FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

Section 67 of the Coroners Act 2008

Court reference: 4232/10

In the Coroners Court of Victoria at Melbourne

I, IAIN TRELOAR WEST, Deputy State Coroner

having investigated the death of:

Details of deceased:

Surname: DENMAN
First name: RORY
Address: Unit 1, 7-9 Deakin Crescent Dandenong North, Victoria 3175

without holding an inquest:

find that the identity of the deceased was RORY BRETT DENMAN
and death occurred on 3 November 2010

at Unit 1, 7-9 Deakin Crescent, Dandenong North, Victoria 3175

from
1a. MIXED DRUG TOXICITY

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. Rory Denman, was a 37 year old unemployed male at the time of his death and resided at Unit 1, 7-9 Deakin Crescent, Dandenong North. Mr Denman's past medical history included marked scoliosis of the spine for which he had initially been treated with analgesics and since 2008, due to increasing pain, he was on frequent pain relief medication. Since 2007, Mr Denman had 11 admissions to hospital due to pancreatitis, the condition believed to be due to excess alcohol use. In 2008, he was referred to the pain management clinic at Monash University by his treating doctor, however he failed to attend for appointments. He was subsequently referred to the Monash Medical Centre for pain management in August 2010, with an appointment being made for the 17th November, however he passed away two weeks before the appointed time.

2. On the 21st October 2010, Mr Denman attended a doctor for treatment of a five centimetre laceration to his right forehead, stating that he had suffered a fall two days earlier. On the 23rd October, he attended another doctor at the Dandenong Clinic presenting with a right forehead laceration and stating that it was caused in a motor car accident and that he hit his head on the inside of the vehicle. On the 29th October, Mr Denman attended another appointment with a doctor at the Dandenong Clinic, reporting that he suffered a fall 12 days prior and that he had struck his right temple on a table, causing loss of consciousness. He reported altered behaviours, cognitive impairment and dizziness since the incident. A CT scan of the brain was conducted which showed no evidence of a lesion or bleeding in the brain, nevertheless, Mr Denman was prescribed antidepressants for his mood disturbance, with a view to him being reviewed in a months time. On his previous attendances for medical assistance, Mr Denman received prescription medication for pain relief and anxiety.

3. On the 1st November 2010, Mr Denman contacted his brother and was noted to be incoherent and slurring his words to the extent that his brother could not understand him. During the course of the afternoon his brother attended the house to check on his welfare and on noting his erratic behaviour and seeing four boxes of Avanze on the kitchen bench, which were open, he took the remaining tablets from each box. The brother removed the medication with a view to decrease the amount of medication Mr Denman had available to him. Mr Denman's brother made him aware of his concerns regarding his well-being, with Mr Denman reassuring his brother that he was 'Ok'. His brother left the premises and on the following day, the 2nd November, tried to contact him but was unable to do so.

4. On the 3rd November 2010, his brother attended Mr Denman's premises but was unable to gain entry. Police were called and entry was gained through an open rear door, resulting in Mr Denman being located deceased on the floor of his bedroom. Attending Police found no suspicious circumstances surrounding the death.

5. No post-mortem was performed in this case as the coroner, on advice from Dr Sarah Parsons, Senior Pathologist with the Victorian Institute of Forensic Medicine, directed that no autopsy was required. Dr Parsons performed an external examination of Mr Denman at the mortuary, reviewed the circumstances of his death and the post mortem CT scan and provided a written report of her findings. Toxicological analysis of post mortem body fluid was positive for multiple drugs, the combination of which would have caused mixed drug toxicity. Dr Parsons reported that in all the circumstances a reasonable cause of death appeared to be mixed drug toxicity.

COMMENTS:

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

6. Medicare history and Pharmacological Benefits history for the period of the 1st July 2010 to 3rd November 2010, show that Mr Denman was provided with prescriptions for a range of medications by 19 different doctors over this period. This case further highlights the need for a centralised notification database in order to prevent prescription shopping to obtain medication.

7. I have had the benefit of reading the Finding delivered by Coroner Olle into the death of James [redacted] (5181/09), delivered on the 15th February, 2012. [redacted]'s death was due to mixed drug toxicity in a setting of prescription shopping. Coroner Olle made recommendations in support of the Victorian Department of Health establishing a real-time prescription monitoring program.

RECOMMENDATIONS:
Pursuant to section 72 (2) of the **Coroners Act 2008**, I make the following recommendations connected with the death, by adopting Coroner Olle's recommendations:

Recommendation 1

The Victorian Department of Health implement a real-time prescription monitoring program within 12 months, in order to reduce deaths and harm associated with prescription shopping. The program should include the following functionality: (a) a primary focus on public health rather than law enforcement: (b) recording of all prescription medications that are prescribed and dispensed throughout Victoria without exception; (c) provision of real-time prescribing information via the internet to all prescribers and dispensers throughout Victoria without exception; (d) a focus on supporting rather than usurping prescribers' and dispensers' clinical decisions and (e) facilitating the ability of the Victorian Department of Health to monitor prescribing and dispensing to identify behaviours of concern.

Recommendation 2

The Victorian Department of Health convene a steering committee to oversee the implementation of the real-time prescription monitoring program in Victoria. Membership should include representatives from prescribing and dispensing peak bodies and the pain management and drug and alcohol sectors.

Recommendation 3

The Victorian Department of Health develop a contingency plan to implement a Victorian based real-time prescription monitoring program in the event that the anticipated Australian Government Department of Health and Ageing information technology infrastructure for

electronic recording and reporting of controlled drugs is delayed more than six months beyond the declared July 2012 deadline.

Recommendation 4

The Victorian Department of Health develop a contingency plan to implement a Victorian base real-time prescription monitoring program in the event that the anticipated Australian Government Department of Health and Aging information technology infrastructure does not support the following functionality: (a) a primary focus on public health rather than law enforcement; (b) recording of all prescription medications that are prescribed and dispensed throughout Victoria without exception; (c) provision of real-time prescribing information via the internet to all prescribers and dispensers throughout Victoria without exception; (d) a focus on supporting rather that usurping prescribers' and dispensers' clinical decisions and (e) facilitating the ability of the Victorian Department of Health to monitor prescribing and dispensing to identify behaviours of concern.

8. I find that Rory Denman died of mixed drug toxicity following the ingestion of multiple medications at toxic levels. The evidence does not support a finding that Mr Denman intended the tragic consequences of his actions.

I direct that this finding be distributed to:
Family of Rory Denman
Victorian Department of Health

Signature:

Iain T West
Deputy State Coroner

8 March 2012