Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 1/19

I, Barry Paul King, Coroner, having investigated the death of ***Matthew Neil Hardy Tonkin*** *with an inquest held at the* ***Perth Coroner's Court*** *on* ***14 January 2019 and 16 January 2019****, find that the identity of the deceased person was* ***Matthew Neil Hardy Tonkin*** *and that death occurred on* ***3 July 2014*** *at* ***276 Nicholson Road*** *from* ***bronchopneumonia complicating oxycodone toxicity*** *in the following circumstances:*

Counsel Appearing:

Mr D P Jones assisted the Coroner

Ms P A Aloi of the State Solicitor's Office appeared for the North Metropolitan Health Service, the Department of Health, Dr M Majedi and Mr N Keen

Mr W R Goodheart of Meridian Lawyers appeared for Mr R MacWatt and Ms C Nicotra

Mr M L Williams of Minter Ellison appeared for Dr R Hammond, Dr G Crisp and Dr M Woodall

Mr T Babington of the Department of Veteran Affairs appeared for Mr M Claes

Table of Contents

INTRODUCTION

1. Matthew Neil Hardy Tonkin (the deceased) was an Australian Army veteran who lived in Subiaco with his father. He was 24 years old at the time of his death.

2. The deceased's medical history included post-traumatic stress disorder (PTSD) related to his deployment overseas. He became addicted to prescription drugs, especially the opioid oxycodone,[1] and doctor-shopped in order to obtain the drugs.

3. On the evening of 2 July 2014, the deceased was in bed, unwell with what appeared to be a cold. His father, David Tonkin (Mr Tonkin) last spoke to him at about 8.00 pm.[2]

4. At about 9.30 am on 3 July 2014, Mr Tonkin found the deceased in his bed, unconscious and unresponsive. Mr Tonkin called for an ambulance and administered CPR.[3]

---

[1] For convenience, when referring in this report to the medications used by the deceased, I have used the term 'oxycodone' to refer to either or both of the immediate-release (eg. Endone, OxyNorm) and controlled-release varieties (eg. OxyContin) unless one is specified.
[2] Exhibit 1, Volume 1, Tab 6.1
[3] Exhibit 1, Volume 1, Tab 6.1

5. Ambulance paramedics attended and took over the CPR, but they were unable to revive the deceased.[4] At 10.01 am a paramedic certified that the deceased was life extinct.[5]

6. A forensic pathologist later formed the opinion that the cause of death was bronchopneumonia complicating oxycodone toxicity, which I have adopted as my finding as to the cause of death.[6]

7. The deceased had obtained the oxycodone after a GP had given him a prescription for it on 1 July 2014.[7]

8. The deceased's death was a 'reportable death' under section 3 of the *Coroners Act 1996* (the Act) because it 'appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury'.

9. Under section 19 of the Act, I had the jurisdiction to investigate the deceased's death because it appeared to me that the death was or may have been a reportable death.

10. Under section 22(2) of the Act, a coroner who has jurisdiction to investigate a death may hold an inquest if the coroner believes it is desirable.

11. After preliminary investigations had been undertaken, in early 2016 I determined that an inquest should be held because of the public interest in public health issues related to the circumstances surrounding the deceased's death.

12. A considerable amount of further investigation was undertaken and detailed expert reports were obtained before a hearing date for an inquest could be allocated. The proposed inquest was finally placed on the call-over list for 1 June 2017.

---

[4] Exhibit 1, Volume 1, Tab 7A
[5] Exhibit 1, Volume 1, Tab 3
[6] Exhibit 1, Volume 1, Tab 10.3
[7] Exhibit 1, Volume 3, Tab 2; Exhibit 1, Volume 1, Tab 23.1

13. I held the inquest at the Perth Coroner's Court on 14 January 2019 and 16 January 2019.

14. The main issues at the inquest were:

    a. the means by which the deceased had been able to obtain opioids by prescription despite having a history of drug overdoses, drug-seeking behaviour and doctor-shopping; and

    b. the status of a proposed real-time monitoring system of the dispensing of prescription opioid drugs, which system would allow prescribing doctors and pharmacists to check the up-to-date history of opioid drugs dispensed to a patient before prescribing or supplying such drugs.

15. Another issue that arose at the inquest was the difficulty which faced medical practitioners in WA when attempting to obtain the deceased's medical records from the Australian Defence Force (ADF) or the Department of Defence.

16. The documentary evidence adduced at the inquest primarily comprised a brief of evidence,[8] consisting of five volumes of records, reports, publications, correspondence and witness statements. A further document adduced at the inquest was a letter from the deceased's partner, Meg Duff, describing the deceased's misuse of oxycodone.[9]

17. Oral evidence was provided by (in order of appearance):

    a. Dr Michael Woodall, a psychiatrist who treated the deceased at Hollywood Clinic;[10]

    b. Dr George Crisp, a GP whom the deceased consulted;[11]

[8] Exhibit 1, Volumes 1 – 5
[9] Exhibit 2
[10] ts 5 – 25 per Woodall, M
[11] ts 25 – 48 per Crisp, G

c. Mitchell Claes, the director of pharmacy programs and operations branch at the Department of Veterans Affairs (DVA);[12]

d. Dr Rachel Hammond, a GP who prescribed the deceased oxycodone on 1 July 2014;[13]

e. Caterina Nicotra, a registered pharmacist who, as a dispensary assistant at the time, dispensed the oxycodone to the deceased on 1 July 2014 ;[14]

f. Dr Max Majedi, a pain specialist at the Department of Pain Management at Sir Charles Gairdner Hospital, where the deceased was treated in May 2014;[15]

g. Professor Stephan Schug, the Chair of Anaesthesiology at the University of Western Australia and the Director of Pain Medicine at Royal Perth Hospital. He had provided an independent report of the deceased's case and of the monitoring of doctor-shopping in Western Australia;[16]

h. Neil Keen, the Chief Pharmacist at the Department of Health in Western Australia. He provided a report relating to the legislation and systems governing the monitoring of the supply of medications, including opioid medications, and the provision of relevant information to prescribers and suppliers.[17]

18. I have added my voice to the calls for the proposed real-time system of monitoring the dispensing of prescribed opioid medications to be operational as soon as possible and for the system to encompass all of Australia.

19. I have also recommended that a procedure be considered and, if appropriate, implemented to allow for the timely

[12] ts 49 – 71 per
[13] ts 72 – 86 per Hammond, R
[14] ts 86 – 91 per Nicotra, C
[15] ts 95 – 118 per Majedi, M
[16] ts 119 – 139 per Schug, S
[17] ts 139 – 163 per Keen, N

transfer of medical records of ADF members and veterans to treating medical professionals in WA.

20. I have found that death occurred by way of accident.

THE DECEASED

21. The deceased was born at King Edward Hospital in Subiaco on 2 March 1990. He was an only child. His mother died from cancer when he was nine years old, but his father remarried and he had a good relationship with his step-mother. His early family life was fairly stable.[18]

22. The deceased completed Year 12 at Shenton College in 2007. While at school he worked at a fast food outlet and was also an army cadet, a role which he loved. He attained the rank of Warrant Officer Class 1 and saw his future as a soldier in the Australian Army. He had a wide circle of friends, many of whom were also cadets with him.[19]

23. At his father's insistence, the deceased delayed joining the army after Year 12 in order to take a gap year. Instead, he worked full-time at the fast food outlet and rose to the position of assistant manager.[20]

ENLISTING IN THE ARMY

24. On his nineteenth birthday, the deceased was enlisted in the ADF as a rifleman in the Royal Australian Infantry for an initial period of four years. He was stationed at Enoggera in Queensland.[21]

25. In a recruiting psychology report,[22] the deceased was described as a mature candidate who was team-oriented

[18] Exhibit 1, Volume 4, Tab B
[19] Exhibit 1, Volume 2, Tab 17.2
[20] Exhibit 1, Volume 2, Tab 17.2
[21] Exhibit 1, Volume 3, Tab 34
[22] Exhibit 1, Volume 3, Tab 34

and had a good capacity for dealing with stressful situations. He presented as confident, robust and well-adjusted and appeared to be highly motivated. He was considered to be a low risk for military integration and training.

26. The deceased attended several training courses over the next three years and became qualified as a driver and crew commander of a 'protected mobility vehicle', which was known as a Bushmaster. In November 2011 he was reported to be an enthusiastic and motivated soldier who had been identified as a potential junior leader.[23]

DEPLOYMENT IN AFGHANISTAN

27. In March 2012, the deceased was transferred to Townsville, and on 8 June 2012 he was deployed to the Uruzghan province in Afghanistan. In Afghanistan he was based at patrol bases and, towards the end of his deployment, in Tarin Kowt, the capital of Uruzghan province.[24]

28. In early August 2012, the deceased was at a patrol base when a police checkpoint nearby was attacked by insurgents. Two of the police officers were killed and two or three were seriously injured. The deceased volunteered to be part of the stretcher party and was faced with the sight of gruesome injuries sustained by an officer.[25]

29. Later in August 2012, the deceased was in his Bushmaster during an operation when one of his mates, who was clearing improvised explosive devices (IEDs), stepped on an IED which exploded and amputated his legs. The deceased heard his mate's screams over his radio and raced to the scene with a medical kit to assist in his mate's medical treatment and evacuation.

[23] Exhibit 1, Volume 3, Tab 34
[24] Exhibit 1, Volume 3, Tab 34
[25] Exhibit 1, Volume 2, Tab 17.8

The deceased was badly affected by seeing his mate so terribly injured.[26]

30. On 29 August 2012, three members of a combat team that was part of the deceased's task group were killed by a traitorous member of the Afghanistan National Army (ANA). One of those killed had been the deceased's best mate since his time in the army. The deceased was profoundly distressed as a result of his death.[27]

31. On 2 September 2012, a member of the ANA was assisting two of the deceased's comrades to escort police militia in a safe lane when the ANA member stepped out of the safe lane and detonated another IED, causing casualties. The deceased led the other members of his team to the scene of the explosion to treat the injured. Three people had sustained gruesome injuries; including amputated legs, blast and burn injuries and protruding bones.[28]

32. Following those incidents, the deceased and his team travelled back to the patrol base and eventually moved to Tarin Kowt.

33. On 3 October 2012, not long after moving to Tarin Kowt, the deceased was doing physical training in a gym when he injured his hip and ankle. He was taken to the hospital where an American doctor treated him before he was returned to Australia on 18 October 2012 for treatment and rehabilitation.[29] He later told Mr Tonkin that he had been provided with a significant supply of oxycodone while in the hospital.[30]

34. In Australia, opioid drugs such as oxycodone are 'controlled drugs' due to their high potential for abuse and addiction. They are listed in Schedule 8 to a legislative instrument produced by the Therapeutic Goods

[26] Exhibit 1, Volume 2, Tab 17.8
[27] Exhibit 1, Volume 2, Tab 17.8
[28] Exhibit 1, Volume 2, Tab 17.8
[29] Exhibit 1, Volume 2, Tab 19; Exhibit 1, Volume 4, Tab 1.B
[30] Exhibit 1, Volume 1, Tab 6

Administration,[31] the *Standard for the Uniform Scheduling of Medicines and Poisons*, which state and territory legislation adopt.[32]

BACK IN QUEENSLAND

35. When the deceased returned to Australia, he was again based in Enoggera. An MRI scan showed a small left labral tear, and an ultrasound scan of his ankle showed tenosynovitis with joint effusion. He was given a hydrocortisone injection of his hip and was referred for physiotherapy for both the hip and ankle. For analgesia, he was prescribed tramadol, ibuprofen and paracetamol. He was placed on convalescent leave.[33]

36. In early November 2012, the deceased was on war service leave.[34] He went to Western Australia to be close to his partner and family, and his partner noticed that he had changed. He would wake up sweating profusely due to nightmares of what he had experienced in Afghanistan and would immediately look for his gun.[35]

37. The deceased returned to duty in Enoggera in early February 2013. By then his hip had improved enough to allow him to go for a slow jog, but he reported that he needed support to adjust to the grind of work since he found the situation difficult to handle emotionally. A medical officer referred him to Veterans and Veterans Families Counselling Service (VVCS), which he attended to see a clinical psychologist.[36]

38. On 12 March 2013, the deceased inflicted an injury to himself by attempting to remove what he perceived to be a cyst on his cheek. His medical officer, Dr Andrik

[31] The instrument is the Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)
[32] In WA, Schedule 8 of the SUSMP is currently adopted under the *Medicines and Poisons Act 2014* through regulation 6 of the *Medicines and Poisons Act Regulations 2016,* and was previously adopted under the Appendix A of the *Poisons Act 1964*.
[33] Exhibit 1, Volume 4, Tab 1.B
[34] Exhibit 1, Volume 4, Tab 1.B
[35] Exhibit 2
[36] Exhibit 1, Volume 4, Tab 1.B

Lohman, referred him to a local private hospital, where a plastic surgeon debrided and closed the wound.[37]

39. On 15 March 2013, Dr Lohman discussed the deceased's case with the plastic surgeon, and they identified concerns that the deceased was masking PTSD or psychiatric symptoms with his behaviour.[38]

40. Dr Lohman then referred the deceased to a psychiatrist, Dr John Chalk, who saw him on about 26 March 2013. Dr Chalk thought that the deceased had symptoms of an adjustment disorder with anxious mood, but at that stage Dr Chalk was not prepared to diagnose PTSD. He considered that the deceased seemed to be improving.[39]

41. Dr Chalk continued to see the deceased. On 25 May 2013 he reached the view that the deceased clearly fulfilled the diagnostic criteria for PTSD as a result of his service.[40]

42. On 30 May 2013, the deceased presented to Enoggera Health Clinic (EHC) complaining of severe exacerbation of his hip pain and the commencement of back pain despite having had no acute injury or fall. He sought an increase in pain medication. Dr Lohman prescribed oxycodone 5-10 mg as required and referred him to a surgeon for a possible arthroscopy of his hip.[41]

43. From 3 June 2013 to 8 June 2013, the deceased was admitted into EHC for analgesia and investigation of the exacerbation of his hip pain. The oxycodone was titrated up and he was also prescribed diazepam. He underwent an MRI scan of his back, which was essentially unremarkable.[42]

[37] Exhibit 1, Volume 4, Tab 1.B
[38] Exhibit 1, Volume 4, Tab 1.B
[39] Exhibit 1, Volume 4, Tab 1.B
[40] Exhibit 1, Volume 4, Tab 1.B
[41] Exhibit 1, Volume 4, Tab 1.B
[42] Exhibit 1, Volume 4, Tab 1.B

44. On 13 June 2013, the deceased underwent an MRI scan of his hip. The scan showed no overt labral tear. He underwent a left hip arthroscopy on 10 July 2013, after which his physical activities were significantly reduced for a few weeks. He had come to the conclusion that he should seek discharge from the army, and on 19 June 2013 he completed a form to that effect.[43]

45. On 21 June 2013, the deceased presented at EHC seeking oxycodone and claiming that his last prescription had been provided two weeks previously and that he had run out.[44]

46. For much of July 2013 and August 2013, the deceased was declared not fit for duty due to convalescence or illness.[45]

47. On 1 August 2013, the deceased was in Perth on leave when he saw his family GP, Dr Crisp, at Onslow Road Family Practice in Shenton Park. He told Dr Crisp that he had PTSD and hip pain, and that he had undergone an arthroscopy and was prescribed oxycodone. He said that he could not stop taking oxycodone for chronic pain. Dr Crisp prescribed 10 mg slow-release oxycodone and trialled him on pregabalin.[46]

48. On 28 August 2013, the Army Medical Employment Classification Review Board considered the deceased's continued service and employment within the ADF and determined that there were grounds to issue a separation notice proposing that his service cease. On 24 September 2013, the deceased accepted the determination.[47] His date of separation was 21 December 2013.[48]

49. Because the deceased's PTSD and hip injury had occurred as a result of his service, he was entitled to

[43] Exhibit 1, Volume 4, Tab 1.B
[44] Exhibit 1, Volume 4, Tab 1.B
[45] Exhibit 1, Volume 3, Tab 34; Exhibit 1, Volume 4, Tab 1.B
[46] Exhibit 1, Volume 3, Tab 20
[47] Exhibit 1, Volume 4, Tab 1.A
[48] Exhibit 1, Volume 3, Tab 34

ongoing payment through the DVA of medical care and pharmaceutical products for those conditions.

2013 OVERDOSES

50. On 22 August 2013, the deceased saw Dr Lohman with significant fatigue or drowsiness and with slurred speech. He denied substance abuse but said that he had experienced increased anxiety and had broken up with his partner. Dr Lohman referred him to rehabilitation.[49]

51. On 23 August 2013, the deceased was admitted to EHC following an overdose of oxycodone tablets. He was administered naloxone over three and a half hours with good effect. He was remorseful and apologetic, and was adamant that he was using the drugs recreationally and had no intention of harming himself. He was transferred to the Royal Brisbane Hospital (RBH) because of concerns at EHC about an inability to monitor him appropriately. He was kept in hospital overnight and was lucid by the following afternoon. He was returned to EHC where he denied taking any opiates on 22 August 2013 despite having reacted quickly to naloxone.[50]

52. On 6 September 2013, the deceased was admitted to EHC for observation after members of his unit expressed concerns about his ability to manage his medications. His speech was slow and slurred, but there was no evidence of cognitive impairment. While it appeared that he had been abusing opioids, a urine screen showed only benzodiazepines. A CT head scan showed no intracranial pathology.[51]

53. On 19 September 2013, the deceased and Mr Tonkin attended Dr Lohman after the deceased had been increasingly anxious, with persistent drowsiness and slurring of speech after taking medications. Mr Tonkin had been staying with the deceased for about 10 days.[52]

[49] Exhibit 1, Volume 4, Tab 1.B
[50] Exhibit 1, Volume 4, Tab 1.B
[51] Exhibit 1, Volume 4, Tab 1.A
[52] Exhibit 1, Volume 4, Tab 1.A

54. Dr Lohman diagnosed adverse drug reaction or overuse, with possible underlying psychotic symptoms. He reduced the dosages and directed that Mr Tonkin supervise the medication.[53]

55. When the deceased and Mr Tonkin returned on 20 September 2013 for review, the deceased was much improved, confirming the medication effect. However, the deceased had seen a mental health clinician earlier that day and had presented with slurred speech. Dr Lohman considered that the deceased had a psychological dependence on the medications and that he required cognitive behavioural therapy. He contacted VVCS and arranged for the deceased to get an appointment.[54]

56. On 24 September 2013, the deceased saw Dr Lohman. He appeared much more alert than previously but reported stress, anxiety and flashbacks of the traumas he had experienced in Afghanistan.[55]

57. On 3 October 2013, the deceased saw Dr Lohman for a review. He had seen a psychologist at VVCS a week previously. He said that he still experienced marked anxiety during the day and some physical symptoms such as shortness of breath, palpitations and hyperventilation. He denied suicidal ideation, self-harm or compulsion to harm himself or others. Dr Lohman saw no evidence of thought disorder or delusions.[56]

58. On 4 October 2013, the deceased saw Dr Chalk, who prescribed alprazolam. The deceased spoke to Dr Lohman by phone the next day and said that he was doing well but that he had accidently knocked the lid-less bottle of alprazolam into the toilet. Dr Lohman called the 'Doctor Shoppers Hotline' to ensure that future prescriptions were provided by Dr Chalk only, and he told the deceased about the notification pathway.[57]

---

[53] Exhibit 1, Volume 4, Tab 1.A
[54] Exhibit 1, Volume 4, Tab 1.A
[55] Exhibit 1, Volume 4, Tab 1.A
[56] Exhibit 1, Volume 4, Tab 1.A
[57] Exhibit 1, Volume 4, Tab 1.A

59. The deceased saw Dr Lohman on 9 October 2013. He appeared calm and settled.[58]

60. On 31 October 2013, the deceased was admitted to EHC under escort after clear evidence of misuse of oxycodone and alprazolam. He had forged a prescription in Dr Lohman's name but denied a deliberate misuse of medication or intention to self-harm or suicide, saying that he took extra tablets because of severe pain and anxiety. He remained in EHC until 4 November 2013.[59]

61. On 1 December 2013, the deceased was taken to EHC by unit members with a further overdose of prescription medication; this time, oxycodone and diazepam which he had apparently purchased from another member of the ADF. Dr Greg Sarson transferred him to RBH for review and risk assessment. Dr Sarson noted that this was the third time that he had administered intravenous naloxone to the deceased in four months.[60]

62. On 2 December 2013, the deceased returned to EHC where he was admitted overnight. He had been assessed at RBH as at low risk of deliberate self-harm, and on 3 December 2013 a psychologist assessed him again to be at low risk. He was discharged that afternoon.[61]

MOVE TO WESTERN AUSTRALIA

63. In January 2014, the deceased began to prepare to re-locate permanently to Western Australia. On 16 January 2014, he attended the Brookside Family Clinic near EHC where he saw Dr Moroney in order to obtain an anxiolytic. Dr Moroney prescribed alprazolam 0.5 mg tablets and contacted Dr Lohman to obtain a health summary for the deceased. Dr Lohman faxed him a Clinical Summary Transfer of Health Care which he had prepared. It included the following:

[58] Exhibit 1, Volume 4, Tab 1.A
[59] Exhibit 1, Volume 3, Tab 19; Exhibit 1, Volume 4, Tab 1.A
[60] Exhibit 1, Volume 4, Tab 1.A
[61] Exhibit 1, Volume 4, Tab 1.A

> Prescription substance misuse (oxycodone, benzodiazepam abuse with 4X documented accidental overdose, drug seeking behaviour and two incidents attracting police involvement – forgery of prescription and potential illicit involvement with oxycontin). No previous suicide or deliberate self-harm. Several presentations of intoxication/excessive use of sedative medication (quetiapine, diazepam +/- opiates). No evidence of illicit drug use.[62]

64. The Clinical Summary Transfer of Health Care also indicated that the deceased required psychiatrist follow-up in Perth, psychology follow-up, avoidance of opiate analgesia and avoidance of benzodiazepines unless managed by a specialist.[63]

65. The deceased returned to Dr Moroney on 17 January complaining of back pain. Dr Moroney prescribed paracetamol and tramadol. It appears that further ADF medical records for the deceased were sent to the Brookside Clinic at about that time. One of those records indicated that the deceased had some dependence on opiate analgesia and benzodiazepines.[64]

66. On 28 January 2014, the deceased arrived back in Western Australia. The next day, he saw Dr Crisp, who prescribed tramadol for back pain and prazosin for PTSD. The deceased disclosed that he had been taking opiates, benzodiazepines, and quetiapine.[65] He produced the record which had referred to his dependence on opiate analgesia and benzodiazepines, but he had altered it to remove that reference.[66]

67. The deceased went back to Dr Crisp two weeks later and obtained another prescription for tramadol.[67]

---

[62] Exhibit 1, Volume 3, Tab 19
[63] Exhibit 1, Volume 3, Tab 19
[64] Exhibit 1, Volume 3, Tab 19
[65] Exhibit 1, Volume 3, Tab 20
[66] ts 42 per Crisp, G; Exhibit 1, Volume 3, Tab 20
[67] Exhibit 1, Volume 3, Tab 20

68. On 12 February 2014, the deceased went to another medical practice in Subiaco, Rokeby GP, where he saw Dr Garratt and complained of hip pain and anxiety. Dr Garrett prescribed meloxicam and desvenlafaxine.[68]

69. On the evening of 21 February 2014, the deceased was taken by a friend to the emergency department (ED) at Sir Charles Gairdner Hospital (SCGH) after he became confused and lost consciousness at a party, presumably from misusing opioid medications. His friend told the ED doctor that the deceased had experienced similar confusion episodes three times in the last six weeks and that he was taking oxycodone for a disc prolapse. A neurologist reviewed the deceased, diagnosed possible accidental drug overdose and admitted him overnight.[69]

70. On the morning of 22 February 2014, the deceased was seen by a drug and alcohol practitioner. His partner, who accompanied him, reported that he had many instances of overdoses over the previous few months. The deceased initially denied that but eventually admitted taking oxycodone and alprazolam. The practitioner discharged him with a webster pack of tramadol to manage his pain and referred him to a private pain specialist.[70]

71. On 26 February 2014, the deceased went back to Dr Crisp and again obtained a prescription for tramadol. Dr Crisp wrote a letter of referral to Dr Woodall.[71]

72. On the late morning of 27 February 2014, the deceased was taken by ambulance to the SCGH-ED after he overdosed on tramadol, had a seizure, and fell to the floor. The seizure had lasted for a couple of minutes, after which he regained consciousness but was very confused. He had vomited and had then gone to bed and slept for an hour. He was admitted to SCGH, reviewed by a psychiatrist and transferred to Hollywood Hospital on 1 March 2014 under the care of Dr Woodall.[72]

---

[68] Exhibit 1, Volume 3, Tab 8
[69] Exhibit 1, Volume 5, Tab 1
[70] Exhibit 1, Volume 5, Tab 1
[71] Exhibit 1, Volume 3, Tab 20
[72] Exhibit 1, Volume 5, Tab 2

73. The deceased appeared to settle well in Hollywood Hospital, but within a few days he showed signs of sedation.[73] On 7 March 2014, one of his friends rang the hospital to advise that the deceased was calling friends to ask that they bring him medications. That evening, 17 oxycodone 80 mg tablets were found in his room. Later, his vital signs dropped, prompting a medical emergency team attendance. He responded well to naloxone and was transferred to the intensive care unit (ICU) but later denied taking drugs.[74]

74. The deceased was discharged from Hollywood Hospital on 9 March 2014 with follow-up by Dr Woodall. He was encouraged to contact the DVA to submit a claim for his back condition and to make FOI applications for his medical records because Dr Woodall had not been able to obtain his full history.[75]

75. On 10 March 2014, the deceased went to Onslow Road Family Practice, where he saw Dr Cherie Young instead of Dr Crisp. He complained to Dr Young of back pain and told her that he had been in Hollywood Hospital and had been prescribed oxycodone. Dr Young ceased the tramadol and prescribed oxycodone. She explained that she would need information from Hollywood Hospital and the DVA before she could give him further prescriptions. She wrote a letter of referral to Dr Majedi at the Department of Pain Management (the pain clinic) at SCGH.[76]

76. On 12 March 2014, the deceased attended two medical practices in Subiaco and requested prescriptions for oxycodone. In one case, the practice staff contacted the Onslow Road Family Practice and learned that the deceased had been provided with prescriptions two days earlier, and in the other case the GP who saw him contacted Hollywood Hospital and learned that the

[73] Exhibit 1, Volume 5, Tab 2
[74] Exhibit 1, Volume 5, Tab 2
[75] Exhibit 1, Volume 5, Tab 2
[76] Exhibit 1, Volume 3, Tab 20

opioids had been ceased. In neither case did the GP provide a prescription.[77]

77. On 17 March 2014, the deceased went with Mr Tonkin to see Dr Crisp. They discussed his medication and its use, as well as his DVA form. Dr Crisp provided prescriptions for oxycodone and diazepam and made another appointment for a week later.[78]

78. Three days later, the deceased went to a medical practice in Noranda and told a GP that he was living with his grandmother. He requested and obtained prescriptions for zopiclone, diazepam and oxycodone.[79]

79. The next day, the deceased went to a medical practice in Morley and requested oxycodone. The GP contacted the DVA and was informed that the deceased had received prescriptions on 17 March 2014 and 20 March 2014. The deceased denied receiving them, but the GP did not give him a prescription.[80]

80. On 25 March 2014, the deceased returned to Onslow Road Family Practice and saw a different GP from Dr Crisp. The GP provided him with prescriptions for oxycodone. Three days later, he saw Dr Crisp and obtained a prescription for zopiclone.[81]

81. On 4 April 2014, the deceased saw Dr Crisp due to high blood pressure. He had been started on mirtazapine by Dr Woodall and had been experiencing headaches, nausea and vomiting. Dr Crisp stopped the mirtazapine and prescribed propranolol and oxycodone. When reviewed three days later, the deceased's symptoms appeared to have improved.[82]

82. On 14 April 2014, the deceased saw Dr Vicky Tee at Onslow Road Family Practice. He had commenced

[77] Exhibit 1, Volume 3, Tabs 8 and15
[78] Exhibit 1, Volume 3, Tab 20
[79] Exhibit 1, Volume 3, Tab 16
[80] Exhibit 1, Volume 3, Tab 14
[81] Exhibit 1, Volume 3, Tab 20
[82] Exhibit 1, Volume 3, Tab 20

mirtazapine again with similar results. Dr Tee called Dr Woodall and agreed to trial escitalopram and to keep a close eye on opioids and benzodiazepines. Dr Tee prescribed low doses of oxycodone and diazepam as well as escitalopram and zopiclone, all for weekly pick-up.[83]

83. Two days later, the deceased returned to see Dr Tee and said that he had been to SCGH on the previous week for knee pain and that they took all his medications. She reminded him of his recent prescriptions. He said that his father has some of his medications, and that he could not always contact him. Dr Tee gave him a prescription for oxycodone to last him till his weekly pick-up.[84] That same day, he also unsuccessfully attempted to obtain a prescription for oxycodone from a medical practice in Subiaco at which he had been refused prescriptions previously.[85]

84. Shortly after the deceased left Dr Tee, the local pharmacy rang her to say that the deceased had altered the prescription. Dr Tee called the Health Department's Schedule 8 Prescriber Information Service and ascertained that the deceased was not identified as an addict or a doctor shopper. The next day, Dr Tee called the deceased and informed him that she was aware that he had altered the prescription and that she could no longer treat him.[86]

85. Despite Dr Tee's call, on 19 April 2014 the deceased returned to Onslow Road Family Practice and saw a different GP, who refused to prescribe any addictive medications early.[87] On the same day, he went to the SCGH-ED with back pain, seeking opiates. A pain specialist advised ceasing oxycodone and suggested Targin (oxycodone with naloxone), pregabalin and a buprenorphine patch.[88]

[83] Exhibit 1, Volume 3, Tab 20
[84] Exhibit 1, Volume 3, Tab 20
[85] Exhibit 1, Volume 3, Tab 15
[86] Exhibit 1, Volume 3, Tab 20
[87] Exhibit 1, Volume 3, Tab 20
[88] Exhibit 1, Volume 5, Tab 1

86. On 21 April 2014, the deceased went back to the SGCH-ED with shooting back pains down both legs. A registrar gave him oxycodone and alprazolam and provided a prescription to stay on that regimen. He returned the next day and said that he had not received his prescription the night before. A senior registrar told him that the 'PBS'[89] had informed him that the deceased had filled the script on the previous day. The deceased left without a prescription.[90]

87. Also on 22 April 2014, the deceased went back to Onslow Road Family Practice and saw yet another GP in another unsuccessful attempt to obtain a prescription for oxycodone. The GP told him that they were not prepared to see him again as he had obviously lied to her and other GPs.[91] He then went to the emergency department at Royal Perth Hospital seeking opioids, but the emergency consultant called Onslow Road Family Practice and was advised about the deceased's recent history.[92]

88. On 23 April 2014, the deceased went to three more medical practices seeking oxycodone. Two of the GPs he saw refused him outright and the third agreed only to supply a one-off prescription for oxycodone.[93]

89. On 25 April 2014, the deceased was taken by police to the SCGH-ED after a significant polypharmacy overdose. He had taken a considerable number of oxycodone tablets as well as several antidepressants and anxiolytics. He denied suicidal intention and said that he overdosed because of the pain and because it had been the first Anzac Day he had spent without his Army mates. He was treated with naloxone and admitted for psychiatric review.[94]

90. On 26 April 2014, the deceased saw the alcohol and drug practitioner at the hospital, who noted the emerging

[89] Possibly RPBS – Repatriation Pharmaceutical Benefits Scheme
[90] Exhibit 1, Volume 5, Tab 1
[91] Exhibit 1, Volume 3, Tab 20
[92] Exhibit 1, Volume 3, Tab 20
[93] Exhibit 1, Volume 3, Tabs 3, 10 and 11
[94] Exhibit 1, Volume 5, Tab 1

history of opiate and benzodiazepine misuse and doctor-shopping. The practitioner formed an impression of addiction to those drugs and recommended that the deceased not be provided with prescriptions for them.[95]

91. Still at SCGH on the early morning of 27 April 2014, a psychiatrist reviewed the deceased, who reported that he had taken a few alprazolam. He said that Mr Tonkin had then thrown the rest of the bottle away. They had then had an argument, after which the deceased took a couple of oxycodone tablets and could not remember anything else. He denied any intention to harm himself then or in future. It appears that the altercation became physical because Mr Tonkin was treated for strangulation injuries at the SCGH-ED and then in a ward.[96]

92. Later that morning, the deceased slept well and again underwent a psychiatric review. He was discharged home with Mr Tonkin's blessing.[97]

93. On 30 April 2014, pain specialist Dr Majedi wrote to Dr Young to say that he had not yet seen the deceased, but that he had noted that his colleague had been consulted by the SCGH-ED and had advised changing the deceased's medication to take him off opioids. Dr Majedi said that the use of potent opioids on a background of lumbar spine pain and PTSD was ill-fated, and he recommended multidisciplinary care. Dr Majedi had given the deceased an urgent appointment at the SCGH pain clinic.[98]

94. On 5 May 2014, the deceased presented at a medical practice in Floreat with the same altered medical information report which he had provided to Dr Crisp. The GP faxed the report to the ADF at EHC and requested the urgent transfer of the deceased's medical notes. The request included a consent form signed by the deceased. The GP prescribed diazepam and Stilnox.[99]

---

[95] Exhibit 1, Volume 5, Tab 1
[96] Exhibit 1, Volume 5, Tab 1
[97] Exhibit 1, Volume 5, Tab 1
[98] Exhibit 1, Volume 3, Tab 20
[99] Exhibit 1, Volume 3, Tab 9

95. On 7 May 2014, the deceased attended the SCGH-ED again, seeking oxycodone and alprazolam for pain radiating down both legs. He was denied oxycodone but was offered Targin and was told that the SCGH-ED would never again provide him with prescriptions.[100] On the same day, he attended a medical practice in Subiaco that had refused him drugs in the past. He was again refused.[101]

96. On 8 May 2014, the deceased returned to the practice in Floreat and told the GP that he had been at hospital again on 7 May 2014 with severe back pain and was due to transfer to a different psychiatrist since he was not happy with the service provided by Dr Woodall. He said that he was due to see a pain specialist on 30 June 2014. The GP provided interim prescriptions for controlled-release oxycodone, pregabalin, and Targin. The GP also emailed the ADF to request the deceased's medical notes.[102]

97. On 13 May 2014, the deceased attended the Floreat medical practice for a scheduled appointment. The GP referred him for an MRI scan and prescribed alprazolam and oxycodone. The GP noted that he still awaited the military documents.[103]

98. On 15 May 2014, the deceased attended the Floreat practice again. The GP called the RPBS[104] and learned that the deceased had been prescribed 190 oxycodone tablets in the three weeks before seeing him. The RPBS had records of multiple prescribers and dispensers of oxycodone. The deceased denied all that. The GP told him that he would no longer prescribe to him and they discussed the risks of overuse and dependence. A pharmacist called the GP later that day to say that the deceased was requesting early dispensing of alprazolam. The GP advised against early dispensing.[105]

---

[100] Exhibit 1, Volume 5, Tab 1
[101] Exhibit 1, Volume 3, Tab 8
[102] Exhibit 1, Volume 3, Tab 9
[103] Exhibit 1, Volume 3, Tab 9
[104] Repatriation Pharmaceutical Benefits Scheme
[105] Exhibit 1, Volume 3, Tab 9

99. On 22 May 2014, the deceased attended the SCGH pain clinic, where he was seen by a chronic pain registrar, Dr Anthony Klobas. After examining the deceased and discussing his history with Dr Majedi, the deceased and Mr Tonkin, Dr Klobas ceased all oxycodone-based medication and placed the deceased on methadone and adjunct medication, including clonazepam. The WA Health Department was notified of the deceased's doctor-shopping.[106]

100. On 26 May 2014, Dr Klobas reviewed the deceased, who told him that he had run out of methadone and clonazepam despite the fact that the pharmacy had dispensed a week's supply after the last appointment. The deceased said that he had taken the methadone at a higher dose because of the pain. Dr Klobas considered that the deceased needed to be treated as an inpatient and, after discussions, Mr Tonkin and eventually the deceased agreed.[107]

101. On 27 May 2014, the deceased saw Dr Crisp at the Onslow Road Family Practice, requesting methadone and clonazepam. Dr Crisp called the pain clinic and learned that the deceased had already been given a three week prescription. Dr Crisp told him that he would have to deal with the pain clinic. Dr Crisp noted that the deceased was not registered as an addict with "the PSR', implying that Dr Crisp had called the WA Health Department's Pharmaceutical Service Branch.[108]

102. Later, on 27 May 2014, the deceased attended the pain clinic without an appointment and requested further prescriptions. A senior registrar told him that he would no longer be prescribed methadone and gave him prescriptions for buprenorphine.[109]

103. After attending the pain clinic, the deceased went to the SGCH outpatient pharmacy and attempted to obtain

[106] Exhibit 1, Volume 1, Tab14
[107] Exhibit 1, Volume 1, Tab14
[108] Exhibit 1, Volume 3, Tab 20
[109] Exhibit 1, Volume 1, Tab14

oxycodone and clonazepam with a prescription which he had forged. The prescription form was from a prescription pad that was suspected to have been stolen from the pain clinic. When the deceased attended the pharmacy, he was shaking and unsteady and had red eyes. The pharmacy staff called the senior registrar at the pain clinic, who advised them not to dispense the medication but to advise the deceased to go to the ED.[110]

104. On 28 May 2014, the deceased saw Dr Crisp to seek methadone. He said that he had been prescribed methadone by the pain clinic but had not obtained methadone from the SCGH pharmacy. Dr Crisp verified that the information was correct and provided a new prescription for methadone to be provided daily.[111]

105. From my reading of the medical records, on nine occasions from 29 May 2014 to 30 June 2014 the deceased sought pain relief from medical practices. Apart from receiving one prescription for buprenorphine on 3 June 2014, one for tramadol on 24 June 2014, and one for zopiclone on 30 June 2014, he was advised to see his own doctor or was otherwise denied his requests.[112]

EVENTS LEADING TO DEATH

106. At about 11.20 am on 1 July 2014, the deceased went to a medical practice in Claremont for the first time and requested pain medication. He was refused and advised to see his usual doctor.[113]

107. About an hour later, the deceased went to another medical practice in Claremont, again for the first time, where he saw Dr Rachel Hammond.[114] He told Dr Hammond that he was in the process of a medical discharge from the Army following injury from an IED. He said that he wanted to find a regular GP and that he

[110] Exhibit 1, Volume 1, Tab14
[111] Exhibit 1, Volume 3, Tab 20
[112] Exhibit 1, Volume 3
[113] Exhibit 1, Volume 3, Tab 4
[114] Exhibit 1, Volume 3, Tab 2

had a history of back pain and referred leg pain. Dr Hammond noticed that he walked with a limp and appeared to be in severe disabling pain. He appeared to be honest and genuinely distressed. He was alert and did not display any signs of intoxication or drug-seeking.[115]

108. Dr Hammond was empathetic towards the deceased and did not want to impede the therapeutic relationship with him by calling the prescription shopping service to check whether he was over-prescribed or was recorded as an addict. She obtained his permission to obtain his Army medical records and asked him to return in 10 days with a copy of those records which he said he had.[116]

109. Dr Hammond prescribed controlled-release oxycodone: 28 tablets of 20 mg and 28 tablets of 80 mg. The deceased was to take the 20 mg tablets and to have the 80 mg tablets available if necessary. On the way out of the medical practice, he made an appointment for 10 days later.[117]

110. On the evening of 2 July 2014, the deceased was at home with Mr Tonkin. He had been vomiting during that afternoon and had been displaying signs of a cold. At about 8.00 pm, he was in bed, apparently unwell. That was the last time that Mr Tonkin spoke to him.[118]

111. At about 9.30 am on 3 July 2014, Mr Tonkin went to wake the deceased up but could not rouse him. The deceased was warm to the touch but appeared to be barely breathing. Mr Tonkin called for an ambulance and was told by the call-taker to place the deceased on the floor and to start CPR.[119]

112. Ambulance paramedics arrived promptly and took over resuscitation attempts, but the deceased was in asystole and they could not revive him.[120] An ambulance

[115] ts 74-78 per Hammond, R
[116] ts 76-77 per Hammond, R
[117] Exhibit 1, Volume 3, Tab 2; ts 79 per Hammond R
[118] Exhibit 1, Volume 1, Tab 6
[119] Exhibit 1, Volume 1, Tab 6
[120] Exhibit 1, Volume 1, Tab 7A

paramedic certified that he was life extinct at 10.01 am.[121]

113. In a bitter irony, on 11 August 2014, the WA Department of Health sent Dr Hammond a letter notifying her that the deceased was a notified drug addict who should not be prescribed Schedule 8 drugs without the authorisation of the Chief Executive Officer of the Department of Health (CEO).[122]

CAUSE OF DEATH

114. On 7 July 2014, forensic pathologist Dr A V Spark and forensic pathology registrar Dr V Kueppers performed a post mortem examination of the deceased and found transdermal patches on both upper arms and about 10 intact tablets in the stomach. The lungs were heavy and congested, with possible changes of pneumonia in the right lower lobe. Further investigations were identified as necessary.[123]

115. Histological examination showed widespread acute bronchopneumonia throughout both lungs, and microbiological analysis reported the growth of *Staphylococcus aureus* in both lungs. Toxicological analysis reported fatal levels of oxycodone and detected alprazolam and desmethyldiazepam, a metabolite of diazepam.[124]

116. On 15 January 2015, Dr Spark formed the opinion, which I adopt as my finding, that the cause of death was bronchopneumonia complicating oxycodone toxicity.

HOW DEATH OCCURRED

117. The evidence leads to no other conclusion but that the deceased took a fatal quantity of oxycodone, which led to

[121] Exhibit 1, Volume 1, Tab 3
[122] Exhibit 1, Volume 3, Tab 2
[123] Exhibit 1, Volume 1, Tab 10.4
[124] Exhibit 1, Volume 1, Tabs 10.3 and 11

the complication of bronchopneumonia and caused his death. That is, it is clear that, by his own actions, he caused his death. A more difficult question is whether he had intended to end his life when he did so, or whether death occurred by way of accident.

118. One of the reasons why the issue is difficult is that, as Dr Majedi agreed, the deceased's case was very complex.[125] In particular, though Dr Woodall noted that substance use disorders are commonly comorbid with PTSD,[126] there were elements in the deceased's case which indicated the possibility that he had somatoform pain disorder rather than simply PTSD with substance abuse disorder. [127]

119. After reviewing the evidence, I have reached the conclusion that death occurred by way of accident. I have reached that view on the basis of the following considerations.

120. First, apart from his history of compulsive overdoses, there is no evidence that the deceased was suicidal in the sense that, on any of the occasions he overdosed, he intended to die. There was no evidence of him disclosing suicidal ideation at any time. Each time he overdosed and was later reviewed in hospital, he was adamant in maintaining that he had not intended to end his life. In fact, he would often deny that he even took the drugs leading up to his admission.

121. Dr Woodall said that, although it was possible that the deceased had intended suicide on those occasions, his impression was that most of the occasions that the deceased overdosed were not with the intent of dying. I note, however, that Dr Woodall qualified his assessment by saying that it was complicated by the deceased's denial of intent while not revealing the mechanisms that led to

[125] ts 117 per Majedi, M
[126] ts 10 per Woodall, M
[127] ts 23 per Woodall, M

the overdose, so Dr Woodall could not be sure whether it was impulsive or was due to his emotional state.[128]

122. Second, each time the deceased overdosed to the point of unconsciousness, he took an extraordinary quantity of drugs, often a combination of them, yet within a day or so, he recovered and had little or no memory of what had happened. It seems to me likely that, from a rational perspective, he would not have equated overdosing with fatality because it would not have appeared to him to be a likely outcome. Rather, the evidence suggests that he had a reckless disregard of the risks of abusing the drugs.

123. As Dr Majedi said, the deceased had access to drugs that can be dangerous in the hands of people who may not be aware of how dangerous the drugs are.[129]

124. Third, Dr Woodall and Dr Majedi made clear that the deceased genuinely experienced the back and leg pain he complained about.[130] Dr Woodall said that the pain would cause him distress and would lead him to the medication-seeking behaviour to alleviate the distress. That distress, said Dr Woodall, was emotional rather than physical, and the treatment for it would be largely psychological.[131] It seems to follow, in my view, that the deceased's compulsion to take medication was therefore directed, at least initially, to alleviating what he perceived as physical pain rather than, for example, ending his despair or severe depression.

125. Fourth, when not affected by medication or an obsessive need to obtain it, the deceased appeared to be level-headed and positive. An example of that can be found in a touching letter which he wrote to his prospective step-mother in, I infer, about December 2013.[132] More examples can be found in a letter Mr Tonkin provided to the State Coroner's Office, in which he said that he

[128] ts 23 and 24
[129] ts 118 per Majedi, M
[130] ts 23 per Woodall, M; ts 99 per Majedi, M
[131] ts 23 per Woodall, M
[132] Exhibit 1, Volume 2, Tab 17.4

vehemently believed that the deceased did not deliberately take his own life because of:

a. the progress he had been making while under the care of Dr Woodall;

b. his excitement about an approach that had been made to him to become an instructor in the Army Reserve;

c. the fact that he had been saving money to pay off his debts;

d. the fact that he had been preparing to buy a car when he received disability pension payments; and

e. his positive attitude about staying and working with his godparents on their property in Mandurah at their invitation.[133]

126. Fifth, the evidence indicated that the deceased had difficulty in obtaining access to oxycodone in June 2014. When he attended Dr Hammond's practice on 1 July 2014, he showed no signs of intoxication or drug-seeking. There is no indication at that time that he was intending to end his life with drugs or in any other way.

127. In those circumstances, the following scenario appears to me to be possible, if not probable. The deceased's tolerance to opioids would have decreased over June 2014, resulting in him being relatively opiate-naïve by 1 July 2014. When he indulged in a reckless misuse of oxycodone on 1 July 2014 and or 2 July 2014, he had 80 mg tablets available, the highest strength controlled-release oxycodone tablets. He was not able to survive that combination of opiate-naiveté and high dose oxycodone.

128. Dr Woodall agreed that the foregoing scenario was certainly possible. He added that the other hazard facing

[133] Exhibit 1, Volume 1, Tab 6.2

the deceased was the combination of narcotics with other drugs, particularly benzodiazepines such as alprazolam and diazepam.[134]

129. Given the foregoing, while it is not possible to be certain that, between the time when the deceased attended Dr Hammond and the time when he took an overdose of oxycodone, he had formed an intention to end his life, in my view the preponderance of evidence indicates that he had not. Rather, it appears more likely that he took the oxycodone for impulsive or compulsive reasons and accidently caused his death.

PRESCRIPTION SHOPPING

130. There were information systems in place in 2014 to enable prescribing medical practitioners to control the sort of prescription shopping for Schedule 8 drugs carried out by the deceased. The Prescription Shopping Alert Service was provided by the Commonwealth Department of Human Services[135] and the Pharmaceutical Service Branch of the WA Department of Health provided a similar service. Each of these services could provide patients' prescription histories over the telephone to prescribers. In cases such as the deceased's, that information would have also been available from the DVA with respect to prescriptions which he had obtained through the Repatriation Pharmaceutical Benefits Scheme (RPBS).

131. Each of those three services were limited to some degree. The Commonwealth service related only to prescriptions obtained through the PBS and was seen to be focused on preventing fraud against that scheme.[136] It could not identify whether a patient was a registered drug addict, and it did not include prescriptions that had been filled privately or through the RPBS.[137] The WA service related to all prescriptions for Schedule 8 drugs dispensed in WA

[134] ts 24 per Woodall, M
[135] Exhibit 1, Volume 2, Tab 4.3
[136] ts 129 per Schug, S
[137] ts 138 per Schug, S

but was only available on weekdays during business hours, and the available information was subject to substantial delay.[138] The DVA information related primarily to prescriptions obtained through the RPBS. There was no prescriber information system as such, but a prescriber could call the DVA and speak to a pharmacist who had access to the information.[139]

132. The three agencies had little or no sharing of their information, and there was no sharing between agencies from other states and territories.

133. In order to overcome the inherent limitations of those three services, a national system of accurate real-time reporting of Schedule 8 drug supply has been promoted for several years. Mr Keen provided the following brief history. The national system's practical genesis was in about 2009 or 2010, when Tasmania used a Commonwealth grant to develop and implement its own functioning system within two or three years. The Commonwealth then developed that system into the Electronic Recording and Reporting of Controlled Drugs system (ERRCD) which was to be licensed to states and territories. The Commonwealth would maintain the system, but the data would remain in the possession of the individual states and territories.[140]

134. Due to perceived difficulties with the Commonwealth system, by 2015 or so it had not been taken up by any state. Tasmania kept its system, and NSW had developed its own version of the ERRCD. The Commonwealth then attempted to bring the states into the ERRCD, but WA had determined to proceed independently on the basis of the ERRCD platform. Victoria also decided that it could wait no longer and would implement its own program.

135. Further discussions between the states and the Commonwealth resulted in the planning of a system called the National Data Exchange (NDE), which would

[138] ts 128 per Schug, S
[139] ts 58-59 per Claes, M
[140] ts 147-8 per Keen, N; Exhibit 1, Volume 2, Tab 3

receive data from each of the states and would channel it back to the state from which it originated and to other states, depending on whether there were agreements between them.[141]

136. The WA Department of Health has commenced replacing its database to enable real-time reporting of all WA prescriptions, with a view to joining into the NDE if feasible. Mr Keen was hopeful that the WA database would be operational by October 2019 and that getting it to the stage where a GP or a pharmacist could use it with a pop-up on a computer was about two years away. He also said that he had thought the same thing about seven years ago.[142]

137. Another means of attempting to control prescription shopping was the Schedule 8 Medicines Prescribing Code (the Code) produced by the WA Department of Health. It was apparently implemented initially in 2014 but was seen as an internal administration document to assist the Pharmaceutical Service Branch in making internal decisions when contacted by a prescriber.[143]

138. The Code imposed a requirement for authorisation from the CEO for practitioners to prescribe Schedule 8 medicines to registered drug addicts or to anyone for more than 60 days in a 12 month period, and support from specialist consultants was required for high risk patients, who included patients whose details corresponded to a registered drug addict or were identified as doctor-shoppers. A 'doctor-shopper' was defined to mean a patient who had obtained prescriptions for Schedule 8 medicines from three or more doctors from different practices over a three month period.[144]

139. In 2017 the Code was amended and promulgated under the *Medicines and Poisons Regulations 2016.* New provisions included: '1.3 Prescribers should not prescribe

[141] ts 150 per Keen, N
[142] ts 152 per Keen, N
[143] Exhibit 1, Volume 2, Tab 13; ts 161 per Keen, N
[144] Exhibit 1, Volume 2, Tab 13

or supply an S8 medicine to any new or unknown patient without first contacting the S8 Prescriber Information Service for a prescription history.' The Schedule 8 Prescriber Information Service is a continuation of the service provided by the Pharmaceutical Service Branch.[145]

140. The Code was amended again in 2018[146] to facilitate the prescription of tapentadol over higher risk opioids, among other things.[147]

COMMENTS ON PRESCRIPTION SHOPPING CONTROLS

141. The delay of the implementation of the proposed real-time collection and reporting of Schedule 8 drugs in WA is frustrating.

142. In 2012 and 2014, coroners in Victoria and New South Wales, respectively, identified the need for real-time reporting in their states.[148]

143. In February 2016, Deputy State Coroner Vicker of this Court formally recommended that priority be given to that system,[149] and in the same year the WA Department of Health was allocated a budget to replace its then current system with a modified version of the ERRCD.[150] Mr Keen's evidence described above does not inspire a lot of confidence that a real-time system will be functioning this year.

144. The situation with respect to a national ERRCD is even less optimistic. In some ways, it brings to mind the 150 years of railway gauge 'muddle' which still exists in Australia.[151] As Professor Schug said,

[145] Exhibit 1, Volume 2, Tab 12; Exhibit 1, Volume 2, Tab 1.A; Exhibit 3
[146] Exhibit 3
[147] ts 137 per Schug, S
[148] Exhibit 1, Volume 1, Tab 30.4
[149] Inquests into the deaths of Daniel James Hall (9/15), Shayne Andrew Berry (9/15) and Adrian Marcus Westlund (9/15)
[150] Exhibit 1, Volume 2, Tab 1.A
[151] en.wikipedia.org/wiki/Rail_gauge_in_Australia

> … So I personally think, why on earth can we (not) have a Federal Government-run monitoring prescription system real time where everybody – pharmacist and doctor can log on and say, "Where does this patient get what opiates?" I mean, to me it's incomprehensible that this hasn't happened.[152]

145. The evidence of all the medical practitioners who were either called as witnesses or who provided statements was uniform: real time prescription reporting would be very useful. Dr Crisp said that it would remove a lot of the uncertainty of whether a patient is doctor-shopping and that the deceased would not have been prescribed a lot of the medications had it been in place.[153] Dr Hammond said that it might have saved the deceased's life.[154]

146. On 9 September 2015, the Pharmacy Guild of Australia, the Australian Medical Association, the Consumers Health Forum of Australia, the Medical Software Industry Association, the Pharmaceutical Society of Australia, the Royal Australian College of General Practitioners, The Royal Australian College of Physicians and the Society of Hospital Pharmacists of Australia wrote a joint letter to the Ministers for Health of the Commonwealth and all states and territories, urging them to work together as a matter of urgent priority to implement a national ERRCD system.[155]

147. On 6 October 2015, the then Minister for Heath in Western Australia responded to that letter by strongly supporting the concept of real-time prescription monitoring and stating that WA will work co-operatively with other jurisdictions to address the existing barriers to a national solution.[156]

---

[152] ts 130 per Schug, S
[153] ts 37-38 per Crisp, G
[154] ts 80-81 per Hammond, R
[155] Exhibit 1, Volume 1, Tab 30.3
[156] Exhibit 1, Volume 1, Tab 30.2

148. Yet, here we are almost four years later with a delay of another two years expected for WA alone. For what it is worth, I add my voice to the chorus pleading for urgency.

149. It is worth noting, however, both Dr Majedi and Professor Schug expressed the caveat that, while having a better system of monitoring prescriptions is important, it would not fix the underlying problem of the current over-reliance on drugs to treat chronic pain.

150. Dr Majedi said that we (which I take to mean our society through the medical profession) really need to think about the overall human condition and to put more emphasis on mental health rather than just to numb the patient's symptoms.[157]

151. Professor Schug explained how treating chronic pain with strong opioid painkillers can actually make the pain worse since they can contribute to the central sensitization process, whereby the brain and spinal cord up-regulates in response to past input. He said that the current understanding is that conventional opioids should not be used at all for chronic pain.[158]

152. Professor Schug echoed Dr Majedi in saying that the necessity for a real-time monitoring system was urgent, but that it would not solve the problem because we need to change the way people think about chronic pain: not as something that can be fixed but as something which requires the full input of the patient.[159]

153. Professor Schug said that he was involved in a lot of GP teaching in order to promote a change from the more harmful conventional opioids to drugs such as buprenorphine and tapentadol, which are atypical opioids with lower risk of addiction, lower risk of abuse and better efficiency on function and quality of life.[160]

---

[157] ts 114 per Majedi, M
[158] ts 121-124 per Schug, S
[159] ts 133 per Schug, S
[160] ts 124 per Schug, S

154. The evidence at the inquest did not focus on the current approach by GP's generally to prescribe drugs for chronic pain, so I am unable to be confident in making a formal recommendation about the desirability of providing further up-to-date information and training to GPs generally.

155. It is, however, clear that this area of practice is fundamentally important. This court regularly deals with the tragic results of opioid addictions that appear to have started from the prescription of opioids for chronic pain.

156. I therefore encourage the Department of Health and the Royal Australian College of General Practitioners to consider and, if appropriate, to provide GP's with the requisite information and training to enable them to treat patients with chronic pain in the most suitable way.

157. As to the current Code, it appears on its face at least to encourage prescribers not to prescribe Schedule 8 drugs without first checking with the Schedule 8 Prescription Information Service.

158. However, in my view that provision in the Code has two shortcomings. The first is the continuing untimeliness of the information provided by the Schedule 8 Prescription Information Service (Professor Schug said that the last time he rang that service it was around four months behind).[161]

159. The second shortcoming I perceive is the lack of a requirement in the relevant provision of the Code (1.3 Prescribers *should not* prescribe or supply an S8 medicine to any new or unknown patient without first contacting the S8 Prescriber Information Service). The language in that provision may be contrasted with others, which either prohibit an action (1.5 Prescribers *may not* prescribe an S8 medicine for themselves) or require one (1.8 An authorised health professional *must* make a report to the CEO within 48 hours if they have

[161] ts 128 per Schug, S

reason to believe that a patient is oversupplied or drug dependent).[162]

160. The reason for lack of a requirement in relation to checking with the S8 Prescription Information Service before prescribing Schedule 8 drugs to new patients is not apparent to me and was not explained. While it might be argued that the provision takes into account the possibility that the prescriber is unable to validate a person's prior history, the language of Part 1.3 could nonetheless impose a requirement subject to exceptions. I encourage the Health Department of WA to consider amending the Code to create the requirement and to so amend unless there is a good reason not to do so.

161. Another possible shortcoming was identified by Dr Crisp, who said that he was aware of the Code to a degree, but he said that services available changed on an annual or two-yearly basis, making it difficult to know who to call. He said that it would be nice if there were a consistent and long-term approach to reporting and accessing information.[163] As there was no other evidence about that point, I am not able to comment upon it with any confidence.

162. Lastly, there was evidence at the inquest regarding the prospect of including benzodiazepine medication in Schedule 8, or at least better controlling it.[164] Professor Schug noted that, with opioid overdoses, the cause of death is nearly always a combination of an opioid and a benzodiazepine.[165]

163. Chief Pharmacist Mr Keen[166] favoured that inclusion, and I note that it was recommended by Deputy State Coroner Vicker in 2016. Professor Schug could not see any harm in including benzodiazepines in Schedule 8, but he considered that they should not be prescribed with opioids in any event and that, though they were

[162] Exhibit 3
[163] ts 37 per Crisp, G
[164] Eg. ts 125-126 per Schug, S
[165] ts 125 per Schug, S
[166] ts 141-143 per Keen, N

developed for a maximum of four-week crisis treatment, millions of people were are on them for years.[167]

164. It was apparent that the deceased also doctor-shopped for benzodiazepines, but the evidence does not show that he died as a result of taking them with the oxycodone. In these circumstances, I take the topic no further.

TRANSFER OF ADF MEDICAL RECORDS

165. The oral evidence of Dr Woodall and Dr Hammond and the records of the GP in Floreat indicate that obtaining a veteran's medical records from the ADF or the Department of Defence can be a difficult, time-consuming process.

166. Dr Woodall's practice includes two days a week of providing psychiatric services to military veterans. In most cases those patients would be discharged from the army for some time, so he would be able to get their records from the DVA.[168] In the deceased's case, Dr Woodall tried to get medical records from Dr Chalk but was unsuccessful, though Dr Chalk did provide some information over the phone.

167. Dr Woodall also encouraged the deceased to obtain the records by making a Freedom of Information application because in Dr Woodall's experience that was often the quickest way to get the records. Dr Woodall agreed that FOI applications can take a lot of time and that he lacked any timely information about the deceased's medical conditions. When told of the EHC and RBH medical records describing the deceased's overdosing and drug-seeking behaviours, he agreed that knowing about those sorts of things was definitely crucial to his management of someone like the deceased.[169] He agreed that the deceased coming to WA without his medical records following him was a very poor way to manage him.

---

[167] ts 125 per Schug, S
[168] ts 6-7 and 22 per Woodall, M
[169] ts 20-21 per Woodall, M

168. Mr Claes said that the DVA can request a veteran's records from the Department of Defence, but those records are not routinely given to the DVA. He said that the DVA can obtain those records on the request of a treating medical professional in WA, but that provision of the records can take several months.[170]

169. Mr Claes said that records of the supply of drugs to ADF members when treated at ADF facilities were also not shared with other health systems, and that access to that information was not yet available to the DVA, though a process of 'veteran-centric reform' was occurring to make it available. However, even if Dr Woodall's request for a veteran's records occurred in 2019, it would take some time for him to access them despite the fact that, as Mr Claes agreed, the benefits to the veteran were self-evident.[171]

RECOMMENDATION

170. While the issue of the transfer of ADF medical records to non-ADF medical practitioners was raised only in the inquest without inviting evidence or submissions from the Department of Defence, I consider it appropriate to make the following recommendation:

That the Western Australian Department of Health liaise with the Department of Defence to consider and, if appropriate, implement a procedure to allow for the timely transfer of medical records of ADF members and veterans to treating medical professionals in Western Australia.

CONCLUSION

171. The deceased fulfilled his dreams of becoming a soldier and went on to thrive in the army environment. He was

[170] ts 63 per Claes, M
[171] ts 66-67 per Claes, M

then deployed to the other side of the world, where he accredited himself well but witnessed the death and maiming of close mates and associates. He later sustained injuries to his hip and ankle while exercising. The physical injuries were not permanently debilitating, but the mental injuries that he had sustained from what he had experienced were deep and profound.

172. Upon his return to his Queensland barracks in February 2013, it was apparent that the deceased's mental state was altered, and it was not long before he was diagnosed with PTSD. By early June 2013, he was experiencing increased pain to his hip and had begun to have somatoform lower back pain. His treatment included oxycodone, as was typical in the context.

173. Within a relatively short time, the deceased developed an addiction to oxycodone and sedative drugs, which he began to seek actively and to abuse to the point of oblivion. The addiction became apparent to his treating doctors in Queensland, who arranged for psychological therapy and reduced access to oxycodone, but the deceased obtained further oxycodone through friends or by deception.

174. The deceased moved to WA in early 2014 and eventually began seeking oxycodone. Through sympathy which he engendered as an injured veteran, by relying on a forged record and because of the difficulty which GPs had in obtaining his ADF medical records or his prescription history, GPs in WA were initially willing to prescribe him oxycodone. Pain management specialists attempted to help him in May 2014, but by then his addiction to oxycodone was entrenched.

175. By mid-May 2014, GPs who saw the deceased refused to prescribe oxycodone, partly because his drug-seeking behaviour was so apparent. He kept trying to obtain oxycodone and eventually, six weeks later, attended a GP who, based on his alert presentation and the history he provided, was willing to provide him with a prescription

while awaiting his ADF records. Two days later, he was dead from an oxycodone overdose.

176. While in hindsight it is possible to be critical of that GP, from her perspective at the time there was no indication that the deceased was drug-seeking, something with which she had experience, or was at risk of overdose. She saw a patient who was clearly in pain and she wanted to develop the trust required for a therapeutic doctor/patient relationship. An opioid analgesic was a common treatment for such chronic pain.

177. From 1 January 2014 until 3 July 2014, the deceased had seen 24 different doctors in Queensland and Western Australia and had 99 consultations. He attended 16 different pharmacies and obtained 23 different medications over 99 attendances. He was given 27 prescriptions for oxycodone, of which three were for oxycodone with naloxone. He was given 15 prescriptions for benzodiazepines: 11 for diazepam and four for alprazolam.

178. The evidence suggests that the deceased would have obtained no prescriptions for oxycodone in WA had a national real-time prescription reporting system been available or had the GPs in WA had access to his ADF medical reports. The evidence also suggests that the GPs needed up-to-date education on treating chronic pain.

179. This inquest into the deceased's death exposed several areas of medical management where important improvements might be made. I sincerely hope that such improvements do eventuate and that the deceased's loved ones can take some solace from a reduced likelihood that other young soldiers will follow the deceased's fate.

B P King
Coroner
10 May 2019