IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 001580

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	CJ
Date of birth:	29 November 1978
Date of death:	24 March 2023
Cause of death:	1(a) Mixed drug toxicity (buprenorphine, ketamine, diazepam, fluvoxamine and lacosamide)
Place of death:	148 Collie Road, Gembrook, Victoria

INTRODUCTION

1. On 24 March 2023, CJ was 44 years old when she was found deceased at home in circumstances suggesting a drug overdose. At the time, Ms J lived in Gembrook with her partner and two children.

2. Ms J grew up in Canberra and later became a vet practitioner. Her first job as a vet was in the Caribbean, where she resided for about eight months. It was during this time that Ms J first began using opioids recreationally as expired medications were readily available at work.

3. Over the following years and following her return to Australia, Ms J developed a heroin addiction. It is evident that Ms J's family and close friends, including her partner DJ were aware of her addiction issues and provided ongoing support and love to her over many years.

4. In an effort to move away from the Canberra drug scene, Ms J later moved to Victoria. According to Mr J, the move energised her, and she was hopeful about turning her life around.

5. In about 2007, Ms J was delighted when she became pregnant with her first son. She and Mr J moved in together a short time later. Mr J recalled their son's birth *"sparked a new lease of life"* for their relationship.

6. Mr J explained that during this period Ms J was *"fully addicted to methadone"* and no longer using heroin. Although she was not practising as a vet at the time, she was still registered as one and was able to set up an online account with a supplier and was able to have methadone delivered.

7. Ms J gave birth to her second child before the family's move to Cockatoo. The family later settled in Gembrook. According to Mr J, Ms J's addiction appeared to be under control at this time. Ms J subsequently opened a vet clinic again and later worked at veterinary practices in Avonsleigh and Cockatoo. Mr J recalled that during this time, Ms J's *"natural self just shined through and [she] became confident …Everything was going incredible …"*.

8. In 2015 Ms J was referred to Dr David Jacka, addiction specialist at Monash Heath. In his statement, he noted that Ms J had been on 280mg methadone, and her medical

history also included epilepsy, splenectomy, pancytopaenia, and bacterial endocarditis secondary to injecting methadone.

9. Dr Jacka explained that he steadily increased the methadone dose to 660mg per day to contain Ms J's cravings and drug-seeking behaviour. Other medications at various times included fluvoxamine, lacosamide, doxycycline, pantoprazole, amoxicillin, ursodeoxycholic acid, sumatriptan.

10. Mr J stated that at time, he found his partner in a semi-coherent state following her methadone use.

11. In early 2023, Ms J's family made plans to holiday in Thailand. However, as the holiday neared, Ms J became anxious that she would not be able to take methadone to Thailand despite having all the appropriate paperwork. She subsequently decided not to go on the holiday with her partner and sons.

12. At about this time, Dr Jacka and Ms J decided that Ms J would transition to long-acting injectable buprenorphine (**LAIB**) while her family was away. According to Mr J, Ms J handled the transition well but had some sleeping issues. He described Ms J as experiencing *"teething"* issues following her first monthly dose of buprenorphine.

13. Dr Jacka stated that Ms J underwent transition in outpatient care in January 2023. She was reviewed frequently and reported dramatic improvement at her last review on 20 March 2023. Her last dose of methadone was 22 January 2023 and she had received four doses of LAIB since then. She presented as positive and optimistic at her last review.

14. However, following her transition to LAIB, Mr J caught Ms J using ketamine. They spoke about the possible risk to Ms J's vet registration. Ms J subsequently gave the bottle to Mr J, declaring that she was done with it.

THE CORONIAL INVESTIGATION

15. Ms J's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury.

16. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances

are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

17. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

18. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms J's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

19. This finding draws on the totality of the coronial investigation into Ms J's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

20. On 24 March 2023, CJ, born 29 November 1978, was visually identified by her partner, DJ, who signed a formal Statement of Identification to this effect.

21. Identity is not in dispute and requires no further investigation.

Medical cause of death

22. Forensic Pathologist, Dr Sarah Parsons, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 28 March 2023 and provided a written report of her findings dated 8 June 023.

23. The post-mortem examination was consistent with the reported circumstances.

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

24. Routine toxicological analysis of post-mortem samples detected buprenorphine[2] and norbuprenorphine, ketamine,[3] diazepam[4] and nordiazepam, fluvoxamine,[5] and lacosamide.[6] Dr Parsons explained that this combination of drugs can cause central nervous system and respiratory depression and death.

25. The contents of a syringe containing an unknown clear and colourless liquid was also analysed, which tested positive for ketamine.

26. Dr Parsons provided an opinion that the medical cause of death was *"1(a) Mixed drug toxicity (buprenorphine, ketamine, diazepam, fluvoxamine and lacosamide)"*.

27. I accept Dr Parsons's opinion.

Circumstances in which the death occurred

28. On the morning of 24 March 2023, Mr J got ready for work and left the house at approximately 5.30am. Ms J was still in bed when he left, but they spoke briefly about the day ahead. Ms J was happy to have the day off.

29. At about 9.30am, Ms J telephoned Mr J. He recalled that everything seemed fine, and Ms J sounded like her usual self.

30. In the afternoon, one of the children telephoned Mr J to report that their mother had not picked them up from school. When Ms J did not respond to his telephone calls, Mr J made his way home. Once home, Mr J found Ms J unresponsive on the floor of the lounge-room, determining that she was deceased. He observed a syringe beside her body and another on the table and telephoned emergency services.

31. Mr J concluded his statement by noting that Ms J had struggled with her addiction for 18 to 19 years. He described her as a happy person who loved the life they had created with their children.

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[2] Buprenorphine is indicated for moderate to severe chronic pain and maintenance therapy in opiate addicts. The Department of Health confirmed that Dr David Jacka of Monash Health Drug and Alcohol Service held a permit to treat Ms CJ with buprenorphine and/or methadone for opioid dependence. The permit was effective from 10 September 2015.

[3] Ketamine is an anaesthetic normally used for short and medium duration operations as an induction agent.

[4] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures. Adverse effects of diazepam include confusion, incoordination, physical dependence, sedation, and seizures in withdrawal. Nordiazepam, temazepam, and oxazepam are active but only nordiazepam accumulates in blood.

[5] Fluvoxamine is an antidepressant.

[6] Lacosamide (erlosamide) is indicated for partial seizures.

FINDINGS AND CONCLUSION

32. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was CJ, born 29 November 1978;

    (b) the death occurred on 24 March 2023 at 148 Collie Road, Gembrook, Victoria;

    (c) the cause of Ms CJ's death was mixed drug toxicity involving buprenorphine, ketamine, diazepam, fluvoxamine and lacosamide; and

    (d) the death occurred in the circumstances described above.

33. Having considered all the available evidence, I am satisfied that Ms J's death was an accidental or inadvertent overdose, that is it was the unintended consequence of the deliberate ingestion of drugs.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

34. The coronial investigation has not revealed how or when Ms J gained access to ketamine. However, I am satisfied that it is more likely than not that she obtained the drug in the course of her work as a veterinarian.

35. Veterinarians have routine access to benzodiazepines, opioids, anaesthetic agents, and other addictive drugs in their workplaces. Furthermore, they are exposed to occupational factors (such as high workload, challenging cases, and the emotional consequences of euthanising animals), which may contribute to psychological distress and engagement in dependent substance use, including dependent use of veterinary drugs.[7]

36. However, it appears that the actual incidence of veterinarians developing dependence on veterinary drugs is very rare, at least among deaths reported to the Coroners Court of Victoria.

[7] See for example Geller G, "Dark shadows: Drug abuse and addiction in the veterinary workplace", *DVM360*, 16 June 2016, <https://www.dvm360.com/view/dark-shadows-drug-abuse-and-addiction-veterinary-workplace>, accessed 27 November 2023; Anand A and Hosangar A, "Drug Misuse in the Veterinary Setting: an Under-recognized Avenue", *Current Psychiatry Reports*, 23(3), 2021; Aarnes TK et al, "Medication safety education: more than just a human concern?", *Journal of the American Veterinary Medical Association*, 261(4), April 2023.

37. As part of my investigation, I asked the Coroners Prevention Unit[8] (**CPU**) to compile statistics regarding veterinarian deaths from all causes.

38. Using the National Coronial Information System (**NCIS**) database, the CPU identified 18 deaths in Victoria between 1 January 2013 and 27 November 2023.[9]

39. Among the 18 identified deaths, there was evidence of substance misuse (excluding pentobarbitone) in two deaths, and a further two deaths potentially involving substance misuse.

40. The CPU identified only one instance where the deceased may have sought to obtain veterinary drugs for recreational non-clinical use (and the evidence about this was far from clear in the case).

41. The data does not support a finding that Ms J's death was indicative of a broader systemic issue with veterinarians developing addiction to veterinary drugs such as might support a prevention focused recommendation. Nevertheless, I direct that a de-identified version of this finding is provided to the Australian Veterinary Association for their information and in case the circumstances of the death may be useful in informing future policy development by that body.

[8] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[9] Where the coroner's investigation had been completed.

I convey my sincere condolences to Ms J's family for their loss.

Pursuant to section 73(1A)of the Act, I order that this finding be published on the Coroners Court of Victoria website (in de-identified form) in accordance with the rules.

I direct that a copy of this finding be provided to the following:

DJ, senior next of kin

EJ

Monash Health

Australian Veterinary Association

Detective Senior Constable Talissa Croxford, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 18 March 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.