IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 1967

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Leeanne Matheson
Date of birth:	15 February 1967
Date of death:	19 April 2019
Cause of death:	1(a) Mixed drug toxicity (methadone, pregabalin, valproic acid, benzodiazepines)
Place of death:	3 Ostend Court, Clayton South, Victoria

INTRODUCTION

1. On 19 April 2019, Leeanne Matheson was 52 years old when she died after ingesting a combination of prescribed medication. At the time of her death, Ms Matheson lived at Clayton South.

THE CORONIAL INVESTIGATION

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

3. 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.

4. 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.

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

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

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

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

Identity of the deceased

7. On 19 April 2019, Leeanne Matheson, born 15 February 1967, was visually identified by her partner, Daniel Faulkner.

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

Medical cause of death

9. Forensic Pathologist, Dr Linda Iles, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 25 April 2019 and provided a written report of her findings dated 15 August 2019.

10. Toxicological analysis of post-mortem samples identified the presence of methadone[2] and its metabolite, pregabalin,[3] valproic acid,[4] diazepam[5] and its metabolites, 7-aminoclonazepam,[6] cannabis,[7] and duloxetine.[8] There was an extant permit for Dr Wilson Chong to treat Ms Matheson with buprenorphine and/or methadone for opioid dependence.

11. Dr Iles noted that methadone, pregabalin, valproic acid, diazepam, and 7-aminoclonazepam are all central nervous system depressants and in combination are capable of producing death as a consequence of centrally mediated depression cardiorespiratory function.

12. Dr Iles provided an opinion that the medical cause of death was *"1(a) Mixed drug toxicity (methadone, pregabalin, valproic acid, benzodiazepines)"*.

13. I accept Dr Iles's opinion.

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[2] Methadone is used for the treatment of opioid dependency (methadone maintenance programmes, MMP) or for the treatment of severe pain. Persons prescribed methadone as a pharmacotherapy for drug addiction must have a permit issued from the Drugs and Poisons Regulation Group, Department of Health (Victoria). Exception to the Schedule 8 permit requirement includes patients in prisons, aged care services and hospitals. In addition, doctors treating patients with Physeptone (methadone) tablets for moderate to severe pain do not need a permit for up to two months' treatment.
[3] Pregabalin is clinically used for treatment of partial seizures and neuropathic pain
[4] Valproic acid is primarily used for the treatment of epilepsy, but also clinically indicated as adjunct therapy in mania and schizophrenia where other therapy is inadequate.
[5] Diazepam is a sedative/hypnotic drug of the benzodiazepines class. Metabolites of diazepam include nordiazepam, temazepam, and oxazepam.
[6] Clonazepam is clinically used for treatment of seizures.
[7] Delta-9-tetrahydrocannabinol is the active form of cannabis. Persons under the influence of cannabis will experience impaired cognition (reasoning and thought), poor vigilance, and impaired reaction times and coordination.
[8] Duloxetine is clinically used to treat major depression, generalised anxiety disorder and diabetic neuropathic pain

Circumstances in which the death occurred

14. Ms Matheson's medical history included ovarian cancer, drug dependence, epilepsy, and back pain.

15. Since approximately 2007, Ms Matheson had been prescribed Suboxone (the brand name for combination of buprenorphine and naloxone in film form). She had previously received treatment from CoHealth Kensington.

16. Ms Matheson first presented to Mediclinic Clayton South on 12 February 2017 for treatment of opioid dependence, at which time Dr James Churchman conducted a review and noted she was currently being prescribed Suboxone, duloxetine, pregabalin, clonazepam, temazepam and sodium valproate. Dr Churchman documented a discussion about admitting her to Box Hill Hospital to rotate her from buprenorphine to methadone because the latter is *"better for pain"*, but the notes record that she did not have time for that at the time. Dr Churchman ultimately refused to take her on as a patient given her prescription medication regime.

17. Ms Matheson subsequently transferred from CoHealth Kensington to Mediclinic Clayton South in March 2018, where she commenced seeing Dr Wilson Chong. Dr Chong noted that Ms Matheson had *"multiple issues"*, including post-traumatic stress disorder, burns, and chronic back pain, but she denied opioid dependence. Dr Chong treated her regularly for the next four months, prescribing Suboxone[9] together with pregabalin, duloxetine, clonazepam, temazepam, and sodium valproate to treat her pain and opioid dependence and psychosocial stressors.

18. On 15 September 2018, Ms Matheson fractured her femur when she was struck and run over by a reversing car. She was admitted to The Alfred Hospital for treatment, where her medical history was recorded as including hepatitis C, chronic pain syndrome, depression, bipolar disorder, epilepsy, and methamphetamine use. She was prescribed buprenorphine, duloxetine, pregabalin, clonazepam, temazepam, and sodium valproate during this period of hospitalisation.

19. Ms Matheson was transferred from The Alfred Hospital to the Victorian Rehabilitation Centre on 27 September 2018 for further treatment including medication management, physiotherapy, occupational therapy, and psychological therapy.

[9] Dr Chong noted in the records dated 20 April 2018 that Ms Matheson was *"on Suboxone for pain, not heroin"*. However, in a progress note dated 21 January 2019 he indicated the Suboxone was for *"opiate use disorder"*.

20. She was discharged from the Victorian Rehabilitation Centre on 19 October 2018, with Dr Chong listed as the discharge summary recipient. The discharge summary recommendation was for Dr Chong to *"continue medications as newly prescribed".* Those medications included:

    (a) sodium valproate 500mg tablet twice daily;

    (b) pregabalin 150mg tablet twice daily*;*

    (c) duloxetine 60mg capsule twice daily, plus duloxetine 30mg capsule once daily;

    (d) clonazepam 0.5mg tablet twice daily, plus clonazepam 0.5mg tablet half to one tablet taken twice daily as required;

    (e) buprenorphine 8mg plus naloxone 2mg film (Suboxone); and

    (f) buprenorphine 200mcg sustained release tablet, one to two taken four times daily when required.

21. On 1 November 2018 Dr Chong wrote a referral letter seeking assistance from Dr Kenneth (Kang Yung) Shum, Ms Matheson's treating consultant at the Victorian Rehabilitation Centre, to manage her medications. He wrote:

> *Thanks for seeing Leeanne post-rehab post-MVA. Is experiencing ongoing acute-on-chronic pain and was requesting ongoing Temgesic [sublingual buprenorphine] tablets in addition to her Suboxone, which I am not really comfortable prescribing. I wonder whether you have any suggestions for long term pain management as she is already on the maximum dose of Suboxone so technically the additional buprenorphine (at a minute dose) should not be having much of an extra effect, however I leave this to your clinical judgment.*

22. Dr Chong's medication list for Ms Matheson in the letter included:

    (a) duloxetine 30mg, four capsules in the morning;

    (b) pregabalin 150mg, twice daily;

    (c) clonazepam 0.5mg, four times daily;

    (d) buprenorphine-naloxone (Suboxone) film, 32mg daily;

(e) temazepam 10mg, twice daily;

(f) buprenorphine 0.2mg sublingual tablets, two tablets three times daily; and

(g) valproic acid 500mg, three times daily.

23. Dr Shum conducted his assessment, then wrote to the Transport Accident Commission (**TAC**) on 28 November 2018 requesting approval for Ms Matheson to be admitted to the Victorian Rehabilitation Centre for seven days for peripherally inserted central catheter (**PICC**) line insertion, and inpatient ketamine infusion. The reason was as follows:

> *She has a complicated background of chronic pain on high dose substitution therapy in Suboxone 32mg which is limiting the use and efficacy of other analgesics to manage her new pains attributed to her recent trauma. She would benefit from an inpatient ketamine infusion for desensitisation, pain relief and opioid rationalisation.*

24. Dr Shum and a colleague, Dr Sri Vadesseri, continued to see Ms Matheson at the Victorian Rehabilitation Centre outpatient program over the next few months, treating her for chronic pain and psychosocial stressors. TAC ultimately approved the infusion request and, in a letter to Ms Matheson dated 5 March 2019, Dr Shum confirmed the admission for ketamine infusion would occur on 26 March 2019 at the Victorian Rehabilitation Centre.

25. Ms Matheson's inpatient admission for PICC line insertion and ketamine infusion occurred as scheduled on 26 March 2019, after which she was commenced on methadone 40mg daily. She remained an inpatient in the Victorian Rehabilitation Centre until 5 April 2019. The discharge summary listed Dr Chong as the nominated general practitioner, and the recommendation to Dr Chong was: *"Continue medications as newly prescribed".* The accompanying medication profile specified the following:

(a) methadone 10mg tablet taken four times daily;

(b) duloxetine 60mg tablet taken twice daily;

(c) pregabalin 150mg capsule taken twice daily;

(d) clonazepam 0.5mg tablet taken four times daily; and

(e) buprenorphine 200mcg sublingual tablet, one or two taken every four hours when required.

26. It is not clear which medications Ms Matheson was provided upon discharge from the Victorian Rehabilitation Centre, however the PBS Patient Summary shows that 20 tablets of 10mg methadone were dispensed to her on a script from Dr Shum on 4 April 2019, and another 20 tablets of 10mg methadone on 5 April 2019 (her date of discharge).

27. There does not appear to be any record of Ms Matheson engaging with a health service between 5 April 2019 and 12 April 2019, when she presented to the emergency department of Box Hill Hospital with a report of right hip pain and decreased consciousness. She was examined and the clinicians concluded she was likely to have experienced an overdose involving methadone and clonazepam. She was admitted as an inpatient for treatment.

28. Upon admission an addiction medicine specialist reviewed her medications and recommended that her clonazepam dose be halved from 2mg daily to 1mg daily, and that her methadone dose be halved from 40mg daily to 20mg daily. The medication administration material from Box Hill Hospital shows that she was dispensed this reduced dose of clonazepam and methadone throughout her stay and was also dispensed drugs including oxycodone.

29. The treatment plan dated 15 April 2019 was for her to remain an inpatient at Box Hill Hospital under observation for a further three days after the methadone and clonazepam reduction, to make sure the medications did not compromise respiration. However, Ms Matheson self-discharged from Box Hill Hospital on 17 April 2019. The Box Hill Hospital discharge summary indicated that Leeanne Matheson's principal diagnosis was *"poisoning / overdose, sedative".* Dr Chong was listed on the discharge summary as her general practitioner, and the treatment plan was: *"GP to please review medications, including, clonazepam, methadone and prazosin".* The discharge summary listed three home medication changes: clonazepam reduced to 0.5mg twice daily, methadone reduced to 10mg twice daily, and prazocin withheld. No discharge medications were supplied.

30. The next day, 18 April 2019, Ms Matheson presented to Dr Chong at MediClinic Clayton South. Dr Chong recorded the following progress note (which has been slightly edited for clarity but without changing the meaning):

> *Goes back to see Dr Shum 23/4/19*
>
> *Has been changed over to methadone.*
>
> *Ran out yesterday.*

Feels it is better than Suboxone for analgesia.

Actions:

Prescription printed: Methadone 25mg/5ml oral liquid 40 (forty) mg daily 18/4/2019 to 18/5/2019 inclusive, two split TADs [takeaway doses] per week including when pharmacy closed, to be dispensed from Clayton Central Pharmasave.

Suboxone 8mg-2mg sublingual film ceased.

31. In his statement to the Court, Dr Chong stated Ms Matheson presented to the Clayton Central Pharmasave pharmacy later that day and was dispensed 40mg methadone for supervised consumption.[10] She returned the next morning, 19 April 2019, for another dose of 40mg methadone and was provided a takeaway 40mg dose also for the weekend. This appears to be her last clinical interaction.

32. That afternoon, Ms Matheson's partner, Daniel Faulkner, awoke from a nap and observed Ms Matheson fall heavily into the couch in their bedroom. He could not thereafter rouse her. He called for help from Ms Matheson's son, Dale, and they contacted emergency services. Ambulance paramedics attended but Ms Matheson could not be revived.

REVIEW OF MEDICAL CARE

33. Given the discrepancy between the medications list on the discharge summary of 17 April 2019 and Dr Chong's subsequent prescriptions of 18 April 2019, I obtained advice from the Coroners Prevention Unit (**CPU**) as to the appropriateness of her medical care.

34. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised.

35. The CPU noted that Ms Matheson had spent five nights as an inpatient at Box Hill Hospital, after being admitted in a setting of methadone and clonazepam overdose on 12 April 2019. Dr Ghaly Ramy at Box Hill Hospital sent a letter to Dr Chong dated 13 April 2019, notifying

[10] Dr Chong stated that he learned this from a *"dosage printout"*. The Court has been unable to identify any such dosage printout among the Clayton Central Pharmasave material.

him that *"your patient has been admitted with Overdose F1"*.[11] While in hospital, expert addiction medicine review took place and Ms Matheson's methadone dose was halved to 20mg daily. Dr Chong was notified about this in the discharge summary dated 17 April 2019. Despite this, Dr Chong prescribed 40mg methadone to Ms Matheson when she attended on 18 April 2019. She was dispensed 40mg methadone from this script on 18 April 2019 and again on 19 April 2019, the day of her death. The elevated methadone dose, in combination with other drugs she had previously been prescribed and dispensed, was the probable cause of her death.

Dr Chong's explanation for the methadone prescribing

36. In Dr Chong's statement dated 19 February 2020, he wrote that when he prescribed methadone to Ms Matheson on 18 April 2019 he did not recall receiving or viewing the Box Hill Hospital letter dated 13 April 2019 about the overdose admission, or the Box Hill Hospital discharge summary dated 17 April 2019. He also noted Ms Matheson did not disclose her recent hospital admission. He further wrote that:

> *If I had been aware that the patient had been hospitalised for overdose, in accordance with my usual practice, I would assess the reason for the overdose before prescribing any take-away prescriptions. As it stands, I do not recall reviewing this letter prior to or during my consultation with the patient.*
>
> *If I had received and viewed the final discharge summary dated 17 April 2019, I would have called Dr Shum regarding the patient's hospitalisation and medication review, as I had done previously with the patient's Temgesic prescription. I would have sought Dr Shum's views regarding the prescription of methadone in the context of possible overdose of methadone and/or other illicit drugs, in accordance with my usual practice for patients who may not be compliant with treatment or experiencing complicating factors.*

37. In a statement to the court, MediClinic Practice manager, Maria Rodriguez, stated that the notice of admission was received by facsimile on 15 April 2019. It was automatically converted to an email, which staff forwarded to Dr Chong's work address. The discharge summary was sent and received electronically and automatically imported into MediClinic's

[11] The "F1" probably refers to the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10), which uses the "F1*" (F10 to F19) codes to designate disorders associated with use of psychoactive substances. The phrase "Overdose F1" can essentially be translated as an overdose occurring in a setting of psychoactive substance use disorder (such as dependence).

electronic medical record. MediClinic's electronic medical record (Best Practice) does not have an audit function to be able to tell exactly when that happened.

38. It remains unclear exactly when the hospital discharge summary appeared in the MediClinic medical record and if it was there, how it was not seen by Dr Chong.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Leeanne Matheson, born 15 February 1967;

    (b) the death occurred on 19 April 2019 at 3 Ostend Court, Clayton South, Victoria, from mixed drug toxicity (methadone, pregabalin, valproic acid, benzodiazepines); and

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

40. Having considered all of the evidence, I am satisfied that her death was the unintended consequence of the deliberate ingestion of prescription medication.

COMMENTS

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

41. Chronic pain, depression, and previous drug-misuse are all independent risk-factors for addiction to prescription medications. Once a patient is addicted, it is a long-term process of engaging with chronic pain and addiction medicine specialists in an attempt to convince patients to slowly wean off these medications with patients showing variable desire to do so. These patients have a long-term increased risk of both accidental and intentional overdose.

42. Handover of patient care always presents a risk because critical information may not be successfully conveyed (for any number of reasons). The patient themselves can be an important advocate for their own safety at these points (if they choose to engage).

43. Given that this cohort of patients are both high-risk patients and potentially unreliable medical historians, there may be a benefit in adding an extra layer of handover communication between the hospital system and general practitioners/ authorised prescriber in cases where changes have been made to the patient's opiate/benzodiazepine prescription. For this reason, I will make a recommendation that Eastern Health consider implementing a policy to require direct

verbal communication between the hospital treating team and the authorised prescriber for patients whose opiate prescriptions have been changed during their inpatient stay.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. That Eastern Health consider implementing a policy requiring direct verbal communication between the hospital treating team and a patient's authorised prescriber in instances where a patient's opiate prescriptions have been changed during their inpatient stay.

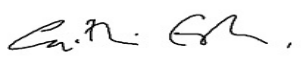
I convey my sincere condolences to Ms Matheson's family for their loss.

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

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

Daniel Faulkner, senior next of kin
Rebecca Grant
Dr Wilson Chong (care or Kennedys (Australasia) Pty Ltd)
Box Hill Hospital (Eastern Health)
MediClinic Clayton
Eastern Melbourne Primary Health Network
Office of the Chief Psychiatrist
Sergeant Adam Verschaeren, Victoria Police, Coroner's Investigator

Signature:



Caitlin English, Deputy State Coroner

Date: 31 January 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after

the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.