IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5553

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*
*Section 67 of the Coroners Act 2008*
*Amended pursuant to section 76 of the Coroners Act 2008 as at 29 January 2020*

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| Findings of: | Simon McGregor, Coroner |
| Deceased: | **Caitlin-Lei Alaya** |
| Date of birth: | 30 September 1974 |
| Date of death: | Between 30 October 2018 and 3 November 2018 |
| Cause of death: | Combined drug toxicity |
| Place of death: | 1/7 Hancock Street, Altona Victoria 3018 |

## INTRODUCTION

1. Caitlin-Lei Alaya was a 44-year-old woman who lived alone at 1/7 Hancock Street, Altona Victoria 3018 at the time of her death.

2. Ms Alaya was found deceased from combined drug toxicity at her place of residence on 3 November 2018.

## THE PURPOSE OF A CORONIAL INVESTIGATION

3. Ms Alaya's death was reported to the Coroner as it appeared unexpected, unnatural or to have resulted, directly or indirectly, from an accident and so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. 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.

5. 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.

6. The Coroner's Investigator, Detective Acting Sergeant Brett Thomas prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist who examined Ms Alaya, treating clinicians and investigating officers.

7. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required. 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.

8. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

[1] This is 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

9. In considering the issues associated with this finding, I have been mindful of Ms Alaya's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

**BACKGROUND**

10. By the time she died, Ms Alaya had already reported a tumultuous family background, marred by alleged molestation, domestic violence and rape. These events affected Ms Alaya's mental health. She subsequently had a diagnosis of post-traumatic stress disorder, anxiety, stress, psychological distress and major depression.[2] Ms Alaya spoke about suicide prior to her death, detailing that she thought about taking her life before the pain of her various medical conditions got worse.[3]

11. Ms Alaya attended with psychologist Robert Chatfield. Mr Chatfield states that Ms Alaya's life circumstances tended to be chaotic and involved cycles of dramatic incidents. As a result, her attendance with him tended to be in groups of sessions, followed by significant gaps in time. He details that in 2018, Ms Alaya attended reasonably regularly between February and October.[4]

12. Ms Alaya's suicidal ideation escalated in early May 2018 as a result of certain family pressures. At this point, a Suicide Prevention Service referral was 'allocated to Ms Alaya but she only attended three of the possible 8 weekly sessions'. Mr Chatfield details that while Ms Alaya had a history of suicidal ideation, she always had plans for the future and had developed safety plans with various agencies and a friend. Ms Alaya had also told Mr Chatfield that there were 'protective factors that would prevent her from killing herself.'[5]

13. In addition to Mr Chatfield, Ms Alaya was also seeking help through cohealth[6] Community Mental Health South West on referral through the Victorian Central Intake Assessment Service for Mental Health Community Support Services. This referral was made on 24 April 2018. Through this service she received various care plans aimed at assisting her to deal

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the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Statement of Alexia Alaya dated 8 May 2018; Robert Chatfield dated 12 April 2019, Coronial Brief.

[3] Statement of Alexia Alaya dated 8 May 2018, Coronial Brief.

[4] Robert Chatfield dated 12 April 2019, Coronial Brief.

[5] Ibid.

[6] cohealth is a not-for-profit community health organisation.

with her various stressors.[7] Ms Alaya was also accessing cohealth Family Violence Counselling Services.[8]

14. I am satisfied with the level of care afforded by the abovementioned services.

15. Ms Alaya was 'anti-medication'. Mr Chatfield states that after pressure from cohealth and Centrelink, she agreed to talk with her general practitioner (GP).[9] Ms Alaya's GP was Dr Rick Woods of The Clinic in Williamstown. Dr Woods states that he consulted with Ms Alaya in September 2018. She presented with 'a lot of pain' and was in financial distress.[10]

16. Dr Woods details that Ms Alaya was on temazepam for sleeping issues, to be taken as needed, in addition to several other medications for pain. Her last attendance was on 5 October 2018, during which Dr Woods provided Ms Alaya with a letter for Centrelink that detailed her inability to work.[11]

17. In addition to her mental health issues, Ms Alaya also suffered from fibromyalgia. This condition physically hindered her every day movements. Ms Alaya's daughter, Alexia, details that her mother's fibromyalgia 'had taken over and she wasn't able to do what she wanted to do. She couldn't even go down to the beach without crying.'[12]

18. On 27 October 2018 at approximately 3.00am, Alexia contacted her mother and asked her for a lift from the St Kilda Police Station. During the conversation, Ms Alaya informed Alexia that her cat had died. Ms Alaya further told Alexia that she had 'taken a bunch of her medication' so she couldn't drive and that she had tried to kill herself.[13]

19. Victoria Police organised for Ambulance Victoria to attend Ms Alaya's residence.[14] Ms Alaya was found in bed with her deceased cat. Ambulance Victoria were called[15] and she was admitted to Footscray Hospital at approximately 6.32am with a horizontal laceration on the ventral aspect of her left wrist. The wound was cleaned in the emergency department and

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[7] Statement of Sarah Palmer dated 15 April 2019, Coronial Brief.
[8] Statement of Cara McMahon dated 16 April 2019, Coronial Brief.
[9] Robert Chatfield dated 12 April 2019, Coronial Brief.
[10] Statement of Dr Rick Woods dated 24 May 2019, Coronial Brief.
[11] Ibid.
[12] Statement of Alexia Alaya dated 8 May 2018, Coronial Brief.
[13] Ibid.
[14] Ibid.
[15] Western Health Emergency Department Clinical Sheet 811573, Coronial Brief.

closed with sutures.[16] She was also noted as having taken '32 OF 75MG LYRICA AT 0300 4 TEMAZAPINE.[17]

20. Ms Alaya was categorised as having made a 'modest suicide attempt' in the context of intensifying social stressors. She was remorseful and considered by medical staff to have adequately 'defended against additional further attempts'. She was cleared after a 'psyche/ ECAT' assessment and was discharged home.[18]

21. Dr Woods details that he received a letter from Richard Mills of Western Hospital Enhanced Crisis and Assessment and Treatment team (ECAT). In his letter, Mr Mills detailed that he had evaluated Ms Alaya following her suicide attempt and felt that she did not require follow-up via the service. Mr Mills further stated that Ms Alaya had agreed to attend with Dr Woods to discuss her problems and obtain further help.[19]

22. On 28 October 2018, Ms Alaya called Alexia and apologised for her suicide attempt the day prior, telling Alexia it was a 'lapse in judgement'. Ms Alaya was distressed over burying her cat. Alexia stayed at her mother's residence the following night of 29 October 2018.[20]

23. On the morning of 30 October 2018, Ms Alaya asked Alexia to stay another night. Due to other commitments, Ms Alaya was unable to stay. Ms Alaya drove Alexia back to her residence and stayed until approximately 3.00pm. The last communication Alexia had with her mother was the same day at approximately 5.18pm.[21]

## CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

24. On the same day at approximately 7.00pm, Alexia tried calling Ms Alaya but her phone was turned off. Alexia considered this to be 'weird'.[22]

25. After midnight, now 31 October 2018, Alexia called Victoria Police and requested a welfare check on her mother.[23]

[16] Western Health, Emergency Medicine Summary by Dr Christopher Sweeney (Emergency Dept Registrar), 811573, Coronial Brief.
[17] Western Health Emergency Department Clinical Sheet 811573, Coronial Brief.
[18] Ibid.
[19] Statement of Dr Rick Woods dated 24 May 2019, Coronial Brief.
[20] Statement of Alexia Alaya dated 8 May 2018, Coronial Brief.
[21] Ibid.
[22] Ibid.
[23] Ibid.

26. On 1 November 2018 at approximately 1.00pm, Alexia called Victoria Police and spoke to Constable Fred Moss. She again requested a welfare check on Ms Alaya.[24] Constable Moss attempted to call Ms Alaya's mobile number. The call went straight to voicemail.[25]

27. Constable Moss states that after attempting to call Ms Alaya, he attended another job and 'failed to call the police communication to create a task for the welfare check'.[26]

28. Alexia called Victoria Police again at 10.25pm to follow up on her request from earlier the same day. She spoke with Sergeant Shannon Grant, who advised that the welfare check had not been actioned. Sergeant Grant told Alexia that she would action the request and call her back.[27]

29. At approximately 11.08pm, Victoria Police attended Ms Alaya's residence. They noted that lights were on inside the residence and made multiple attempts to knock on the front door and side windows. There was no response from inside the property. Victoria Police proceeded to knock on the neighbouring unit doors and inquire about whether anyone had seen Ms Alaya.[28]

30. Neighbours advised Victoria Police that the last time they saw Ms Alaya was around midday on 31 October 2018, when she took her bins out. Victoria Police proceeded to enter the backyard of Ms Alaya's neighbours and looked over the adjoining fence and into Ms Alaya's backyard. They noted that 'the rear door was wide open and the light was emitting from inside.[29]

31. Victoria Police jumped the fence and entered Ms Alaya's property, walking through the living room to the front door. A search of inside the property was conducted. They noted that nothing appeared 'to be out of place'. They determined that no one was present and left the residence, leaving a calling card on the front door.[30]

32. At approximately 11.29pm, Sergeant Mark Drieberg called Alexia and advised that the welfare check had been conducted and that upon arrival, they had 'jumped the neighbour's fence into the backyard' and that the back door was wide open and all the lights were on but

[24] Statement of Alexia Alaya dated 8 May 2018; Statement of Constable Fred Moss dated 5 November 2018, Coronial Brief.
[25] Statement of Constable Fred Moss dated 5 November 2018, Coronial Brief.
[26] Ibid.
[27] Statement of Alexia Alaya dated 8 May 2018; Statement of Constable Milos Sumonja dated 27 November 2019, Coronial Brief, Coronial Brief.
[28] Statement of Constable Milos Sumonja dated 27 November 2019, Coronial Brief, Coronial Brief.
[29] Ibid.
[30] Ibid.

Ms Alaya was not home.[31] The decision was made to list Ms Alaya as a missing person[32] and various actions were taken to commence investigations under a missing persons report.[33]

33. On 2 November 2018 at approximately 6.27pm, Sergeant Grant attended Ms Alaya's residence. A short time later, two other Victoria Police officers attended and further searches around the property conducted. Victoria Police left the area at approximately 6.40pm.[34]

34. At approximately 8.45pm, Victoria Police liaised with Alexia and updated her that they had not heard from Ms Alaya.[35] At approximately 11.13pm, Victoria Police conducted another welfare check. Upon arrival, they noticed the calling card still on the front door, although it had been moved from its original placement. Victoria Police attempted to rouse a response from inside the property, with no success.[36]

35. On 3 November 2018 at approximately 4.17am, Victoria Police returned to Ms Alaya's residence and observed that the Victoria Police calling card was still on the front door and the lights were still on inside the property. Attempts were again made to rouse a response, with no success. They left the property soon after.[37]

36. On the same day, Ms Alaya's neighbour, Shane Cutajar, wanted to see if Ms Alaya's back door was open, broken or closed. He had been approached by Victoria Police during their welfare checks and decided to look over his fence into Ms Alaya's backyard.[38]

37. As Mr Cutajar looked into Ms Alaya's backyard, he saw her lying in the garden bed. He immediately got down from the fence and ran to the front of Ms Alaya's house, where he took the Victoria Police calling card from her front door and contacted the number listed.[39] The time was approximately 11.51am.[40]

38. Ambulance Victoria arrived at approximately 12.03pm. Paramedics declared Ms Alaya deceased and no resuscitation efforts were attempted.[41]

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[31] Statement of Alexia Alaya dated 8 May 2018; Statement of Constable Milos Sumonja dated 27 November 2019, Coronial Brief, Coronial Brief.

[32] Statement of Alexia Alaya dated 8 May 2018, Coronial Brief.

[33] Statement of Sergeant Shannon Grant dated 24 November 2018, Coronial Brief.

[34] Ibid.

[35] Ibid.

[36] Statement of Constable Milos Sumonja dated 27 November 2019; Statement of Senior Constable Gretta Lanyon dated 23 April 2019, Coronial Brief.

[37] Statement of Senior Constable Gretta Lanyon dated 23 April 2019, Coronial Brief.

[38] Statement of Shane Cutajar dated 3 November 2018, Coronial Brief.

[39] Ibid.

[40] Statement of Sergeant Shannon Grant dated 24 November 2018, Coronial Brief

[41] Statement of Jayden Estacamento dated 30 November 2018, Coronial Brief.

## IDENTITY AND CAUSE OF DEATH

39. On 13 November 2018, Caitlin-Lei Alaya, born 30 September 1974 was identified by way of Victoria Police Report of Death, initial family contact and DNA analysis. Identity is not in dispute and requires no further investigation.

40. On 11 November 2018, Dr Heinrich Bouwer, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine (VIFM), conducted an autopsy upon Ms Alaya's body and reviewed a post mortem computed tomography (CT scan), photographic evidence, Coroners Court of Victoria and VIFM documentation and the Police Report of Death for the Coroner. Dr Bouwer provided a written report, dated 27 August 2019, in which he formulated the cause of death as '*I(a) Combined drug toxicity*'.

41. Toxicological analysis of post mortem samples taken from Ms Alaya identified the presence of pregabalin[42], ibuprofen[43], meloxicam[44] and temazepam and its metabolite oxazepam[45].

42. Dr Bouwer commented that there was no significant natural disease detected that may have caused or contributed to Ms Alaya's death. There was no post mortem evidence of violence or injury that contributed to death.

43. Dr Bouwer further commented that the post mortem toxicological analysis detected an elevated level of pregabalin together with temazepam and oxazepam. He noted that, in combination, these drugs potentiate their central nervous system and respiratory system depression effects. This causes severe sedation, coma and ultimately death. The level of pregabalin identified in Ms Alaya was elevated. In addition, elevated levels of ibuprofen and meloxicam were also detected. These are anti-inflammatory drugs used for pain relief. Toxic levels are not necessarily fatal and may cause nausea, dyspepsia, abdominal pain, oedema and a rash.

44. I accept Dr Bouwer's opinion as to cause of death.

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[42] Pregabalin is used clinically as an analgesic, anticonvulsant and anxiolytic agent.
[43] Ibuprofen is a non-steroidal anti-inflammatory agent and analgesic.
[44] Meloxicam used as an anti-inflammatory.
[45] Temazepam is a sedative/ hypnotic drug of the benzodiazepine class.

## Intent

45. Victoria Police found several suicide notes in the kitchen and bedroom of Ms Alaya's residence.[46]

46. On the basis of the available evidence, I am satisfied to the requisite standard that Caitlin-Lei Alaya intentionally ended her own life.

## COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

### Victoria Police welfare checks

47. I note that there were several welfare checks conducted by Victoria Police between the period of 1 November 2018 through to the early hours of 3 November 2018. I consider it extraordinary that despite these checks, including one of the backyard, Ms Alaya was not located earlier.

48. I further note that several suicide notes were also located inside Ms Alaya's residence. The fact that these were overlooked during searches raises significant concerns as to the quality of welfare checks being conducted by Victoria Police.

49. While I am satisfied that it is unlikely to have altered the outcome, a more thorough welfare check conducted by Victoria Police would have likely resulted in the earlier discovery of Ms Alaya's body. This is especially so, for the welfare check on 1 November 2018 at approximately 11.08pm, whereby an attending Victoria Police officer jumped a neighbouring fence and walked through Ms Alaya's backyard. While I appreciate that it was late at night, statements indicate that ample light was emitting from the premises and an adequate scan of the relatively small area should have identified Ms Alaya in the garden bed.

50. I consider the execution of the welfare checks in this matter is less than the community is entitled to expect.

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[46] Statement of Sergeant Shannon Grant dated 24 November 2018; Statement of Sergeant Lori Cuthbert dated 2 May 2019, Coronial Brief.

**Footscray Hospital**

51. I note that on the morning of Ms Alaya's admission to the Footscray Hospital Emergency Department on 27 October 2018, she requested temazepam upon her discharge. Specifically, she told staff that she had no more left at home and that she had no money to fill her scripts. Mr Mills of ECAT was comfortable with the provision of the medication, given that Ms Alaya had 'no ongoing ideation', was regretful and had future planning.

52. Emergency Department Registrar, Dr Christopher Sweeney, states that Footscray Hospital is obliged to treat presenting patients' underlying medical and psychiatric issues and that in this instance, Ms Alaya's current treatment was temazepam.[47]

53. I am satisfied that the abovementioned action was appropriate.

**Prescribing and dispensation of medication**

54. A statement obtained from Tom Sarros Pharmacy details that on 9 September 2018, Ms Alaya filled a script from Dr John Haddad for '56 x Lyrica Capsules (75mg)'[48]. Seventeen days later, Ms Alaya filled another script, this time from Dr Louise Pyle, for another '56 x Lyrica Capsules (75mg)'.[49]

55. On 14 September 2018, Ms Alaya filled a script from Dr Woods for '25 x Temaze[50] tablets (10mg) and 30 x Meloxicam[51] capsules (15mg)'.[52]

56. On 26 September 2018, in addition to the Lyrica Capsules prescribed by Dr Pyle, Ms Alaya also filled a script from Dr Woods for '25 x Temaze tablets (10mg)'. This was an additional 25 tablets 12 days after the dispensation of the script from Dr Woods.[53]

57. On 30 October 2018, Ms Alaya filled a script from Dr Woods for '30 Meloxicam capsules (15 mg)' and '90 x Ibuprofen tablets (400mg)'.[54]

58. I note that Ms Alaya did not have a history of substance abuse, prescribed or otherwise and therefore, no red flags for treating clinicians and pharmacists pertaining to the prescribing

[47] Western Health Emergency Department Clinical Sheet 811573, Coronial Brief.
[48] The active ingredient is pregabalin. Post mortem toxicology found 25 mg/L.
[49] Statement of Simon Jiao dated 12 April 2019, Coronial Brief.
[50] The active ingredient is temazepam. Post mortem toxicology found 0.1 mg/L.
[51] Post mortem toxicology found 24 mg/L.
[52] Statement of Simon Jiao dated 12 April 2019, Coronial Brief.
[53] Ibid.
[54] Ibid.

and dispensation of medication. To the contrary, statements in the coronial brief indicate a reluctance on Ms Alaya's behalf to be medicated.

59. There is no evidence to suggest that these scripts were written in unreasonable proximity to each other and I recognise that scripts can be filled within a twelve month window. While taking this into consideration I nonetheless do consider the dispensation of two scripts for Lyrica and two scripts for Temaze in such a short space of time to be of concern. I therefore take this opportunity to make general comments pertaining to prescription and dispensation practices going forward.

60. Victorian doctors have historically experienced difficulty establishing who else is prescribing drugs to a patient. In the absence of accurate and honest patient self-reporting, doctors have needed to rely on resources such as the Medicare Prescription Shopping Information Service and the Medicines and Poisons Regulation (formerly Drugs and Poisons Regulation) information line, which can only provide limited information about limited cohorts of patients.

61. With clinicians unable to coordinate their care, patients have been able to attend multiple doctors to access and use drugs in ways not clinically indicated, thus leading to the development of dependence and contributing to pharmaceutical drug-involved mortality and morbidity.

62. The implementation of the SafeScript real-time prescription monitoring (RTPM) system represents a substantial improvement in this situation. The SafeScript RTPM system involves gathering information on target prescription medications immediately as they are dispensed and storing this information in a central electronic database. This database can be accessed by clinicians when a patient attends for treatment and by pharmacists when a patient presents a script for a pharmaceutical drug.

63. Through the SafeScript RTPM system, both prescribers and dispensers can identify and intervene to prevent excessive use of prescribed drugs, use of contraindicated drug combinations, prescription shopping and other issues that underpin pharmaceutical drug harms. The dispensing information can also be centrally monitored by the Department of Health and Human Services to identify prescribing and dispensing of concern and deliver targeted countermeasures to improve clinical practice.

64. The SafeScript RTPM system was made available to all Victorian pharmacies and medical practices in October 2018. From April 2020 it will be mandatory to check the SafeScript

RTPM system prior to writing or dispensing a prescription for a medicine monitored through the system, which means that for now prescribers and dispensers are using it only on a voluntary opt-in basis. However, I note that regulation 17 of the *Drugs, Poisons and Controlled Substances Regulations 2006* (Vic) specifies that a doctor should not prescribe such a drug unless 'the practitioner has taken all reasonable steps to ensure a therapeutic need exists'.

65. It is arguable that this, in itself, creates a legal requirement for doctors and pharmacists to use the SafeScript RTPM system regardless of it not being compulsory at present. I consider it wise for all clinicians to be mindful of this when considering whether or not to prescribe medication.

## RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

66. I recommend that Victoria Police review and update their policies and procedures pertaining to welfare checks to ensure the inadequacies detailed in this finding are prevented in the future.

## FINDINGS AND CONCLUSION

67. Pursuant to section 73(1B) of the Act, I direct that this finding be published on the Internet.

68. I express my sincere condolences to Ms Alaya's family for their loss.

69. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Caitlin-Lei Alaya, born 30 September 1974;

    (b) The death occurred sometime between 30 October 2018 and 3 November 2018 at 1/7 Hancock Street, Altona Victoria 3018 from combined drug toxicity; and

    (c) The death occurred in the circumstances described above.

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

    (a) Ms Alexia Alaya, senior next of kin

    (b) Dr Rick Woods, The Clinic, interested party

    (c) Dr John Haddad, The Clinic, interested party

(d) Dr Louise Pyle, The Clinic, interested party

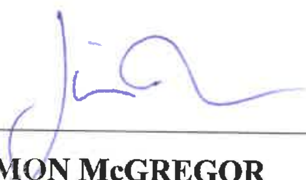
(e) Mr Robert Chatfield, Psychologist, interested party

(f) Mr Simon Jiao, Tom Sarros Pharmacy, interested party

(g) Mr Alex Austin, Civil Litigation, Victoria Police, interested party

(h) Detective Acting Sergeant Brett Thomas, Coroner's Investigator

Signature:



**SIMON McGREGOR**

**CORONER**

Date: 29 January 2020