IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3264

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**DIANE MARIA HILLGROVE**
Date of birth:	22 DECEMBER 1983
Date of death:	7 JULY 2018
Cause of death:	MIXED DRUG TOXICITY
Place of death:	72 MONASH ROAD, NEWBOROUGH, VICTORIA 3825

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HIS HONOUR:

BACKGROUND

1. Diane Maria Hillgrove was 33 years old when she died on 7 July 2018 from mixed drug toxicity. Immediately prior to her death, Ms Hillgrove lived with her mother, Maria Hillgrove and father, John Hillgrove, at 72 Monash Grove, Newborough. Ms Hillgrove never married and had no living children. At the time of her death, Ms Hillgrove was in a loving relationship with Dave Hughes who she met in January 2018.

2. Mrs Hillgrove provided a statement to the court in which, *inter alia,* she described her daughter's relationship with Mr Hughes;

> *"..in the 6 months she knew him he showed her the most amazing times. Simple things like going to the zoo and rides on his motorbike. She was in her element. Her last dinner was with him".*

3. Mr Hughes provided a statement to the CI. He stated that Ms Hillgrove's physical state had been improving in the weeks prior to her death. He described her mental state as "*always chirpy and outgoing".* They were making plans to travel to Bora Bora together and Ms Hillgrove had an appointment to undergo cosmetic dental work in Melbourne in a few days time and was excitedly looking forward to it.

4. Ms Hillgrove had a complex and extensive medical history commencing from about the age of fifteen. This included a subtotal colectomy for hamartoma[1], asthma, cholecystectomy, multiple abdominal surgeries including seven laparoscopies to treat endometriosis, cholecystectomy, bilateral cyst drainage, three inguinal hernia repairs (including one mesh repair), appendectomy, anxiety, a chronic, complex pain condition causing her to present regularly to her GP with abdominal pain and substance abuse. She had attended the Monash Pain Clinic from 2012.

5. In her poignant statement to the court Mrs Hillgrove impressed upon me the impact of chronic pain on her daughter's life:

> *"She was unemployed and unemployable due to her health issues... she never knew when the pain would strike... Her adult life was not one anyone would want".*

[1] A benign slow growing tumour.

6. From 2013, Ms Hillgrove was a regular patient at Trafalgar Medical (**the clinic**) where her primary GP was Dr Michael Kunze. From 2016, Ms Hillgrove also consulted GP Dr Pete Verbeek at the clinic. Both Dr Kunze and Dr Verbeek provided detailed and informative statements which were particularly helpful. It was clear from the statements of both doctors that management of Ms Hillgrove, especially with regards to medication, was challenging.

7. Dr Kunze described Ms Hillgrove as often presenting as anxious or teary:

> *"She presented as naïve and vulnerable, although she was often deceitful in her history especially around the provision and use of medication. We had multiple disagreements in our doctor-patient relationship, usually when I declined to provide early prescriptions or challenged her on discrepancies in her history. She never expressed any significant suicidality although she had one medication overdose in June 2017. I do not believe that she used illicit substances, although our therapeutic relationship had a significant focus on minimising harm from prescribed medications. Over time we developed rapport and understanding but only limited trust".*

8. It was noted that in 2008, Ms Hillgrove, who at the time owned and operated a hairdressing salon, was the victim of an armed robbery at work. She was threatened with a blood-filled syringe and subsequently developed PTSD and severe anxiety.

9. Ms Hillgrove initially attended Dr James Ting, a GP registrar, at the clinic and transferred to Dr Kunze when Dr Ting's rotation ended. Ms Hillgrove was identified under the Prescription Shopping Program[2] criteria for having seven prescribers for diazepam. Dr Ting agreed to treat her on the proviso that he would be the sole prescriber. (At the time she was being prescribed mersyndol forte, diazepam and stilnox). At the commencement of his therapeutic relationship with Ms Hillgrove in 2013 Dr Kunze stated that:

> *"My impression was of an anxious woman, with potential PTSD, a dependence on benzodiazepines and chronic pain problems. I agreed to take on her care... and we formalised a behavioural contract in September 2013. I communicated with eight local GP clinics from Warragul to Morwell to ensure she was not receiving further prescriptions there, as well as local pharmacies. Prescriptions were provided on a weekly basis".*

[2] A service provided by Medicare to assist medical practitioners to identify patients who may be accessing prescriptions from multiple providers.

10. Dr Kunze explained that Ms Hillgrove continued to see a pain specialist (Dr Debra Devonshire), a surgeon and a gastroenterologist. She was also seen by a psychiatrist. Ms Hillgrove trialled several antidepressant medications which she did not tolerate. She was referred to a psychologist for counselling.

11. During 2016, Ms Hillgrove became pregnant. Antenatal management was provided by Dr Verbeek who has training in GP obstetrics, and obstetrician Dr David Simon. Dr Kunze continued to manage Ms Hillgrove's medication and provide psychological support. On 20 December 2016, Ms Hillgrove gave birth to a stillborn baby (a daughter she named Blaire) at 30 weeks gestation. No discernible cause for the stillbirth was identified. In January 2017 she underwent a dilatation and curettage to remove retained products of conception. She was commenced on pregabalin for abdominal pain which appeared to be neuropathic in nature. It is also noted that some time after the stillbirth of her daughter, Ms Hillgrove expressed the intention of undergoing IVF treatment to achieve a further pregnancy.

12. In February 2017 Ms Hillgrove was admitted to hospital with enteritis and was treated with the opioid analgesic Targin whilst an inpatient. Dr Kunze refused to prescribe Targin after her discharge from hospital.

13. In May 2017, Ms Hillgrove was diagnosed with ovarian torsion and underwent an open salpingo-oophorectomy[3]. Following this she was treated with oxycodone for one month.

14. In June 2017, Ms Hillgrove was admitted to Latrobe Regional Hospital (**the hospital**) following an apparently accidental overdose of mersyndol forte, Endone, zolpidem, diazepam and mirtazapine. During this admission she developed aspiration pneumonia and a pneumothorax. She denied suicidal intent.

15. Ms Hillgrove continued to see Dr Kunze on a weekly basis. Dr Kunze explained that:

> *"We were able to reduce her diazepam back to 25mg a day and have some days where she took less than eight mersyndol forte. She was taking 150mg of pregabalin bd. She continued on 1-2 zolpidem a night, most commonly taking 2 tablets. All medications were prescribed with limited amounts and weekly pickups at Elizabeth Street Pharmacy, Moe, which was documented on the prescription.*

[3] Surgical removal of fallopian tube and ovary.

In November 2017 using information from the Prescription Shopper Program it was evident that her prescribing of diazepam from her specialists was increasing and over the next few months I communicated with them and limited this additional prescribing."

16. In October 2017 Ms Hillgrove required further abdominal surgery to treat an ovarian polyp.

17. The chronology of Ms Hillgrove's medical management between 9 May and 7 July 2018 is set out by both Dr Verbeek and Dr Kunze and reproduced below as follows.

18. On 9 May 2018, Ms Hillgrove was seen by Dr Kunze. She complained of pain in her left lower side of a week's duration. Dr Kunze considered the pain to be muscular in nature. He examined a diary Ms Hillgrove maintained to track her benzodiazepine use and pain symptoms and noted that she had taken 10 mersyndol forte tablets in one day. He reduced her weekly prescription of mersyndol forte tablets to 56. As at 9 May 2018, Ms Hillgrove's regular medications were diazepam 5mg, two tablets twice a day and on tablet at 12.00pm; mersyndol forte, two tablets to be taken four times daily as required and zolpidem CR 12.5mg 1-2 daily as required.

19. Dr Kunze reviewed Ms Hillgrove on 16 May 2018. She reported increased pain which had localised to the left iliac fossa. Dr Kunze ordered a pelvic ultrasound and otherwise prescribed Ms Hillgrove's normal medications and included pregabalin 75mg capsules – 1-2 twice a day as required.

20. On 18 May 2018, Ms Hillgrove was reviewed by Dr Verbeek who noted abdominal swelling and painful swelling in her legs. He prescribed pregabalin 150mg capsule, 1 daily as required for pain and, given the severe abdominal oedema, queried the possibility that she was suffering from renal or heart failure and referred her to West Gippsland Healthcare.

21. On 23 May 2018, Ms Hillgrove was reviewed by Dr Kunze who noted that a haemorrhagic ovarian cyst had been diagnosed on ultrasound. She reported ongoing abdominal pain which was less than that experienced the previous week. She reported that her pain was worse when she was anxious and Dr Kunze referred her to psychiatrist, Dr Adey. Dr Kunze documented that the dose of pregabalin was changed from 150mg to 75mg given previous prescriptions had frequently been '*lost"* or *"misplaced"*.

22. On 24 May 2018, Ms Hillgrove was reviewed by Dr Mitchell Kraan at the clinic. She requested additional pregabalin.

Dr Kraan refused the request and recommended that any increase in dosage of medication should be discussed with Dr Kunze in a planned appointment. Approximately 30 minutes after the consultation, Dr Kraan received a call from a local pharmacist who reported that Ms Hillgrove had presented to the pharmacy requesting a box of pregabalin, stating that she had lost her tablets. Dr Kraan advised the local pharmacist that no extra pregabalin tablets should be provided to Ms Hillgrove.

23. Dr Kunze saw Ms Hillgrove on 30 May 2018. They discussed her IVF plans and the challenges posed by her medication use. He reinforced the importance of re-engaging with her psychologist and psychiatrist neither of whom she had seen for some time. Dr Kunze provided prescriptions for diazepam 5mg x 35 tablets; mersyndol forte x 56 tablets; pregabalin 75mg x 56 capsules and stilnox 12.5mg CR x 12 tablets. The prescriptions were labelled to be dispensed at the Elizabeth Street Pharmacy in Moe.

24. On 31 May 2018, Dr Kunze received a telephone call from a pharmacy in Sale advising him that Ms Hillgrove had presented with the prescription for pregabalin dated 30 May 2018 together with a prescription in her father's name and well as for repeats of zolpidem and alprazolam. Save to indicate that the latter prescriptions did not appear to be from Trafalgar Medical, the pharmacist did not disclose their origin. Dr Kunze confirmed that pregabalin should not be dispensed to her.

25. On 5 June 2018, Dr Kunze received a discharge summary from St Vincent's Hospital Emergency Department advising that Ms Hillgrove had presented there on 3 June 2018 complaining of abdominal pina. She had been treated with fentanyl and provided with a prescription for pregabalin.

26. When challenged by Dr Kunze on 6 June 2018, Ms Hillgrove acknowledged the attendance at St Vincent's Hospital but denied she was given a prescription for pregabalin. She also denied the reported visit to the pharmacy in Sale. Dr Kunze advised Ms Hillgrove that he was considering terminating the doctor-patient relationship and would see her in a week's time. In his statement, he elaborated that:

> *"I outlined that future care from myself would involve her being able to provide a convincing account as to how a woman presented to Sale with her prescription and that there would be no other requests for dosage escalations, or mislaid prescriptions. She was also expected to be proactive in volunteering other medical contacts and prescribing".*

27. Dr Kunze provided prescriptions for diazepam 5mg x 35 tablets; mersyndol forte x 56 tablets; stilnox 12.5mg CR x 14; all labelled to be dispensed at Elizabeth Street Pharmacy, Moe.

28. On 13 June 2018, Ms Hillgrove attended Dr Kunze. She presented as anxious and keen to continue to see him. She reported that she had seen Dr Devonshire and had been given prescriptions for alprazolam 1mg x 40 tablets and endone 5mg x 20 tablets and ondansetron. She was unable to account for the prescription presented in Sale and produced evidence that she had been in Morwell at the time. Dr Kunze gave her a warning and said that:

> *"I retained my suspicions and Ms Hillgrove was left with a clear understanding that she needed to maintain our agreement. I had arranged for Ms Hillgrove to see Dr Verbeek while I was on leave for four weeks. She was aware that he could terminate our prescribing if there were any requests for dose escalation, early prescriptions, lost medications".*

29. Dr Kunze provided Ms Hillgrove with prescriptions for diazepam 5mg x 35 tablets; mersyndol forte x 56 tablets; pregabalin 75mg x 56 capsules and stilnox 12.5mg CR x 1 – all labelled as before to be dispensed by the Elizabeth Street Pharmacy in Moe. That was Dr Kunze's last consultation with Ms Hillgrove.

30. On 20 June 2018, Ms Hillgrove was seen by Dr Verbeek. She told him that she had decided to postpone her IVF plans and indicated that she was very keen to adhere to Dr Kunze's strict prescribing conditions. She told Dr Verbeek that she was *"going to focus on getting herself straight, is going to take control of her own life'*. Dr Verbeek referred Ms Hillgrove to a gynaecologist for review of her pain and pelvic issues and prescribed her regular medications.

31. On 23 June 2018, Ms Hillgrove saw Dr Burke following a head injury and was referred to Latrobe Regional Hospital for assessment and imaging of facial injuries. Dr Verbeek also reviewed Ms Hillgrove on 23 June 2018. He noted that she continued to experience headache and nausea with some vomiting. Dr Verbeek considered her symptoms were due to an infective process and recommended increased fluids, ondansetron and further review if she became dehydrated. He prescribed her regular medications together with pregabalin and ondansetron.

32. When seen by Dr Verbeek on 4 July 2018, Ms Hillgrove told him that she was much improved. He prescribed her regular medications.

THE CORONIAL INVESTIGATION

Coroners Act 2008

33. Ms Hillgrove's death was a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**) because her death occurred in Victoria, was unexpected and not from natural causes.[4]

34. The Act requires a coroner to investigate reportable deaths such as Ms Hillgrove's and, if possible, to find:

    (a) The identity of the deceased;

    (b) The cause of death; and

    (c) The circumstances in which death occurred.[5]

35. For coronial purposes, "*circumstances in which death occurred*",[6] refers to the context and background to the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death relevant circumstances are limited to those which are sufficiently proximate to be considered relevant to the death.

36. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[7] It is not the Coroner's role to determine criminal or civil liability,[8] nor to determine disciplinary matters.

37. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through comments made in findings and by making recommendations.

38. Coroners are also empowered to:

    (a) Report to the Attorney-General on a death;[9]

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[4] *Coroners Act 2008* (Vic) s 4.
[5] *Coroners Act 2008* (Vic) preamble and s 67.
[6] *Coroners Act 2008* (Vic) s 67(1)(c).
[7] *Keown v Khan* [1999] 1 VR 69.
[8] *Coroners Act 2008* (Vic) s 69 (1).
[9] *Coroners Act 2008* (Vic) s 72(1).

(b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[10] and

(c) 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.[11]

Standard of Proof

39. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[12] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[13] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of proof; there is no such thing as a "*Briginshaw Standard*" or "*Briginshaw Test*" and use of such terms may mislead.[14]

40. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[15] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[16] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved and the content of the finding based on those facts.[17]

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[10] *Coroners Act 2008* (Vic) s 67(3).
[11] *Coroners Act 2008* (Vic) s 72(2).
[12] (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
[13] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[14] *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].
[15] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[16] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[17] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

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

Identity of the Deceased - Section 67(1)(a) of the Act

41. On 7 July 2018, Maria Hillgrove identified the deceased as her daughter, Diane Maria Hillgrove, born on 22 December 1983.

42. Ms Hillgrove's identity is not in dispute and requires no further investigation.

Cause of death - Section 67(1)(b) of the Act

43. On 11 July 2018, Dr Joanna Glengarry a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted a post-mortem examination upon Ms Hillgrove's body. Dr Glengarry provided a written report, dated 26 October 2018, in which she opined that the cause of Ms Hillgrove's death was '*Mixed drug toxicity*. I accept Dr Glengarry's opinion.

44. Toxicological analysis of post-mortem samples detected the presence of pregabalin [Lyrica], morphine, diazepam, nordiazepam, doxylamine and ondansetron in blood; and morphine, codeine, diazepam [Valium], nordiazepam, temazepam, oxazepam, zolpidem [Stilnox] doxylamine and paracetamol in urine. No alcohol was detected.

45. Dr Glengarry commented that the elevated level of pregabalin (~51 mg/L) detected in Ms Hillgrove's post-mortem blood sample was a level associated with fatalities.

46. She also noted that:

> *"The combined effects of central nervous system depressants (drugs that reduce the drive to breath and cause unconsciousness) such a pregabalin, morphine and diazepam and additive and are sufficient to cause death".*

Circumstances in which the death occurred - Section 67(1)(c) of the Act

47. In his statement, Mr Hughes noted that during the day on 6 July 2018, Ms Hillgrove did not feel well and complained of abdominal pain which she described as uncomfortable rather than severe.

48. Ms Hillgrove attended a consultation with Dr Verbeek that day and told him that she had developed abdominal pain the previous night and was experiencing nerve pain over her abdomen where the nerve was cut during one of her abdominal surgeries. Dr Verbeek noted that her abdomen was bloated and queried whether it had stretched.

49. On examination, Dr Verbeek noted that Ms Hillgrove's abdomen was tender but still soft and not peritonitic with obvious tenderness on the right side abutting her scars. He acceded to Ms Hillgrove's request for an increase of pregabalin to 150mg and reminded her to attend the emergency department if her pain became worse. He suggested that she try Capsaicin cream to treat the surface elements of the pain.

50. That evening, Ms Hillgrove had dinner and watched movies with Mr Hughes at his home following which he drove her home at approximately midnight. Mr Hughes said that Ms Hillgrove had planned to go shopping with her mother the following day.

51. In her statement, Mrs Hillgrove said that Mr Hillgrove heard his daughter arrive home and that she wished him goodnight and went to her room.

52. At approximately 1.00pm on 7 July 2018, Ms Hillgrove's parents decided it was time to wake her up. Mr Hillgrove went into his daughter's bedroom and discovered her lying prone and unresponsive on the floor. Emergency services were notified, and Mrs Hillgrove performed CPR until the arrival of paramedics who declared Ms Hillgrove deceased.

53. At the scene, police located empty prescription boxes containing empty blister packs for dolased forte[18] x 40 tablets (1 box) prescribed (by Dr Verbeek and dispensed on 4 July 2018; stilnox 12.5mg x 14 tablets (1 box) prescribed (by Dr Verbeek) and dispensed on 27 June 2018; mersyndol forte x 20 tablets (3 boxes) prescribed by Dr Verbeek and dispensed on 27 June 2018, 27 June 2018 and 13 June 2018; 1 empty box containing empty blister packs of Lyrica[19] 75mg x 10 tablets, prescribed by Dr Yassin[20] and dispensed at Chemist Warehouse, Morwell on 23 June 2018. Also located was a receipt from Chemist Warehouse, Morwell dated 23 June 2018 which records the purchase of pregabalin 75mg x 56 tables; and 1 box of ondansetron containing 4 tablets in a blister pack. Also located in a garbage bin at the premises was an empty prescription box for pregabalin 150mg x 56 tablets prescribed to Ms Hillgrove by Dr Verbeek and dispensed on 6 July 2018 and an empty prescription box for Lyrica 75mg x 56 prescribed by Dr Sean Atkinson for Mrs Maria Hillgrove and dispensed on 3 July 2018 together with empty blister packs of MS Contin and pregabalin.

[18] Analgesia containing paracetamol, codeine and doxylamine (also known as mersyndol forte)
[19] A brand name for pregabalin.
[20] The investigation has been unable to identify the location of Dr Yassin's practice.

54. A finding that a person died as a result of suicide is a finding of great moment which can impact upon the memory of a deceased person. It can also reverberate throughout a family for generations. Such a finding should only be made on compelling evidence, not indirect inferences or speculation.

55. The evidence against such a finding is that Ms Hillgrove had made plans; to go shopping that day with her mother; to have cosmetic dentistry the following week and to travel with Mr Hughes. She gave no indication to Dr Verbeek, her parents or Mr Hughes that she was depressed or had suicidal intent. No *"suicide note"* was located after her death.

56. However, as I have noted above, the available evidence indicates that Ms Hillgrove struggled with chronic pain, substance abuse, PTSD and severe anxiety for many years resulting in her inability to work in her chosen, or indeed, any employment. She found herself, at the age of 33, living with her parents.

57. I have noted that amongst the numerous prescription boxes and blister packs found at the scene of Ms Hillgrove's death, only four tablets (ondasentron) were located. Although it cannot be known exactly when she consumed the majority of the contents of the various boxes, it is at least likely that between 6 -7 July 2018, Ms Hillgrove consumed the 56 x 150mg pregabalin tablets dispensed on 6 July 2018. Such consumption is consistent with the elevated post-mortem serum pregabalin level. Ms Hillgrove would likely have known of the danger of death associated with excessive consumption of pregabalin.

58. When excess of prescribed medication and chronic overuse of prescription medication is involved it is often difficult to determine whether a person decided to deliberately end their own life or whether death was the advertent consequence of taking more than a prescribed amount of medications. A finding of suicide ought only to be made on the basis of clear cogent evidence of intent. Whilst the coronial brief contains some circumstantial evidence supporting the contention that Ms Hillgrove took her own life it does not contain sufficient evidence for me to so find that it to find that Ms Hillgrove deliberately took an excessive amount of prescribed medication, including pregabalin intending to end her own life.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

59. The evidence in the coronial brief makes clear that Ms Hillgrove had longstanding medical problems including chronic abdominal pain and substance abuse; she was known to take medication in amounts greater than prescribed.

The evidence also sets out Dr Kunze's and Dr Verbeek's considerable effort to manage Ms Hillgrove's chronic pain and medication regime and to prevent medication escalation. Dr Kunze summarised his:

> *"Specialist management by a psychiatrist, psychologist and pain specialist*
>
> *Communication with local clinics and pharmacies*
>
> *Multiple conversation with Ms Hillgrove and her family around potential harms*
>
> *Monitoring her medication use through the Prescription Shopping Program*
>
> *Weekly clinical reviews*
>
> *Written agreement on prescribing*
>
> *Limiting her supply through weekly pickups at a designated pharmacy*
>
> *Providing limited prescriptions*
>
> *Resisting dose escalation; and*
>
> *Regular attempts to reduce her doses"*

59. In his statement Dr Kunze also notes that he last prescribed morphine to Ms Hillgrove in 2013 and had never prescribed temazepam or oxazepam to her. There is no evidence of any of those medications on the PBS patient summary.

60. There is little doubt that, had the current real-time prescription monitoring service, SafeScript, been in effect in Victoria throughout Dr Kunze's and Dr Verbeek's management of Ms Hillgrove, it would have been of significant value to them. Although SafeScript was introduced by the Victorian government in the period since Ms Hillgrove's death, pregabalin is still not included as one of the drugs monitored.

61. Pregabalin is used as an anticonvulsant in the treatment of epilepsy and is also used to treat neuropathic (nerve) pain. It is abuse. Research recently identified by the Coroners Prevention Unit[21] advises that;

[21] The role of CPU is to assist coroners investigating deaths, particularly deaths that occur in a healthcare setting. It is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration.

"When prescribing pregabalin, clinicians should consider completing a risk assessment for misuse. Precautions used when prescribing other pharmaceuticals (eg benzodiazepines, opioids) should be considered when prescribing pregabalin, especially in patients with a substance abuse history. In light of potential harms, off-label prescribing of pregabalin for indications without a strong evidence base should be avoided"[22]

62. I have made recommendations in previous cases regarding the inclusion of pregabalin in the SafeScript scheme in order to prevent deaths in the future, by drawing the attention of clinicians to excessive prescribing of the drug. I reiterate that recommendation.

63. I have noted the use of the methods available to Dr Kunze at the time such as weekly checks with the Prescription Shopping Program and regular contact with other treating and/or local medical practitioners and pharmacies. Dr Kunze and Dr Verbeek are to be commended for their cautious, thoughtful and caring management of Ms Hillgrove. However, despite their efforts, Ms Hillgrove was clearly *"doctor shopping"* and possibly diverting medications prescribed to her mother for her own use. Dr Kunze's suspicions about her veracity appear, sadly, to be well founded.

64. A PBS patient summary for Ms Hillgrove reveals that in addition to the prescriptions provided by Dr Verbeek and Dr Kunze between May and July 2018, Ms Hillgrove also obtained prescriptions for pregabalin [strength not specified] x 56 tablets from Dr David Wynne[23] (dispensed on 4 June 2018 in Ascot Vale); from Dr Saghir Muhammed[24] [strength not specified] x 10 tablets (dispensed on 27 May 2018 in Hallam); from Dr Heidi Woolford[25] [strength not specified] x 56 tablets (dispensed on 5 May 2018 in Moe). This is in addition to the prescription from Dr Yassin for 10 x pregabalin 75mg tablets (dispensed on 23 June 2018 in Morwell) which does not appear on the PBS Patient Summary indicating that it was possibly requested as a private prescription, presumably for the purposes of avoiding its detection during a check of the Prescription Shoppers Scheme.

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[22] See for example Cairns R et al, "Rising Pregabalin use and misuse in Australia: trends in utilization and intentional poisonings", Addiction, 2019, doi:10.1111/add.14412; Crossin R, et al "Pregabalin misuse-related ambulance attendances in Victoria, 2012-2018: characteristics of patients and attendances", Medical Journal of Australia 210(2), 2019; Munnion B and Conigrave K, "Pregabalin misuse: the next wave of prescription medication problems", Medical Journal of Australia, 210(2), 2019.

[23] Dr Wynne is not identified as practising at Trafalgar Medical. His place of practice is otherwise unknown.

[24] Dr Muhammad practices at Hallam Medical Clinic.

[25] Dr Woolford practices at Central Gippsland Family Practice.

The PBS patient summary does not specify what strength of pregabalin tablets was dispensed, however the evidence is that Dr Kunze limited Ms Hillgrove to 75mg tablets as did Dr Verbeek except at the last consultation on 6 July 2018 when he prescribed 150mg tablets. The total number of pregabalin tablets of varying strengths prescribed and dispensed to Ms Hillgrove between May and June 2018 is 412.

65. There is no evidence that MS Contin was prescribed to Ms Hillgrove suggesting that if this was the source of the morphine detected in Ms Hillgrove's blood post-mortem, it was obtained by diversion. Similarly, there is no evidence as to the origin of the temazepam or oxazepam detected in post-mortem samples.

66. With regards to the prescription he provided on 6 July 2018, Dr Verbeek explained in his statement that:

> *"Ms Hillgrove's previous abdominal surgeries and chronic pain condition meant that there was always some degree of abdominal pain associated with presentations. Based on my examination findings and Ms Hillgrove's presentation, it did not appear that Ms Hillgrove was suffering from an acute abdominal condition and I did not believe that a referral to hospital was required. I felt her request for an increase in her Lyrica dose (to 150mg bd) for the acute episode of pain was reasonable"*

67. He also noted that later that day, he received a telephone enquiry from the pharmacist who advised Dr Verbeek that he had filled a prescription for pregabalin 150mgs for Ms Hillgrove two weeks previously indicating that there should be 28 tablets remaining. The origin of the prescription referred to by the chemist [date assumed to be 23 June 2018] is unknown – Dr Kunze's and Dr Verbeek's previous prescriptions, dated 13 June and 27 June 2018 respectively, were for 75mg tablets. Dr Verbeek continued:

> *"While I was concerned that she might have been taking more Lyrica than she had been subscribed* [sic], *I did not want to deny her pain relief given her acute abdominal pain. I authorised the script for Lyrica 150mg to be filled with a plan to discuss it at the Wednesday appointment the following week".*

68. Dr Verbeek may have been alerted by the apparent discrepancy in dates and dosage; however, he appears to have a made a considered clinical decision based on the history given and his clinical findings on examination that the increased dose was warranted in the circumstances.

RECOMMENDATIONS

69. Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I recommend that:

In order to reduce the risk of harm associated with pregabalin, the Victorian Department of Health and Human Services consider the inclusion of pregabalin in the scope of drugs monitored in the Safe Script real-time prescription monitoring scheme.

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

FINDINGS AND CONCLUSION

70. 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 Diane Maria Hillgrove, born on 22 December 1983;

b. Ms Hillgrove's death occurred;

i. on 7 July 2018 at 72 Monash Road, Newborough, Victoria;

ii. from mixed drug toxicity; and

iii. in the circumstances described in paragraphs 47-58 above.

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

a. Mr John Hillgrove and Mrs Maria Hillgrove, senior next of kin;

b. Dr Pete Verbeek, Trafalgar Medical;

c. Dr Philippa Hawkings, Latrobe Regional Hospital;

d. Mr Martin Foley, Minister for Health, Department of Health, Victoria; and

e. Senior Constable Mark Woodbridge, Coroner's Investigator, Victoria Police.

Signature:

DARREN J BRACKEN

CORONER

Date: 28 January 2021.