IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2007 0549

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: ROBERT ANDERSON

Delivered On:	11 September 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	30, 31 January 2012 and 2, 3 February 2012
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr Simon LOFTUS of Counsel, instructed by McDonald Murholme, appeared on behalf of Mrs Lillian ANDERSON Mr Sean CASH of Counsel, instructed by Avant Law, appeared on behalf of Dr Hui-Qui (Angel) LIANG Ms Sarah HINCHEY of Counsel, instructed by Perry Maddocks Trollope, appeared on behalf of Dr Michael O'TOOLE
Police Coronial Support Unit:	Leading Senior Constable Remo ANTOLINI, assisting the Coroner

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of ROBERT ANDERSON
AND having held an inquest in relation to this death on 30, 31 January 2012 and 2, 3 February 2012
at Melbourne
find that the identity of the deceased was ROBERT CHARLES ANDERSON
born on 28 February 1956
and that the death occurred on 10 February 2007
at the Alfred Hospital, Commercial Road, Melbourne, Victoria 3004
from:

1 (a) COMPLICATIONS OF RIGHT BUTTOCK NECROTISING FASCIITIS
1 (b) CHRONIC RIGHT BUTTOCK INTRAMUSCULAR INJECTIONS
CONTRIBUTING FACTORS
2 CHRONIC PAIN

in the following circumstances:

BACKGROUND & PERSONAL CIRCUMSTANCES[1]

1. Robert Anderson was a 50 year old married man who resided with his wife and daughter at Reed Lane, Bass. Mr Anderson left school at 14 to become a professional jockey. He rode on the flat for the first five years of his career and then for some eleven years as a jumps jockey. Over the course of his career he suffered a number of falls and injuries including multiple fractures and concussive head injuries. After suffering a serious fall during a race on 3 June 1995 and sustaining multiple injuries to his knees, legs and back, Mr Anderson was unable to return to professional riding. He felt this loss keenly and over time began to suffer from depressive symptoms, migraine and chronic pain, ultimately leading to dependency on prescription analgesics, pethidine at first, and then morphine sulphate in the years immediately preceding his death.

[1] Paragraphs 1- are a summary of facts which were uncontentious, and provide a context for those aspects of clinical management and care which were contentious and will be discussed in some detail from paragraph onwards.

DR O'TOOLE AND THE LANGTON MEDICAL CENTRE

2. Mr Anderson first consulted General Practitioner Dr Michael O'Toole at the Langton Medical Centre, Dandenong, in June 1996. He gave a history of multiple injuries related to falls sustained in the course of his employment as a jockey and of pethidine use for pain relief since 1992. Dr O'Toole diagnosed pethidine dependency and commenced Mr Anderson on a methadone replacement program, eventually weaning him off methadone on to slow release morphine for pain relief, in accordance with specialist input from Dr Brendan Holwill, a Consultant Psychiatrist with a special interest in the management of chronic pain. Despite the successful weaning of Mr Anderson from parenteral pethidine by about mid-1999, it was re-introduced in October 2000 as a last resort treatment of his migraines in particular, and used with some regularity until January 2003.[2]

3. While the use of slow release oral morphine had been part of Mr Anderson's pain relief regime for some years, Dr O'Toole began the regular prescription of morphine sulphate by intramuscular injection (IM morphine) for Mr Anderson to self-administer at home from August 2005. The rationale for this aspect of his clinical management and care of Mr Anderson was at the heart of the inquest and will be discussed in some detail below. Suffice for present purposes to say that although a complete reconciliation of the available records has not been attempted, the records from Langton Medical Centre and those provided by Medicare Australia as to the Pharmaceutical Benefits Scheme, indicate the prescription of disturbing quantities of IM morphine for self-administration, generally at a dosage of 120-240mgs per day over the 18 months or so immediately preceding Mr Anderson's death.[3]

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[2] See pages 129 and following of the inquest brief (Exhibit T) which is a list of scripts generated at the Langton Medical Centre derived from their medical practice software. This re-introduction of pethidine could be said to be supported by Dr Holwill's reviews of Mr Anderson. See Exhibit N.3 - "If all else fails, and he continues to have the migraines, I think it is appropriate that he has pethidine parenterally to control them. This seems to work very well, and he told me that he averages an injection about every 2-3 weeks, which I think is entirely reasonable." Exhibit N.5 - "He continues to suffer from intermittent severe migraines lasting up to several days at a time. When they occur he requires regular pethidine. He is still averaging 200mg per day. There does not appear to be any increase in his pethidine use." Exhibit N.6 – "I would certainly endorse the idea of change to the methadone as noted above, but if all else fails he may have to go back to using pethidine irregularly, but with very strict controls on the amounts." However, a fair reading of Dr Holwill's reports to Dr O'Toole, consistent with his evidence at inquest, could not be said to support the amount of pethidine prescribed during this period. See transcript page 178 and following. Pethidine injections also appear in the list of scripts in May 2004, but not thereafter.

[3] See pages 129 and following of the inquest brief (Exhibit T) for the list of scripts generated at the Langton Medical Centre, predominantly but not exclusively by Dr O'Toole. See also pages 147 and following for the relevant Medicare/PBS records. I note the prescription of IM morphine by doctors in another practice in February & May 2006.

4. On 22 January 2007, while Dr O'Toole was away on holiday, Mr Anderson went to the Langton Medical Centre and was seen for the first time by Dr Hui-Qui (Angel) Liang, a General Practice Registrar. Mr Anderson told Dr Liang that he was going to Warrnambool for a holiday and wanted a repeat prescription of IM morphine. The details of that consultation will be discussed in some detail below, but after consulting the practice's computerised medical records and obtaining an authority prescription number from the "phone approval hotline", Dr Liang provided Mr Anderson with a prescription which she believed was in the same terms as he had been supplied for some time – that is, morphine sulphate ampoules (30mg/ml), at a dosage of 1ml x 6 intramuscular injections daily, with three repeats and instructions to the pharmacist for a 7 day dispensing interval.[4]

5. According to Mr Anderson's wife, Lillian, she was concerned about the nature and quantity of prescription medications provided to her husband, particularly during the last five-six years of his life and had attempted to communicate these concerns to Dr O'Toole, in particular, with little response. She gave evidence of the extent of Mr Anderson's dependency, and its increasing dominance of his life to the detriment of the marital relationship and their family life. She described a man who used IM morphine on waking, alternated between sleeping and injecting throughout the day, perhaps going to the pub to drink in the afternoon, ate very little, had fluctuating moods, and had been verbally abusive towards her.[5]

MR ANDERSON FALLS ILL - 6 FEBRUARY 2007

6. In an effort to get away from their domestic woes, Mrs Anderson took her daughter away for a couple of days and asked her parents to keep an eye on Mr Anderson. When her mother called to say that Mr Anderson had an episode of urinary incontinence and looked unwell, she returned home, satisfied herself that he was indeed unwell and called "000".

7. Ambulance officers arrived a short time later. They found Mr Anderson was somewhat confused and a poor historian. Mrs Anderson told them that he had an addiction to morphine, poor oral intake, had been incontinent, vomiting and hallucinating. She drew their attention to the large quantity of IM morphine, which had been recently dispensed to her husband in the

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[4] Exhibit J is Dr Liang's statement dated 27 January 2010.

[5] Exhibit A is Mrs Anderson's statement dated 28 September 2009. Mrs Anderson was the first witness to testify at the inquest – transcript pages 6 and following, especially from page 15. Her description of a typical day resonated with Dr McDonough's evidence about "salience" as one of the criteria for diagnosing a drug dependent person – transcript page 227.

order of 18-20 boxes each containing 5 x 30mg ampoules, and they searched the bedroom and found only 6 boxes and one ampoule remaining (31 ampoules in total).[6] They found a drawer full of prescription medication which they took with them to Wonthaggi Hospital.

8. One of the attending ambulance officers was Gary Robinson who testified at inquest. He stated that although Mr Anderson did not appear to be suffering from the effects of an acute overdose of medication, he thought it was possible that his illness was related to his morphine use, and so took the drawer of medication to hospital for the information of those treating Mr Anderson.[7] Mr Robinson agreed that the clinical presentation of Mr Anderson when he attended him, was more consistent with sepsis than opiate toxicity.[8]

ADMISSION TO HOSPITAL – 6 FEBRUARY 2007

9. Mr Anderson was taken by ambulance to Wonthaggi Hospital where he was seen in the casualty department by Dr Peter Ward, a General Practitioner who was regularly rostered to work in the casualty department. Dr Ward was made aware of Mr Anderson's long term use of IM morphine and of the nature and quantity of medication brought in with him.[9] Mrs Anderson said that her husband had been gradually less well over a three week period. On initial examination he found Mr Anderson talking but confused, with adequate respiratory effort and rate, reduced oxygenation at 93%, with a rapid pulse at 136bpm, blood pressure 115/61, and slightly elevated temperature at 38°C. He was dehydrated with a dry mouth and reduced jugular venous pressure, but otherwise unremarkable. Dr Ward ordered routine bloods and started intravenous fluid therapy.[10]

10. Mr Anderson responded somewhat. However, some time later when Dr Ward later rolled him, he saw a large indurated area over the buttock to the iliac crest and proximal thigh, that was not tender or cellutic, but had a central black area with obvious needle marks throughout.

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[6] Exhibit C is the statement of Gary Phillip Robinson, Ambulance Officer, dated 5 March 2010. See also transcript from page 37, especially page 39.

[7] Transcript pages 39, 49.

[8] Transcript pages 51-52.

[9] Exhibit E is Dr Ward's statement dated 16 February 2010. Exhibit F is his letter dated 8 February 2007 addressed to the Medical Practitioner's Board in which he described as "astounding" the quantity of MS Contin, Valium and Morphine 30mg ampoules and empty boxes brought in by the ambulance officers with Mr Anderson, a position he maintained when he testified at inquest – transcript pages 53 and following.

[10] Exhibit E. As to the results on admission bloods, Dr Ward stated - "Bloods revealed hyponatraemia 128, urea 15 and creatinine 112, Hb 187, WCC 7.3 with bands, platelets 140…"

Dr Ward thought this area was infective, possibly gangrenous, and required transfer to a tertiary hospital. Blood cultures were taken and sent with Mr Anderson who was commenced on antibiotics after consultation between Dr Ward and the admitting officer at Dandenong Hospital.[11]

TRANSFER TO DANDENONG HOSPITAL

11. In due course Mr Anderson was transported by ambulance to Dandenong Hospital and, in the early hours of 7 February 2007, admitted to the Intensive Care Unit (ICU). Investigations there confirmed a diagnosis of necrotising fasciitis, a serious infective process with a high mortality rate. Mr Anderson underwent surgical debridement of the necrotic tissue of the right gluteal muscles, the muscles of the posterior compartment of his thigh, his adductor brevis and longus muscle and resection of the sciatic nerve. His illness was complicated by sepsis, an episode of ventricular tachycardic arrest, and right radial artery thrombosis likely secondary to intra-arterial cannulation.[12]

TRANSFER TO THE ALFRED HOSPITAL – 8 FEBRUARY 2007

12. In light of Mr Anderson's increasing clinical complexity, arrangements were made for transfer to the Alfred Hospital for hyperbaric therapy and further management. Mr Anderson was reviewed by the Plastic Surgery and the Infectious Diseases Units and was commenced on antibiotics and hyperbaric therapy. He became unstable requiring increasing doses of adrenaline and noradrenaline, and his right hand ischaemia worsened. On 9 February 2007, Mr Anderson underwent a right radial and brachial thrombectomy, and radial vein patch and forearm fasciotomy, under the care of the Vascular Surgery Unit.

13. On 10 February 2007, Mr Anderson required a sciatic nerve ligation at the gluteal level as it was part of the necrotising fasciitis. This resulted in complete paralysis to the right lower leg compounded by the total absence of the posterior thigh muscles previously debrided at Dandenong Hospital. Mr Anderson continued to deteriorate with worsening renal and hepatic failure despite all interventions. Treating clinicians discussed his poor prognosis with the family, in particular their assessment that he would require a right hind-quarter amputation and right hand amputation if he was to have any chance of survival. Given Mr Anderson's

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[11] Exhibit E. The antibiotics were benzyl penicillin 1.2g and flucloxacillin 2g intravenously.

[12] Summarised in the Forensic Pathologist, Dr Iles' report at pages 1-6 of the inquest brief Exhibit T.

multi-organ failure and the prospect of amputations, the family agreed to the withdrawal of active treatment. Mr Anderson was treated palliatively thereafter, and passed away at 1420hrs on 10 February 2007.[13]

INVESTIGATION – SOURCES OF EVIDENCE

14. This finding is based on the totality of the material the product of the coronial investigation of Mr Anderson's death, that is the inquest brief compiled by my assistant LSC Remo Antolini from the Police Coronial Support Unit (PCSU); the statements/reports and testimony of those witnesses who testified at inquest and any documents tendered through them; and the final submission of Counsel. All this material, together with the inquest transcript, will remain on the coronial file.[14] In writing this finding, I do not purport to summarise all the material/evidence, but will refer to it only in such detail as appears to me to be warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

15. The purpose of a coronial investigation of a *reportable death*[15] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[16] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[17]

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[13] Dr Iles' report and Associate Professor Michael Leung's statement at pages 5 and 200-201 respectively of the inquest brief, Exhibit T.

[14] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[15] The *Coroners Act 2008,* like its predecessor the *Coroners Act 1985*, requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria the definition of a reportable death in section 4 includes deaths that appear *"to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury"* and the *death of a person who immediately before death was a patient within the meaning of the Mental Health Act 1986".*

[16] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.

[17] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

16. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[18] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[19] These are effectively the vehicles by which the prevention role may be advanced.[20]

FINDINGS AS TO UNCONTENTIOUS MATTERS

17. In relation to Mr Anderson's death, most of the matters required to be ascertained, if possible, were uncontentious from the outset, others were clearly uncontentious by the conclusion of the inquest. Mr Anderson's identity, the date, place and medical cause of death were never at issue. I find, as a matter of formality, that Robert Charles Anderson born on 28 February 1956, aged 50, late of Lot 12, Reed Lane, Bass, Victoria 3991, died at the Alfred Hospital, Commercial Road, Melbourne, Victoria 3004 on 10 February 2007.

THE MEDICAL CAUSE OF DEATH

18. Forensic Pathologist Dr Linda Iles from the Victorian Institute of Forensic Medicine (VIFM), performed an external examination in the mortuary, reviewed the medical deposition and medical records, the circumstances as reported by the police to the coroner and post-mortem CT scanning of the whole body. Dr Iles also noted that the family had raised no concerns about the clinical care and management provided to Mr Anderson at either Wonthaggi, Dandenong or the Alfred Hospitals. Having done so, Dr Iles advised that the events surrounding Mr Anderson's illness are well documented in the Alfred Hospital medical record, that those events are consistent with her findings on external examination, and that an autopsy

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[18] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act of the *Coroners Act 1985* where this role was generally accepted as "implicit".

[19] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[20] See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

was unlikely to add any further information of significant value to the coronial investigation of his death.

19. Dr Iles concluded that it would be reasonable to attribute Mr Anderson's death to *complications of right buttock necrotising fasciitis secondary to chronic right buttock intramuscular injections* noting *chronic pain* as a contributory factor, not directly related to the death, and I find accordingly.

FOCUS OF THE CORONIAL INVESTIGATION/INQUEST

20. The focus of the coronial investigation of Mr Anderson's death was threefold and will be dealt with under the following three headings –

(1) Dr O'Toole's clinical management and care in the last five years or so before Mr Anderson's death. This corresponds broadly with Mrs Anderson's concerns about her husband's welfare over this period, and is also a period during which Dr O'Toole is Mr Anderson's primary treating clinician within the practice, and manages his complex clinical presentation/chronic pain without specialist input and with heavy reliance on IM morphine.

(2) Dr Liang's clinical management and care of Mr Anderson on 22 January 2007, the one occasion when he consulted her and when she provided him with the last script for IM morphine dispensed before his death.

(3) The permit system for treatment with Schedule 8 "Poisons" managed by the Department of Health, which includes opiates such as morphine, as it emerged that Dr O'Toole had never held a permit to prescribe IM morphine to Mr Anderson at any time, and this discrepancy did not come to the attention of the Department of Health.[21]

DR O'TOOLE'S CLINICAL MANAGEMENT ~ 2002-2007

21. Lest silence be interpreted as endorsement, I note that even a cursory examination of the inquest brief would indicate that significant quantities of other prescription medications were

[21] Exhibit G is the statement of Mr Justin Lam, Manager, Treatment Approvals and Projects, Department of Health dated 3 August 2010, with attached schedule of permits issued in respect of Mr Anderson since 1994. This statement was adopted at inquest by Mr Matthew McCrone, Chief Officer of Drugs and Poisons Regulation, Department of Health, who gave evidence in Mr Lam's stead. Transcript pages 83 and following.

also being prescribed by Dr O'Toole to Mr Anderson, many of which have central nervous system depressant properties and may have contributed to his tendency to sleep for much of the day and/or otherwise compounded his difficulties.[22] However, my focus at inquest was on the provision of IM morphine for self-administration by the patient at home, as I understood this to be a practice not generally condoned in Australia, and the evidence established a clear, if indirect, connection between repeated intramuscular injections administered by Mr Anderson to his right buttock area, and his death from the complications of necrotising fasciitis first evident in that area.

22. There were elements of good practice in Dr O'Toole's clinical management of Mr Anderson, particularly in the early stages, from about 1996 to 2002. I accept that Mr Anderson was a challenging patient in that he had sustained numerous serious injuries and required multiple surgeries, generally of an orthopaedic nature. Undoubtedly, he suffered from chronic pain with intermittent exacerbations. He also suffered periodically from debilitating migraine, thought to be "cluster" migraine. His longstanding use of analgesics leading to pethidine dependence although treated, with some success by Dr O'Toole with methadone, posed particular clinical challenges thereafter. Dr O'Toole appears to have established and maintained a good rapport with Mr Anderson. I accept that he felt sympathy for him and wanted to alleviate his distress.[23] These are not undesirable qualities in a general practitioner, but at what cost to professional detachment and sound clinical judgement?

23. A threshold issue is why Dr O'Toole decided in August 2005 to add IM morphine to Mr Anderson's already significant medication regime. His own rationale for this clinical decision is unclear, somewhat internally inconsistent, and unconvincing. In his statements, he offers no clear rationale. Rather the use of IM morphine is described as an established and ongoing situation, in the first statement saying *"I continued to see Mr Anderson during the course of 2005. Overall there was little change in his condition. He complained of pain and suffered recurring episodes of cluster migraine. He continued to take MS Contin tablets and Morphine*

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[22] See for example, the practice's computerised medical records from page 69 of the inquest brief, the list of scripts provided to Mr Anderson by doctors at the practice between June 1997 and February 2007 from page 125 and the Medicare/Pharmaceutical Benefits Scheme data from page 147. The latter is unlikely to be comprehensive as Mr Anderson had an extant WorkCover application and some medical and pharmaceutical expenses would likely have been reimbursed through that system. Also, apart from prescriptions provided to Mr Anderson, the medical records indicate the administration of pethidine, presumably from the doctor's "black bag" supply during consultations – see 15/08/2005, 10/11/2005, 16/11/2005.

[23] Transcript page 314 for example.

injections for pain relief. He used Valium tablets to relieve anxiety and Stilnox tablets to help sleep. He took Celebrex, an anti-inflammatory agent."[24] Similarly in the second statement – *"I saw Mr Anderson on 12 April 2006. He was complaining of post-operative pain. His dosage of oral morphine was increased to 100mg, twice a day. He continued to use injectable morphine for pain relief...on 19 April 2006 ... He told me he was using six injections per day for pain relief...on 21 July 2006. he said that overall he felt better. He told me he was no longer using injectable morphine for his post-operative pain...on 30 August 2006 ...his usage of morphine had decreased to 5 injections per day..."*[25]

24. To the extent that Dr O'Toole implies reliance on the previous opinions of Consultant Psychiatrist Dr Brendan Holwill and Neurologist Dr Bernard Gilligan, it has to be said that neither doctor provided such advice, quite apart from the questionable currency of their views. Whereas Dr Holwill recognised that Mr Anderson had significant pain and would require narcotic analgesia, he noted the use of pethidine periodically and MS Contin (oral morphine), but never suggested IM morphine in his reports, let alone self-administration.[26] Dr Gilligan wrote two reports following consultations in July 2002 in which he alluded to drug-seeking behaviour on Mr Anderson's part, noted the use of MS Contin; Prednisolone, Deseril and Cafergot specifically for migraine, but made no reference to IM morphine at all, let alone recommending its use.[27]

25. At inquest, Dr O'Toole sought to clarify and justify his rationale. He described a pattern of fluctuating use of analgesics over time, with Mr Anderson typically suffering an exacerbation of pain thought due to one injury or another, a period of increased reliance on analgesics before and immediately after a surgical procedure, and then a weaning back of analgesia to more "normal" levels required for his usual "chronic pain".[28] This is entirely consistent with chronic pain and intermittent exacerbation, but does not provide the rationale for introduction of IM morphine in particular in August 2005 - without specialist input and without the

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[24] Exhibits Q Dr O'Toole's statement dated 29 September 2007.

[25] Exhibit R Dr O'Toole's statement dated 15 January 2010. It appears that while Mr Anderson may have told Dr O'Toole on 21 July 2006, that he had ceased using injectable morphine, he continued to have scripts dispensed – one on that same day (see the Medicare/PBS records at page 158 of the inquest brief Exhibit T) and throughout August 2006, although one of these may have been prescribed by Dr Window, another doctor in the practice (see the practice's computerised medical records at page 113 of Exhibit T).

[26] Exhibits N.1-N.6 are Dr Holwill's reports to Dr O'Toole dated from 7 July 1998 to 10 July 2002 inclusive.

[27] Pages 55-58 of the inquest brief Exhibit T are the reports of Dr Gilligan dated 5 June 2001, 3 and 15 July 2002.

[28] Transcript page 299. I have paraphrased here but this was my understanding of the gist of Dr O'Toole's evidence.

appropriate permit – and does not sit comfortably with amount prescribed, the length of time over which it was prescribed, and lack of evidence in the medical and other available record, of any sustainable decrease in dose.[29]

26. As others had done at inquest, Dr O'Toole pointed to Mr Anderson's migraine and associated nausea as justification for treating him with IM morphine, but also relied on the severity of his pain. While he recognised the phenomena of addiction/dependence and tolerance from long-term use, he was confident that Mr Anderson had done it before and could do it again. That is, if he developed a dependence, it could be overcome by treatment.[30] It seems that rather than give him pause, the fact of previous addiction/dependence to parenteral pethidine fortified Dr O'Toole in his choice of IM morphine.

27. A number of medical practitioners gave evidence at the inquest, some asked incidentally to comment on Dr O'Toole's clinical management, others explicitly asked to assess clinical management. Although aspects of their evidence were nuanced, none supported Dr O'Toole's prescription of IM morphine to Mr Anderson for self-administration, particularly the quantity and length of time over which it was continually prescribed in the period immediately preceding Mr Anderson's death.

28. Dr Ward's evidence was clear, categorical and reiterated. He maintained that appropriate management for a patient requiring strong pain relief on an ongoing basis might involve slow release oral morphine, but that it was outside the bounds of normal practice to prescribe IM morphine for self-administration by the patient at home. That this was an abhorrent practice that neither he nor any other competent general practitioner would engage in.[31] The only possible exception countenanced by Dr Ward was the palliative patient being cared for at home, where there was a responsible relative or carer who could be instructed in safe injection.[32] Dr Ward conceded that parenteral narcotic analgesia might also be required where a patient could not swallow oral medications, but maintained that he would not supply parenteral narcotics for administration by the patient at home. In terms of the rationale for his strong views against the practice of prescribing IM morphine for self-administration by the

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[29] See pages 103-116; 138-142; 157-160.

[30] Transcript pages 301-302.

[31] Transcript pages 59-62, 70, 77.

[32] Transcript page 78.

patient at home, he referred to the risk of abuse/dependence, heightened in the case of someone like Mr Anderson, who had a history of narcotic dependence, and the risk of infection which increased with the frequency of injection.[33]

29. Dr Bella Freeman was an experienced General Practitioner who was engaged to provide a medico-legal opinion on behalf of Dr Liang. In the course of testifying at inquest, she was asked to comment on the practice of prescribing IM morphine for self-administration by the patient at home, outside of the palliative context. Her evidence was that - *...I don't think that that has been the case for more than 20 years. You don't hand patients ampoules of opiates".* Dr Freeman also testified that at least since 1997, it was agreed, both internationally and within Australia, that intramuscular opioids should play no part in the treatment of chronic non-malignant pain (particularly intramuscular pethidine) and that this was commonly known in the pain management community in 2007.[34]

30. General Practitioner Dr Mark Overton was nominated by the Royal Australian College of General Practitioners to provide an independent assessment of Dr O'Toole's clinical management of Mr Anderson, with particular emphasis on the long term prescription of IM morphine for self-administration at home. Dr Overton was familiar with and somewhat sympathetic to the problems faced by General Practitioners dealing with patients with chronic or even intermittently serious pain. He testified that he had *occasionally* prescribed IM morphine for self-administration and gave one example, outside of the palliative context, of a woman who suffered from severe migraines possibly once every 6-12 months. With specialist input, he provided her with IM morphine and instructed her husband in its safe administration.[35]

31. Dr Overton agreed that this was a quantum difference from the situation which pertained and that, faced with Mr Anderson as a patient, he would not have provided him with IM morphine at any stage. He testified that *"in principle...it is not a good idea to prescribe morphine for a patient to self inject ... I don't think that's general practice, like, acceptable common practice to be prescribing such high doses of injectable morphine".*[36] He gave evidence about how he

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[33] Transcript pages 62, 67, 69, 71-72.

[34] Transcript page 168. See also Exhibit G which also reflects this stance.

[35] Transcript pages 190-193.

[36] Transcript pages 194-195, 205, 209.

might manage a similar hypothetical patient including detoxification probably involving a hospital admission, substitution of oral for parenteral analgesia and referral to specialist pain management services, which he complained could be difficult to access in some regional areas, particularly for public patients.[37]

32. Dr Brendan Holwill is a Consultant Psychiatrist with a special interest in pain management to whom Mr Anderson was referred by Dr O'Toole between 1998 and 2002. He was critical of the use of IM morphine and self-administration by patients on the basis that there were slow release and acute release preparations of morphine and patches which were more appropriate for chronic pain than injectable preparations. To the extent that he accepted that injectable narcotic analgesics might be required for intermittent/acute pain such as cluster migraine, he envisaged administration by a clinician, not the patient themselves. Dr Holwill accepted that Mr Anderson had chronic and severe pain which required pain relief around the clock, and that appropriate clinical management would involve a set regime and dosage aimed at providing pain relief 24/7, with additional fast release analgesia for breakthrough pain, and a need to present to the doctor for negotiated variations testifying that – *"you set up a treatment regime that works and that would be something like MS Contin or Methadone in a set dosage and then what we would do is have an arrangement over and above that for break-through pain and that's usually another, like, an instant release version of the same drug or an alternative, like Panadeine Forte or Oxycontin or something like that, prescribed in a very set amount..."*[38]

32. I sought an independent expert opinion of the clinical management of Mr Anderson by Dr O'Toole (and Dr Liang) from Dr Michael McDonough, a specialist in Clinical Toxicology and Addiction Medicine. Having reviewed all available material, he provided a comprehensive eleven page report, in which recognising elements of good practice evidenced by the use of methadone to wean Mr Anderson from injectable pethidine during the early stages of their therapeutic relationship, he was nevertheless critical of Dr O'Toole's clinical management

[37] Transcript pages 209-212.

[38] Transcript page 180-181.

overall, in particular of the significant quantities of IM morphine prescribed by him for self-administration at home in the period immediately preceding his death.[39]

33. In his report, Dr McDonough identified a number of deficiencies in the clinical notes made by Dr O'Toole, including the lack of any apparent or documented treatment plan, and the prescription of IM morphine for some five years without the appropriate permit.[40] The clinical notes, such as they were, indicated to Dr McDonough that Mr Anderson was being seen at least weekly and sometimes more frequently, and that on almost every occasion, he was provided with significant quantities of drugs of dependence, including morphine, pethidine and benzodiazepines. This led Dr McDonough to make the following observation –

"... it appears Mr Anderson's Morphine provision was more related to his personal pattern of "usage", suggesting Dr O'Toole played a passive role as a "provider" of Morphine on the basis of patient "usage", rather than on the basis of considered medical evaluation..."[41]

34. Aside from this perceived inappropriate passivity of the doctor in the doctor/patient relationship, Dr McDonough was very critical of Dr O'Toole's overall clinical management of Mr Anderson, which he characterised in the following terms –

"Despite prior knowledge of Mr Anderson's Pethidine Addiction/Dependence, Dr O'Toole's association with Mr Anderson, according to the clinical notes, appears to be that of a long-term provider of drugs of dependence to a patient with Drug Dependence; his prescribing continued (and doses increased) despite indication of harm (e.g. arm infections) and calls from Mr Anderson's wife expressing concern ... there is no evidence to support long term (i.e. over twelve months) opiate prescribing for patients who have chronic, non-cancer pain; also, there is evidence that patients receiving long-term doses of Morphine in excess of 200mgs daily have a significant increased risk for mortality ...Furthermore, providing patients who have known Drug-Addiction/Dependence problems, with injections, for their own self-administration is contrary to generally accepted practise in both the Pain Management and

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[39] Exhibit P is Dr McDonough's statement dated 4 November 2011 which includes details of his formal qualifications and experience and the references on which his opinions are based. Apart from his private practice, Dr McDonough is the Medical Director of the Department of Addiction Medicine & Toxicology at Western Hospital and a Consultant to the Victorian Drug & Alcohol Clinical Advisory Service. See also transcript page 235

[40] Exhibit P at page 7. The failure to obtain an appropriate DHS permit will be discussed in some detail below.

[41] Exhibit P at page 2 where as an example of this passivity Dr McDonough cites the following – "In Dr O'Toole's statement on 15/01/2010 [at page 2] ... in view of his (i.e. Mr Anderson) increased usage of Morphine, [Dr O'Toole] applied for a new permit for 400mgs Morphine ..."

Addiction Management fields ...[I am] left to conclude that Dr O'Toole's provision of narcotics to Mr Anderson was likely contributory to a worsening of Mr Anderson's Dependence/Addiction."[42]

35. Dr McDonough did not resile from these criticisms and, if anything, entrenched in his views when testifying at inquest.[43] He advocated for a comprehensive multi-disciplinary approach to chronic pain, particularly for a patient such as Mr Anderson with a past history of drug dependence, encompassing treatment modalities such as physiotherapy, psychological counselling, and complementary therapies, in combination with the judicious use of prescription narcotics/analgesics.[44] He did not accept that difficulties in accessing specialist pain management or addiction medicine services were insurmountable, arguing that medical practitioners routinely face such difficulties, and should be able to negotiate their way around the service delivery system/realities or, if all else fails, could seek telephone advice by contacting the nearest tertiary hospital if they needed assistance with clinical management and/or were unfamiliar with available resources.[45]

36. In common with the other medical practitioners who testified at inquest, Dr McDonough was critical of the provision of IM morphine to Mr Anderson for self-administration at home. He testified that under no circumstances would he prescribe IM morphine to a patient such as Mr Anderson to self-administer at home, the more so because of his past dependence on injectable pethidine. In common with the other medical practitioners who testified, his rationale was the potential for infection and the risk of abuse or developing dependence. Speaking as a clinical toxicologist, he cited as an additional concern, the known immunosuppressive qualities of opiates, particularly in high doses and over the long-term.[46]

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[42] Exhibit P at page 8.

[43] Transcript at pages 223, 231-235,

[44] Transcript at pages 224 and following, 241-243.

[45] Transcript page 219-221.

[46] Transcript pages 249 and following. I note that Dr McDonough drew a distinction between subcutaneous injections such as those routinely used to deliver insulin and IM injections

CONCLUSION

38. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities with the *Briginshaw* gloss or explication.[47] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals or institutions involved in the clinical management or care of the deceased, unless the evidence provides a comfortable level of satisfaction that their negligence and/or departure from the generally accepted standards of their profession caused or contributed to the death.[48]

39. The weight of the evidence supports an adverse finding against Dr O'Toole on the basis of his clinical management of Mr Anderson, in the five year period immediately preceding his death. In particular, the provision of IM morphine for self-administration by Mr Anderson at home, the dosage and length of time over which the morphine was prescribed, the lack of a clear treatment plan, the failure to seek specialist input, and the failure to monitor how and where Mr Anderson was injecting, were practises which found no support in the views of any of the medical practitioners who testified. By relying so heavily on IM morphine to the virtual exclusion of other treatment modalities, Dr O'Toole compounded Mr Anderson's drug dependence and contributed to his death.

40. Dr McDonough's evidence about the nature of addiction/dependence and the phenomenon of "salience" as a criterion for determining addiction/dependence, resonated clearly with Mrs Anderson's evidence about the extent to which her husband was drug-affected during a typical day, effectively retreating from family life and all other normal daily activities.[49] Another way of looking at the inadequacies of Dr O'Toole's clinical management, is to recognise that Mr Anderson was a drug dependent patient, albeit one with underlying chronic pain, whose

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[47] Briginshaw v Briginshaw *(1938) 60 C.L.R. 336 esp at 362-363 - "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."*

[48] Anderson v Blashki *[1993] 2 VR 89 at 95;* Secretary to the Department of Health & Community Service v Gurvich *[1995] 2 VR 69 at 73-74;* Re State Coroner; ex parte Minister for Health *(2009) 261 ALR 152 at [21]*

[49] Transcript at page 227-228. "...the criteria listed by the World Health Organisation's International Classification of Diseases, and the American Psychiatric Association's DSM IV... Both give seven criteria that define drug addiction or drug dependence and one of those seven criteria is called salience, and what that refers to is procurement of, and use of, the drug, become of paramount importance and become increasingly salient in a person's life and that's, I guess, that is one of the internationally recognised, peak body recognised features of being drug addicted, so the scenario you describe is absolutely consistent with the drug use pattern ..."

drug dependence Dr O'Toole, not only failed to address, but compounded with tragic consequences.

DR LIANG'S CLINICAL MANAGEMENT – 22 JANUARY 2007

41. In her statement dated 27 January 2010, Dr Liang expanded significantly on the contemporaneous entry made by her in the computerised practice medical records on 22 January 2007.[50] Dr Liang also testified at inquest, further expanding and clarifying what transpired during the consultation, which concluded with her provision of the prescription to Mr Anderson. According to Dr Liang, Mr Anderson said he was going to Warrnambool for a holiday and asked for a repeat prescription for IM morphine. She obtained a detailed history from him and consulted the medical records which indicated that he had been prescribed IM morphine at a dose of 30mg/mL/1ml four to eight times daily for at least two years. She then discussed safety issues, in particular the need to store the injections safely while on holiday. Dr Liang recalled Mr Anderson telling her that Dr O'Toole had told him similar things many times, that he knew about it as he had used the "stuff" for many years and had a locked storage box for it.[51]

42. Three versions or rather configurations of the medical records were produced at inquest.[52] Suffice to say that any version consulted by Dr Liang would have corroborated that Mr Anderson had been prescribed IM morphine sulphate at the same strength and at doses generally between 4 to 6 injections daily for at least two years, generally by Dr O'Toole but also by other general practitioners within the practice. Also evident on two versions was the existence of a permit expiring May 2007 for 400mg morphine daily, without reference to route of administration, that is whether the permit was for oral or parenteral morphine. Dr Liang's evidence at inquest was that she went further than simply looking at these entries and perused the permit itself which was stored as a pdf document within the computerised medical record.[53] Regrettably, she failed to notice that the permit was for "long acting oral morphine

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[50] Exhibit J at page 116 of the inquest brief. The entry in its totality is as follows – "**Monday January 22 2007** 11:03:26 Dr Hui-Qi Liang Needs scripts. Going to Warrnambool for a week. Discussed security for medication **Actions:** Prescriptions printed: MORPHINE SULPHATE INJECTION 30MG/ML 6 daily"

[51] Exhibit J and transcript pages 127 and following.

[52] Exhibits K (the first page of the "Full Summary"); Exhibit L (screen dump of list of prescriptions) and pages 70 and following in the inquest brief Exhibit T ("Complete Record as at 2/10/2007").

[53] Transcript pages 128 and following.

to a maximum daily dose of 400mg".[54] Furthermore, she telephoned the "telephone approval hotline", received confirmation that the permit was due for renewal and authorisation for a repeat prescription for IM morphine in the same quantity and dosage as previously.[55]

43. Dr Freeman was not critical of Dr Liang's clinical management of Mr Anderson on this one occasion when he consulted her. She advocated that the appropriate yardstick against which to measure her conduct was that of a relatively inexperienced albeit senior general practice registrar who was performing as locum tenens for a more senior doctor within the practice in which she was completing her training. As Mr Anderson was a patient with a settled diagnosis and settled course of management and there could be no question of changing his treatment regime, unless she felt there was something imminently life threatening in Mr Anderson's condition when she saw him, or in the treatment regime, or at least not without first discussing the matter with Dr O'Toole.[56] Dr Freeman explained that this arose not simply from professional courtesy, but from the desirability of preserving the existing therapeutic relationship. On the other hand, she considered it entirely appropriate for a locum to make a clinical note of their differing assessment of the patient or suggested alternative treatment.[57]

CONCLUSION

44. Mr Cash argued against an adverse finding or adverse comments being made against his client Dr Liang. To the extent that he argued that morphine as such was irrelevant to Mr Anderson's death, and that it was the fact of unmonitored repeated injection and/or self-administration which led to the development of sepsis, his argument ignores the addictive nature of the substance being injected. On the other hand, his submission that any assessment of Dr Liang's limited clinical management should be tempered by her relative inexperience, locum tenens status and limited knowledge and experience with drugs of dependence is more apposite.

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[54] Exhibit T at pages 25-27.

[55] Transcript page 132.

[56] In her statement (Exhibit M) Dr Freeman was labouring under the misapprehension that Dr O'Toole was absent from the practice for one week, whereas he was away for one month. At inquest she testified that this didn't alter her views. Transcript page 161-165, 167, 174-175.

[57] Exhibit M at page 174 in the inquest brief (Exhibit T).

45. Two other ameliorating aspects of the evidence should be highlighted in this regard. In the first place, it is apparent from the evidence before me that a number of other medical practitioners, both within the practice and outside it, prescribed IM morphine for Mr Anderson over the years. Although none prescribed on the same scale as Dr O'Toole, it is little more than serendipity which distinguishes them from Dr Liang who prescribed a significant quantity of IM morphine which was dispensed and apparently used by Mr Anderson, proximate in time to his illness and death. The second aspect is the absence of a clear treatment plan in Dr O'Toole's clinical notes, which Dr McDonough testified would have been problematic for any other medical practitioner within the practice who Mr Anderson might have consulted.

46. I accept that Dr Liang was a senior registrar in the final stages of her training and relatively inexperienced as a general practitioner; that she took reasonable steps to obtain a history from Mr Anderson and to investigate Dr O'Toole's clinical management which had been settled for some time and included long-term use of IM morphine at a similar dose; and that her obligations as locum tenens supported continuation of an established course of treatment in all the circumstances. While it is clear that some of the IM morphine prescribed by Dr Liang was implicated in his death, the evidence supports a finding that her clinical management of Mr Anderson on 22 January 2007 is more appropriately seen as a continuation of the treatment regime which had been established by Dr O'Toole, for better or worse.

SCHEDULE 8 PERMITS

47. It was accepted that, at all material times, neither Dr O'Toole nor any other medical practitioner held a permit under the Drugs Poisons and Controlled Substances Act 1981 or Regulations to prescribe IM morphine to Mr Anderson, which is a "poison" as defined in Schedule 8 of that Act. What Dr O'Toole had obtained from August 2002 was a series of permits to prescribe/treat with long acting oral morphine at an initial dose of 120mg daily increasing to 200mg in October 2002 and 400mg daily in May 2006. The latter permit expired on 15 May 2007 and was the only extant permit for Mr Anderson at the time.[58]

48. According to a statement from Mr Justin Lam, Manager, Treatment Approvals and Projects, Department of Health (DH), and the evidence of Mr Matthew McCrone, Chief Officer, Drugs

[58] Exhibits G and H.

and Poisons Regulation, DH, who gave evidence at the inquest in his stead, the purpose of the permit scheme is *"to ensure that the chronic use of Schedule 8 poisons, which are otherwise referred to as controlled drugs or drugs of dependence, is coordinated so that a single prescriber is prescribing for a particular patient. Effectively it's to stop what's commonly referred to as doctor shopping."*[59]

48. Mr McCrone, a qualified pharmacist, explained that the regulatory regime at the time of Mr Anderson's death envisaged that a medical practitioner in Dr Liang's position, seeing the patient for the first time, could prescribe Schedule 8 drugs without a permit so long the patient was not a drug dependent patient. If the patient gave a history, or the medical practitioner otherwise concluded the patient was drug dependent, a permit was required as a condition precedent to lawful prescription of a Schedule 8 drug. A medical practitioner in Dr Liang's position could not simply rely on the permit issued to Dr O'Toole, even if it had been for IM morphine.[60] As at the date of the inquest, the regulatory regime had changed so that a medical practitioner could prescribe a Schedule 8 drug for a patient of another medical practitioner within the same practice. Of course the permit only supports prescription of the particular Schedule 8 drug up to the maximum dose and dosing interval stipulated and for administration via the route stipulated.[61]

49. Significantly, the permit did not then and does not now contain any stipulation as to whether or not the Schedule 8 drug is to be administered by the medical practitioner (or a practice nurse), or whether the patient is to be provided with the wherewithal to self-administer at home, with or without monitoring.[62] Neither does the permit scheme provide any endorsement of the clinical decision to prescribe. This remains a matter for the clinical judgement of the treating clinician. Indeed, in seeking a permit, a clinician is indicating an intention to treat with a Schedule 8 drug, not giving an undertaking to do so.[63]

49. Given the circumstances surrounding Dr O'Toole's clinical management of Mr Anderson, an important change to the regulatory regime is the requirement that applications for injectable

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[59] Transcript page 85

[60] Transcript pages 85-90.

[61] Transcript pages 105-106.

[62] Transcript page 91

[63] Exhibits H and I and transcript pages

opioids will generally require evidence of recent supportive advice from a relevant specialist and/or a treatment or management plan. Although the policy is couched in terms of discretionary refusal of a permit, the thrust of Mr McCrone's evidence was that a specialist endorsement would be required to support the prescription of IM morphine, particularly over such a long period of time.[64]

50. Mr McCrone also testified about the "phone approval hotline" consulted by Dr Liang. This is an aspect of the Commonwealth Pharmaceutical Benefits Scheme (PBS) pursuant to which medical practitioners are required to obtain specific approval for certain prescriptions, in this case because Mr Anderson was being chronically prescribed IM morphine. This related to the patient's entitlement to Medicare/PBS benefits and in no way compensates for the absence of a Schedule 8 permit. Although a common misconception among medical practitioners, they should understand their obligations under both State and Commonwealth legislation.[65]

CONCLUSION

51. It was obvious enough that Dr O'Toole's clinical management of Mr Anderson with its heavy reliance on IM morphine, did not come to light until his final illness. Although a degree of auditing of permit compliance is undertaken by the Department of Health, and some ad hoc investigations undertaken as information is provided, this is not a comprehensive quality assurance mechanism to ensure that doctors are prescribing in accordance with the Schedule 8 permits they hold and/or otherwise safely. Nor did anything trigger a query from Medicare/PBS as to the amount of IM morphine being prescribed, albeit with a permit from the phone approval hotline.[66]

52. Mr McCrone gave some evidence about an initiative of the Tasmanian Health Department which provided real time information to the department each time a permit drug was dispensed by way of upload of date relating to that dispensing episode. Although the system does not currently provide real time information to the prescriber or dispenser of the drug, it does have a system of algorithms which set up alerts for follow-up by the department, and

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[64] Transcript pages 101 and following.

[65] Transcript pages 107 and following.

[66] Transcript page 95 and following.

does create a database which can be interrogated, audited or otherwise used to found investigation of permit compliance.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. Although I make no adverse findings against Dr Liang beyond a formal finding that some of the IM morphine dispensed pursuant to her prescription was implicated and contributed to his death, what was lost during the consultation on 22 January 2007 and should be acknowledged, is the opportunity for fresh eyes to review the established treatment regime, to notice the absence of an appropriate DHS permit and, whether by consulting another medical practitioner within the practice, or by making a clinical note of the discrepancy, to set Mr Anderson's clinical management on a better path. The difference is the difference between optimal and adequate management, or between being a lever for change and a rubber stamp. Clearly, from the perspective of improved patient safety, the former is preferable.

2. Recognising that Dr O'Toole's clinical management of Mr Anderson raises fundamental issues of clinical competence, and that enhancement of the Schedule 8 permit system, is an inelegant solution for such a problem, it is nevertheless concerning that IM morphine was provided to Mr Anderson "ostensibly" with a permit and funded by the PBS over such a long period of time without question.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. That the Australian Health Practitioners Regulation Authority take whatever action it deems appropriate against Dr O'Toole in respect of his clinical management of Mr Anderson, in particular based on his long-term prescription of IM morphine for self-administration commencing in August 2005 until his death.

2. That the Department of Health consider enhancement of the Schedule 8 permit scheme so as to audit permit compliance more comprehensively, ensuring at a minimum, that Schedule 8 drugs are being prescribed in strict accordance with the permit and not otherwise.

3. That the Department of Health considers enhancement of the Schedule 8 permit scheme so as to require all prescriptions to be dispensed only if accompanied by a copy of the relevant Schedule 8 permit, and only if prescribed in strict accordance with the permit as to strength of preparation, dose and dosing frequency, and route of administration.

4. That the Department of Health initiate a dialogue with its Commonwealth counterparts about the feasibility of reconciliation of information from the Schedule 8 permit scheme on the one hand and the Medicare/PBS phone approval hotline, on the other.

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

The family of Mr Anderson c/o McDonald Murholme

Dr Michael O'Toole c/o Perry Maddocks Trollope

Dr Hui-Qui (Angel) Liang c/o Avant Law

Dr Peter Ward, San Remo Medical Centre

Dr Michael McDonough, Malvern Specialist Centre, 3/266 Glenferrie Road, Malvern

Mr Matthew McCrone, Chief Officer, Drugs and Poisons Regulation, Department of Health

Australian Health Practitioner Regulation Authority

Commonwealth Department of Health

Health Insurance Commission/Medicare/Pharmaceutical Benefits Scheme

Therapeutic Goods Administration

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 11 September 2012