription Shopping Program, the restrictions on prescribing Schedule 4 and Schedule 8 drugs and the PBS had no significant impact on the prescribing to any of the deceased.

263. The Prescription Shopping Program did not result in any meaningful form of alert. By way of example, it was not brought to anyone's attention that nine different doctors prescribed Mr Attard medication on the PBS within a three-month period and Ms Akhtar had forty-nine different supplies of medication on the PBS in a three-month period. Each of these patients also received other private prescriptions.

264. I accept Dr Wilson's evidence that this program is inadequate and leads to detection of only a minority of problem users and with out of date results.

265. The restrictions on prescribing Schedule 4 and Schedule 8 drugs are supplemented by guidance from professional bodies.[23] It is apparent from the medical records and evidence in this inquest that there was very little compliance with these guidelines in prescribing to the three deceased.

266. The PBS did not appear to have any real impact on the prescribing to any of the deceased. The evidence makes it clear that authorisation to prescribe is given to a prescriber by PBS without any investigation of the clinical justification or previous prescribing history of the patient. Furthermore, the PBS does not in any way restrict supply of medication on private prescriptions. This is becoming more pertinent as the prices of relevant medications are falling and patients elect to have medications dispensed outside the PBS, rendering PBS monitoring unsatisfactory.

Real time prescribing

267. The criticisms by the independent experts of the individual doctors and pharmacists who prescribed and dispensed the medication involved in each death is tempered, partly due to the fact that the individual doctors and pharmacists had no way of knowing what prescription medications other doctors or pharmacists had provided to their patients. This highlights that a significant part of the problem is a systemic one. If large quantities of prescription medication can quite properly be put into the hands of persons who then go on to become addicted, drug seeking and ultimately

[23] See Annexure 4

unintentionally overdose, then it is clear that there is a need for systems to be put in place to ameliorate this risk.

268. In NSW there is no current system for co-ordination amongst doctors and/or pharmacists to ensure that they are aware at the time of prescribing or dispensing drugs of addiction what medications a patient has already been provided with. Most of the doctors involved in the deaths that are the subject of this inquest have stated that they would not have prescribed as they did if they had known about the other drugs their patient had been given.

269. Such a system would allow health professionals to check in real time what a patient had been prescribed/supplied by other prescribers or pharmacists. It would link the health professionals electronically, providing an extra tool at the consultation, which would alert the doctor so as to determine whether addiction had become an issue, whether reported ailments could be side effects of addiction and then appropriately arrange treatment.

270. A Victorian Coroner in an inquest into the death of James in Victoria on 15 February 2012 noted that the need for such a program was acknowledged by the Victorian Government, the Commonwealth Government, the Victorian Alcohol and Drug Association, the Royal Australasian College of Physicians, the member organisations of the National Pain Strategy, the Pharmaceutical Society of Australia, the Pharmacy Guild of Australia, the Public Health Association of Australia, his fellow coroners and individual members of the public who wrote submissions. The Coroner in that case noted "a universal concern at the harm and death caused by prescription drug diversion and misuse" and the "universal desire to put a halt to it". The Coroner noted that the Australian Government Department of Health and Ageing was to implement a national real-time recording and reporting system for prescription medications by July 2012.

271. In total Victorian Coroners have made seven recommendations calling for a real time prescribing monitoring system to prevent deaths from prescription medications. As at this date Victoria does not have such a system.

272. In a media release on 12 February 2012 the then Minister for Health, Ms Plibersek, announced that the Commonwealth Government would set up a new electronic records system to combat abuse of prescription medication.

273. The Australian Government Department of Health has made available to all states and territories an Electronic Recording and Reporting of Controlled Drugs (ERRCD) system. The system would provide authorised health practitioners with contemporary information about:

- a patient's previous supplies of Controlled Drugs from any hospital or community pharmacy (whether supplied on the PBS or not)
- supplies of other drugs of abuse potential
- the patient's participation in state-run Opiate Dependency Treatment Programs
- If there have been repeat presentations, whether the prescriber has been authorised to prescribe drugs of addiction to the patient on an ongoing basis. [24]

274. The system is designed to compliment and support the current controls. I have been informed by Ms McNeill the First Assistant Secretary of the Pharmaceutical Benefits Division of the Australian Government Department of Health that it is open to the states and territories to implement the system within their jurisdiction.[25]

275. In 2012 the Tasmanian Department of Health and Human Services signed a licensing agreement with the Commonwealth and successfully implemented the real time data based system. Doctors in Tasmania now have access to key clinical information on controlled medications dispensed to patients who attend upon them for treatment.

276. At the commencement of this Inquest in October 2013, the NSW Government Ministry of Health informed this Inquest that consideration is being given to implementing the ERRCD system in NSW, but indicated that a source of funding had yet to be

[24]Responses to Proposals for Change, Tab 2A
[25] Responses to Proposals for Change, Tab 2A

identified.[26]In March 2014, at the conclusion of evidence in this Inquest a submission was made on behalf of the Ministry that a commitment had been made to the program and in principle it had been approved, however, there were still outstanding issues including, funding and software.

277. One of the striking features of this Inquest is the real and urgent need for the ERRC. The co-ordination between doctors and pharmacists is required to ensure that they are aware at the time of prescribing or dispensing drugs of addiction what a patient has already been provided with.

278. It is imperative the ERRC includes benzodiazepines as well as current Schedule 8 drugs. The poor prescribing and the devastating impact of benzodiazepines were a common theme throughout this inquest. Benzodiazepines were also found to be the most frequent contributing prescription drug in Victorian overdose deaths.[27]

279. I note that Alprazolam was shifted from a Schedule 4 drug to Schedule 8 as of 1 February 2014. Alprazolam is now classified as a drug of dependence and cannot be prescribed for regular use exceeding two months without an authority by the Drug Dependence Unit. While I commend the steps that have been taken to further regulate Alprazolam I fail to see why all benzodiazepines were not rescheduled. This inquest has clearly demonstrated that Alprazolam is not the only benzodiazepines of concern. The Victorian Drug Overdose Deaths Register[28] demonstrates that Diazepam, rather than Alprazolam, is of greatest concern in Victoria. It is important that all benzodiazepines are included in any real time prescribing system.

Other problems with prescribing

280. The independent experts also raised the following further areas for concern in the prescribing of medication to the deceased;

    a) The prescribing of psychiatric medication without assessment or involvement of a psychiatrist (Dr. Ryan, Independent Psychiatrist, Ex 3 Vol 2 Tab 3)

[26]Responses to Proposals for Change, Tab 3
[27]Annexure 1
[28]Annexure 1

b) The prescribing of medication for psychiatric symptoms when that medication was not first line treatment (Dr. Ryan, Independent Psychiatrist, Ex 3 Vol 2 Tab 3)

c) The prescribing of benzodiazepines despite being aware of substance dependence problems ((Dr. Ryan, Independent Psychiatrist, Ex 3 Vol 2 Tab 3)

d) The prescribing of sedating drugs which only seemed to feed an addiction for sedatives (Dr. Ryan, Independent Psychiatrist, Ex 3 Vol 2 Tab 3)

e) Many of the symptoms being treated with multiple medications were in fact possibly symptoms of drug dependence or addiction or withdrawal from drugs and the medication exacerbated the problem (Dr. Ryan, Independent Psychiatrist, Ex 3 Vol 2 Tab3)

f) The prescribing of short acting benzodiazepines on a long-term basis when it is known to lead to drug dependence. (Dr Wodak, Expert Addiction Medicine, Tab 1, page 8, 9, 11 and 20). Also, the prescribing of this medication for disorders such as panic disorder and insomnia when the recommended first line of treatment is not medication. (Dr Ryan, Expert Psychiatrist, Ex 3 Vol 2 Tab 3)

g) The prescribing of opioids in non cancer pain without the necessary level of discrimination, and without ensuring that the opioids are limited in dose and duration, and are appropriately trialled (Dr Wodak, Independent Expert Addiction Medicine, Tab 1 page 10)

h) The prescribing of medication without communication with other treating GPs, specialists, hospitals or pharmacies. (Dr Wodak, Independent Expert Addiction Medicine, Ex 5 Tab 1 pages 11, 21)

281. This Inquest has exposed that the knowledge and training of prescribers of addictive medication could be a great deal more effective. The following suggestions have been proffered by the experts as possible changes that would lead to improvements in this regard;

a) Expanding and possibly making it mandatory for all prescribers to undertake as part of their accreditation a course on prescribing addictive medication,

b) Education and new approaches in treatment of non cancer chronic pain, in particular that the prescribing of opioids should be avoided

c) That warnings be placed on Doctor's computer software about the risks or prohibitions of prescribing when a prescription is being written,

d) That prescription for opioids and benzodiazepines not be allowed for unknown patients. That a single clinician/team be responsible for prescribing addictive medication.

e) General practitioner peer review groups

f) That consideration be given to discontinuing the availability of shorter acting benzodiazepines in the community as they cause dependency, tolerance and withdrawal and there are few clinical reasons to continue on a long term basis.

g) Improved communication and co-ordination of care between health professionals including primary carers, specialists and hospitals.

I endorse those suggestions in the recommendations that I have made.

FINDINGS

I find that Christopher Salib died on 6 February 2011 at 517/18 Maloney Street, Eastlakes, NSW. I am satisfied the cause of his death was ischaemic heart disease with multiple prescription drug toxicity as a condition contributing to the cause. The manner of his death was natural causes.

I find that Nathan Attard died on or about 20 March 2012 at 4/32 Morehead Street, Redfern, NSW. I am satisfied the cause of his death was the unintentional consequences of ingesting a lethal combination of prescription drugs. The manner of his death was misadventure.

I find that Shamsad Akhtar died on 6 June 2011 at 6 Alvis Place, Plumpton, NSW. I am satisfied the cause of her death was the unintentional consequence of ingesting a lethal combination of prescription drugs. The manner of her death was misadventure.

RECOMMENDATIONS

To the Secretary of the Australian Government Department of Health and Aging

1. I recommend that all benzodiazepines should be moved to Schedule 8 of the Standards for the Uniform Scheduling of Medicines and Poisons.

To the NSW Minister for Health

1. I recommend that the New South Wales Department of Health consider steps to be taken to implement a real-time web based prescription monitoring program available to, at least, pharmacists and general practitioners within 12 months, that:

    a. records the dispensing of all Schedule 8 poisons in New South Wales;
    b. provides real-time prescription information to all prescribers and dispensers throughout New South Wales; and
    c. facilitates the New South Wales Department of Health to monitor the dispensing of these medications and identify behaviours of concern,with an expected completion date of 36 months.

2. I recommend that the New South Wales Department of Health consider including all benzodiazepines within the program set out above.

3. I recommend that the New South Wales Department of Health consider what if any additional steps can be taken to educate pharmacists and general practitioners on the ability to report inappropriate prescribing to the Pharmaceutical Services Unit, Ministry of Health (NSW), on means of identification of inappropriate prescribing, and on the authority requirements when prescribing schedule 8 drugs.

3A. I recommend that New South Wales Department of Health consider:

    a. imposing a requirement that a doctor should not commence prescribing a schedule 8 drug or a benzodiazepine to a patient without making enquiries to verify the patient's prescribing history, or if not practicable, such supply should be limited to that which is necessary until the prescribing history can be obtained; and

    b. expanding the restrictions on the prescribing of schedule 8 drugs in sections 27 to 29 of the *Poisons and Therapeutic Goods Act 1966* to also cover a list of restricted drugs of dependence.

To the CEO of the Pharmacy Guild of Australia

1. I recommend that the Pharmacy Guild of Australia consider preparing de-identified case studies involving misuse of prescription medications with a view to providing continuing education to pharmacists in identifying and responding to prescription shopping and/or drug dependency.

2. I recommend that the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Royal Australian College of General Practitioners liaise with a view to:

    a. promoting the use of staged supply and other means to reduce the risk of the misuse of prescription medication;

b. promoting the use of supervised administration of medication in a pharmacy; and

c. developing education modules on lawful options available to respond to suspected misuse of prescription medications.

To the President of the Royal Australian College of General Practitioners

1. I recommend that the Royal Australian College of General Practitioners consider developing a short 1-2 page clinical guideline for use by general practitioners regarding:

   a. The management of chronic non-cancer pain;

   b The prescription of benzodiazepines;

   c The prescription of opioids;

   d. The circumstances in which the use of private and/or repeat prescriptions may be appropriate; and

   e. Available resources including the Drug and Alcohol Specialist Advisory Service and the form to authorise the release of personal Medicare and Pharmaceutical Benefits Scheme claims information to a third party.

2. I recommend that the Royal Australian College of General Practitioners consider developing a clinical governance framework for General Practices and General Practitioners to address the rising problem of prescription drug abuse in Australia.

3. I recommend that the Royal Australian College of General Practitioners and the National Coronial Information System (NCIS) liaise to consider how to facilitate sharing of information on the NCIS database in relation to deaths linked to the abuse of prescription medication.

4. I recommend that the Royal Australian College of General Practitioners consider including within its continuing professional development requirements for general practitioners:

   a. A requirement that all general practitioners who prescribe Schedule 8 poisons and/or benzodiazepines, be required to attend an unit of skills training within 3 years (or within 3 years of qualification) dealing with pain management, drug dependency and the proper prescribing of opioids and benzodiazepines, and including, once it is completed, the guideline referred to above; and

   b. An education module which addresses sharing of information about patients, including the legal constraints upon this; and

c. Use of de-identified case studies in these education modules, and liaise with the Pharmacy Guild of Australia in relation to these.

5. I recommend that the Royal Australian College of General Practitioners and the Australian Medicare Local Alliance (with those entities seeking to involve such national bodies as they consider appropriate in the circumstances)consider establishing a program, available on a non-mandatory basis for members of the Royal Australian College of General Practitioners, for establishing local forums to be attended by general practitioners, and to invite also pharmacists and other specialists or hospital services, to identify problems of doctor shopping within that area and to establish channels of communication to deal with the problem.

To the Minister for the Australian Government Department of Health and Aging

1. I recommend that the Minister together with the Chief Executive Officer of Medicare:

a. consider working with the Pharmaceutical Society of Australia, the Pharmacy Guild and other relevant peak bodies to facilitate access to the prescription hotline by pharmacists and to promote the use of the prescription hotline by pharmacists;

b. consider adopting mechanisms to make it compulsory for all medical prescribers to be registered under the Prescription Shopping Program(administered by the Department of Human Services on behalf of the Department of Health (Cth));

c. consider the efficacy of the Prescription Shopping Program (administered by the Department of Human Services on behalf of the Department of Health (Cth)) and consider what, if any, means might be adopted to assist in ensuring that the system is used by practitioners and that it enables prompt identification of the abuse of prescription medications having regard to the issues arising in these matters.

To the Secretary Australian Government Department of Health and Aging and the Minister of the New South Wales Department of Health

1. I recommend that the Commonwealth Department of Health and Aging and the New South Wales Department of Health (through the PBS) consider imposing a requirement that a general practitioner should not, other than in exceptional circumstances, prescribe long term anti-depressant and/or anti-psychotic medication to a patient without seeking advice and/or input from a psychiatrist, who should if relevant, be the patient's treating psychiatrist.

C.Forbes

Deputy State Coroner

27 June 2014

APPENDIX 1

Coroners Court of Victoria - Drug Overdose Deaths Register

Coroners Court of Victoria

Appendix 1

The Drug Overdose Deaths Register

The Coroners Prevention Unit (CPU) developed and maintains a register of drug overdose deaths investigated by Victorian coroners. A drug overdose death is defined as a death for which the acute toxic effects of one or more drugs played a causal or contributory role.[1] Deaths for which no acute toxic effects contributed but other drug effects (such as behavioural effects) may have contributed, are excluded from the Register.[2]

The CPU draws on the determination of the death investigators (coroner, forensic pathologist and forensic toxicologist) to identify relevant deaths, and codes certain information regarding each death into the Drug Overdose Deaths Register. Coded information includes the specific drugs that the expert death investigators identified as playing a causal or contributory role.

The information contained in the Drug Overdose Deaths Register is regularly revised as coroners progress and complete their investigations. Therefore, overdose death data generated from the Register can change over time.

Overdose deaths, Victoria 2010-2013

On 2 April 2014, the CPU used the Drug Overdose Deaths Register to extract data pertaining to all overdose deaths investigated by Victorian coroners in the period 1 January 2010 to 31 December 2013. Data for both completed investigations and investigations still underway was extracted, where the current available evidence indicated the death was an overdose.

Table 1 shows the annual frequency of Victorian overdose deaths by the number of drugs that were found to have caused or contributed to the death. The bracketed figures in the table are the frequencies expressed as percentages of all overdose deaths for the year (for example, in 2013 there were 113 single drug overdose deaths, which was 30.2% of the 374 drug overdose deaths for that year).

The majority of overdose deaths (approximately two-thirds) involved multiple drugs rather than a single drug. There was an overall slight upward trend in frequency over time, from 349 deaths in 2010 to 374 deaths in 2013. The CPU expects that as coroners' investigations progress and causes of death are confirmed, the 2013 frequency will be revised further upwards.

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1 The CPU definition of the term 'drug' is largely consistent with the Australian Bureau of Statistics (ABS) definition, encompassing substances that "may be used for medicinal or therapeutic purposes, or to produce a psychoactive effect". Like the ABS, the CPU excludes tobacco and volatile solvents such as petrol and toluene from its definition of a drug. However, the CPU considers alcohol to be a drug, whereas it is excluded under the ABS definition. See Australian Bureau of Statistics, "Drug-induced deaths: a guide to ABS causes of death data", 8 August 2002, p.2.

2 For example, if a person fatally assaulted another person while his or her mental state is affected by methamphetamine, this death would be excluded. Likewise, if a person drowned after stumbling off a pier while heavily intoxicated by alcohol and quetiapine, this would be excluded. Only drug overdose deaths are included.

Table 1: Annual frequency of overdose deaths by number of contributing drugs, Victoria 2010-2013.

Contributing drugs	2010	2011	2012	2013
Single drug	124 (35.5%)	138 (37.6%)	115 (31.3%)	113 (30.2%)
Multiple drugs	225 (64.5%)	229 (62.4%)	252 (68.7%)	261 (69.8%)
All overdose deaths	349 (100.0%)	367 (100.0%)	367 (100.0%)	374 (100.0%)

Overdose deaths by drug type, Victoria 2010-2013

Table 2a shows the annual frequency of Victorian overdose deaths by broad contributing drug type: pharmaceutical drugs, illegal drugs and alcohol. The bracketed figures are the frequencies expressed as percentages of overall overdose deaths for the year.

In interpreting the Table 2a data, it is important to note that where an overdose death involves more than one drug type, the death is counted under all relevant drug types. For example, a 2012 fatal overdose from heroin and diazepam would be counted both under pharmaceutical drugs (diazepam) and illegal drugs (heroin) for that year. This is why the percentages in Table 2a do not sum to 100%.

Table 2a: Annual frequency of overdose deaths by contributing drug types, Victoria 2010-2013.

Drug type	2010	2011	2012	2013
Pharmaceutical	267 (76.5%)	275 (74.9%)	305 (83.1%)	310 (82.9%)
Illegal	149 (42.7%)	153 (41.7%)	131 (35.7%)	164 (43.9%)
Alcohol	84 (24.1%)	88 (24.0%)	80 (21.8%)	93 (24.9%)

The data indicates that pharmaceutical drugs played a causal or contributory role in around 80% of Victorian overdose deaths between 2010 and 2013, whereas illegal drugs played a role in around 40% of deaths.

To explore the findings from Table 2a in further detail, the deaths involving pharmaceutical drugs were disaggregated by specific contributing pharmaceutical drug types. Table 2b shows the annual frequency and percentage of Victorian overdose deaths by the major pharmaceutical drug types that played a causal or contributory role.[3]

Table 2b: Annual frequency of overdose deaths by contributing pharmaceutical drug group, Victoria 2010-2013.

Pharmaceutical drug type	2010	2011	2012	2013
Benzodiazepines	168 (48.1%)	180 (49.0%)	196 (53.4%)	212 (56.7%)
Opioids	144 (41.3%)	183 (49.9%)	210 (57.2%)	191 (51.1%)
Antidepressants	105 (30.1%)	101 (27.5%)	141 (38.4%)	133 (35.6%)
Antipsychotics	64 (18.3%)	65 (17.7%)	77 (21.0%)	75 (20.1%)

3 Table 2b includes only pharmaceutical drug groups that contributed in an average of at least 12 overdose deaths per year. Pharmaceutical drugs are classified into groups using a slightly modified version of the 2010 Drug Abuse Warning Network (DAWN) Drug Vocabulary classifications; the main modification is that the DAWN 'anxiolytics' group was divided into benzodiazepine and non-benzodiazepine anxiolytics, and the DAWN 'analgesics' group was divided into opioids and non-opioid analgesics.

Non-benzodiazepine anxiolytics	28 (8.0%)	33 (9.0%)	37 (10.1%)	54 (14.4%)
Non-opioid analgesics	24 (6.9%)	30 (8.2%)	52 (14.2%)	41 (11.0%)
Anticonvulsants	13 (3.7%)	12 (3.3%)	9 (2.5%)	36 (9.6%)
Beta blockers	7 (2.0%)	4 (1.1%)	17 (4.6%)	15 (4.0%)
Gastrointestinal stimulants	8 (2.3%)	8 (2.2%)	14 (3.8%)	13 (3.5%)
Antihistamines	11 (3.2%)	11 (3.0%)	10 (2.7%)	11 (2.9%)

As with Table 2a above, if multiple pharmaceutical drug types contributed to a death then the death was counted separately under each drug type, which is why the percentages do not sum to 100%. Table 2b shows that benzodiazepines and opioids were the two most frequent contributing pharmaceutical drug types in Victorian overdose deaths between 2010 and 2013, followed by antidepressants and antipsychotics.

Individual drugs in overdose deaths, Victoria 2010-2013

Table 3 shows the annual frequency of Victorian overdose deaths by individual drugs that played a causal or contributory role.[4] The bracketed figures are the frequencies expressed as percentages of all overdose deaths for the year.

Table 3: Annual frequency of overdose deaths by individual contributing drugs, Victoria 2010-2013.

Drug	Drug type	2010	2011	2012	2013
Diazepam	Benzodiazepine	109 (31.2%)	124 (33.8%)	131 (35.7%)	164 (43.9%)
Heroin	Illegal drug	139 (39.8%)	129 (35.1%)	109 (29.7%)	132 (35.3%)
Alcohol	Alcohol	84 (24.1%)	88 (24.0%)	80 (21.8%)	93 (24.9%)
Codeine	Opioid	56 (16.0%)	66 (18.0%)	91 (24.8%)	71 (19.0%)
Methadone	Opioid	55 (15.8%)	72 (19.6%)	74 (20.2%)	70 (18.7%)
Oxycodone	Opioid	39 (11.2%)	46 (12.5%)	46 (12.5%)	60 (16.0%)
Methamphetamine	Illegal drug	14 (4.0%)	29 (7.9%)	34 (9.3%)	50 (13.4%)
Alprazolam	Benzodiazepine	57 (16.3%)	43 (11.7%)	55 (15.0%)	45 (12.0%)
Quetiapine	Antipsychotic	37 (10.6%)	34 (9.3%)	40 (10.9%)	41 (11.0%)
Paracetamol	Non-opioid analgesic	20 (5.7%)	24 (6.5%)	50 (13.6%)	39 (10.4%)
Mirtazapine	Antidepressant	20 (5.7%)	23 (6.3%)	26 (7.1%)	30 (8.0%)
Nitrazepam	Benzodiazepine	16 (4.6%)	11 (3.0%)	24 (6.5%)	26 (7.0%)
Amitriptyline	Antidepressant	26 (7.4%)	22 (6.0%)	33 (9.0%)	25 (6.7%)
Citalopram	Antidepressant	21 (6.0%)	21 (5.7%)	25 (6.8%)	24 (6.4%)
Tramadol	Opioid	9 (2.6%)	15 (4.1%)	17 (4.6%)	24 (6.4%)
Doxylamine	Non-benzo anxiolytic	16 (4.6%)	11 (3.0%)	20 (5.4%)	23 (6.1%)
Temazepam	Benzodiazepine	23 (6.6%)	48 (13.1%)	36 (9.8%)	22 (5.9%)
Venlafaxine	Antidepressant	12 (3.4%)	16 (4.4%)	15 (4.1%)	20 (5.3%)
Clonazepam	Benzodiazepine	9 (2.6%)	14 (3.8%)	18 (4.9%)	19 (5.1%)
Oxazepam	Benzodiazepine	19 (5.4%)	44 (12.0%)	41 (11.2%)	17 (4.5%)
Olanzapine	Antipsychotic	18 (5.2%)	17 (4.6%)	22 (6.0%)	15 (4.0%)
Zopiclone	Non-benzo anxiolytic	3 (0.9%)	6 (1.6%)	13 (3.5%)	14 (3.7%)
Metoclopramide	Gastrointestinal stimulant	8 (2.3%)	8 (2.2%)	14 (3.8%)	13 (3.5%)
Valproic Acid	Anticonvulsant	9 (2.6%)	5 (1.4%)	5 (1.4%)	13 (3.5%)
Sertraline	Antidepressant	6 (1.7%)	4 (1.1%)	12 (3.3%)	12 (3.2%)

4 Table 3 includes only drugs that contributed in at least 30 overdose deaths across the four-year period. Certain drugs (such as pregabalin and propranolol) were significant contributors in 2013 but not previous years, and were not included in Table 3.

Duloxetine	Antidepressant	5 (1.4%)	7 (1.9%)	14 (3.8%)	11 (2.9%)
Fentanyl	Opioid	2 (0.6%)	5 (1.4%)	17 (4.6%)	11 (2.9%)
Fluoxetine	Antidepressant	9 (2.6%)	8 (2.2%)	14 (3.8%)	10 (2.7%)
Risperidone	Antipsychotic	3 (0.9%)	11 (3.0%)	8 (2.2%)	10 (2.7%)
Amphetamine	Illegal drug	10 (2.9%)	19 (5.2%)	11 (3.0%)	9 (2.4%)
Morphine	Opioid	10 (2.9%)	10 (2.7%)	13 (3.5%)	7 (1.9%)
Promethazine	Antihistamine	10 (2.9%)	8 (2.2%)	8 (2.2%)	6 (1.6%)

As with Tables 2a and 2b, deaths where multiple drugs contributed were separately counted for contributing drug, which is why the percentages do not sum to 100%. Diazepam and heroin were the two most frequent contributing drugs in Victorian overdose deaths between 2010 and 2013, followed by alcohol. Three pharmaceutical opioids (codeine, methadone and oxycodone) comprised the next most frequent contributing drugs.

APPENDIX 2

Summary of the Prescription Shopping Program

The Prescription Shopping Program is administered by Medicare under the *Medicare Australia (Functions of Chief Executive Officer) Direction 2005 (Cth).* This defines a prescription shopper as

"a person who, within any 3 month period (being the 3 month period ending on 31 December 2002, or a later period):

(a) has had supplied to him or her pharmaceutical benefits prescribed by 6 or more different prescribers; or

(b) has had supplied to him or her a total of 25 or more target pharmaceutical benefits; or

(c) has had supplied to him or her a total of 50 or more pharmaceutical benefits" (regulation 30(2))

The "target" pharmaceutical benefits are defined in regulation 30(1) and include analgesics, psycholeptics, and central nervous system drugs.

The Chief Executive Officer of Medicare is given certain functions in relation to prescription shoppers. These include:

a. An education and prevention function which includes promoting awareness of the Prescription Shopping Project and promotion of measures to assist health care providers to manage prescription shoppers or people who may be at risk of prescription shopping (reg 30(6));

b. An identification and detection function, which is, includes identification of prescription shoppers, prescribers prescribing pharmaceutical benefits to prescriptions shoppers and approved suppliers to prescription shoppers (reg 30(7)).

c. A disclosure function including disclosing PBS information about whether or not a person is a prescription shopper to the prescription shopper, a prescriber and approved supplier.

The Prescription Shopping Program website indicates that the program offers two services:

d. The Prescription Shopping Information Service that is available to registered prescribers 24 hours a day 7 days a week to provide information on the prescribing history of people identified by the program, accurate up to the last 24 hours (available

by phone, online, mail or fax). Legislation provides that this information is available without the patient's consent;

e. An alert service provided by the Prescription Shopping Program where Medicare may send out a PBS Patient Summary Report notifying if a prescriber has prescribed to a patient of concern.

The frequently asked questions section of the website indicates, in response to the question why do patients get more medicines than they need, it suggests four responses, stockpiling for later use, drug dependence, selling, exchanging or giving to relatives or illegally exporting it overseas.

APPENDIX 3

Summary of Schedule 4 and Schedule 8 drugs

Section 4 of the *Poisons and Therapeutic Goods Act 1966 (NSW)* (the Act) defines:

a. A "*restricted substance*" as any substance specified on Schedule 4 of the Poisons List; and

b. "*Drug of addiction"* as any substance specified in Schedule 8 of the Poisons List. Oxycodone and Morphine sulphate are Type C drugs of addiction (as defined in s 28 of the Act). Buprenorphine (other than in transdermal patches) is a Type B drug of addiction.

Section 10 of the Act restricts the supply of Schedule 4 drugs to those who fall within various categories, including a medical practitioner, and a pharmacist in accordance with the prescription of a medical practitioner.

Section 28 provides restrictions on the prescription or supply of drugs of addiction.

It precludes the supply of a type B drug of addiction for a period of 2 months or more without an authority.

It precludes the supply of a type C drug of addiction without an authority under s 29 of the Act to supply the drug of addiction to the person concerned if *"in the opinion of the medical practitioner or nurse practitioner, [the person] is a drug dependent person"* (unless authorised by the regulations to prescribe that drug without an authority).

There is an exception to s 28 under regulation 83 if:

> *(a) the medical practitioner or nurse practitioner is of the opinion that the person requires the use of the drug in the course of treatment as an in-patient in a public hospital or private health facility, and*
> *(b) the prescription is for a course of treatment for a period of not more than 14 days following the person's admission as an in-patient.*

There are other exceptions to the requirements of s 28 in regulations 83& 84, in particular In relation to methadone and buprenorphine if the holder has a particular authorisation to prescribe the drug of addiction, and also in relation to some prescriptions for amphetamines.

Authorities under s 29 relate to the specific drug of addiction and the specific person for whom the drug is prescribed. It may specify the maximum quantity of the drug that may be prescribed, the period, and may be given subject to conditions.

Under regulation 77 of the Poisons and Therapeutic Goods Regulations 2008 (NSW) (the Regulations) a person must not issue a prescription for a drug of addiction unless authorised to do so. Under regulation 78, no such prescription can be issued unless for the purpose of medical treatment. Under regulation 79 there is a requirement that "An authorised practitioner must not issue a prescription for a drug of addiction in a quantity, or for a purpose, that does not accord with the recognised therapeutic standard o what is appropriate in the circumstances". Under regulation 80, the form of the prescription must include details, including the maximum number of times the drug may be supplied on the prescription and "the intervals at which the drug may be supplied on the prescription". Under regulation 82 an authorised practitioner must make a record of these particulars and keep it at their surgery, hospital or office.

Under regulation 86, a pharmacist may not then supply a drug of addiction if the prescription is within the proscribed interval of time. Under regulation 87, a pharmacist must not supply a drug of addiction unless he is familiar with the prescriber, knows the person for whom the drug is prescribed, or has verified that the person who is purported to have issued the prescription has actually issued the prescription.

Restricted substances, i.e. schedule 4 drugs, are regulated under Part 3 of the Regulations. The form of the prescription is regulated by regulation 35. As regards a special restricted substance (defined in appendix B to the regulations) there are additional requirements, including the time interval for filling of repeat prescriptions.

The Act and the Regulations also deal with what are described as "prescribed restricted substances". These are defined in regulation 61(1) as those listed in Appendix D to the Regulations (Appendix D). Quantities of prescribed restricted substances are set out in Appendix D. Possession of a quantity of a prescribed restricted substance in excess of that set out in Appendix D leads to a rebuttable evidentiary presumption of possession for the purpose of reply.

APPENDIX 4

Summary of the Pharmaceutical Benefits Scheme

1. The PBS is governed by the *National Health Act 1953 (Cth)* (**NHA**) and the *National Health (Pharmaceutical Benefits) Regulations 1960 (Cth)* (**NH Regs**). These place various restrictions upon the supply of medication under the PBS. In particular:

    a. Under s 85(7) of the NHA the Minister may, by legislative instrument, determine the circumstances in which a prescription for the supply of a particular pharmaceutical benefit may be written. Under paragraph 10 of the the *National Health (Listing of Pharmaceutical Benefits) Instrument 2012,* it is provided that these circumstances are set out in the Schedule to that Instrument. These are described as the "prescription circumstances".

    b. Under s 85A the Minister may determine, by reference to strength, type of unit, size of unit or otherwise the form or forms of a pharmaceutical benefit that are allowable for prescription, the maximum number of occasions on which the supply may be repeated, and the manner of administration that may be directed to be used.

    c. By way of example, in relation to Alprazolam, the *National Health (Listing of Pharmaceutical Benefits) Instrument 2012* provides for prescription under the PBS of tablets in 250 micrograms, 500 micrograms, 1 mg or 2 mg, to be administered in an oral form, with a maximum pack quantity of 50. C1975 is the prescribed circumstance in which it may be prescribed, and this is defined in Schedule 4 to the *National Health (Listing of Pharmaceutical Benefits) Instrument 2012* as "*panic disorder where other treatments have failed or are inappropriate*". The permitted number of repeats varies from 0 to 2. The "Authority Requirements" identify that compliance with Authority Required Procedures is required.

    d. According to regulations 11-13 of this Instrument, means that a prescription must be submitted by the authorised prescriber to the Chief Executive Medicare (by a number of possible methods, including telephone) and authorised by the Chief Executive Medicare (again including by telephone).

    e. The restrictions upon supply of PBS prescriptions are readily available on the PBS website. They include the indications for the prescription of particular medications,

or particular forms or strengths of medications. By way of example, for Mirtazapine, the circumstance in Schedule 1 to the Instrument is C1211. This is “major depressive disorders”. A search on the website for the PBS identifies the restriction for supply of Mirtazapine as “major depressive disorders”.

f. Under regulation 14 of the Instrument, sets out procedures for a particular pharmaceutical benefit if the circumstances include a Streamlined Authority Code. If so, then the requirements of authorisation are taken to have been complied with and authorisation taken to have been given if the prescription is prepared and signed in accordance with subparagraph 12(1) (a) i.e. the prescription is delivered in the appropriate form to the Chief Executive Medicare with a Streamlined Authority Code on the prescription.

g. Regulation 24 enables a doctor to authorise the supply under a number of repeat prescriptions upon one single occasion.

APPENDIX5

Summary of Guidance from professional bodies

1. In relation, specifically, to the use of opioids, the NSW Therapeutic Assessment Group has provided prescribing guidelines for primary care clinicians. These identify a number of key principles:

    a. The goal of the treatment of chronic pain is to control pain and maintain an acceptable level of functioning (p 1);

    b. Pain management requires a multi-modality approach, which emphasises the role of non-drug techniques (p 1);

    c. A written pain management plan, agreed between patient, general practitioners and pain management team, is an important component of treatment (p 1);

    d. A Step-wise approach should be adopted assessing response to medication after 2-3 weeks, with the steps being: first line – non-opioid analgesics, second line combination using non-opioids first and then substituting weak opioid analgesics such as Paracetamol + Codeine or Tramadol, third line strong opioid such as Oxycodone or morphine (p 3);

    e. Ideally assessment by a pain clinic or consultation with a pain physician should precede the prescription of oral opioids (p 3);

    f. In a patient known or suspected to be drug dependent there are sources of clinical advice, but "*Where drug-seeking behaviour is suspected … doctors should usually refuse to prescribe opioids unless they believe they are clinically indicated or unless that they feel they are putting themselves in danger by refusing*". Further, it is not appropriate to withhold analgesia from a patient who may be in genuine need of pain relief. … the worse error is to withhold analgesia" (p 4).

    g. Drug seeking behaviour should be suspected when a patient…seeks repeated supply of opioid…requests supplies of opioid in more than one form...requests opioid by name… has a lack of accompanying signs…attends multiple practitioners.

2. The Royal Australasian College of Physicians, The Faculty of Pain Medicine at the Australia and New Zealand College of Anaesthetists, the Royal Australasian College of General Practitioners and the Royal Australian and New Zealand College of Psychiatrists also published a Prescription Opioid Policy in April 2009 (Ex 3 Tab 3A). They recommended enhancement of clinical practice at the primary health care interface and greater training and research in opioid prescribing and the management of chronic non-malignant pain (p.38):

    a. Comprehensive assessment including somatic assessment of pain, psychological assessment, assessment of social environment and assessment of actual and potential substance use in patients and their family;

    b. A failure of adequate trial of other therapies, including the range of treatment options including non-pharmacological techniques;

    c. A contractual approach to opioid use including only one prescriber or team in charge of opioid prescriptions, reasonable and measurable goals, a contract with the patient, and particular caution with patients not known to the prescriber;

    d. Practical considerations, including emphasis on the outcome of improved function not just increased comfort, initiation of therapy as a trial with regular and careful review of both pain and function, monitor of usage using databases, pill counting and urine toxicology, maintaining good documentation, and considering opioid therapy as an adjunct not a sole modality;

    e. Response to apparent increase in dose requirements should be assessed, including asking whether tolerance has developed.

3. The NSW Department of Health, in December 2008, published guidance on Responsible Opioid Prescribing: identifying and handling drug seeking patients (Attached to Dr Ryan's report at Ex 3Tab 3A). One of the key recommendations of this report is that the prescriber should be satisfied as to the patient's pain state, that opioid medication is the most appropriate in the circumstances, and that a prescriber

obtains written independent support by an appropriate specialist for ongoing use, including a well documented treatment plan. It states quite clearly that ongoing prescription of opioid should only occur where medically appropriate and in accordance with recommendations from a specialist, with clearly documented treatment goals and the treatment of interventions planned to achieve them (pp1&3). In these guidelines, the indicators of behaviour that may raise a suspicion of drug seeking include:

a. Seeking after hours appointments

b. Stating that he or she is travelling or visiting friends

c. Claims to have lost a prescription or that the medication was stolen or damaged

d. Exaggeration or feigning of medical problems

e. Inability or unwillingness to provide name of regular doctor

f. States that a specific non-opioid drug does not work

g. Request of particular opioid medication by name(identified as leading to particular suspicion)

The risks of providing an opioid to a person who is suspected of abusing them were noted to include:

- Diverting opioids to the illicit market
- Promoting or maintaining a patient's drug dependence
- Missing an opportunity to refer for treatment of dependence
- Increasing the risk of overdose or possibly death
- Interfering with a patient's existing drug treatment

4. The Pharmaceutical Society of Australia has published guidelines (attached to M O'Donnell's report Ex 3 Vol 1 Tab 2)on dispensing. A pharmacist is required to ensure that the medication is appropriate for the needs of the patient, and there is a requirement to contact the prescriber if there is doubt about the suitability of the medicationfor the patient, if there is potential for drug misadventure, or if there is apparent or underutilisation. These guidelines provide that the patient's consent should be obtained, when possible (p 2). Any interaction with the prescriber should be documented. If the prescriber is unavailable, or is unwilling to accept the pharmacist's advice, the pharmacist must make a professional judgement as to what action is required to satisfy their duty of care to the patient (p 2). This make clear that the pharmacist is required to do more than play a subsidiary role, but must independently consider the appropriateness of the supply of the particular medication.