IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 0686

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**TATE ASHLEY HOBBS**
Date of birth:	11 DECEMBER 1982
Date of death:	6 FEBRUARY 2019
Cause of death:	COMBINED DRUG TOXICITY (PREGABALIN, MORPHINE, AMITRYPTILINE)
Place of death:	1 MCLAREN COURT, MILDURA, VICTORIA 3502

HIS HONOUR:

BACKGROUND

1. Tate Ashley Hobbs was 36 years old when he died on 6 February 2019 from combined drug toxicity (pregabalin, morphine and amitriptyline). Immediately prior to his death, Mr Hobbs lived with his parents, Rodney and Denise Hobbs at 1, McLaren Court, Mildura. Mr Hobbs was not married and had no children. He had one older brother, Klae and younger sister, Paige.

2. Mr Hobbs, a motor mechanic by trade, was a keen motorcycle and sidecar enthusiast.

3. Mr Hobbs was unemployed at the time of his death due to a work-related injury to his left knee. The injury, which occurred in 2014, resulted in Mr Hobbs undergoing multiple surgical procedures, the last of which was performed in Adelaide in January 2019. His treating general practitioner, Dr Douglas Schneider, provided a statement to the coroner's investigator (**CI**) in which he described the knee injury as "*catastrophic*" and opined that, as a consequence, Mr Hobbs was unable to return to work as a mechanic. Mr Hobbs' father, Rodney Hobbs, provided a statement to the CI in which he explained that Mr Hobbs had been advised that he would eventually require knee replacement surgery. Mr Hobbs' WorkCover claim was ultimately rejected by the WorkCover authority in 2017.

4. Prior to sustaining the knee injury Mr Hobbs had a medical history of chronic back pain following a car accident in 2008. In 2016, Mr Hobbs was diagnosed as an insulin dependent diabetic. His medical history also included diabetic ketoacidosis, renal tubular acidosis, lumbosacral back pain, neuropathic pain and lymphadenitis.

5. For at least ten years prior to his death, Mr Hobbs was prescribed numerous painkillers, in particular the opioids, oxycodone and codeine and pregabalin. Mr Hobbs attended pain management clinics in Adelaide and Melbourne but continued to suffer chronic knee pain.

6. In 2009 Mr Hobbs was diagnosed as suffering from anxiety following the breakdown of a relationship. His family understood that he had been prescribed antidepressants and that, additionally, approximately 18 months prior to his death, Mr Hobbs had seen a local psychologist.

   However, the investigation revealed that, at the time of his death, there was no evidence that that Mr Hobbs had actually seen any mental health practitioners.

7. Mr Hobbs' family considered that, at the time of his death, Mr Hobbs was mentally and physically the best he had been for months. He ate what his parents considered to be a good diet, rarely drank alcohol and walked his dog regularly.

THE CORONIAL INVESTIGATION

Coroners Act 2008

8. Mr Hobbs' death was a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**) because his death occurred in Victoria, was unexpected and not from natural causes.[1]

9. The Act requires a coroner to investigate reportable deaths such as Mr Hobbs' and, if possible, to find:

   (a) The identity of the deceased;

   (b) The cause of death; and

   (c) The circumstances in which death occurred.[2]

10. For coronial purposes, "*circumstances in which death occurred*",[3] 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.

11. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[4] It is not the Coroner's role to determine criminal or civil liability,[5] nor to determine disciplinary matters.

12. 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.

13. Coroners are also empowered to:

   (a) Report to the Attorney-General on a death;[6]

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

Standard of Proof

14. 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*.[9] 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.[10] 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.[11]

15. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[12] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[13] 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.[14]

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

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

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[7] *Coroners Act 2008* (Vic) s 67(3).
[8] *Coroners Act 2008* (Vic) s 72(2).
[9] (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.
[10] *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.
[11] *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].
[12] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[13] *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.
[14] *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.

16. On 6 February 2019, Rodney Hobbs identified the deceased as his son, Tate Ashley Hobbs, born on 11 December 1982.

17. Mr Hobbs' identity is not in dispute and requires no further investigation.

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

18. On 11 February 2019, Dr Gregory Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted a post-mortem examination on Mr Hobbs' body. Dr Young provided a written report, dated 19 June 2019, in which he opined that the cause of Mr Hobbs' death was "*Combined drug toxicity (pregabalin, morphine, amitriptyline)*". I accept Dr Young's opinion.

19. Toxicological analysis of post-mortem samples detected the presence of morphine, pregabalin, amitriptyline (and its metabolite nortriptyline) and ranitidine. Ethanol (alcohol) was not detected.

20. Dr Young commented that pregabalin, morphine and amitriptyline all cause depression of the central nervous system and, in combination, may lead to decreased respiratory drive and death.

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

21. On the evening of 5 February 2019, Mrs Hobbs arrived home from work to find her son in bed. He told her he had taken some pain killers with a glass of Canadian Club (whisky) and fell asleep. Mrs Hobbs recognised the signs of hypoglycaemia and gave Mr Hobbs chocolate and chocolate milk to increase his blood sugar levels. Later that evening, Mr Hobbs had dinner with his family.

22. On the morning of 6 February 2019, Mr Hobbs took his dog for a walk returning home at approximately 9.15am, before his parents left for work. At approximately 10.30am Mr Hobbs visited his uncle, Greg Marshall, to arrange new tyres for his ute. Mr Marshall noted that when he arrived, Mr Hobbs was pale and sweating profusely; however, he declined Mr Marshall's offer to drive him home.

23. At approximately 4.10pm when Mr Rodney Hobbs arrived home from work, he noticed his son's ute in the driveway. He located Mr Hobbs collapsed and unresponsive on his bedroom floor. Mr Rodney Hobbs commenced CPR and called emergency services. Ambulance paramedics arrived at 5.36pm and took over resuscitation which was unsuccessful, and Mr Hobbs was declared deceased at 5.40pm.

24. Police who attended located a large amount of prescription medication in Mr Hobbs' bedroom including pregabalin, amitriptyline, prochlorperazine, codeine, ondansetron, oxycodone, ranitidine and morphine. Apart from morphine, the medications had been prescribed to Mr Hobbs.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

25. A review by the CI of Medicare Pharmaceutical Benefits Scheme (**PBS**) records revealed that between 6 February 2018 and 6 February 2019, Mr Hobbs was prescribed a significantly large number of medications from 16 different medical practitioners with GP Dr Schneider being the primary prescriber. The medications prescribed included pregabalin, amitriptyline, oxycodone, codeine, prochlorperazine and quetiapine.

26. Given the quantities of medication involved, I referred the matter to the Coroners Prevention Unit (**CPU**)[15]and requested that it review the appropriateness of the manner and amounts of medication prescribed to Mr Hobbs in the twelve months prior to his death.

27. The CPU's review focussed primarily on pregabalin, oxycodone and morphine.

Coroners' Prevention Unit

Pregabalin

28. Pregabalin is used to treat neuropathic (nerve) pain. According to the PBS records, in the three months immediately prior to his death, pregabalin was prescribed and dispensed to Mr Hobbs five times on four separate occasions, twice in doses of 150mg and three times in doses of 300mg. The prescriber of all five prescriptions was Dr Schneider. The tablets were always prescribed in packs of 56 tablets, a total of 280 tablets in a 47-day period, equivalent to almost six tablets a day or 1430mg daily.

29. The clinical directions to Mr Hobbs were to take one 150mg tablet each morning and one 200mg tablet each evening. Therefore, Mr Hobbs was never directed to take more than a total of 450mg daily during this period despite being prescribed and dispensed pregabalin at a level equivalent to three times this amount daily.

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[15] 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.

Morphine

30. Photographs taken by the CI at the scene of Mr Hobbs' death identified a bottle of Ordine 10 – a brand name for an oral solution of liquid morphine hydrochloride 10mg per ml. On 6 February 2019, at approximately 10.17am Mr Hobbs sent a Facebook message to a friend stating:

"...just had some liquid morphine so hopefully feel better"

31. Although the label on the bottle containing the morphine had been mostly torn off, the CPU was able to identify the dispensing pharmacy. When contacted by the CPU, the pharmacy denied it had ever dispensed liquid morphine to Mr Hobbs. Despite further investigations, including a review of records relating to Mr Hobbs' most recent surgery in Adelaide, the CPU was unable to identify the origins of any prescribing or dispensing of liquid morphine to Mr Hobbs.

32. Ultimately the CPU advised me it had concluded that the morphine detected in Mr Hobbs' post-mortem blood samples originated in the bottle of liquid morphine found at the scene of his death. However, given the lack of evidence that liquid morphine had ever been prescribed or dispensed to Mr Hobbs, the CPU advised me that it was likely that he had obtained it by diversion.

Amitriptyline

33. Amitriptyline is a tricyclic antidepressant used widely to treat chronic neuropathic pain. It was prescribed and dispensed to Mr Hobbs ten times on nine separate occasions. Amitriptyline was dispensed nine times in a dose of 25mg and once in a dose of 10mgs. The prescriber for six of these occasions was Dr Schneider. The remainder were prescribed by two medical practitioners in Adelaide.

34. The tablets were all prescribed in packs of 50 tablets, a total of 500 tablets in a 68-day period equivalent to over seven tablets per day or 173mg of amitriptyline daily.

35. The clinical directions were for three 25mg tablets to be taken each evening before bed – ie no more than 75mg daily.

36. The CPU advised me that there was no explanation in the records available to the court as to why Mr Hobbs was directed to take 75mg daily during the three months prior to his death, whilst being prescribed and dispensed double this daily amount.

Prescribing and dispensing of pharmaceutical drugs

37. The CPU advised me that opioids, and in particular oxycodone and codeine, were prescribed to Mr Hobbs for many years prior to his death and from at least 2009 (in the case of oxycodone) and 2010 (in the case of codeine). Dr Schneider was by far the most common prescriber of all medications dispensed to Mr Hobbs.

38. Oxycodone was prescribed 102 times to Mr Hobbs between 12 February 2018 and 29 January 2019 by 11 clinicians. Dr Schneider prescribed it 82 times. The remaining 10 clinicians who prescribed oxycodone to Mr Hobbs did so a total of 20 times between them.

39. Codeine was prescribed to Mr Hobbs 34 times between 12 February 2018 and 29 January 2019. 33 of those prescriptions were provided by Dr Schneider.

40. Pregabalin was prescribed to Mr Hobbs on 14 occasions between 7 February 2018 and 5 February 2019 by six different clinicians. Five of those clinicians prescribed it only once and without repeats. Dr Schneider prescribed pregabalin to Mr Hobbs nine times during this period and on five occasions authorised five repeats.

41. Amitriptyline was prescribed to Mr Hobbs 18 times between 7 February 2018 and 22 January 2019 with Dr Schneider being the prescriber on 13 occasions.

42. By letter dated 3 October 2018, Medicare's Prescription Shopping Programme **(PSP)** wrote to Dr Schneider advising him that Mr Hobbs had been identified as possible doctor shopper.[16] The PSP advised Dr Schneider that during a three-month period, Mr Hobbs had been supplied with target medications[17](in this case, oxycodone, pregabalin and amitriptyline) by several different prescribers including Dr Schneider, in amounts possibly in excess of clinical need.

43. The CPU advised me that a review of Dr Schneider's records revealed no evidence that he took any action following receipt of this information from the PBS.

Excessive amounts of opioids

[16] Defined in Section 30(2) of the Medicare Australia (Functions of the Chief Executive Officer) Direction 2005 (Cwth)
[17] Target medicines are a subset of medicines that are classified as analgesics, antiepileptics, psycholeptics, psychoanaleptics, and other nervous system medicines as defined by the World Health organisation.

44. The CPU advised me that given the length of time for which Mr Hobbs had been prescribed opioids, it was almost certain that he had developed a dependence on them. In the year leading up to his death, it appeared to the CPU that Mr Hobbs was prescribed oxycodone in amounts that were markedly greater than the clinical directions for dosage. For example, he was commonly prescribed oxycodone with instructions to take a maximum of 60-70mg daily.

45. However, throughout the twelve months prior to his death, Dr Schneider prescribed 2415 oxycodone tablets for Mr Hobbs, equivalent to approximately 103mg daily. As by far the most prolific prescriber of oxycodone to Mr Hobbs, the CPU concluded that Dr Schneider was regularly prescribing oxycodone to Mr Hobbs in excess of therapeutic need.

46. The CPU referred me to the Royal Australasian College of General Practitioners (**RACGP**) guideline for prescribing drugs of dependence in general practice[18]which states:

> "*Outside of end-of-life care, the research on long-term opioid therapy for chronic pain remains limited and insufficient to determine long-term benefits. Available evidence suggests dose-dependent risk of serious harm*".

47. In relation to use of opioids for chronic non-cancer pain, the RACGP recommends that opioids:

> *"should be limited for select patients with moderate or severe pain that significantly affects function or quality of life and that has not responded to other therapies. An opioid trial should occur in conjunction with formal measures of analgesia and functionality".*[19]

48. Given that Mr Hobbs was regularly supplied with oxycodone and codeine for chronic pain from 2008 onwards and continued to complain of chronic pain until his death in February 2018, the CPU considers it most likely that Mr Hobbs did not obtain meaningful pain relief from the opioids prescribed to him and that instead developed an iatrogenic dependence on opioids. In turn, this dependence may have prompted him to seek to obtain liquid morphine for additional pain relief.

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[18] Royal Australian College of General Practitioners, *Prescribing drugs of dependence in general practice, Part C2: The role of opioids in pain management, 1.3 Opioids in management of chronic non-cancer pain, Key points*, 12, October 2017

[19] Royal Australian College of General Practitioners, *Prescribing drugs of dependence in general practice, Part C2: The role of opioids in pain management, Undertaking an opioid trial*, 18, October 2017

Concurrent prescribing of multiple opioids

49. The CPU noted that Mr Hobbs was prescribed codeine from at least 2010 until his death in February 2019 at the same time as he was regularly being prescribed oxycodone. In the twelve months prior to his death, Mr Hobbs was prescribed 680 x 30mg codeine tablets – 660 having been prescribed by Dr Schneider. This amount was equivalent to 58mg per day. Dr Schneider's directions for consumption were for Mr Hobbs to take half to one 30mg tablet three times daily as required, equivalent to 45 – 90mg per day. Although codeine was not a drug considered to have been contributory in the death of Mr Hobbs, it is nevertheless an opioid and, in the opinion of the CPU, would have contributed greatly to his dependence on opioids, even without it exceeding the clinical directions for consumption as it was being prescribed concurrently with large amounts of oxycodone.

50. Regarding the specific use of codeine to treat chronic pain, the CPU referred me to the relevant RACGP guideline[20] which states:

> *"There is high quality evidence that combination codeine medicines provide clinically important pain relief in the immediate term, but this is mostly in acute pain...there is no role for codeine in chronic pain".*

51. Despite this negative assessment of codeine's role in treating chronic pain, Dr Schneider continued to use it to treat Mr Hobbs. The CPU considers this to be further evidence that Dr Schneider was not properly reviewing his treatment methods and prescribing on a regular basis.

Failure to obtain a permit to prescribe schedule 8 opioids

52. Opioids such as oxycodone are classified as Schedule 8 (S8) poisons under the *Standard for the Uniform Scheduling of Medications and Poisons (***SUSMP),** commonly known as the Poisons Standard. In Victoria the relevant legislation covering S8 poisons is the *Drugs, Poisons and Controlled Substances Act 1981 (Vic)* and the *Drugs, Poisons and Controlled Substances Regulations 2006 (Vic)* which are administered by the Medicines and Poisons Branch (**MPR)** at the Victorian Department of Health.

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[20] Royal Australian College of General Practitioners, *Prescribing drugs of dependence in general practice, Part C2: The role of opioids in pain management, 6.3.1 Codeine*, 52, October 2017

53. A key control for S8 drugs, set out in Section 34 of the *Drugs, Poisons and Controlled Substances Act 1981 (Vic)* is, that in certain circumstances a prescriber must apply for a permit to prescribe S8 drugs; for example:

- Before prescribing an S8 to a drug-dependent person
- To prescribe an S8 drug for a continuous period of more than eight weeks to any person, regardless of whether the person is drug dependent.
- A medical practitioner who prescribes an S8 drug must immediately apply for a permit if there is reason to believe the prescription will contribute to the patient being treated with that drug for a continuous period of greater than eight weeks by one or more prescribers.

54. The MPR confirmed there was no evidence of Mr Hobbs in their systems and therefore no clinician had ever held a permit to treat him with an S8 opioid such as oxycodone. The CPU advised me that Dr Schneider should have held a permit to prescribe oxycodone to Mr Hobbs given that he was prescribed this medication in a continuous period far greater than eight weeks in duration.

55. Moreover, the CPU noted that, in his statement to the CI, Dr Schneider stated:

> *"His pain was such that he often needed his medication early".*

56. The CPU notes that an individual struggling to manage chronic pain may indeed take medication in excess of clinical directions and seek their next prescription ahead of the scheduled time. This is a common issue in similar cases and one which clinicians treating such patients are required to manage with caution. However, individuals presenting to request medication early may also be showing a clear sign of drug dependence. Based on the evidence available regarding the amounts of medication taken by Mr Hobbs, the CPU advised me that it is likely that he was dependent on opioids (and likely pregabalin) and therefore a permit should also have been obtained to prescribe opioids to him on that basis.

Prescription of pregabalin in excess of therapeutic need:

57. The CPU advised me that it considered Mr Hobbs had likely dependence on pregabalin, which he was prescribed in amounts that significantly exceeded the clinical directions, particularly in the three months prior to his death. Pregabalin was prescribed and dispensed to Mr Hobbs at levels that there more than three times the clinically directed dose.

58. According to Dr Schneider's clinical records, pregabalin was initially prescribed to Mr Hobbs as a trial in 2013 for "*back pain radiating to leg*".

59. A subsequent entry in the records on 5 July 2013 stated:

> "*Lyrica*[21] *75mg capsule ceased (migraine)*"

60. However, Dr Schneider subsequently prescribed pregabalin on a regular basis to Mr Hobbs from 31 May 2016 until his death. Between 7 February 2018 and 5 February 2019, Mr Hobbs was supplied with pregabalin in amounts equivalent to almost 1460mg of pregabalin per day but was never directed by any clinician to take more than 450mg per day.

61. The CPU advised me that there was little evidence to show how Dr Schneider satisfied himself of the clinical need for his prescribing of pregabalin to Mr Hobbs.

62. The CPU expressed concern that, despite being informed that other clinicians had also prescribed pregabalin to Mr Hobbs, Dr Schneider did not appear to take any action to investigate or address this issue.

63. In addition, the CPU queried whether Dr Schneider fully understood the misuse risk profile of pregabalin. Recent research on pregabalin identified by the CPU stated that:

> *"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]

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[21] A brand name for pregabalin.

[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.

64. Although this understanding of issues surrounding the prescribing of pregabalin has admittedly come to the fore more recently, there was a general awareness about the risks of pregabalin misuse at the time Dr Schneider was treating Mr Hobbs.

Prescribing multiple central nervous system depressants simultaneously

65. The CPU identified that Mr Hobbs was regularly and simultaneously prescribed a number of pharmaceutical drugs that act as central nervous system depressants which slow down the activity of the central nervous system which can result in decreased rate of breathing, decreased heart rate and loss of consciousness, possibly leading to coma or death. In the three months prior to his death, Mr Hobbs was prescribed oxycodone, pregabalin and amitriptyline. In addition, he managed to obtain and take liquid morphine.

66. The CPU concluded that the concurrent use of these central nervous system depressants in such large amounts markedly increased the risk of fatality, even without considering Mr Hobbs' additional use of diverted liquid morphine. The CPU advised me that it considered Dr Schneider did not give appropriate or accurate consideration to the increased risks stemming from prescribing multiple central nervous system depressants to Mr Hobbs simultaneously.

Lack of coordination with specialists and other clinicians

67. Based on the available evidence, the CPU advised me that it appears Dr Schneider failed to coordinate his treatment of Mr Hobbs with the advice provided by treating specialists.

68. Dr Schneider's records contain a letter dated 17 May 2018 from Dr Christopher Chan, a Pain Fellow at the Barbara Walker Centre for Pain Management (**BWCPM**) based at St Vincent's Hospital in Melbourne). In his letter, Dr Chan noted that:

"With regards to the opioids, I explained to Tate today that there is no strong indication for ongoing use of opioids in chronic non-cancer pain. I also explained to him the risks of opioid induced hyperalgesia.[23]

Tate is happy to work with us to review his opioid dose, potentially to cessation. I have asked him to initially add an extra dose of the slow release oxycodone so that he is taking 20mg tds[24] *the extra slow release oxycodone is* [to] *take the place of prn Endone*[25] *which he should limit use as much as possible. After two weeks, I have asked Tate to step down the use of oxycodone slow release by 5mg each week while limiting or stopping use of prn Endone.*

I would appreciate your assistance in continuing to support this weaning regime. I am happy for him to continue on the pregabalin and amitriptyline for now. If Tate starts to run into difficulties with weaning in terms of withdrawal symptoms, a small dose of clonidine might be helpful. Once the dose is a bit lower, we could also consider opioid rotation."

69. Despite this clear plan put forward by Dr Chan (to which Mr Hobbs had apparently agreed) the CPU advised me that it could identify no evidence that Dr Schneider took any action to assist or support Mr Hobbs in weaning himself off opioids. Instead, Dr Schneider continued to prescribe both oxycodone 20mg tablets three times daily and oxycodone 5mg tablets twice a day as required, from receipt of Dr Chan's report until Mr Hobbs' death in February 2019.

70. The CPU also referred me to a subsequent letter dated 14 February 2019 from Dr Safa Hamza at the BWCPM dated 14 February 2019 also included in Dr Schneider's records and which reads as follows:

"I am writing to inform you that we had a team meeting on 14 February 2019 to discuss Mr Hobbs' engagement in our clinic. Due to multiple non-attendances and as a policy of Barbara Walker Centre for Pain Management, we have discharged him from our clinic".

71. Although this meeting was held several days after Mr Hobbs' death on 6 February 2019, it indicates that Mr Hobbs had failed to engage with the proposed plan drawn up by Dr Chan and failed to attend the BWCPM for review on a number of occasions prior to his death. The CPU advised me it was

[23] A condition which causes generalised pain not necessarily confined to an already affected pain site. Over time, individuals taking opioids can develop an increasing sensitivity to actual or potential tissue damaging events. Like tolerance to opioids, therefore, opioid induced hyperalgesia can drive a similar need for individuals to escalate their opioid dose to receive the same level of effect to treat pain.

[24] A medical abbreviation meaning three times a day.

[25] A brand name for oxycodone.

unable to find any evidence that Dr Schneider had sought information from Mr Hobbs regarding his ongoing treatment at the BWCPM, whether he was attending as planned, or that Dr Schneider factored the actions of the pain management clinicians into his own treatment and prescribing.

72. As part of Mr Hobbs' workers' compensation claim, CGU Insurance commissioned a report dated 21 December 2018 from orthopaedic surgeon, Dr Bruce Low. The CPU advised me that a copy of this report was located in Dr Schneider's records. In his report, Dr Low stated:

> *"His knee is never going to be normal but if the function can be improved, it will improve his chances of being rehabilitated into something of a more sedentary through the local TAFE college and the job search agency. He has also got chronic intractable problems with chronic back pain. He is on a massive dose of Lyrica and OxyContin as well, plus he has some mild mental health problems as well, associated with chronic anxiety and depression as a result of his situation. He is altogether a highly complex problem. All these issues are interrelated"*

73. Again, despite this description of the "*massive*" doses of pregabalin and oxycodone Dr Schneider was prescribing to Mr Hobbs, Dr Schneider continued to prescribe both medications without change following receipt of Dr Low's report.

74. The CPU advised me that, having been made aware in October 2018 that Mr Hobbs was potentially a prescription shopper, Dr Schneider was obliged to ensure that his prescribing was in keeping with the extant regulations by taking all reasonable steps to ensure that a therapeutic need existed for the prescribing of the S8 drug. The CPU advised me that it found no evidence that Dr Schneider ever attempted to identify or liaise with any of the other prescribers in order to maintain adherence to the legal requirement to take all reasonable steps to ensure the existence of a therapeutic need for the medications he was prescribing to Mr Hobbs.

75. The CPU considered that Dr Schneider's apparent failure to act on the recommendation of specialists and other treating clinicians together with his failure to act on information which suggested that some of his prescribing may have been in excess of therapeutic need, made his prescribing for Mr Hobbs unsafe.

Standard of clinical notes not in keeping with guidelines

76. The CPU expressed concern that Dr Schneider, as the clinician who saw Mr Hobbs most regularly in the year leading up to his death, was not closely monitoring the medication prescribed to Mr Hobbs or his overall progress.

77. The RACGP publishes Standards for General Practices (**the Standards)** which, at the time of Mr Hobbs' death, were in the fifth edition (updated July 2017). These include several standards for patient medical records. The CPU advised me that many of the progress notes in Dr Schneider's records fail to comply with the Standards, often containing only a simple description of the presenting complaint and the prescriptions printed. Other entries do not even include a description of the presenting complaint nor any information as to whether such an appointment involved any kind of assessment of review of the medications prescribed to Mr Hobbs. For example, for a consultation on 5 February 2019, Dr Schneider recorded only the following:

> *"Actions: Prescription printed: Lyrica 300mg Capsule 1 before bed".*

78. Dr Schneider did not record clinical indications for prescribing pregabalin to Mr Hobbs nor indeed any other issue that may have been discussed during this consultation. Further there was often no detail about the nature of the medical complaint not Dr Schneider's rationale for the drugs prescribed. This appears to be true for the vast majority of the entries into the medical records made by Dr Schneider in the year prior to Mr Hobbs' death.

79. The CPU advised me that it concluded that many of the notes and records made by Dr Schneider regarding Mr Hobbs are similarly lacking in detail and thus do not meet the applicable RACGP Standards.

80. I accept the CPU's advice that Mr Hobbs was misusing pregabalin. The ease with which he was able to obtain pregabalin from six different clinicians (predominantly Dr Schneider), and in amounts in excess of therapeutic need, undoubtedly contributed to the continuing misuse, which ultimately played a part in his death.

81. Whilst the issues arising from the prescribing of pregabalin to Mr Hobbs were largely attributable to Dr Schneider's regularly prescribing it to him in excess of therapeutic need, these issues were also compounded by the lack of a real-time prescription monitoring (RTPM) system that would have enabled doctors instantly to find out which other clinics he had attended and the drugs he had been

prescribed by other doctors. In turn, this might have prompted one of the other clinicians prescribing pregabalin to take positive action where Dr Schneider did not.

82. Although an RTPM system (named SafeScript) has been introduced by the Victorian government in the period since Mr Hobbs' death, pregabalin is not included as one of the drugs monitored. Ultimately, the involvement of pregabalin in the death of Mr Hobbs appeared to be far more attributable to Dr Schneider's prescribing practices than as a result of prescription shopping on the part of Mr Hobbs. The inclusion of pregabalin in the SafeScript RTPM scheme may well prevent deaths in the future, by drawing the attention of clinicians to excessive prescribing of the drug, of which they would have otherwise been ignorant. Accordingly, I make the recommendation below.

83. On or about 25 August 2020, I directed my solicitor to write to Dr Schneider to provide him with a copy of my findings as set out above in draft form and to invite Dr Schneider to make submissions if he wished to respond to the contents of the draft findings. Dr Schneider responded by letter dated 6 October 2020.

Dr Schneider's response

84. It is clear from his response that Dr Schneider reflected on his prescribing practices in relation to Mr Hobbs. He noted, at the outset, that he found the draft findings confronting. Although he had always considered there to be a therapeutic need for the medications he prescribed to Mr Hobbs, he advised me that, with the benefit of hindsight, he recognises that Mr Hobbs was dependent on the medications and that he, Dr Schneider, should have been alert to, and taken active steps to address the associated risks.

85. Dr Schneider noted that it did not occur to him until late in the therapeutic relationship to doubt Mr Hobbs' honesty when he presented in severe pain and/or requesting early supply of a prescription because of reported lost or stolen prescriptions. Again. with the benefit of hindsight, Dr Schneider recognised that this behaviour represented "*red flags* "which were missed.

86. Dr Schneider advised me that, on or about 7 November 2018, he confronted Mr Hobbs about the letter he received from the Medicare "*doctor shopping* "service. Mr Hobbs' response was that he had required additional prescriptions whilst in Adelaide. Dr Schneider conceded that he should have delved more deeply into the possibility that Mr Hobbs was attending multiple prescribers.

87. Dr Schneider explained that in December 2018 he was uncomfortable with Mr Hobbs' requests for repeat prescriptions without a consultation. He felt that *"something's not right"* and insisted that Mr Hobbs attend for a consultation. He said that, at a consultation on 29 January 2019, Dr Schneider explained to Mr Hobbs his intention to regulate his medication by only prescribing sufficient medication for one month's supply. At this time, Dr Schneider still thought that Mr Hobbs was engaged with St Vincent's Hospital Pain program.

88. Dr Schneider stated that he did consider alternative medications such as paracetamol, anti-inflammatories and tramadol. However, Mr Hobbs reported that paracetamol did not provide adequate pain relief, he had side effects from anti-inflammatories (renal acidosis) and had a history of seizures after taking tramadol.

89. Dr Schneider told me that he was aware of Dr Chan's recommendations which he discussed with Mr Hobbs. Although Dr Schneider *"wanted to stick to Dr Chan's plan"*, Mr Hobbs would present with a history of repeated dislocations of his patella and it was not possible to reduce his pain medications to the baseline recommended by Dr Chan. Dr Schneider conceded that he should have sought further assistance from Dr Chan.

90. With benefit of hindsight, Dr Schneider accepts that his management of Mr Hobbs' pain management was not to the standard to be expected of him and that he should have taken proactive steps to ensure that Mr Hobbs received specialist pain management care by insisting that Dr Chan's plan be followed and by not providing earlier medication when requested to do so by Mr Hobbs. Dr Schneider concedes that he should have been alert to the possibility that Mr Hobbs was dependent on the pain medication and required further support to manage his dependence.

91. Dr Schneider accepts the criticisms of the standard of his record keeping and has taken steps to improve this, whilst appreciating the importance of recording the necessary clinical information from each consultation.

92. For reasons that are unclear Dr. Schneider did not address the issue of him having prescribed opioid medication without obtaining the necessary permit.

93. Dr Schneider has listed details (and provided evidence) of 16 hours of self-guided education he has undertaken to improve his knowledge of pain management. In addition, he advised me that he has

engaged with a GP educator, Dr Tamara Nation to undertake a personalised one-on-one education/mentoring program to address the issues identified in my findings.

94. Concluding that Dr Schneider's clinical management of Mr Hobbs was a cause of Mr Hobb's death would be a very serious conclusion to reach. That management probably played a part although I am not able to say it was a cause given the involvement of other prescribers and the liquid morphine likely taken by Mr Hobbs.

95. However, despite Dr Schneider's apparent insight and undertaking of further education, his response does not assuage my concerns regarding his prescribing practices generally. I have noted for example that, despite being asked specifically about the issue of the requirement to obtain the requisite permit to prescribe opioid medication to Mr Hobbs, Dr Schneider failed to address this issue in his response. Accordingly, I make the recommendation below.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendations:

(1) I recommend that, in order to reduce the risk of harm associated with pregabalin, the Victorian Department of Health consider the inclusion of pregabalin in the scope of drugs monitored in the Safe Script real-time prescription monitoring scheme.

(2) I recommend that the Australian Health Practitioner Regulation Agency (**AHPRA**) consider these findings in relation to Dr Schneider's prescribing practices and take any action that it considers appropriate to assist Dr Schneider to improve his prescribing practises and understand the significance of obtaining relevant permits to prescribe opioid medications.

96. For the purposes of my recommendation above, I direct that the Principal Registrar provide a copy of this finding and the coronial brief to the Department of Health and Human Services and to the Australian Health Practitioner Regulation Agency.

97. Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

FINDINGS AND CONCLUSION

98. 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 Tate Ashley Hobbs born on 11 December 1982;

(b) Mr Hobbs' death occurred;

i. on 6 February 2019 at 1, McLaren Court, Mildura;

ii. from combined drug toxicity (pregabalin, morphine, amitriptyline); and

iii. in the circumstances described in paragraphs 21-24 above.

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

(a) Mr Rodney and Mrs Denise Hobbs, senior next of kin;

(b) Mr Martin Foley, Victorian Health Minister;

(c) Ms Caroline Tuohey, Avant Law;

(d) Mr Martin Fletcher, CEO, The Australian Health Practitioner Regulation Agency; and

(e) First Constable Megan Hammond, Coroner's Investigator, Victoria Police.

Signature:

DARREN J BRACKEN

CORONER

Date: 18 March 2021.