CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the deaths of Lars Falkholt; Vivian Falkholt; Jessica Falkholt and Annabelle Falkholt, and Craig Whitall
Hearing dates:	8 -11 June 2021
Date of findings:	21 December 2021
Place of findings:	Coroners Court, Lidcombe
Findings of:	State Coroner O'Sullivan
Catchwords:	CORONIAL LAW – traffic incident – five deaths – manner of driving – methadone dispensing – impact of various medications – adequacy of treatment in regional areas – expert evidence
File Number:	2017/00391031

Representation:	Ms D Ward SC assisting the Coroner, instructed by L Nash (Crown Solicitor’s Office)
	Mr S Barnes, instructed by J Kamaras (Avant Mutual Group) for Dr McLeod
	Mr T Saunders, instructed by N Brown (Meridian Lawyers) for Dr Rossi
	Ms G Furness, instructed by F Menniti (Curwoods) for Illawarra and Shoalhaven Local Health District and Ministry of Health
	Mr B Hearnden (Hunt & Hunt Lawyers) for Transport for NSW
	Ms S McCarthy, instructed by L McCarthy (HWL Ebsworth) for Dr Alsha'Er
	Ms R Mathur, instructed by K Poh (Moray & Agnew) for Dr Geary and Dr Venables

Findings

Identity:

Lars Falkholt

Place of death:

Princes Highway, Conjola

Date of death:

He died on 26 December 2017.

Cause of death:

He died from multiple injuries.

Manner of death:

He died as a result of a motor vehicle collision

Identity:

Vivian Falkholt

Place of death:

Princes Highway, Conjola

Date of death:

She died on 26 December 2017.

Cause of death:

She died from multiple injuries.

Manner of death:

She died as a result of a motor vehicle collision

Identity:

Annabelle Falkholt

Place of death:

Liverpool Hospital.

Date of death:

She died on 29 December 2017.

Cause of death:

She died from multiple blunt force injuries.

Manner of death:

She died as a result of a motor vehicle collision

Identity:

Jessica Falkholt

Place of death:

St George Hospital

Date of death:

She died on 17 January 2018.

Cause of death:

Complications of multiple blunt force injuries

Manner of death:

She died as a result of a motor vehicle collision

Identity:

Craig Whitall

Place of death:

Princes Highway, Conjola

Date of death:

He died on 26 December 2017.

Cause of death:

Combined effects of multiple blunt force injuries and the effects of fire.

Manner of death:

He died as a result of a motor vehicle collision.

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Introduction

1. This inquest concerns the deaths of Lars, Vivian, Annabelle and Jessica Falkholt and Craig Whitall.

2. On the morning of 26 December 2017 Mr Whitall was driving a blue Toyota Prado (**Prado**) south from Nowra along the Princes Highway. He failed to negotiate a bend near the Princes Highway intersection with Luncheon Creek Road, just north of the turn-off to Bendalong. The Prado crossed into the northbound lane and collided with a white Mazda CX3 (**white Mazda**) heading north. This car was being driven by Lars Falkholt.

3. Three people died at the scene: Lars Falkholt, the driver of the white Mazda, his wife, Vivian Falkholt, who was sitting next to her husband; and Craig Whitall, the driver of the Prado. Annabelle Falkholt, the 20-year-old daughter of Mr and Mrs Falkholt, survived the accident and was airlifted to Liverpool Hospital. Her 28-year-old sister, Jessica, also survived the accident and was airlifted to St George Hospital. Both sisters sustained horrific injuries and tragically, they both succumbed to their injuries. Annabelle died on 29 December 2017, whilst Jessica died on 17 January 2018.

4. The tragedy of the events was compounded by the fact that the accident occurred on Boxing Day: a day when many of us look forward to celebrating with our family and friends. The graphic impact of the collision, together with the seemingly random nature of the accident reverberated throughout the community and, unsurprisingly, the accident received extensive media coverage. Paul Ponticello was Vivian's only sibling. He attended the inquest, in part accompanied by his daughter Natalie. His grief was evident. Graciously, he shared with the court memories of his sister, his brother-in-law Lars, and his two beautiful and much-loved nieces, Annabelle and Jessica. Mr Ponticello described Vivian and her family as gentle souls, who were extremely close-knit and devoted to each other. He recounted a deep mutual love between him and Vivian and that he always thought they would grow old together. He described Lars as the love of Vivian's life and noted that, together, they were immersed in their girls' lives.

5. Jessica had followed her childhood dreams and pursued an acting career, where she was very much carving out a successful path for herself, appearing in many well-known television series, including *Home and Away*, as well as a feature length movie titled *Harmony*, which was released after her death.

6. Annabelle's gentle and caring nature led her to seek employment in early childcare, which she enjoyed greatly and excelled at. Her friends remembered her radiance and

kindness, and that she loved to laugh, her laughter being a fond memory for many of them.

7. Equally, Lars' family also attended the inquest remotely from Sweden, where Lars was born. Ingrid, Marie, Leif, Krista and Beau Falkholt all intermittently logged into the proceedings, notwithstanding that they occurred during the middle of the night in Sweden. They described Lars as a wonderful brother who was loving, caring and honest. They stated that Vivian and his daughters meant everything to him. The tyranny of distance compounded their loss and heightened their sense of helplessness. They recalled a lifelong friendship between Lars and his best friend Alta. This friendship spanned 57 years and took both Lars and Alta to Australia. The Falkholt family described their closeness to Lars, Vivian and the girls and recalled many special memories forged in Sweden and Australia during visits.

8. The loss of Lars, Vivian, Jessica and Annabelle remains ever present and their extended families' grief is ongoing. I extend my sincerest condolences to the various family members left behind by this tragedy, both in Australia and in Sweden.

9. The families of both Vivian and Lars expressed their deep gratitude to everyone who assisted in extricating Jessica and Annabelle from the wreckage, as well as to the first responders and medical teams at Liverpool and St George Hospitals. I very much echo those expressions of gratitude. Particular mention should be given to the community members who happened upon the fatal accident and attempted to assist Jessica and Annabelle, at considerable personal risk. As Mr Ponticello noted, their actions provide him with the reassurance and knowledge that his family was not alone following the accident, but were being supported, and given the best chance for recovery that the circumstances would allow. The heroic actions of many community members and off-duty medical staff was notable throughout the documentary material collated in the brief of evidence. I thank these people, and all of the treating medical staff, for their actions and best efforts.

10. In circumstances such as these and given the terrible consequences of Mr Whitall's driving on that fateful day, it is easy to overlook the fact that a fifth person died as a result of the collision. I acknowledge that the Whitall family too, lost someone they loved. Mr Whitall may have had a troubled life and many flaws, but he was still part of a family who miss and mourn him. His mother, sisters and daughter all participated in the inquest in a dignified manner and did not wish to detract from its, which they very much wished to be upon the memories of the Falkholt family. I acknowledge their loss. I extend my sincere condolences to the Whitall family, including Mr Whitall's son.

The role of the coroner

11. The role of the coroner is to make findings as to the identity of the deceased persons and in relation to the place and date of their death. The coroner is also tasked with addressing issues concerning the cause and manner of the death. A coroner may also make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.

12. In this case, there was no dispute in relation to the identity of the deceased persons or the date or place of their death. Equally, the medical cause of Mr Whitall's death and each of the members of the Falkholt family was adequately known. They each died from injuries sustained in a motor vehicle accident that occurred on 26 December 2017. The focus of the inquest, therefore, was in relation to the manner or circumstances of the deaths and this required significant investigation.

13. In short, the inquest was concerned with understanding the various factors that led to Mr Whitall's Prado failing to take the left hand bend on the Princes Highway near Luncheon Creek Road and causing him to fatally collide with the white Mazda driven by Mr Falkholt and carrying his entire family.

The issues

14. A list of issues was prepared before the proceedings commenced and circulated to the parties. The issues explored at inquest included:

    1) Consideration of the weather, road and traffic conditions in the vicinity of the Princes Highway, near Bendalong Road, on the morning of 26 December 2017.

    2) The progress of the Prado in a southerly direction along the Princes Highway, Bendalong leading to a collision with the white Mazda travelling in a northerly direction along the Princes Highway near the intersection with Bendalong Road.

    3) Mr Whitall's driving history.

    4) Toxicology results for Mr Whitall and the likely effects of the following drugs and their metabolites (alone and in combination) on Mr Whitall's driving ability:

        a. Methamphetamine and amphetamine.

        b. Doxepin (tricyclic anti-depressant).

        c. Methadone.

d. Diazepam, nordiazepam, oxazepam, temazepam.

5) The prescribing and dispensing history for Mr Whitall and in particular, his access to doxepin and methadone and communication between prescribing doctors.

6) Mr Whitall's attendance at Milton Ulladulla Hospital on 25 December 2017 requesting methadone and leading to provision of 1 x 5mg tablet of diazepam (no methadone provided).

7) Mr Whitall's attendance at Shoalhaven District Memorial Hospital on 26 December 2017 requesting methadone and leading to provision of 4 x 5mg tablets of diazepam (no methadone provided).

The evidence

15. The court took evidence over four hearing days. The court also received extensive documentary material, compiled in a five-volume brief of evidence. This material included witness statements, medical records and expert reports. While I do not intend to refer to all of the material in detail in these findings, it has been comprehensively reviewed and assessed.

16. I have taken particular care to review statements from each of the people who came upon the accident scene and rendered whatever assistance they could. This included a number of motorists who had earlier observed the Prado driving erratically along the Princes Highway. Some of this evidence will be specifically considered below.

17. In addition to oral evidence from the officer in charge, Senior Constable Christopher Warren, the following witnesses gave evidence:

1) Dr Francis McLeod, a general practitioner and Opioid Treatment Program (**OTP**) prescriber;

2) Dr Francesco Rossi, a general practitioner working at Ulladulla Medical Clinic;

3) Dr Qays Alsha'Er, a senior medical officer at the Milton Ulladulla Hospital;

4) Dr Amanda Venables, a general practitioner at Milton Medical Centre and a visiting medical officer at the Milton Ulladulla Hospital;

5) Dr Brona Geary, staff specialist in the emergency department at Shoalhaven District Memorial Hospital;

6) Professor Paul Haber, a specialist in addiction medicine, gastroenterology and hepatology;

7) David Reid, the director the Illawarra Shoalhaven Local Health Districts Drug and Alcohol Service;

8) Dr Michael Robertson, a pharmacologist and forensic toxicologist;

9) Dr Judith Perl, a pharmacologist;

10) Dr Robert Day, a senior staff specialist in emergency medicine;

11) Associate Professor Randall Greenberg, the director of critical care for the Dubbo health service.

18. I thank all of the witnesses for their willingness to assist the court. No doubt many of the medical professionals from the South Coast community have been affected by the accident, and it would have been taxing for them to recount their decision-making and thought processes two and a half years after the incident occurred. I also wish to thank the experts who prepared reports for the court, in addition to providing oral evidence. This allowed the court to better understand the complexities surrounding the lead up to the accident.

Structure of these findings

19. In both opening and closing submissions, counsel assisting provided a detailed chronology and review of the evidence before this court. I accept counsel assisting's summary of the evidence as accurate and reproduce much of it below. I note that the other interested parties did not significantly depart from any of the submissions made by counsel assisting and, accordingly, it provides a helpful chronology of the events that led to the accident on 26 December 2017, in addition to outlining the expert evidence received.

20. Relevant factual findings will be addressed below in relation to the specific issues I determined should form the focus of the coronial inquest. Before addressing those issues, I will briefly and separately refer to Mr Whitall's long term participation in the NSW OTP and the other medications that he was regularly prescribed.

21. I will also here provide an overview of the events of 25 and 26 December 2017, although those events will be addressed in greater detail further in these findings.

The NSW Opioid Treatment Program and Mr Whitall's methadone history

22. Methadone is a medication used to assist people living with an addiction to opioids The OTP provides opioid replacement therapy to participants, mostly in the form of methadone (although this has shifted in recent times and now increasingly involves

buprenorphine). The goal of the methadone program is to stabilise opioid dependent patients through the provision of regular and safe dosing. Some patients may gradually reduce their dependence upon methadone and perhaps reach a point where they no longer require the medication. Others might continue on the program but reach a level of stability that permits them to live a productive life within their community.

23. Opioid dependence is a chronic and relapsing disorder that affects an individual's physical and mental health. Reducing opioid dependence is a major focus of drug and alcohol treatment services due to the immense harm to both the opioid user, and the community at large, that is inherent in an addiction to illicit opiates.

24. The OTP guidelines included in the brief of evidence provide a comprehensive overview of the OTP, including its goals and guiding principles for practitioners working in this area. New participants on the OTP must take observed doses of methadone. This is an onerous but necessary requirement. Over time however, if OTP participants stabilise, both in terms of their dosage and their opioid use, they may be permitted to take some of their methadone doses at home. These are known as takeaway doses. There are limits as to how many takeaway doses an OTP participant can obtain, which will depend predominantly on a person's length of participation in the OTP and stable dosing. Each OTP participant is overseen by a medical practitioner who oversees their methadone dosing and scripts.

25. Mr Whitall commenced on the OTP after a history of heroin use. He had experienced some difficult events and personal tragedies in his life which had long-term effects upon him. Mr Whitall had been taking methadone as part of the OTP since 1990 and accordingly, he had been on the OTP for more than 20 years.

26. Dr Frank McLeod was Mr Whitall's OTP prescriber at the time of his death. Mr Whitall had predominantly consulted with Dr McLeod on and off since 1997, and full time since 2010. Dr McLeod gave evidence that he was initially a General Practitioner (**GP**) who also prescribed methadone to patients who were on the OTP. He oversaw Mr Whitall's methadone dosing. Dr McLeod later obtained an additional qualification in addiction medicine.

27. Dr McLeod provided evidence that Mr Whitall's methadone dose was 160mg (32ml) daily in 2001 but slowly, over time, this was reduced to 145mg (29ml) daily. He had not found opioids to be a problem with Mr Whitall for many years and regarded him as stable in this respect. Because of this stability, Mr Whitall was permitted takeaway doses of methadone.

28. Dr McLeod explained that the long term goals for Mr Whitall were:

> "…*to keep him out of gaol and normalise his life as best we could. He'd had a very long and sort of fractured history and a lot of contact with custodial and, and legal, legal services. So, it's to try and normalise his life as best he can as long as it's safe and legal*."

29. The documentary evidence showed that Mr Whitall's methadone dosing arrangements changed over the years he participated in the OTP. He had periods of daily supervised dosing and periods when he stabilised on the OTP and was able to manage some takeaway doses. This involved Mr Whitall literally taking away doses a few days each week to consume at home without needing to travel every day to receive a daily dose of his medication.

30. Mr Whitall also had periods when he was required to attend the Lawrence Avenue Methadone Program (**LAMP**), based at the Nowra Community Health Centre adjacent to the Shoalhaven District Memorial Hospital, to receive his methadone. At other times he was able to get his methadone from local pharmacies in accordance with prescriptions issued by Dr McLeod.

31. Mr Whitall was not an easy patient. At times he could be aggressive, demanding and intimidating, and local pharmacies would decline to provide his methadone.

32. Dr McLeod explained some of the complexities with treating patients who suffer from addiction and described Mr Whitall as a "*high maintenance*" patient, meaning he was difficult to keep going in a positive direction.

33. By way of example, on 5 October 2017 Mr Whitall was refused a methadone dose from his local dispensing pharmacy in Mollymook because he had already been provided with an extra takeaway dose earlier in the week. According to an account from the pharmacy provided to Dr McLeod, Mr Whitall was distressed about not getting his extra dose and he went to walk into the dispensary area of the pharmacy. A female staff member needed to physically put her hand on Mr Whitall's chest to stop him from entering and had to call on support from another staff member. The pharmacy then banned him from further attendance.

34. Given the limited pharmacies available in the area that dispensed methadone, Mr Whitall had to return to LAMP for the purpose of receiving his methadone in person (observed) for a period of about 10 days, ending on 17 October 2017, when he was able to transfer his methadone dispensation back to takeaways, at another pharmacy; Chemist Outlet in Nowra.

35. This was significant because whether he was attending LAMP or Chemist Outlet in Nowra to receive his methadone, Mr Whitall needed to travel to Nowra from his home in Ulladulla, a distance of some 63km each way. Whilst it is true that it was Mr Whitall's

own conduct that saw him banned from pharmacies closer to home, it is also true that he needed to regularly travel in excess of 120km just to receive the medication he needed to manage one of his complex health problems.

36. By late 2017, Mr Whitall's methadone prescribing typically involved attending Chemist Outlet in Nowra on Mondays, Wednesdays and Saturdays, with the standard days for his takeaway doses being Tuesdays, Thursdays, Fridays and Sundays.

Other medication prescriptions

37. Methadone was not the only medication Mr Whitall was regularly prescribed. Dr McLeod would provide Mr Whitall with scripts for diazepam to take on days where Mr Whitall was due to have takeaway doses of methadone. This was to assist with the onset of withdrawal symptoms prior to taking the takeaway methadone dose.

38. In addition, the evidence demonstrated that Mr Whitall would also sometimes attend Milton Ulladulla Hospital or Shoalhaven District Memorial Hospital requesting diazepam.

39. Dr McLeod also prescribed Mr Whitall the antidepressant doxepin (brand name Deptran). During his evidence, Dr McLeod explained that doxepin was no longer a popular antidepressant due to its significant side effects, including cardiac arrythmias, dry mouth, trouble passing urine, constipation, blurred vision and increased somnolence with higher doses. Historically, it was typically provided to inmates in custody and some inmates, such as Mr Whitall, continued using it once released. Dr McLeod noted that these days, antidepressants have modernised and doxepin is no longer routinely prescribed, however Mr Whitall remained on it because he had been using it in prison for its sedative effect. Dr McLeod was trialling reducing Mr Whitall's doxepin dosage in order to move him to a safer, newer and different type of antidepressant.

40. The evidence amply demonstrated that Mr Whitall would sometimes attend other local general practitioners seeking additional doxepin scripts even though Dr McLeod was regularly prescribing the medication for him at a rate that, if Mr Whitall had been taking the medication as prescribed, would have been adequate for his needs.

41. No single doctor was aware of the extent of the prescribing by other doctors, something that was confirmed by several doctors during their oral evidence and will be specifically referred to below in relation to the fifth issue on the issues list.

42. At this stage, it is sufficient to observe that on occasions, various local doctors would provide Mr Whitall with doxepin scripts based upon his report of running short of the medication. At times some doctors would prescribe him with just enough to get Mr

Whitall through the day so that he could call Dr McLeod (his prescribing doctor) the following day to sort out his prescription. On other occasions, Mr Whitall would receive a prescription with two repeats from a local doctor even though Dr McLeod had prescribed sufficient doxepin to cover the period in question.

The events of 25 and 26 December 2017- an overview

43. Throughout 2017, Mr Whitall was living in Ulladulla. On 25 December 2017, he spent time with his mother and in the afternoon, Mr Whitall drove his mother to his sister's house to feed her cat before driving his mother back home.

44. In the evening of 25 December 2017, Mr Whitall then attended Milton-Ulladulla Hospital, which was only a short drive from his home, seeking methadone. He was triaged by a registered nurse at about 18:37. The triage form noted that Mr Whitall was "*reducing methadone did not realise chemist would be closed unable to attain todays and tomorrow's dose. Now experiencing leg cramps and fells is beginning to withdraw* (sic)". It was noted that he was usually administrated 27mls of methadone daily by Chemist Outlet Nowra.

45. On that occasion, the medical officer who saw Mr Whitall, Dr Qays Alsha'Er, provided him with 1 x 5mg tablet of diazepam at 20:00 and a referral letter was written to Dr Francesco Rossi, a GP that Mr Whitall attended from time to time.

46. On the morning of 26 December 2017, Mr Whitall drove the 63 kilometres to Nowra to attend Shoalhaven District Memorial Hospital, again seeking methadone. The triage form noted that he had been seen at Milton Ulladulla Hospital the previous evening, and that Mr Whitall was regularly dosed with 129 millilitres of methadone daily. It was noted that Mr Whitall was seeking methadone as he had not realised that the dispensing chemist would be closed over the Christmas holiday period.

47. It should be noted at this stage that contrary to what he was telling hospital staff, I am satisfied Mr Whitall had in fact been given sufficient prescriptions from Dr McLeod and had received sufficient takeaway doses of methadone to cover the holiday period.

48. The Shoalhaven District Memorial Hospital discharge referral was entered at 10:02 and a referral letter was again written to Dr Rossi. It noted that Mr Whitall "*presented to this facility requesting Methadone. He stated he was not organised enough and his Pharmacy didn't think to plan ahead for his dispensing across the Christmas period*". The letter also noted that 20mg of Valium (diazepam) had been supplied to Mr Whitall and that he was told to "*sort his prescription out as soon as practicable tomorrow*". The hospital pharmacy records indicate that Mr Whitall was provided with 20 mg of Valium at 09:50. This was in the form of 4x5mg tablets.

49. The decision to provide Mr Whitall with 20mg of Valium needs further consideration, and will be outlined in detail below, however at this stage it is sufficient to note that at some time after 09:50, Mr Whitall left Shoalhaven District Memorial Hospital in Nowra and started driving his Prado south on the Princes Highway back towards Ulladulla.

50. The court received extensive documentary evidence regarding the manner in which Mr Whitall drove along the Princes Highway after leaving Nowra.

51. Mr Martin Jones provided a statement to the court, noting that as he was driving south on the Princes Highway on the morning of the accident, he saw the Prado parked on grass under some trees by the side of the road, near South Nowra. He noticed it because all the doors and even the rear window of the Prado were open. Mr Jones continued traveling south along the Princes Highway. As he reached a point on the highway where an overtaking lane merged back into a single southbound lane, he says he saw the Prado speed up and almost collide with him as it sought to get in front of his car prior to the lanes merging again. He said the Prado nearly clipped the side mirror of his car and then veered onto the shoulder of the road. Mr Jones thought the driver must have been reaching down for something but then seemed to overcorrect and swerve into the oncoming lane. Mr Jones records the Prado being driven aggressively and erratically, speeding up and then slowing down, attempting to overtake a caravan in front even before an overtaking lane appeared.Mr Jones backed off and the Prado took off once it got past the caravan. A short time later Mr Jones came upon the crash, although he did not witness it.

52. Mr Darren Collier was also driving south on the Princes Highway that day when the Prado overtook him on the inside lane and nearly collided with his side mirror. Mr Collier similarly described the driver of the Prado being all over the lane, cutting corners onto the verge and then, when the road straightened out, the Prado was "absolutely flying." Mr Collier came upon the scene just as the accident occurred.

53. Mr Roger Thomas was also driving south on the Princes Highway with his wife on 26 December 2017. He said the Prado overtook him and then instead of following the curve as the road moved into a left-hand bend, the Prado went straight ahead and crossed the double lines hitting an oncoming car (the white Mazda). Mr Thomas described the Prado flipping over and rolling towards the centre of the road.

54. Ms Lisa Elmas was driving south along the Princes Highway and also saw the Prado head onto the wrong side of the road and, as earlier described, collide with the oncoming car. The two vehicles were pushed up into a triangle before landing again.

55. The totality of the evidence from those who witnessed the Mr Whitall's Prado shortly before and during the accident points to Mr Whitall driving in an erratic and

dangerous manner. Whilst this driving tragically resulted in the death of the Falkholt family and Mr Whitall himself, it seems that there were other 'near misses' prior to the actual accident occurring.

56. In summary, after leaving Shoalhaven District Memorial Hospital at some time after 09:50, Mr Whitall proceeded to drive south along the Princes Highway, by all accounts erratically, at times drifting from his lane. As he approached the turnoff to Bendalong, Mr Whitall failed to negotiate a left-hand bend and crossed into the northbound lane at approximately 10:42 and collided with the white Mazda carrying the Falkholt family.

The issues to be explored in each inquest

Issue 1: The weather, road and traffic conditions in the vicinity of the Princes Highway, Bendalong on the morning of 26 December 2017.

57. These findings are largely drawn from the documentary evidence in the brief, coupled with some short additional oral evidence from the officer in charge of the investigation.

58. The officer in charge, Senior Constable Warren, has extensive experience in crash scene investigations and has been in the NSWPF Crash Investigation Unit since November 2007. He attended the accident scene at around 12:00 on 26 December 2017. He noted that the day was overcast, however visibility was good, the roadway was dry and the surrounding area (predominantly bushland) was dry. The bitumen was in good condition and there was no sign of foreign fluid or debris on the road that might have contributed to the crash.

59. Senior Constable Warren described the area of road where the crash occurred in the following way:

> *"Travelling south towards the area of impact there are overtaking lanes for approximately 600m. At the conclusion of the overtaking lane the southbound lanes merge into a single southbound lane. The southbound lane continues straight for approximately 200m. At the conclusion of the straight there is a long gradual left hand curve in the road. At the area of impact the road is relatively level."*

60. As such, Senior Constable Warren found no evidence that would suggest that the driving conditions on 26 December 2017 were anything other than good. Thus, he concluded weather and road conditions did not play any causative role in the crash.

61. This was further illustrated in several photographs of the scene that I received into evidence.

62. I note that Boxing Day holiday traffic meant the Princes Highway was busier than normal but there is no evidence that this directly contributed to the accident.

63. I accept Senior Constable Warren's evidence. I find that the weather, road and traffic conditions did not play a causative role in the accident that claimed the lives of the Falkholt family and Mr Whitall.

Issue 2: The progress of the Prado in a southerly direction along the Princes Highway, Bendalong leading to a collision with the white Mazda traveling in a northerly direction along the Princes Highway near the intersection with Bendalong Road.

Observations of other drivers

64. I have already outlined at paragraphs [50]-[55]the evidence from eyewitnesses to Mr Whitall's driving prior to the accident.

The collision

65. At this point it is important to note that Mr Falkholt had only two traffic offences on his driving record, which were separated by 23 years. He was by all accounts an exceptionally safe driver.

66. Further, I am satisfied that Mr Falkholt was driving appropriately at the time of the accident.

67. Although the Prado Mr Whitall was driving was largely destroyed in the ensuing fire, the wreckage of the vehicle was nonetheless further examined and did not reveal any fault or defect that might have contributed to the crash.

68. As I have noted above, Senior Constable Warren concluded that the collision was caused by the vehicle driven by Mr Whitall crossing onto the incorrect side of the road and entering the northbound lane.

69. I am satisfied that Mr Whitall, for reasons explored further below, lost control of his vehicle at approximately 10:42 on 26 December 2017, resulting in the Prado that he was driving leaving the southbound lane of the Princes Highway and crossing into the northbound lane. There it collided with the white Mazda, which was being driven by Mr Falkholt. I find that there was nothing that Mr Falkholt could have reasonably done to prevent the collision from occurring.

Events and assistance after the collision

70. I earlier briefly referred to the involvement of passers-by and first responders to the accident. Their involvement warrants more detailed comment.

71. Mr Collier described running up to Mr Whitall's car and noticing he was trapped but murmuring. Mr Thomas could see steam coming out from Mr Whitall's car when he first went over to it. He held Mr Whitall's hand until he passed away. When he left Mr

Whitall's car he could see smoke and "*knew the car was on fire*". Ms Elmas also noticed "*slight flames*" underneath Mr Whitall's car.

72. Mr Jones continued to the car of the Falkholt family. He noted that Lars appeared to be deceased. He then noticed Annabelle and Jessica in the rear of the car. He noted that the girl behind the driver (Annabelle) was semi-conscious but with significant injuries. He said the girl (Jessica) behind the passenger side of the car was unconscious and non-responsive. He then said he went to the lady in the front passenger seat (Vivian) and checked her pulse and "*there were no signs of life*".

73. Mr Collier also went to the car of the Falkholt family and spoke to Lars. He reached into the car and touched Lars' shoulder and got "*absolutely no response*" and Mr Collier could see that he was deceased. Mr Collier looked over at Vivian and could see that she was also deceased. He described Annabelle being "*quite with it, but in deep shock*". Mr Collier could see that she had bad injuries to both of her arms and to her forehead.

74. Mr Collier estimated that after about 10-15 minutes of being at the scene, he noticed a small fire in the engine of the Prado. Mr Jones recalled that, when Mr Whitall's car caught fire, the people assisting Annabelle and Jessica decided to get them out of the car. Annabelle was extricated first, just before Jessica. Mr Thomas described that Jessica was conscious and appeared to be breathing. She was placed into the recovery position. Jessica said a few words.

75. Senior Constable Darryn Threthewey and Senior Constable Belinda Wiley were the first police officers that attended the crash. They arrived after the Falkholt sisters had already been extricated from the car. Senior Constable Wiley "noticed that flames were coming from the front bonnet of the [Mr Whitall's] car". Senior Constable Wiley attempted to unsuccessfully extinguish the fire with her fire extinguisher. The car of the Falkholt family then also caught fire. Both Lars and Vivian could not be removed from their car prior to it setting alight.

76. The Falkholt sisters were moved further away from the burning vehicles.

77. Mr Aaron McNeil, an off-duty paramedic travelling north on the Princes Highway and Ms Rhianna Bunna, an off-duty nurse travelling south on the Princes Highway approached Senior Constable Wiley and Senior Constable Threthewey and offered their assistance. They both assisted with the medical care of the Falkholt sisters until they were airlifted to St George and Liverpool Hospitals respectively. At some point, ambulance services attended the scene and assisted in treating the Falkholt sisters. The fire brigade arrived and began putting out the fire to the cars, followed shortly afterwards by the medical teams from the medical helicopters. As noted earlier,

Annabelle and Jessica were subsequently airlifted to Liverpool and St George Hospitals.

78. Other civilians and first responders were likely involved in some form or another.

79. Although it is no doubt painful for the family to read the above detail, I wish to particularly acknowledge and thank in these findings the people who assisted the Falkholt family and Mr Whitall immediately following the accident.

Issue 3: Mr Whitall's driving history

Prolonged history of driving without a licence and associated offences

80. As counsel assisting emphasised in submissions, Mr Whitall first obtained his learner driver licence in February 2016, aged 49. This was notwithstanding the fact that Mr Whitall's driving record dated back to September 1983 when, aged 16, he was first charged with being an unlicensed driver. The seven pages of his driving record which I received into evidence make for difficult reading: there were numerous infringements for driving without a licence, driving whilst disqualified, driving an unregistered and/or uninsured vehicle.

81. Mr Whitall's driving record also extended to more serious offences, including PCA offences (driving with a prescribed content of alcohol in his blood) in 1983 and 1984 and a conviction for driving in a manner dangerous (in 1994).

82. Mr Whitall was declared a habitual traffic offender in 2005 and was incarcerated for 9 months in 2005 and for 16 months again later in that year. A 9-month sentence in 2011 was suspended upon entering a bond under s.12 of the *Crimes (Sentencing Procedure) Act 1999* (NSW).[1]

83. I accept counsel assisting's submission that Mr Whitall's driving record demonstrated a long-term willingness to ignore the "road rules" and legal requirements for safe and licensed driving. It also demonstrated that Mr Whitall was willing to drive even without a licence, or whilst disqualified from driving. Incarceration for driving offences did not seem to change his willingness to contravene the law, or at least did not change things immediately.

84. However, I also accept counsel assisting's submission that it appears Mr Whitall was trying to turn things around by 2016. I base this on two main factors.

85. Firstly, Mr Whitall finally committed to obtaining his driver licence, which allowed him to lawfully drive for the first time in his adult life. He finally obtained his provisional

[1] Section 12 of the *Crimes (Sentencing Procedure) Act 1999* was subsequently repealed as per Sch 1, [14] of the *Crimes Sentencing Procedure) Amendment (Sentencing Options) Act 2017* (NSW), commencing 24 September 2018.

licence in April 2016, despite being required to attend for various additional testing due to a neurological condition. I am here referring to an additional medical review by Dr McLeod and, separately, by a Professor of Neurogenetics (and a specialised driving examination conducted by an occupational therapist). None of these reviews suggested Mr Whitall was not fit to drive.

86. I accept that the evidence suggests that Mr Whitall was belatedly attempting to do the right thing by applying for his licence. Perhaps this was the result of the maturity that comes with age. This is something that Dr McLeod commented upon during his oral evidence, noting that Mr Whitall "*was really sort of maturing through some of the behaviours, the behaviours that got him into trouble earlier on*."

87. Secondly, Mr Whitall's driving offences had become less frequent and less serious in recent years, notwithstanding that Mr Whitall continued to breach the road rules right up until the date of the accident. As counsel assisting submitted, this is not to downplay the significance of Mr Whitall's behaviour, but rather to suggest that the nature of his offending became less serious over time, up until 26 December 2017.

88. Nevertheless, Mr Whitall's longstanding participation in the OTP, coupled with a history of significant driving infringements over the course of 33 years, raised important questions regarding his suitability to drive whilst he participated in the OTP.

89. This was specifically explored at the inquests, in particular through the expert evidence of Dr Judith Paul (pharmacologist) and Professor Paul Haber (addiction medicine specialist), who each have a special expertise in the effect of prescription and illicit drugs upon driving skills. I will now consider this evidence.

Driving and the OTP scheme

90. As discussed earlier, the OTP is a medically supervised program that aims to allow patients to stabilise and recover in a way that gives them an opportunity to better contribute to the community. Ideally, it can help people manage their addiction, protect them from other health and social problems arising from illicit drug use, and allow them to recover and contribute to the community. Of course, not every participant on the OTP will achieve all or any of these goals: one cannot generalise about individual progress through the program.

91. Importantly, participation on the OTP does not automatically bar someone from obtaining a driver licence. I accept that there are good reasons for this as outlined in the expert evidence below.

92. Dr Perl and Professor Haber each outlined specific research around the potential effect of methadone on driving skills.

93. Professor Haber observed:

> *"It is well recognised that all opioids are impairing when administered to opioid naïve individuals. These drugs cause impairment during the initial period of methadone treatment and the opioid treatment guidelines recommend not driving during this period. Similarly during dose changes either increased or decreased are similarly associated with impairment and the need to temporarily stop driving. At other times, most patients can drive safely. There is some capacity for impairment at some times, post-dosing, but this is usually a minor issue compared to the effects of other medications, non-prescribed drugs and illnesses".*

94. Whilst Dr Perl observed:

> *"The controlled oral administration of methadone (on a methadone program) tends to produce stable levels in the non-naïve patient (i.e. a daily user) and it is generally safe for such patients to drive with methadone alone. However, there has been some evidence that even stabilised daily users of methadone can have some impairment of some skills performance tests and impairment has been noted on measures of attention span and perceptions."*

95. Dr Perl further observed as a matter of generality:

> *"Long-term methadone maintenance patients have been noted to have some impairments of performance around the time of the peak blood level (Rass et al., 2014)…Methadone is known to enhance impairment caused by co-consumption of benzodiazepines…and in combination with psychoactive drugs".*

96. However, Professor Haber did not view the *Rass* study as authoritative, noting:

> *"I infer that the effects observed in this study are not sufficient to conclude a significant effect of stable methadone treatment in regards to driving. Other studies find either no impairment or indeed modest improvement in measures. Most evidence supports driving in stable patients".*

97. Putting aside for the moment, the issue of co-consumption of methadone with other medications, I accept that the studies demonstrate it is *generally* safe for a non-naïve patient to drive with methadone alone. Of course, there will be some patients who cannot ever do so safely and there are some patients who can usually, but not always, do so safely.

98. The point here is that one should not generalise from the terrible circumstances of this case in order to draw broad conclusions about the general driving safety of patients on the OTP. As both the reports of Dr Perl and Professor Haber make clear, this is already an area of specialised medical and pharmacological research, and such experts can and do draw upon the totality of research results in the course of their work, extending far beyond this Court's consideration of one driver.

99. Turning then to that driver, Mr Whitall had a long history (more than 20 years) on the OTP and his methadone use was largely consistent. This was demonstrated through his fairly stable methadone dosing.

100. Further, the methadone dispensing records from both Mollymook pharmacy and Chemist Outlet in Nowra showed that Mr Whitall attended his dispensing pharmacy regularly and rarely missed a scheduled observed methadone dose.

101. Additionally, I accept the evidence of Dr Perl who observed that the level of methadone in Mr Whitall's blood sample at autopsy was consistent with his therapeutic dose of 145mg daily.

102. Particularly in comparison with some dysfunctional behaviour in other domains of his life (evident, for example, in his driving history) Mr Whitall demonstrated a level of overall stability in his participation on the OTP. Whilst there was good reason to be concerned about Mr Whitall's driving in light of his driving history, his attendance for dosing through the OTP did not, per se, give cause for concern about his driving.

103. Finally, I note the difficulties facing patients and prescribers for the OTP in regional areas. Dr McLeod provided evidence regarding the dearth of addiction medicine specialists on the south coast of New South Wales and the challenges that distance plays in patients accessing specialised treatment. Dr McLeod said that so far as he was aware, he was the only practitioner along the eastern coastline between Wollongong and the Victorian border specialising in addiction medicine. Accordingly, his patients often had to travel long distances to either access their medical care or their methadone.

104. Mr Whitall lived in a semi-rural area on the South Coast of NSW. Mr Reid, the director the Illawarra Shoalhaven Local Health District's Drug and Alcohol Service, told the Court that "*public transport options are notoriously poor in the Shoalhaven. There is no train that goes from Bomaderry south. There are private bus routes that operate but public transport is very poor*."

105. In circumstances where Mr Whitall had to drive a round trip of approximately 120km several times a week to access his methadone in Nowra, not being able to drive would have significantly impaired his ability to participate in the OTP. This would be true for many participants in the OTP living outside of the Sydney metropolitan area.

106. Indeed, in this case, Dr McLeod's clinical notes, recorded that Mr Whitall was losing weight. Dr McLeod suspected that Mr Whitall was not consuming enough food because much of his money was being spent on the petrol that was required to drive between Ulladulla and Nowra.

107. This is not, of course, to suggest that all OTP participants should be permitted to drive in all circumstances to obtain their medication. Rather, I set out this evidence in some detail in these findings because it highlights the complexity of the problems involved in treating Mr Whitall's addiction.

108. Again, although it is tempting to see this as a case solely concerned with the issue of whether an individual should be permitted to drive whilst taking methadone as a participant on the OTP, the reality is far more complex. Mr Whitall had consumed other medication and some illicit drugs prior to the accident. It was not just methadone potentially impacting upon his driving skills.

109. In these circumstances there is not an evidential basis upon which to ground any particular finding or recommendation about the general impact of methadone upon driving skills of non-naïve users.

110. As an aside, I am buoyed by the evidence provided by both Professor Haber and Mr Reid in relation to developments in this field. Mr Reid told the Court that the recent shift to depot injections of buprenorphine to treat opioid addiction has altered the landscape drastically for both OTP participants and the community.

111. Mr Reid explained that buprenorphine depot injections last up to three months and allow the user stability in dosing during this period. The patient is freed from the onerous requirements of observed and takeaway methadone dosing and accordingly need attend their medical practitioner much less frequently.

112. Finally, I record the matters raised in final submissions on behalf of the Illawarra and Shoalhaven Local Health District, including an additional two addiction medicine specialists now providing a service in the Shoalhaven, and an additional nurse practitioner being recruited for the region.

2017 offences and the suspension scheme

113. Given Mr Whitall's terrible driving history, it is necessary for me to further consider the status of his licence throughout 2017.

114. As discussed above, Mr Whitall obtained his learner driver licence in February 2016, however he was given a learner driver licence with the additional condition "*may only drive with a licenced driving instructor*", so that he could undertake the Occupational Therapist Driving Assessment. This assessment was deemed necessary, due to a background of seizures.

115. In March 2016, Mr Whitall passed the Occupational Therapist Driving Assessment. The assessor determined he did not demonstrate any deficits related to his medical condition. Mr Whitall accordingly was determined to be eligible for a learner licence,

subject to further medical review in 12 months' time i.e. March 2017. Mr Whitall obtained his Class C Provisional P1 driver licence in April 2016. Mr Whitall did not submit a satisfactory medical report when due in March 2017 and as a result, his licence was suspended as of 19 March 2017. A short time later, on 21 March 2017 the suspension was lifted following receipt of a satisfactory medical report from a general practitioner confirming fitness to drive.

116. Mr Whitall also incurred certain demerit points whilst on his provisional licence throughout 2017, due to committing further traffic offences, namely:

1) On 13 March 2017 Mr Whitall incurred 2 demerit points (failure to display P signs);
2) On 23 October 2017 Mr Whitall incurred 4 demerit points (speeding more than 10km/H but not more than 20 km/h); and
3) On 19 December 2017 Mr Whitall incurred 2 demerit points (failure to display P signs).

117. As at 23 October 2017, Mr Whitall held a Class C Provisional P1 driver licence (red P-plate). This class of licence had a 4 point demerit threshold. That is, if a holder of a Class C Provisional P1 driver licence committed enough demerit point offences within 3 years so as to reach or exceed the threshold of four demerit points, the licence would be suspended and not renewed for three months.

118. Given Mr Whitall's two driving infringements in March and October 2017, by 23 October 2017, he had incurred six demerit points in total. Had those demerit points applied at the time the second demerit point offence was committed in October 2017, Mr Whitall would have exceeded the four demerit point threshold for a Provisional P1 licence and his licence would have been suspended.

119. However, demerit points do not apply against the licence holder on the date the alleged demerit point offence occurred. This is to allow licence holders the opportunity to take their matter to court for hearing if necessary, or to provide further time to pay the fine linked to their offence.

120. As a result, Transport for NSW do not become aware of any traffic offences committed until:

1) The fine has been paid;
2) A court convicts the licence holder of an offence in those cases where the licence holder elects to go to court; or

3) When the deadline for electing to go to court or to pay the fine has passed, which in 2017 was three months.

121. As a result of this system, Revenue NSW first advised Transport for NSW that Mr Whitall had exceeded his demerit point threshold (triggered by the traffic infringement on 23 October 2017) on 18 January 2018, three months after the events leading to the infringement that gave rise to the loss of his licence.[2] Mr Whitall, of course, was already dead by this time, but Transport for NSW were not aware of that and proceeded to apply the demerit points to his licence.

122. On 19 December 2017, Mr Whitall incurred another two demerit point penalty for failure to display his P plates. Again, Transport for NSW was not aware of this offence prior to Mr Whitall's death because Transport for NSW had not yet been notified of the offence by Revenue NSW.

123. Had the demerit points applied at this time, Mr Whitall would have accrued 8 demerit points as at 19 December 2017. This exceeded the demerit point threshold for the P1 Provisional licence and also exceeded the demerit point threshold for the P2 Provisional licence, which he ultimately received 3 days later, on 22 December 2017. That is, Mr Whitall progressed to receive his Class C Provisional P2 driver licence (green P-plates) at a time when he had allegedly committed sufficient offences that the licence would be suspended once the demerit points applied.

124. Details of the final demerit offence from 19 December 2017 were notified to Transport for NSW on 15 March 2018. This culminated in eight demerit points being applied to Mr Whitall's licence, exceeding the Provisional P2 licence threshold and subsequently his licence was suspended almost three months after his death.

125. I observe here that the historical driving record allows me to conclude that it is entirely possible that Mr Whitall would have continued to drive to collect his methadone or to attempt to obtain additional medication, even if the demerit points had applied and his licence had been suspended at the time of the accident.

Issue 4: Toxicology results for Mr Whitall and the likely effects of the following drugs and their metabolites (alone and in combination) on Mr Whitall's driving ability:

a) Methamphetamine and amphetamine;

b) Doxepin (tricyclic anti-depressant);

c) Methadone;

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[2] As at 26 December 2017, the period until automatic application of any demerit points were notified to Transport for NSW was three months. This now has been extended to four months.

d) Diazepam, nordiazepam, oxazepam, temazepam.

126. As I have already said, Mr Whitall had consumed more than just methadone in the lead up to the accident.

127. Mr Whitall was found to have four drugs and their metabolites present in his blood at the time of collision. These were:

1) Amphetamine (less than 0.01 mg/L) and Methamphetamine (0.01 mg/L);
2) Doxepin (3.5 mg/L);
3) Diazepam (0.12 mg/L), nordizepam (0.01 mg/L); oxazepam (0.006 mg/L) and temazepam (0.01 mg/L); and
4) Methadone (0.24 mg/L).

128. On this topic the court the benefit of receiving expert evidence via:

1) A pathology report in relation to Mr Whitall, including toxicological screening;
2) An expert report from Dr Perl (as discussed above);
3) An expert report from Dr Michael Robertson; and
4) An expert report from Professor Haber (as also discussed above).

Amphetamine and Methamphetamine

129. The toxicology result demonstrated that Mr Whitall had methamphetamine and its metabolite amphetamine present in his blood in low levels. Dr Perl was of the view that this represented a very low level of methamphetamine use and did not suggest recent use (most likely not within 24-48 hours prior to the accident). I therefore find that methamphetamine did not contribute to Mr Whitall's impairment on 26 December 2017.

130. Dr McLeod provided evidence that Mr Whitall had in the past abused methamphetamine, which led to a confrontation with police in March 2014. In December 2017, he noticed that Mr Whitall had been losing weight and carried out a urinary drug screen, as he suspected Mr Whitall may have recommenced using methamphetamine. The results of the drug screen showed no signs of methamphetamine.

Doxepin/ Deptran (tricyclic anti-depressant)

131. At the time of the accident, Mr Whitall was prescribed 150mg of doxepin by Dr McLeod to be taken at night, largely for its sedative effect (although the drug is a tricyclic anti-depressant also used in the treatment of depression). He had been prescribed doxepin for many years. As discussed above, Dr McLeod thought that Mr Whitall had first

received doxepin in prison and he continued Mr Whitall on that drug, notwithstanding newer antidepressants had become available.

132. Toxicology screening revealed doxepin at markedly high levels. Dr Pokorny, who undertook Mr Whitall's autopsy, observed that doxepin was detected at 3.5 mg/L and that this *"level is within the reported lethal range; although doxepin may show considerable post mortem redistribution and a slight elevation post mortem, even in femoral samples, artefactual change alone would not be expected to cause such a markedly high level"*.

133. Dr Pokorny is not a pharmacologist nor an addiction medicine specialist but it was her observations that prompted further expert evidence from those fields.

134. Each expert noted that doxepin can cause drowsiness, even in patients who might develop a small degree of tolerance through regular consumption.

135. Dr Perl observed "*given the very high blood concentration of doxepin in the deceased at the time of his death [I] would expect significant impairment of [Mr Whitall's] cognitive and motor functions which would have resulted in impairment of his driving ability*".

136. Both Dr Perl and Dr Robertson gave oral evidence regarding the timing of Mr Whitall's doxepin consumption and posited several possibilities that could account for both the high level of doxepin in Mr Whitall's blood at autopsy and his lack of obvious intoxication when he saw Hospital staff on the day of the accident (considered further below).

137. Counsel assisting summarised the possible conclusions as follows and I don't understand any of the sufficient interest parties took issue with this summary:

    i. Peak concentration of doxepin is likely to occur in the first one to two hours after ingestion.

    ii. It follows, if the amount observed at autopsy was at or near peak concentration, consumption of the doxepin would have taken place 1-2 hours prior to the collision at about 10.40am, that is, placing consumption around 8.40-9.40am.

    iii. It is possible that Mr Whitall had taken doxepin on more than one occasion across the morning but was not yet visibly intoxicated when Dr Geary concluded her consultation at around 10.00am.

    iv. It is also possible that Mr Whitall took a significant amount of doxepin after leaving the hospital and the drug was not yet at peak concentration at the time of the accident. Here the Court would note that the pathologist did not record the presence of tablets in the stomach or small intestine at autopsy, however

this is not definitive. As Dr Robertson observed, the pathologist may not have been looking for the presence of tablets at that time.

v. Finally, whilst Dr Robertson was prepared to work backwards to try and estimate the number of tablets involved, Dr Perl thought this too speculative and said she would never do that calculation.

138. I accept the submissions of counsel assisting that ultimately it is impossible to know when and how much doxepin Mr Whitall consumed prior to the accident. The reality remains that at some stage during the morning of 26 December 2017, Mr Whitall consumed a large amount of doxepin (in addition to other medication) that inevitably impaired his driving ability.

Diazepam its metabolite nordiazepam and minor metabolites oxazepam and temazepam

139. At autopsy diazepam was observed at a blood concentration of 0.12 milligrams per litre. This needs to be considered in the context of Mr Whitall being routinely prescribed diazepam at 2mg daily. As outlined above, diazepam was prescribed to assist with any withdrawal symptoms Mr Whitall would experience prior to taking a takeaway dose of methadone. However the concentration found in Mr Whitall's blood was higher than what the experts would expect from his regular prescribed dose.

140. Dr Perl noted that there was "*no suggestion from [Mr Whitall's] blood concentrations of diazepam or it's metabolites that he had been using excessive amounts of diazepam in the days preceding the collision*".

141. However in addition to his regular 2mg dose, on the morning of 26 December 2017, Mr Whitall was provided with 4 x 5mg diazepam tablets (Valium) by Dr Geary. The decision by Dr Geary to give Mr Whitall 4 x 5mg diazepam tablets will be explored in greater detail below. The experts were slightly at odds regarding the likely amount of diazepam that was taken. Dr Perl and Dr Robertson gave evidence concurrently.

142. Dr Perl was of the view that the amount of diazepam found in Mr Whitall's blood was consistent with him ingesting 4 x 5mg of diazepam. Dr Robertson on the other hand thought the concentration of diazepam present in Mr Whitall's blood was lower than what he would have expected had Mr Whitall taken and fully absorbed all 4 x 5mg diazepam tablets prescribed by Dr Geary.

143. Both Dr Perl and Dr Robertson agreed that generally, peak absorption happened within one to two hours after ingestion of diazepam, although allowing for individual variance, peak absorption could be later or sooner. Dr Perl explained that diazepam can cause adverse side effects commonly including *"somnolence (drowsiness/ sedation), unsteadiness and light-headedness or dizziness"*.

144. The medication register relating to Mr Whitall's attendance at Shoalhaven District Memorial Hospital notes that at 09:50, Mr Whitall was given 4 x 5mg tablets of Valium (diazepam). His discharge was entered at 10:02. The accident occurred at about 10.40-10.43. It follows, if Mr Whitall took the 4x5mg of diazepam after discharge but before driving away from the Hospital, the accident occurred approximately 40 – 45 minutes after consumption.

145. However, as with Mr Whitall's doxepin consumption, there are various scenarios that could have resulted in the diazepam being detected in Mr Whitall's blood post-mortem in the concentration that it was. I accept submissions from counsel assisting that Mr Whitall may have taken some of the diazepam tablets provided by Dr Geary but not all of them, he may have taken all of the tablets and still been on the way to peak concentration at the time of the accident, he may have taken one or more of the tablets as he left the hospital and further taken one or more tablets later in the trip.

146. The evidence does not permit me to make a finding about how many diazepam tablets Mr Whitall actually consumed and over which time frame on the morning of 26 December 2017.

147. I am however satisfied that the ingestion of diazepam as evident on the toxicology screening at autopsy (irrespective of whether Mr Whitall consumed all or some of the 4 x 5mg diazepam tablets he received at Shoalhaven District Memorial Hospital) would have had a further sedating effect upon Mr Whitall in conjunction with the doxepin and methadone and would have further affected his driving ability. (Again, however, I note it was the doxepin that was observed at a reportedly lethal range in circumstances where according to the pathologist, artefactual change along would not be expected to cause such a markedly high level.)

Methadone

148. As outlined above, the toxicology results available to the court confirmed the presence of methadone in Mr Whitall's blood sample. The amount of methadone detected was consistent with the therapeutic amount prescribed to Mr Whitall. I find that the consumption of methadone alone (in and of itself) is unlikely to have caused Mr Whitall's impairment on 26 December 2017. Nevertheless, it contributed to a cumulative effect of sedating medications.

The cumulative effect of these medications

149. It follows that I am of the view that the cumulative effects of the medication (primarily the doxepin, but also the diazepam and methadone) present in Mr Whitall's blood caused a degree of sedation that impaired Mr Whitall's driving skills.

150. This finding is consistent with evidence from witnesses to Mr Whitall's driving on the day, who noted that he was at times inattentive and drifting from his lane and that he did not seem to brake in the immediate lead up to the accident (I infer that this was because he was not aware of the imminent danger he was in as he drifted from his lane).

151. This finding is also consistent with the crash scene findings reported by the Officer in Charge of the investigation which indicated that Mr Whitall continued straight ahead without braking, rather than following the left-hand bend in the road.

152. To this end, Dr Perl observed in her evidence:

> *"Generally things such as braking time would be much slower when there is a depressant drug present, so as soon as the person realises they need to brake it may be too late and they may not apply the brakes."*

153. In his expert report, Dr Robertson raised the issue that Mr Whitall's driving pattern was interspersed with occasions of driving recklessly and aggressively, which to him was not consistent with the sedative effects of the diazepam or doxepin.

154. Although I accept that Mr Whitall did at times drive recklessly and aggressively during his trip to the accident site, I find that these instances of reckless and aggressive driving do not detract from the conclusion that Mr Whitall was also experiencing sedation as a result of the medications he had consumed causing him at other times to be inattentive and drift from his lane.

155. Professor Haber provided helpful evidence on this point. He noted that Mr Whitall:

> *".. definitely had multiple classes of drugs on board, and we do observe a complex picture. So for example, if I see a very heavily sedated person who is drug affected in the hospital, if we leave them to their own devices, they might just lie there drowsy, but if we stimulate them, they can lash out and become quite aggressive, and then we leave them and they might literally go back to sleep. So we might see patients who go from one extreme to the other quite quickly. So I guess my answer to you is yes, it's within my experience that people can go from one extreme to the other with reasonably limited stimulation and reasonably quickly.*

156. Dr Perl noted that given the level of doxepin found in Mr Whitall's blood, she would expect him to be displaying signs of an overdose in the lead up to the accident. She noted that one of the signs of overdose can be:

> *"…extrapyramidal effects, so things such as agitation and a person may be hallucinating. So they may well be driving at a more rapid speed in addition the other effects that you would expect, with the depressant effects of the drug…they're the unexpected effects on the central nervous system from overactivity, because this is*

an antidepressant drug that affects the neurotransmitters. So you get some unusual effects with extremely high doses."

157. Dr Robertson similarly accepted that extrapyramidal effects were a possible explanation for Mr Whitall's erratic/reckless driving. However he also noted that Mr Whitall may simply have intentionally driven recklessly and that this overcame his fatigue. Nevertheless he ultimately accepted that Mr Whitall may have gone *"through phases of succumbing to the fatigue and the tiredness, drowsiness and then having bursts of intentional reckless driving".*

158. I am satisfied that Mr Whitall was sedated to the point where his driving skills were impaired. This impairment resulted in Mr Whitall not being able to navigate the left-hand bend of the Princes Highway near Luncheon Creek Road and resulted in him colliding with the north bound white Mazda of the Falkholt family.

Issue 5: Prescribing and dispensing history for Mr Whitall and in particular, access to doxepin and methadone and communication between prescribing doctors.

Access to methadone

159. As outlined above, Mr Whitall had been on the OTP since 1990 and had been consulting Dr McLeod on and off since 1997 and full time since 2010.

160. It is not necessary to set out the full OTP history of Mr Whitall and the details of his methadone use dating back almost 27 years. Instead, I shall focus on 2017 and how Mr Whitall's methadone use changed across the course of the year.

161. As at 2017, Mr Whitall was receiving a mixture of observed and takeaway dosing.

162. The OTP Guidelines attempt to strike a delicate balance regarding methadone dispensation. As outlined above, observed dosing is particularly onerous, particularly in rural areas. Takeaway dosing is an important feature of the OTP and provides participants with a degree of normality.

163. The evidence demonstrates that Mr Whitall was not an easy patient and was described as "difficult" by Dr McLeod. I accept that at times he could be aggressive, demanding and intimidating and local pharmacies would decline to provide his methadone (for instance on 5 October 2017 his behaviour towards staff at Mollymook Pharmacy caused the Pharmacy to ban him). Mr Whitall had been refused attendance at several pharmacies over the course of his participation on the OTP. It also seems, with the benefit of hindsight, that Mr Whitall's mental health was fluctuating across this period. For instance, on 4 October 2017 Mr Whitall reported to Dr McLeod he had been cutting his right wrist but declined a referral for mental health treatment. Then in November

2017 Mr Whitall's mother reported to Dr McLeod that Mr Whitall was hearing voices and was increasingly paranoid.

164. This history, particularly Mr Whitall's aggressive and intimidating behaviour at times, raises the question of whether Mr Whitall remained a suitable candidate for takeaway methadone dosing or whether he should have had closer supervision via observed dosing.

165. Given his extensive experience with patients on the OTP, Dr McLeod was realistic about the treatment goals. In his statement provided to the Court, Dr McLeod emphasised that *"Substance Use Disorder is a lifelong chronic illness"* and that "*a doctor cannot work in this area of Medicine without expecting to be deceived, either by omission of the truth or of commission of an untruth"*.

166. In terms of Mr Whitall's treatment, Dr McLeod described 2017 as an ordinary year *"apart from moving [Mr Whitall's] takeaway doses around*".

167. I found Dr McLeod to be an earnest and forthright witness. I have no doubt that working in addiction medicine poses many challenges, and that as a medical practitioner in this field, one needs to make difficult decisions that significantly impact the livelihood of one's patients. The evidence supports that Dr McLeod had a good therapeutic relationship with Mr Whitall and I accept that Dr McLeod attempted to find the correct balance for Mr Whitall, within the permissible parameters of the OTP Guidelines.

168. In Dr McLeod's view, Mr Whitall was a suitable candidate for takeaway methadone dosing. In this regard, Dr McLeod told the Court that he tried to be as accommodating as possible (within the context of Mr Whitall's clinical picture and the regulatory scheme). As he told the court *"[m]ethadone's a very restrictive thing in a person's life"* and that flexibility is a key factor in a patient's success.

> "*The whole concept is to normalise their existence. And I think if you impose the rules, or if you play hard game with them, it makes (sic) really quite difficult, in a difficult situation".*

169. Even for patients who are stable and are able to access takeaway dosing, Dr McLeod noted:

> *"The restriction of takeawy doses to set dates or times is very confining to patients on Opioid Substitution Treatment Programs and more so in regional and rural areas…. inflexibilities simply increases the difficulty of life as a patient on the program".*

170. As an experienced practitioner in the field, Dr McLeod tried to balance the challenges of a difficult patient with positive therapeutic outcomes. This included providing a

degree of flexibility regarding Mr Whitall's methadone dispensation. As he told the Court*" "I will take – go the extra step if I can make it that little bit more convenient and easier for [the OTP participant].*

171. This does not however mean that Dr McLeod had a complete disregard for the risks posed by Mr Whitall. Quite the contrary. He gave frank evidence that takeaway dosing of methadone at times could act as a lever. He told the court that if he suspected that Mr Whitall was being untruthful or deceptive, one of the options he would have considered is a reduction of Mr Whitall's takeaway doses and/or a reduction in his methadone.

172. Up to August 2017, Mr Whitall had his methadone dispensed at Mollymook pharmacy for a relatively long period of time. Mollymook pharmacy is of course only a short drive (approximately 4kms) from Ulladulla, where Mr Whitall lived. However, Mr Whitall's behaviour was challenging. As Senior Constable Warren noted, Mr Whitall had been refused service at three chemists in the Ulladulla area (including ultimately Mollymook pharmacy), because he was abusive and threatening to staff and other customers.

173. From August 2017, Mr Whitall requested that Dr McLeod provide him with a mixture of his takeaway dosing scripts for both Mollymook pharmacy and Chemist Outlet in Nowra, until October 2017.

174. As outlined above, on 5 October 2017, Mr Whitall was refused a methadone dose from Mollymook pharmacy because he had already been provided with an extra take away dose earlier in the week. According to an account from the pharmacy provided to Dr McLeod, Mr Whitall was distressed about not getting his extra dose and he went to walk into the dispensary area of the pharmacy. A female staff member needed to physically put her hand on Mr Whitall's chest to stop him from entering and had to call on support from another staff member. The pharmacy then banned him from further attendance.

175. As a result, Mr Whitall had to return to LAMP in Nowra for the purpose of receiving his methadone for a period of about 10 days, ending on 17 October 2017 when he was able to transfer his methadone dosing to Chemist Outlet in Nowra permanently.

176. Having takeaway dosing interspersed with periods of observed dosing is not unusual. Mr Whitall had previously attended LAMP as part of his participation on the OTP. As Mr Reid explained:

> *"the intention of a public clinic [like LAMP] is to stabilise people and get them out into the community. That is a process that doesn't generally happen very quickly. On average, people would be with us for probably two to three years before that would happen and…there are some people who will stay with us for a long period of time"*.

177. He also noted that certain clients, such as Mr Whitall, might "rebound" to LAMP for treatment for short periods of time.

178. The benefits of having methadone dispensed in a public clinic such as LAMP is readily apparent. It is a service providing public, specialised care for individuals with opioid addiction disorders. As Mr Reid explained in his statement:

> *"For LAMP public clients, LAMP undertakes a comprehensive assessment and determines the most appropriate therapeutic option. The clients then attend the clinic on a daily basis to receive their opioid substitution dose. When clients are assessed as stable in treatment (i.e., have reduced/eliminated illicit drug use and are compliant with the clinical and behavioural goals of the service) they may be offered the opportunity to dose and/or collect their dose at a local pharmacy. They remain a LAMP client. All LAMP public clients receive regular clinical reviews by LAMP staff. This incorporates a structured review process to identify risk and assess substance use, dose adequacy, client safety, child safety, concurrent medications, education, collection of urine drug screen samples and actioning any referrals, such as housing or counselling support."*

179. Dr McLeod highlighted another important advantage: cost. Dispensation of methadone at LAMP is free, whereas at a pharmacy a patient will pay \$5 - \$7 per dose. Unfortunately, LAMP does not however provide takeaway methadone dosing. Given the vast area that LAMP seeks to cover, it is understandable why patients on the OTP would then choose to have their methadone dispensed via a local pharmacy rather than undertake the onerous drive to Nowra, notwithstanding the cost.

180. Returning to the chronology, having later secured Chemist Outlet in Nowra as a pharmacy willing to dispense methadone to Mr Whitall on a regular basis, Dr McLeod thought it was appropriate to recommence Mr Whitall on takeaway dosing. As a result, from 17 October 2017, Mr Whitall had his methadone dispensed permanently from Chemist Outlet in Nowra. His methadone prescribing typically involved attending the Chemist Outlet on Mondays, Wednesdays and Saturdays. The standard days for his takeaway doses were Tuesdays, Thursdays, Fridays and Sundays.

181. Although the transfer back to takeaway dosing no doubt eased the burden of daily travel to Nowra, the reality was that Mr Whitall still needed to travel to Nowra several times a week to receive medical care and this came at a cost to Mr Whitall, both in terms of his finances, but also in terms of his time and energy. This undoubtedly was a complicating factor in Mr Whitall's case.

182. Mr Whitall appears to have had a relatively stable period of methadone dispensation up to Christmas, however it is worth highlighting a change in his takeaway dispensation between the period of 16-26 December 2017. On 18 December 2017, Mr Whitall

attended Chemist Outlet in Nowra and in addition to taking his observed dose, he received two takeaway doses to cover 19 and 20 December 2017.

183. Mr Whitall's last appointment with Dr McLeod took place on 19 December 2017. In the intervening period Dr McLeod had received a call from Mr Whitall's mum (referred to above) outlining her concerns that her son was losing weight and seemed increasingly paranoid. She said she was frightened for him but not for herself. Dr McLeod thought Mr Whitall looked fine although he was still losing weight.

184. Nevertheless, Dr McLeod was sufficiently concerned by Mr Whitall's weight loss to suspect methamphetamine use. He told Mr Whitall that he would not provide his next methadone script until after Mr Whitall had a urine drug screen performed. The testing was duly performed and the results confirmed the absence of amphetamine like substances.

185. Dr McLeod provided a prescription to Mr Whitall that provided him with additional takeaway doses to cover a period of pharmacy closure over the holiday period (from 22 December to 26 December 2017 (inclusive).

186. Dr McLeod explained his rationale for prescribing the additional takeaways in the following manner:

> "*On Tuesday 19 December - the last week I worked before the Christmas break - Craig requested additional takeaways as he wanted to travel to Queanbeyan to see his daughter over the holiday period. Other than his weight loss, I had no reason to suspect Craig was inappropriately using other drugs. However as methamphetamine can lead to weight loss, I insisted he have a urinary drug screen before I would write the script for the requested takeaways. He did as I asked and so I complied with his request. The test results came back on 23 December and showed no signs of methamphetamine. Craig's dosing pharmacy was to be closed from midday Saturday 23 December to Tuesday 26 December inclusive so in view of the circumstances and his request, I gave additional takeaways to cover him to 26 December.*"

187. Professor Haber made no criticism of this decision in light of Mr Whitall being a reasonably stable long-term patient of Dr McLeod and it being permissible under the OTP Guidelines.

188. As a result, Mr Whitall once again attended Chemist Outlet at Nowra on 19 December 2017 and received six additional take away doses of methadone to cover the period 21 – 26 December 2017.This would see him through until 27 December 2017 when his chemist would presumably re-open after the public holidays.

189. On the evening of 25 December 2017 and the morning of 26 December 2017, Mr Whitall then attended Milton Ulladulla and Shoalhaven District Memorial Hospital respectively, seeking methadone.

190. As already observed, it is evident that Mr Whitall was untruthful regarding his methadone usage when he attended each hospital. He had enough methadone to cover the Christmas period and to account for any periods of pharmacy closure.

191. The evidence does not permit me to find why Mr Whitall was seeking additional methadone. Despite Mr Whitall's attempts, neither of the local hospitals complied with his request for additional methadone.

Access to diazepam and doxepin

192. I now turn to a review of Mr Whitall's access to diazepam and doxepin.

193. As Dr McLeod explained, he typically wrote Mr Whitall a diazepam script to accompany his takeaway dosing via a scheme of staged supply. This was aimed at ensuring that Mr Whitall *"didn't have a full box of Valium at home",* a sensible approach.

194. However the Medicare and PBS records obtained during the course of the coronial investigation showed that Mr Whitall had been procuring additional diazepam and doxepin from others. This was despite the fact that Dr McLeod regularly prescribed each medication at a rate that, if Mr Whitall had been taking the medication as prescribed, would have been adequate for his needs.

195. Without traversing all of the history in relation to prescribing for Mr Whitall, a short review of selected examples will serve to highlight some of challenges arising for the medical practitioners who saw Mr Whitall throughout 2017, and most particularly in the latter part of that year.

196. On 5 October 2017 Mr Whitall attended Milton Ulladulla Hospital complaining of left lower rib cage pain after falling in the bathroom. He asked for diazepam and said there had been a mix up so he didn't get his daily pick up from a pharmacist in Mollymook. The emergency department doctor who saw him on this occasion, Dr Qays Alsha'Er offered a script for 1 tablet to get him through until he could speak to Dr McLeod the next day. This seems to have prompted Mr Whitall to change his story such that Dr Alsha'Er suspected Mr Whitall was exhibiting some drug seeking behaviour. The contemporaneous hospital records show that Dr Alsha'Er rang and spoke to Mollymook pharmacy to clarify the diazepam dose (which was 2mg not 10mg as reported by Mr Whitall) and Dr Alsha'Er subsequently wrote a script for 1x 2mg diazepam tablet.

197. Subsequent to this visit at Milton Ulladulla Hospital, Mr Whitall filled separate scripts, at two different pharmacies for:

1) Diazepam, 7 x 2mg tablets;

2) Doxepin, 9 x 50 mg tablets; and

3) Prodeine Forte (a paracetamol codeine mix), 20 tablets.

198. According to Mr Whitall's PBS records the scripts had been prescribed by Dr Alsha'Er, the emergency room doctor who had seen Mr Whitall at Milton Ulladulla Hospital.

199. Yet Dr Alsha'Er had no memory of writing any script other than a diazepam script on 5 October 2017. Further, Dr Alsha'Er told the Court that it would not be his usual practice to write a script for seven diazepam tablets and the discharge referral letter confirms that he wrote a script for only one diazepam tablet.

200. Dr Alsha'Er did not recall providing Mr Whitall with a script for doxepin. He told the court in any event it would not be his usual practice to prescribe nine doxepin tablets. There is no record of doxepin prescribing in the hospital records.

201. It strikes me as odd that any doctor would write a script for 7 diazepam tablets and 9 doxepin tablets in the circumstances described by Dr Alsha'Er, and this was recorded differently in the hospital records.

202. I accept Dr Alsha'Er's evidence that he provided a script for 1 x 2mg tablet for Mr Whitall on 5 October 2017. I also accept that Dr Alsha'Er did not provide Mr Whitall with a script of doxepin.

203. Finally, Dr Alsha'Er did not recall writing a script for Prodeine forte. However, Dr McLeod's notes from 5 October 2017 record him speaking with a doctor from Milton Ulladulla Hospital and that that doctor reported he *"gave him [Mr Whitall] a script for 20 x Panadeine forte. Issues discussed and I left my mobile with the doctor".*

204. Given the detail Dr McLeod recorded in his contemporaneous file note, I accept that a conversation took place as documented and that the conversation took place between Dr McLeod and Dr Alsha'Er as the doctor from Milton Ulladulla Hospital. Although Dr Alsha'Er did not recall a discussion with Dr McLeod, he conceded it was possible the conversation took place.

205. Dr Robert Day, a senior staff specialist in emergency medicine, was asked to review Mr Whitall's attendance at Milton Ulladulla Hospital on 5 December 2017. Dr Day concluded Mr Whitall's presentation should have prompted strong consideration of an alert being placed on the hospital's record system [called Firstnet] for future reference. Alerts can refer to drug seeking behaviour. As I understand Dr Day's evidence, a specific alert stands a greater chance of being seen by other staff in the course of later

hospital presentations than does an alert contained within a progress note buried elsewhere within medical records.

206. Dr Alsha'Er told the court that at the time of Mr Whitall's presentation, he did not know he could arrange for an alert to be inserted onto the system. Even at the time of his evidence he was unaware as to whether he could insert such an alert although he said if the situation were to arise again he *"would certainly raise it with the in-charge nurse*."

207. I accept Dr Day's evidence that the insertion of an alert into Firstnet should have been considered. I am troubled by the fact that Dr Alsha'Er was unaware of the process to insert such an alert even at the time of hearing. What is the point of an alert system if staff don't know how to use it? This is something that the Illawarra Shoalhaven Local Health District should consider further, although I am not going to make a formal recommendation that the LHD do so in the circumstances that follow

208. An alert placed into Firstnet regarding Mr Whitall may well have specifically alerted subsequent treating staff to the fact that Mr Whitall may be drug seeking. However, the evidence before me demonstrates that in large part, staff who saw Mr Whitall on subsequent emergency department attendances were conservative with their treatment and turned their mind to the possibility of drug seeking behaviour when he was asking for diazepam and/or complaining that he had not received his methadone.

209. Suspicions were not as heightened around Mr Whitall's requests for doxepin because, as many of the medical witnesses told the inquest, doxepin is not a typical drug of addiction.

210. Between 10 October 2017 and 2 December 2017, Mr Whitall saw four different medical practitioners and was able to obtain a doxepin script from each practitioner. In addition to Dr McLeod, Mr Whitall's regular doxepin prescriber, the three other doctors who saw Mr Whitall and prescribed him with doxepin (in differing amounts) during this period were Dr Matthew Allan (GP), Dr Francesco Rossi (GP), and Dr Amanda Venables (GP who was working at the Emergency Department of Milton Ulladulla Hospital at the time of her prescribing).

211. On 10 October 2017 Mr Whitall attended Ulladulla Medical Centre, where he was seen by Dr Allan. Mr Whitall requested a doxepin script, telling Dr Allan this was due to Dr McLeod's surgery presently being closed. Yet strangely the medical records show Mr Whitall had seen Dr McLeod earlier that day. Perhaps he had forgotten to ask for Deptran scripts at that time. In any event, Dr Allan prescribed Mr Whitall 3 x 50mg doxepin tablets only; enough to get Mr Whitall through until the next day when Dr McLeod's surgery was open again. This was judicious prescribing.

212. On 11 October 2017 Mr Whitall saw Dr McLeod and he was indeed given a script for 50 x 50mg doxepin tablets with two repeats, at a dose of three each night. If taken as prescribed this would have lasted Mr Whitall at least 7 weeks.

213. Less than two weeks after seeing Dr McLeod, on 24 October 2017, Mr Whitall attended Ulladulla Medical Centre again and this time saw Dr Rossi, telling him that he had forgotten to ask Dr McLeod for a doxepin script (presumably when he saw him on 11 October 2017). This was not truthful. Dr Rossi proceeded to also write a doxepin script with two repeats for Mr Whitall which, if taken as prescribed, would have lasted at least 7 weeks.

214. With the benefit of hindsight, this decision was part of a series of unfortunate events that ultimately resulted in Mr Whitall having access to more than his normal amount of doxepin.

215. Dr Rossi considered himself to be Mr Whitall's regular GP, although he was aware that Dr McLeod was also involved in managing his addiction medicine issues. Dr Rossi told the court that Mr Whitall was a somewhat difficult patient:

> "*Sometimes [Mr Whitall] would turn up and he'd be a little bit, little bit aggressive, other times he would be – he was incredibly forgetful, his short-term memory wasn't very good at all. He made a habit of not turning up for appointments and, and that's why I didn't sort of question him when he said he'd lost prescriptions, cause that seemed in, consistent with him and his behaviour.*"

216. Importantly, and consistent with the evidence of all of the other medically trained witnesses, Dr Rossi told the Court that he "*didn't consider [D]eptran to be a drug of, a drug someone would abuse*." Similar evidence was provided by Dr McLeod and Dr Venables.

217. Dr Rossi was asked whether he considered, as his colleague Dr Allan had, prescribing only sufficient doxepin to get Mr Whitall through until he could presumably speak to Dr McLeod the next day.

218. Dr Rossi explained:

> *"I think that Dr Allan acted accordingly on the – on 10 October because he didn't know the patient, I think it was the first time he'd seen him. And my actions on 24 October I think were reasonable because I – number 1, I didn't…feel that that medical [sic] was commonly being abused by patients. Number 2…I thought he was being given Deptran as a treatment for depression, but it's sometimes used for sedation and mood stabilisation at night and, having seen his mood vary over, over the time I was involved with him, I thought it was important for him to continue – have continuity of treatment for that condition. And I guess,*

I trusted that what, what he told me was true, because when patients come in and tell you things, you don't immediately thing 'Oh you're lying to me' you know".

219. Dr Rossi told the Court that had he known that Dr McLeod had written a doxepin script with two repeats less than two weeks prior, he would not have given Mr Whitall another doxepin script.

220. On 5 November 2017 Mr Whitall again attended Milton Ulladulla Hospital seeking doxepin, but he did not wait to be seen.

221. On 2 December 2017, Mr Whitall returned to Milton Ulladulla Hospital seeking another script for doxepin, telling the medical staff that he was out of medication. The Court knows that Mr Whitall had in fact been provided with sufficient doxepin to cover this period, if he was taking his medication as prescribed.

222. Mr Whitall saw a junior medical officer under the supervision of Dr Amanda Venables, who ultimately was responsible for writing a doxepin script for Mr Whitall, 50 x 50mg tablets, with two repeats.

223. Dr Day was also asked to comment upon this prescribing and explained some of the challenges of providing episodic care to patients in an emergency department:

"*Emergency Departments (EDs) provide acute episodic care for patients rather than continuity of care. Providing patients with scripts for continuing medications is not a core function of the Emergency Department, as it is for GPs. Mostly EDs will not have an up to date medication list for a patient so the correct provision of any routine medication relies primarily on the word and knowledge of the patient…I believe it was practical for the ED doctor to provide a script on the day, not knowing how long it would take for Mr Whitall to get an appointment with his GP…the general rule would be to give the script to the patient without repeats to ensure they maintain regular follow up with their GP. The ED doctor was aware Mr Whitall was taking prescribed addictive drugs and regular GP contact was essential. As a doctor not familiar with Mr Whitall's current situation it was unwise to provide a large amount of medication by prescribing repeats on the script"*

224. As referred to above, Dr Venables was working as a Visiting Medical Officer at Milton Ulladulla Hospital on 2 December 2017 and otherwise worked as a General Practitioner, also in Milton. When asked to explain her decision to provide a script with two repeats to Mr Whitall in the ED (and which amounted to Mr Whitall receiving another 150 tablets of doxepin) Dr Venables could not recall why the two repeats were provided.

225. Dr Venables told the Court that it was not her usual practice when working in the emergency department to provide a patient a script with repeats included. She told the Court that she may have subconsciously gone into GP practice mode and written the script out of force of habit. As with many of the other medical practitioners who gave

evidence, Dr Venables also told the Court that doxepin didn't raise a "red flag" for her that a patient may be drug seeking, unlike, for example benzodiazepines.

226. Dr Venables was also asked about Mr Whitall's attendance on 2 December 2017 (when she was involved in his care) within the context of his previous attendances at hospital, particularly on 5 October (seeking diazepam) and 5 November 2017 (seeking doxepin). She told the Court that had she been aware of these events they would have "*raised suspicions*" for her and she "*would hope*" that she would have "*inserted [her]self into that consultation more than [she] did*".

227. Again, with the benefit of hindsight and with some laborious effort in reviewing hospital and GP records along with Medicare data, the coronial investigation has been able to piece together evidence of Mr Whitall's drug seeking behaviour. However I accept the submission by counsel assisting, that Mr Whitall was seeing a number of different doctors for prescribing purposes. At times he was untruthful about when his next appointment with his usual prescriber Dr McLeod would take place, at other times he would complain about having lost a script or being out of medication which seems unlikely given what is now known about his pattern of obtaining and filling prescriptions.

228. This permits me to find that Mr Whitall knew how to access medication in addition to that prescribed by Dr McLeod. Some of the additional medication he received may well have been needed to make up for lost prescriptions or lost medication, I accept that there were times when Mr Whitall was chaotic and could have easily lost things. But it is also likely that Mr Whitall was accessing additional doxepin because he was taking the medication at a rate greater than prescribed. So much is clear, for instance, from the doxepin levels observed at autopsy.

229. The only person who knew how much medication Mr Whitall was obtaining and consuming was Mr Whitall himself. I accept submissions from counsel assisting that no single doctor had a clear view of all the other doctors and hospital attendances, nor all the other prescribing.

230. Indeed, it is unlikely Mr Whitall's family themselves had a clear view of this. The evidence demonstrates Mr Whitall's mother was concerned enough about her son that she contacted Dr McLeod in November 2017 to discuss her concerns but it seems that much of Mr Whitall's history of medical attendances only became known to his family during the course of the coronial proceedings.

231. It's important to provide a balanced picture of Mr Whitall in order to portray him accurately. As counsel assisting submitted, not all attendances with other medical professionals (whether in private practice or in hospital) were for the purpose of procuring additional medication. Mr Whitall was at times in genuine need of medical

care. He was not always and inevitably drug seeking when he attended local hospitals or doctors.

232. This is demonstrated via some short examples.

233. Mr Whitall attended Milton Ulladulla Hospital on 3 April 2017 complaining of pain in his right hand and said that he was on the methadone program and did not want any pain relief. He returned two days later worried about an infected tooth and again declined analgesia.

234. On 15 August 2017 Mr Whitall attended an appointment with Dr McLeod and said that life was generally okay. Later that day he attended Milton Ulladulla Hospital with an injury to his forearm which he said he had injured on a piece of metal about two days prior. Mr Whitall had attempted to suture the wound himself with his own needle and cotton. He had removed the sutures that morning because he was worried about infection.

235. On 14 September 2017 Mr Whitall was again at Milton Ulladulla Hospital with a laceration injury to his right wrist which he said he sustained on barbed wire. He denied intentional self-harm and suicidal ideation.

236. When Mr Whitall saw Dr McLeod the following week, Dr McLeod thought that Mr Whitall seemed a bit chaotic, noting Mr Whitall "*is really all over the place but gives no sign of using or intoxication or undue sedation*."

237. On 4 October 2017 Mr Whitall reported to Dr McLeod he had been cutting his right wrist and said he really tried to get the artery. When Dr McLeod suggested that mental health treatment was needed Mr Whitall said it wouldn't help. Dr McLeod's notes record "*his behaviour is really chaotic at the moment. I could not bring myself to stop his takeaways as he really doesn't look good. He may well be a risk but I can't help him if he doesn't let me know what's happening. Does not look to be ice affected. Urine drug screen ordered*."

238. There clearly were some significant physical and mental health problems facing Mr Whitall throughout 2017. These problems of course needed treatment and ideally treaters would be able to understand the wider picture in which they were being asked to treat the patient.

239. Evidence was received regarding the introduction of Real Time Prescription Monitoring (**RTPM**), which as at the time of hearing was being rolled out in NSW. RTPM will go some way in helping doctors and pharmacists understand how frequently certain patients are accessing certain medications. This includes doctors working in Emergency Departments.

240. However, as I understand the evidence, only certain medications as determined by an expert panel will be monitored. Relevant to this case, the monitored medicines list will include:

    1) All medicines that are included in Schedule 8 (including methadone); and
    2) All medicines that contain a benzodiazepine when included in Schedule 4 (including diazepam)

241. Doxepin is not a monitored medicine. The expert panel considered the inclusion of antidepressants in RTPM, however decided not to include them on the monitored medicine list for reasons including:

    1) They are a marker for increasing clinical complexity and risk rather than an independent cause of harm.
    2) There would be substantial regulatory burden due to high volume of use (i.e. a very large number of records for clinicians to consider).

242. RTPM has the flexibility that if new trends in the use and abuse of prescription medicines emerge in the future, "*other medicines may be added to the list of monitored medicines over time if there is evidence of an emerging risk that the overuse or non-medical use of a medicine is causing harm".*

243. The introduction of RTPM is most welcome, and in many respects, given the various inquests involving doctor and prescription shopping heard before me and other senior Coroners, it is most overdue.

244. The reality however is that not all medication can be monitored via RTPM. Even if RTPM had been in place in 2017, it would not have flagged Mr Whitall as a person who was seeking doxepin in excess of his therapeutic dose.

Issue 6: Mr Whitall's attendance at Milton Ulladulla Hospital on 25 December 2017 requesting methadone and leading to provision of 1 x 5mg tablet of diazepam

245. As outlined earlier in these reasons, Mr Whitall told hospital staff at Milton Ulladulla Hospital that he did not realise the chemist would be closed over the holiday period and so had been unable to get his methadone dose for Christmas Day and Boxing Day. This was demonstrably untrue.

246. Dr Alsha'Er said Mr Whitall was complaining of muscle cramps in his legs but otherwise appeared well, although he was quite demanding and intimidating when requesting medication. Accordingly, Dr Alsha'Er provided Mr Whitall with a single dose of 5mg of oral diazepam at about 8:00pm and told Mr Whitall he would need to seek further assistance the next day in daytime hours when more services would be open.

247. Dr Day reviewed this attendance at the request of the Court and was not critical of the treatment Mr Whitall received. Dr Day said that a single dose of 5mg of diazepam was at the lower end of the available treatment range and unlikely to have caused significant drowsiness or other adverse effects on Mr Whitall.

248. I am of the view that Mr Whitall received appropriate medical treatment at Milton Ulladulla hospital on the evening of 25 December 2017 and no criticism can be made of the decision to give Mr Whitall 1 x 5mg tablet of diazepam.

Issue 7: Mr Whitall's attendance at Shoalhaven District Memorial Hospital on 26 December 2017 requesting methadone and leading to provision of 4 x 5mg tablets of diazepam

249. Much of the following is taken from submissions from counsel assisting.

250. As already explained, on the morning of 26 December 2017 Mr Whitall drove himself to Nowra and attended the Shoalhaven District Memorial Hospital. He was triaged at approximately 8:08am. According to the triage nurse, Mr Whitall again presented requesting methadone, telling her he had missed his dose for three days and his chemist was closed on Boxing Day. The triage nurse was alerted to the fact he had presented to Milton Ulladulla Hospital the previous day. Her notes include "*told staff at MUH he has 27 mls daily, told me today he has 129 mls daily, unable to check dose due to chemist being closed, pt was also given take home doses prior to xmas*."

251. Mr Whitall was next seen by Dr Brona Geary, who is a staff specialist in emergency medicine. The triage nurse approached Dr Geary directly on a busy Boxing Day in the Emergency Department rather than let Mr Whitall wait to be assessed by a junior member of the medical staff.

252. Dr Geary recorded in notes written after Mr Whitall's death that she saw him when she could. Mr Whitall was a little intimidating with Dr Geary and so she left the curtain open in the treatment area whilst assessing him. Amongst other things, Dr Geary questioned Mr Whitall about organising his methadone supply across the Christmas period, given he had reported being on the methadone program over many years. According to her, he said he was not organised enough.

253. She asked a series of questions around withdrawal symptoms and checked for signs of recent injection sites on Mr Whitall's forearms and elbows. Dr Geary was aware of Mr Whitall's presentation at Milton Ulladulla Hospital the previous day and "*felt it unusual that he present [sic] to a different hospital within a 24 hour period with the same request*." However her "*clinical assessment of him was that he showed both signs of opiate withdrawal and complained of symptoms consistent with opiate withdrawal*" and so she treated the patient for opiate withdrawal. This did not mean Mr Whitall would be receiving

methadone to manage his opiate withdrawal symptoms. Dr Geary told Mr Whitall from the outset she would not be administering methadone to him (in fact she could not provide methadone because emergency departments are not authorised to do so under the OTP for good reason as outlined below).

254. Instead Dr Geary offered Mr Whitall some relief in the form of 5mg of diazepam to be taken four times a day over the following 24 hours, until he could sort out his methadone administration on 27 December. She also told the Court that she remembered telling Mr Whitall to space the dosing over the course of the day for sustained relief of symptoms, rather than taking all four tablets at once. Dr Geary recalled specifically telling Mr Whitall not to take all 4 tablets at once. Dr Geary also placed some weight on the fact that Mr Whitall had presented on Christmas Day complaining he had not been able to obtain his methadone and it was "*conceivable that he still was unable to access his usual prescriber on Boxing Day".*

255. Mr Whitall accepted this and asked Dr Geary for a supply of the drug, rather than a prescription, as he felt so unwell. Dr Geary told the court she asked if there was anything else she could do to help and whether he wanted a sandwich or a cup of tea. Mr Whitall declined her offer.

256. In terms of the decision making regarding her prescribing, Dr Geary explained:

> *"[g[iven Mr Whitall's agitation and the fact that I could not be entirely sure of whether he was still using IV drugs, I thought he merited treatment with 20mg Diazepam (4 x 5mg tablets) to cover a 24 hour period rather than consider Buprenorphine for such a short prescription…I gave him the 4 tablets, offered him a glass of water and he said he would rather buy a can from the fridge outside and take the first dose himself."*

257. Dr Day, court appointed expert, also reviewed the treatment and prescribing on 26 December 2017 and acknowledged that Dr Geary was clearly trying to manage a difficult patient in a context where there was pressure to attend to him and then rapidly discharge him from the ED. He observed that as methadone could not be specifically given, it was reasonable to provide alternative medication to Mr Whitall to suppress withdrawal symptoms and discharge him from the ED. Dr Day further opined that Dr Geary should have asked Mr Whitall about his other prescribed medication and his current use. However he stated that he thought that it was unlikely that Mr Whitall would have been forthcoming with any useful information. Even knowing about earlier attendances at Milton Ulladulla Hospital on 2 and 25 December 2017, Dr Day told the court that knowledge would not have changed the requirement for symptomatic treatment.

258. Dr Day further noted that the NSW Health Drug and Alcohol Withdrawal Clinical Practice Guidelines list diazepam 5 mg four times a day (as needed) as symptomatic treatment for opioid withdrawal, agitation or anxiety.

259. Therefore, Dr Day was not critical of the 4 x 5 mg diazepam dose provided to Mr Whitall on Boxing Day, but stated that giving Mr Whitall a total of 20 mg to take away led to a significant risk the patient would take all 20 mg immediately, with sedative effects likely within 30-60 minutes.

260. Associate Professor Randall Greenberg provided an expert report at the request of Dr Geary and determined her assessment of Mr Whitall was very reasonable in the circumstances.

261. I found Dr Geary to be an honest and impressive witness who frankly conceded that her taking of Mr Whitall's medical history was "imperfect". When asked whether her treatment might have differed had she been aware of attendances at Milton Ulladulla Hospital in the previous two months seeking doxepin Dr Geary fairly said:

> *"Yes and no. I think the clinical indication from managing his symptoms still remained, notwithstanding his repeat presentations and while it was difficult to accept it is conceivable that he didn't arrange for his doses across the public holidays and I very much was trying to treat and alleviate the symptoms that he complained of and the one objective sign that was consistent with his story".*

262. Again, the Court has the benefit of hindsight denied to those involved with Mr Whitall at the time. Subsequent events demonstrate Mr Whitall should not have been trusted with 4 x 5mg of diazepam (regardless of how many he actually consumed on the day). The preferable course would have been to provide 5mg and a script for the remainder of the dose even if that meant the patient had to try and find a chemist open on Boxing Day to fill the script (and which still leaves open the possibility the patient might have later consumed all the medication at once, contrary to directions).

263. Having read her statements and observed her giving evidence, I accept that had Dr Geary thought Mr Whitall was intoxicated at the time of her treatment or was likely to take excessive diazepam prior to driving off, she would not have prescribed in that fashion.

264. I again note here that the doxepin observed at autopsy was at markedly high levels likely to have led to impairment of Mr Whitall's driving ability even absent the diazepam Mr Whitall had also taken prior to the accident.

265. The last question to ask is whether Mr Whitall could have received appropriate treatment from LAMP on Boxing day 2017 and should have been referred there instead of treated

in the emergency department of the hospital. The Court knows that LAMP was open for a few hours on Boxing Day morning and had been involved in providing methadone to Mr Whitall as recently as October 2017. This did not though, mean that Dr Geary could simply refer Mr Whitall to LAMP to obtain methadone to cover the doses that he alleged he had been unable to organise across the public holiday period.

266. As Mr Reid observed in his statement:

> *"In accordance with NSW Health's Guideline applicable as at December 217…LAMP staff may only provide methadone to an individual who has a current and valid script to receive that medication from the LAMP dosing point…If Mr Whitall presented to LAMP in December 2017 without a current and valid script to dose at LAMP, and if Mr Whitall told LAMP who was his authorised prescriber, LAMP staff would do their best to contact that person. If successful, it would be a matter for the prescriber whether they issued a script. If they issued a script, LAMP staff would have then dosed Mr Whitall. If Mr Whitall's regular prescriber could not be contacted or did not issue a script, LAMP would not provide him with a dose."*

267. Mr Reid further emphasised in his oral evidence:

> *"You can't just give somebody a schedule 8 drug when they turn up. There are very clear processes that have to be…undertaken, very clear risks involved in doing that, and to minimise those risks we need – and legally we need a valid script…before we can prescribe*."

268. I appreciate the complexities attached to treating patients on the OTP and that there are careful considerations that need to be made regarding appropriate dispensation of methadone. These decisions cannot be made on a whim and need to be considered within the broader context of the OTP and its various participants. I further appreciate that the provision of methadone through busy public hospital emergency departments may well create an additional problem if people living with an opiate dependency started flooding emergency departments seeking ad hoc replacement doses of their carefully prescribed medication.

The Falkholt family

269. I tried at the start of these findings to emphasise that the Falkholt family were blameless in their deaths and the enormity of their loss would not itself be lost within the mountain of evidence obtained in the course of the coronial investigation.

270. Yet the focus of these findings needed to be upon Mr Whitall and the series of tragic missteps that led to his decision to drive whilst intoxicated on prescription medication on 26 December 2017.

Formal findings

271. The findings I make under section 81(1) of the Act are:

Identity:

Lars Falkholt

Place of death:

Princes Highway, Conjola

Date of death:

He died on 26 December 2017.

Cause of death:

He died from multiple injuries.

Manner of death:

He died as a result of a motor vehicle collision

Identity:

Vivian Falkholt

Place of death:

Princes Highway, Conjola

Date of death:

She died on 26 December 2017.

Cause of death:

She died from multiple injuries.

Manner of death:

She died as a result of a motor vehicle collision

Identity:

Annabelle Falkholt

Place of death:

Liverpool Hospital.

Date of death:

She died on 29 December 2017.

Cause of death:

She died from multiple blunt force injuries.

Manner of death:

She died as a result of a motor vehicle collision

Identity:

Jessica Falkholt

Place of death:

St George Hospital

Date of death:

She died on 17 January 2018.

Cause of death:

Complications of multiple blunt force injuries

Manner of death:

She died as a result of a motor vehicle collision

Identity:

Craig Whitall

Place of death:

Princes Highway, Conjola

Date of death:

He died on 26 December 2017.

Cause of death:

Combined effects of multiple blunt force injuries and the effects of fire.

Manner of death:

He died as a result of a motor vehicle collision.

272. I thank those assisting me in the investigation and in preparation of this inquest, in particular counsel assisting, Donna Ward SC, and her instructing solicitor, Lena Nash.

273. I also wish to thank Jaqueline Krynda for her assistance in reviewing these findings.

274. I close this inquest.

Magistrate Teresa O'Sullivan
State Coroner
21 December 2021
NSW State Coroner's Court, Lidcombe