IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002849

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Bradley Scott Liefvoort
Date of birth:	26 January 1975
Date of death:	Between 31 May 2021 and 1 June 2021
Cause of death:	1(a) Opioid toxicity (tapentadol and oxycodone)
Place of death:	5/7 Bulong Street, Dandenong, Victoria, 3175
Keywords:	Unintentional death, Opioid Toxicity, Prescription shopping, *SafeScript*, Medicines and Poisons Regulation, Recommendation.

INTRODUCTION

1. Bradley Scott Liefvoort (Bradley) was 46 years old when he was found deceased in his home on 1 June 2021. At the time of his death, Bradley was separated from his wife Linda Liefvoort (Linda) and resided at 5/7 Bulong Street, Dandenong, Victoria, 3175.

2. Bradley and Linda had three young children, triplets – two sons and one daughter, who were toddlers at the time of their father's death.

3. Bradley is survived by his wife, his children, his parents Anne Strengers (Anne) and Robert Liefvoort (Robert), and his younger sister Rebecca Bodger (Rebecca).

Bradley's childhood and formative years[1]

4. Growing up in Corio near Geelong, Bradley attended Lovely Banks Primary School then Norlane High School and Western Heights College. According to Anne, her son 'had a normal upbringing' and 'was generally into whatever his mates were doing when he was at school'. When Bradley was 17 years old he left school to take up a position as a kitchen hand at a restaurant, then moved on to various other roles in the hospitality industry.

5. Anne and Robert separated when Bradley was about 18 years old. Bradley and Rebecca both stayed with Robert initially, before Rebecca went to live with Anne. Anne believed that Bradley 'took the separation ok' because, when her son came to visit her, staying overnight or over a weekend, he was 'always friendly' to her new partner, Hans.

6. Anne described her son as a 'character' with 'great personality' who 'would talk to anyone'. During his teenage years, Bradley was part of a close circle of four friends and was known to enjoy life.

7. According to Robert, his son always had 'big ideas' and, because he was a good cook, he had his sights set on becoming a chef. After Bradley had worked in a few different roles in the hospitality industry, though, he soon realised that being a chef was 'different [to] cooking at home' and that he was not really suited to it. When Bradley was about 19 years old, having given up on his ambition of becoming a chef, he sought other employment opportunities, one of which was as a forklift driver at the Steel Lion metalwork fabrication plant.

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[1] Coronial Brief of Evidence [CB], statements of Anne Strengers and Robert Liefvoort.

Early adulthood[2]

8. Bradley met his first partner, Lianna Van Der Idsert (Lianna), while he was working at Steel Lion. Bradley and Lianna were married in 2001 after cohabitating for several years and moved into a house they bought in Ocean Grove. Around the same time, Bradley developed a keen interest in information technology (IT). He started working in the IT industry and enrolled in a course in Melbourne.

9. According to Robert, Bradley experienced great difficulty in balancing his work commitments with the demands of study; this was further compounded by the time he spent travelling to Melbourne to attend classes. To ease the pressure, Robert purchased a laptop computer for Bradley so that he could 'do a lot of his work on the train to and from the course'.

10. Bradley and Lianna separated in 2007. Anne recounted that while the reasons for their separation were manifold, 'their marriage ended on good terms' and Bradley and Lianna maintained a friendly relationship thereafter. Bradley had also maintained a good relationship with Lianna's parents.

11. After his separation from Lianna, Bradley started working at 'an IT place in Werribee'. While working there, he met and started a relationship with a lady known to his family only as Tamara. Bradley and Tamara shared a home in Yarraville for some time. Anne recalled that they were together for about 18 months, and Bradley moved back to his father's house in Corio when they separated.

The onset of Bradley's health concerns[3]

12. According to his parents, Bradley was a healthy child and there were never any major health-related concerns other than a relatively minor incident during his high school years when a motor vehicle collided with the push bike he was riding. The evidence indicates that neither Anne nor Robert was aware of any serious health condition that Bradley may have suffered in early adulthood. Anne observed that he 'always seemed happy'.

13. During the period 2010-2012, however, while Bradley was living in Patterson Lakes with his partner at the time, Joanne Cohen (Joanne), Anne learned from Joanne that her son had

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2 Ibid.

3 CB, statements of Anne Strengers, Robert Liefvoort and Joanne Cohen

been taking ‘a lot’ of ibuprofen while he was studying and working on his computer because ‘it helped with his headaches’. Anne did not ‘think much of it’ at the time, but in retrospect wondered whether this might have presaged the prescription medication dependence he developed later in his life.

The emergence of Bradley’s prescription drug-related dependence

14. According to Joanne, when Bradley moved in with her he ‘seemed like a pretty healthy guy’, other than him reporting to her that he suffered headaches as a result of a fall from his bicycle when he was younger. A maternal health nurse and midwife by profession, Joanne did not find Bradley’s consumption of ibuprofen (usually the brand-named product Nurofen) for his headaches unusual. She did, however, notice that Bradley displayed what appeared to be ‘anxiety and other issues’ related to past events such as being bullied as a child.

15. Joanne recounted that when her friends visited her from time to time, Bradley was fairly shy and ‘would always find something useful to do’ when they had visitors so that he could ‘keep himself busy’. His behaviour around people led Joanne to believe that Bradley experienced social anxiety; she suspected that he may have been treated for anxiety or depression at some stage during his lifetime.

16. Joanne related the following incident about when they went on a holiday abroad in 2012. On the day after their arrival at their destination, Bradley started to complain of ‘bad back pain and started looking for a doctor’. In retrospect, Joanne attributed Bradley’s search for a doctor to his inability to obtain codeine (an opioid analgesic classified as a drug of dependence because, like all opioids, it can be addictive when taken regularly) without a prescription. She also recalled that without her knowledge, Bradley took some of the Valium (a brand name for the benzodiazepine diazepam, which is also a drug of dependence) she had brought on their vacation. This appears to be the first time anyone noticed that Bradley had a possible issue with prescription drug use.

17. In around July 2013, Bradley was increasingly lethargic and would present with emesis if he ate certain dairy foods. Taking Joanne’s advice, Bradley underwent a blood test and when he received the results, he reported to her that he was anaemic and had been prescribed Nexium (a brand name for esomeprazole) to treat ulcers.

18. Joanne did not believe Bradley was telling the whole truth about the anaemia, because he was healthy and relatively young and did not have lifestyle factors consistent with this

diagnosis. To allay her concerns, she insisted that Bradley obtain a second opinion and accompanied him to another doctor. However, when Bradley was referred for a second round of blood tests as well as a gastroscopy and a colonoscopy, he was reluctant and took some months to follow through with the referrals. When he eventually presented himself for the tests, they revealed that Bradley 'had a big [gastrointestinal] ulcer'.

19. Around the same time, Joanne noticed that Bradley's consumption of analgesic medication increased, and she advised him to desist from taking 'too much Nurofen Plus' (the brand name for a medication containing ibuprofen and codeine in combination) because she 'knew that taking too much [Nurofen plus] makes ulcers worse'. Joanne also noticed that when Bradley reported he had a headache, he did not adhere to the directions for use found in the medication packaging. Specifically, he would not wait the recommended four hours between doses of Nurofen Plus, and instead would take the medication more frequently if his pain did not subside.

20. Over the next few weeks Bradley's medication use became more of a cause for concern. Joanne related one occasion when she and Bradley had an impromptu arrangement to spend some time together, but unexpectedly in the early evening Bradley excused himself to attend a doctor's appointment so that the doctor could reissue his esomeprazole prescription. After Bradley returned, Joanne observed that 'he was a bit dazed and sleepy and clearly affected by something' and he 'walked into the wall'. When Joanne enquired what he had taken, Bradley reported that the doctor prescribed medication to assist to him to sleep because 'he was sleeping badly'. Joanne did not know that Bradley had trouble sleeping; she believed she would have noticed this because she herself was 'a really light sleeper'.

21. On further enquiry, Joanne discovered that Bradley had taken 'at least two [but possibly] four' tablets of Stilnox (a brand name for the sedative drug zolpidem), which he claimed was dispensed directly by the doctor at the consulting rooms. Shortly afterwards, while sitting down and drinking a cup of tea he had made, Bradley 'kept nodding off almost spilling his tea'. After Joanne put Bradley to bed, she checked on him and found she was unable to rouse him, but she 'was comfortable that he was okay but just really out of it'. She then discovered six loose tablets while rummaging through his jeans pockets, and when she went to his vehicle she found a packet of zolpidem (brand name Stilnox) that had been prescribed that evening. Joanne also discovered an empty Stilnox blister pack that should have contained 14 tablets, meaning Bradley had potentially taken up to eight zolpidem

tablets. On further inspection of Bradley's vehicle, Joanne also observed 'at least 30' empty packets of Nurofen Plus.

22. Upon her return to the house, whilst sitting on the couch, Joanne was alarmed by the smell of gas. When she went to the kitchen to investigate, she discovered that Bradley had not turned the gas off when he made his cup of tea. At this point, Joanne stated that she realised Bradley was 'a full blown drug addict'.

23. Joanne confronted Bradley with her concerns about his prescription medication use, by piling up all his empty medication packaging on the kitchen table. Bradley was angry but admitted that 'on a really bad day' he would take up to a packet of Nurofen Plus (noting the directions for use specify the maximum of eight tablets per day).

Breakdown of Joanne's relationship with Bradley

24. After Joanne realised the extent of Bradley's problem with prescription medication, she alerted his treating doctors and the dispensing pharmacists, 'who all knew Brad very well from him frequenting them so much'.

25. When Joanne and Bradley discussed the issue, he informed her that in the past when he would visit or stay with his grandmother who was prescribed Panadeine Forte (the brand name for a medication containing codeine and paracetamol), he began taking it from her and using it himself. Joanne believed that by Bradley sharing this information with her, 'he was kind of admitting that this is when his codeine dependency started'.

26. Joanne wanted to support Bradley with his codeine dependence and suggested that he seek professional help. When Bradley declined this option, Joanne offered to monitor his access to codeine by providing the drug to him only when he had a headache.

27. In December 2013 Bradley experienced a bout of severe gastric pain, and Joanne accompanied him to a hospital emergency department (ED) where the staff administered intravenous (IV) morphine (a potent opioid) to manage his pain. According to Joanne, Bradley 'sat there with the biggest smile on his face ever'. At this point Joanne realised the true extent of Bradley's dependency on opioid drugs.

28. From the ED, Bradley was admitted to a ward for further treatment and remained in hospital for approximately one week. On the third or fourth day, when the clinicians started to wean Bradley from the IV morphine, he became 'agitated', 'pacing the ward and [was] rude to the

nurses'. Bradley's behaviour towards the facility's treating team was such that, according to Joanne, as a nurse herself, 'she was embarrassed to be his partner'.

29. Arrangements were made in hospital for Bradley to consult an addiction medication specialist, to assist him with managing his withdrawal from opioid medication. At this stage Bradley admitted to taking up to three packets of Nurofen Plus daily (which equated to 72 tablets). However, Bradley was discharged from hospital two days before Christmas without any follow-up appointment or medication to assist him in weaning from his dependence.

30. By the next day, 24 December 2013, Bradley appeared to be experiencing severe withdrawal symptoms and was 'back climbing the walls looking for his fix'. All the pharmacies were closed, so Joanne called Lifeline for assistance because Bradley 'was feeling so bad'. Eventually Joanne was able to secure an appointment on 27 December 2013 for Bradley to consult a doctor at the Young Street Clinic in Frankston. Accompanying him to this appointment, Joanne recalled that Bradley was prescribed some medication but could not recall exactly what it was. Bradley was also referred for counselling at Frankston Health which he attended initially. After about three weeks, Bradley 'started to say that he couldn't get to his counselling sessions'.[4]

31. In January 2014 Bradley admitted to Joanne that he had relapsed in his pharmaceutical drug use. The couple were about to embark on a planned holiday, so Joanne offered to support him 'to get better' but set an ultimatum, telling Bradley that if after their holiday he did not make an effort to improve his ways or his addiction to medication, then she would end their relationship.

32. Approximately one week before they departed, Joanne discovered that Bradley did not have any funds for their holiday and could not account for approximately $1000.00 of their savings. According to Joanne, she went ahead with the holiday plans 'and made the most of it' but about a fortnight after they returned from their holiday, she 'kicked him out' because 'nothing had changed'. For approximately six months thereafter, Joanne and Bradley saw each other intermittently, but Joanne subsequently stopped making arrangements to meet up with Bradley altogether, because she 'felt that he wasn't moving on emotionally'.

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[4] CB, statement of Joanne Cohen, according to whom she could not remember what medication was prescribed to Bradley at the time.

Escalation in Bradley's opioid use[5]

33. Bradley remained single for approximately two years after Joanne ended her relationship with him.[6] During this time Anne did not observe anything untoward about Bradley's pharmaceutical drug use. She saw him often at family functions such as birthday celebrations and, whenever they met, Bradley 'still seemed his happy self'.

34. In 2015, around the time of Bradley's 40th birthday, Anne noticed that her son had become withdrawn. She though it unusual that Bradley chose not to spend his birthday with his friends, because this 'was just not like him at all', but Bradley told her that he was going to celebrate with his friends at another time. During the same year, at a family visit to a playground to entertain Rebecca's children, Anne also noticed that Bradley did not interact with his niece and nephew as he usually did but appeared to be 'very withdrawn' and complained that 'he had a headache'.

35. Around this time Bradley gained employment with the National Broadband Network (NBN) Company. Soon afterwards, during early 2016, he met Linda, who was his wife at the time of his death.

36. According to Linda, when she met Bradley he was 'suffering from stomach ulcers' and was taking medication to manage his condition. Bradley informed Linda that his stomach ulcers stemmed from his use of ibuprofen when he was younger, as he and his friends would take 'handfuls' of ibuprofen when they used to go dirt bike or BMX riding.

37. Soon after their relationship commenced and Bradley began to spend more time at Linda's house, he started looking for a medical clinic in the area where she lived. According to Linda, Bradley consulted multiple doctors at the Ferngate Medical Centre (FMC) in Ferntree Gully to obtain prescription medication. Linda related an incident when Bradley consumed almost 100 Panamax Co tablets (Panamax Co is the brand name for a medication containing codeine and paracetamol in combination) while she was away for the weekend visiting her family. When she enquired, Bradley told her that 'he was having a lot of pain from his stomach ulcers'. Linda was concerned by this and took him to the ED at the Angliss Hospital, where test results showed that he was in danger of kidney failure. Bradley was

5 CB, statements of Anne Strengers and Linda Liefvoort.

6 CB, statement of Joanne Cohen

transferred to the Intensive Care Unit at Maroondah Hospital for further management of his health.

Management of Bradley's health concerns[7]

38. Linda estimated that over the four or five years she knew Bradley, he attended hospital every two to four weeks. These attendances ranged from 'day trips' to the ED, to overnight and multi-day admissions.

39. According to Linda, Bradley's visits to the ED were primarily for pain relief. He reported to the ED staff that he suffered allergies to several medications, and consequently would be given strong opioid analgesics such as oxycodone, morphine and fentanyl to manage his pain. Upon discharge from the ED or hospital unit, Bradley usually managed to secure prescriptions for oxycodone and other drugs such as pregabalin (an anticonvulsant that has some analgesic properties and is now increasingly being recognised as a drug subject to dependence and misuse). Linda stated that when she perused Bradley's discharge summaries and hospital pharmacy receipts for the year 2016, many of them showed oxycodone being prescribed on discharge as well as diazepam.

40. In September 2016 Bradley was diagnosed with a duodenal ulcer that constricted his duodenum, and was advised that this condition is usually treated through a 'ballooning' or 'dilatation' procedure that had to be repeated approximately every eight weeks because it would only provide temporary relief. The evidence indicates that throughout 2016, to manage his pain, Bradley was prescribed opioid analgesic medication and became progressively more dependent on it.

41. In a March 2017 letter, Medicare cautioned Bradley that for the period 1 October 2016 to 31 December 2016 he may have accessed Pharmaceutical Benefits Scheme (PBS) medicines in excess of his medical need. Under their Prescription Shopping Program (PSP), Medicare informed the doctors at the FMC about concerns with his access to prescription drugs.[8]

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7 CB, statement of Linda Liefvoort.

8 Medicare is the publicly funded national health care insurance scheme in Australia. It is administered by Australia's Social Security Department, Services Australia. The FMC was advised to exercise caution with regard to the safety of their prescribing practices in relation to Bradley.

The effect of Bradley's health concerns on his work at NBN Co

42. Bradley and Linda were married in April 2017, when Bradley was still employed at the NBN Co. Linda explained that as a condition of employment, the NBN Co required their employees to report their alcohol or drug use to their employer because the workplace was known as a 'dry site', meaning that 'no one was allowed to be under the influence of any alcohol or drugs while on site'. In accordance with the NBN Co policy in this regard, Bradley disclosed his ongoing health concerns to his employer including that he had been prescribed oxycodone and other strong opioid analgesic medications. Bradley agreed that he would not take any medication while at work and, if he had to take medication before he came to work, he would then simply take the day off. The NBN Co was also informed when Bradley was admitted to hospital and what drugs had been administered to him while he was hospitalised. According to Linda, Bradley 'took a lot of time off work due to pain/taking medication' and on several occasions he became so unwell while on duty that his colleagues needed to call an ambulance for him.

43. Eventually Bradley complained to Linda that he was under a lot of stress at work because he was being given 'a hard time for taking so much time off for his health issues'. The evidence indicates that the NBN Co management took issue with the extended periods of time that Bradley was off work.

44. On 7 August 2017, when Bradley returned to work after an absence of about four days, his colleagues observed that he appeared to be drug-affected and was 'slurring his words and bumping into things'. In accordance with NBN Co policy, Bradley was subjected to a drug test and was subsequently stood down from work and was required to consult an NBN Co aligned doctor to assess his fitness for work. According to Linda, Bradley was aggrieved by the action taken by NBN Co in this regard because he believed that he was 'set up' and the NBN Co 'just wanted to catch him with drugs in his system so that they could sack him'. Bradley therefore engaged the services of a lawyer to initiate legal action against his employer.[9]

45. By letter dated 22 November 2017, Bradley's legal representative lodged a grievance with NBN Co against their action taken in relation to Bradley's ongoing medical conditions for

[9] CB, statement of Linda Liefvoort, according to whom Bradley had been admitted to hospital from 1 to 3 August 2017 where he was treated with morphine and discharged with a prescription for oxycodone which he took on 4, 5 and 6 August 2017.

which he required analgesic medication. In summary, the letter alleged that the action taken or the conduct of the employer was tantamount to workplace bullying, contravening the relevant provisions of the *Fair Work Act 2009* (Cth). The letter further articulated three instances where NBN Co subjected Bradley to what his lawyers termed 'adverse actions'; these included placing him on a 'Performance Improvement Plan'. To resolve his matter, Bradley offered to resign from his position if certain conditions were met.[10]

46. After a protracted process that included ongoing assessments of Bradley's medical fitness for duty, Bradley was deemed to be unfit for work following an assessment on 29 March 2018 by Consultant Occupational Physician, Dr Mark Floyd, at the consulting rooms of the Medico Legal Consultants of Australia (MLCOA).[11]

47. The evidence indicates that Bradley's contract of employment with the NBN Co was terminated shortly afterwards. The evidence indicates further that Bradley was subsequently unable to obtain gainful employment elsewhere and, although he 'decided to try and to go back to work' in December 2020, he remained unemployed until his death.[12]

Decline in Bradley's health and further exacerbation of prescription drug dependence[13]

48. On 15 September 2017 Bradley underwent a duodenal strictureplasty: a surgical procedure to improve the passage through the duodenum of partially digested food exiting the stomach. Although his surgery was deemed successful, Bradley continued to report pain that the clinicians could not explain. For symptomatic relief of his inexplicable pain, Linda stated that his treating clinicians 'prescribed large amounts of painkillers' and placed Bradley on a 'modified diet'.

49. According to Linda, during 2018 Bradley's doctors came to recognise that he had become opioid dependent. Linda stated further that Bradley's usual general practitioner at the FMC,

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[10] CB, Letter of Complaint from McDonald Murholme Barristers & Solicitors to Mr Tony Wilson, NBN Co Ltd General Manager.

i. The letter made reference to at least five instances of Workplace Bullying.

ii. Conditions of Bradley's resignation included a "Statement of Service" and "12 months' salary" amongst others.

[11] CB, Letter from Dr Floyd to NBN dated 10 April 2018.

[12] CB,

i. statement of Anne Strengers, according to whom her son 'stopped working at NBN approximately two years before he passed away'.

ii. Statement of Linda Liefvoort, according to whom, after he finished working at NBN, Bradley 'wasn't working' for what she believed was 'a period of 18 months'.

[13] CB. Statement of Linda Liefvoort and the references cited therein.

Dr Gregory Field, commented in a letter of referral to other colleagues that in his opinion Bradley's 'main problem is his opioid need'.

50. Over the course of approximately the next two years Linda noticed a deterioration in Bradley's health which coincided with an increase in his use of and dependence upon opioid medication, particularly prescribed oxycodone. Linda related that when Bradley tried to wean himself from his medication, he would experience withdrawal symptoms that inevitably led him to calling an ambulance and being transported to the ED.

51. Bradley was also known to use the Doctor on Call service when he was unable to consult his usual general practitioner. Linda stated that Bradley 'had a doctor come to the house and write him scripts for painkillers on the weekend or after hours'. On those occasions when Bradley felt that he needed to go to the hospital, he preferred to use an ambulance service rather than have Linda drive him to their nearest ED (which was only minutes from their home). Linda believed that he preferred the ambulance because the paramedics 'would give him a shot of morphine or fentanyl' before he even arrived at the hospital. By Linda's account there were many occasions when Bradley, appearing well, 'smiling and laughing', would surreptitiously disappear into the bedroom to call an ambulance and when they arrived 'he would be putting on the appearance of someone who was in agony'.[14]

52. Linda related that during the latter half of 2018 Bradley appeared to reduce and cease oxycodone use. However, he then developed sinus pain and headaches due to sinusitis that recurred despite numerous courses of antibiotic therapy. When Bradley was referred to an ear, nose and throat (ENT) specialist, it was discovered that he suffered from a deviated septum and nasal polyps which required surgical intervention. After this diagnosis, in April 2019 Bradley was placed on a waiting list for the surgical procedure. As an interim measure pending surgery, Bradley was prescribed Palexia (a brand name for the strong opioid analgesic tapentadol) to manage his headaches and the nasal discomfort.

53. Later that year a second ENT specialist diagnosed that Bradley was suffering from the rare autoimmune disorder, granulomatosis with polyangiitis (GPA). According to Linda, this diagnosis was accompanied by a poor prognosis and the indications were that Bradley may not fully recover from this condition. Additionally, Linda learned from Bradley's treating

[14] CB, statement of Linda Liefvoort who refers to a statement from her partners health insurance fund which documented that for the period 25 September 2019 to 20 September 2020, Bradley 'had 11 ambulance call outs'.

team of clinicians that Bradley's symptoms (particularly the 'headaches' and the severe 'pain' he complained of) were atypical of his GPA diagnosis.[15]

54. Bradley was prescribed methotrexate (a chemotherapy agent and immunosuppressant drug) in conjunction with tapentadol to manage his GPA-related pain. In this context Bradley was also recommenced on oxycodone in early 2020. According to Linda, Bradley had been advised to alternate between tapentadol and oxycodone. The evidence indicates that this medical advice was obtained after Bradley informed his GP that the tapentadol wasn't giving him 'relief from the pain'.

55. Around the same time, Linda also noticed that in addition to his regular Monday morning appointments with his GP, Bradley was scheduling other appointments when he ran out of medication. She also suspected he may be using her medication and became concerned at his episodes of strange behaviour. An example she gave was when he tried to use frozen peas, an avocado and lemon sorbet to prepare a stir-fry meal. When Linda questioned him, Bradley 'shook his head as if to clear it' and told her that 'he was a little bit tired'.

Further ED attendances[16]

56. On the morning of 12 April 2020 Bradley called an ambulance complaining of excruciating pain. On the way to Dandenong Hospital the paramedics administered the potent opioid fentanyl, but on arrival at the ED Bradley reported that the fentanyl gave him only minimal relief. When Linda later perused the Dandenong Hospital discharge summary document, she found the reason for Bradley's ED attendance was described as: 'the *patient claiming [that he] needs further Palexia until [his] usual GP review*'. Bradley's *SafeScript* records[17] revealed that two prescriptions for tapentadol had been issued to him on 4 April 2020, one for a slow release formulation (where the tapentadol is trapped in a tablet matrix that breaks down slowly after ingestion, releasing the drug slowly and steadily over time rather than all at once) and the other for an instant release formulation. According to Linda, if Bradley had followed the directions for use then the tapentadol dispensed to him should have lasted for at least 11 days, rather than only eight days.

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15 CB, statement of Linda Liefvoort according to whom, although she attended Bradley's specialist appointments with, she was 'never allowed to attend a single appointment with his GP'.

16 Ibid.

17 *SafeScript* is the State of Victoria's real-time prescription monitoring scheme, a clinical tool which provides access to a patient's prescription history for high-risk medicines to enable safer clinical and prescribing practices. The role and functioning of SafeScript is described further below in the finding.

57. The Dandenong Hospital clinician prescribed eight tablets of tapentadol and made a note strongly advising that Bradley's tapentadol dose be reviewed. The evidence indicates his clinician may have recognised that Bradley had a propensity to actively seek out opioid drugs.[18]

58. Over the course of the next few months, particularly after the triplets were born in April 2020, Bradley's behaviour became more unpredictable. Linda noticed that he would be in 'a very good mood' when he returned from a consultation with his GP on the Monday, however as the week progressed he would retreat to the bedroom where he would eat his meals and refuse to shower for a number of days until his next GP consultation. Linda related that she would dread the weekends because she knew Bradley would be experiencing serious withdrawal by then and would call an ambulance to convey him to the ED. After his next round of medications were dispensed, Bradley would then revert to 'his happy, cheery self'.

59. In August 2020 Linda asked Bradley to leave their common home and move to his mother's house in Geelong because she could no longer tolerate his behaviour including his constant state of opioid withdrawal and his refusal to help with the triplets. After living with his mother for a few weeks, Bradley returned to live with Linda when he accepted her conditions 'to stop mistreating his medication, to shower every day, eat properly and exercise'. However, he soon reverted to the pattern of frequent doctor and pharmacy visits, long days spent in his bedroom and opioid withdrawal on weekends.

60. During September 2020 Linda noticed that Bradley was again exhibiting strange behaviour, such as referring to her in the third person during conversations as though he did not know he was actually talking to her. The following month, at Linda's request, Bradley went to spend three weeks with his mother so that he could reconsider the conditions she set the first time she asked him to leave.

61. When Bradley returned he tried to wean himself from his medication again. This time, however, in addition to him becoming miserable and agitated, his symptoms included 'vomiting and diarrhoea and stomach cramp[s]'. When Bradley found his withdrawal symptoms too difficult to endure, he would attend doctors for more medication. The evidence indicates that whenever Bradley relapsed into using opioid medication, his

[18] Ibid.

dependency issues became worse and he would spend substantial amounts of money on medications at pharmacies. For the period 1 October 2020 to 1 January 2021, having reviewed their bank statements, Linda discovered that Bradley had visited 14 different pharmacies.

62. In December 2020 Linda and the triplets went to visit her parents in Alexandra (a regional Victorian town) over the Christmas holiday period and stayed there for five weeks. Bradley chose not to accompany them. According to Linda, Bradley did not make any effort to contact her and the children while they were away. After some consideration, Linda decided to separate from Bradley and informed him of this on 28 December 2020.

63. After their separation, Bradley visited Linda and the triplets only intermittently but created the impression with his other family members that he spent most of his time with them. According to Linda, when the triplets fell ill Bradley preferred to keep his distance because he was 'on immunosuppressant medication' and exposure to even just a '[common] cold' would compromise his health.[19]

THE CORONIAL INVESTIGATION

64. Bradley'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.

65. The role of a coroner is to conduct an independent investigation into reportable deaths to establish if possible the deceased's identity, the 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.

66. 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.

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[19] CB, statement of Linda Liefvoort, according to whom Bradley 'continued to bombard' her with text messages prompting her to provide him with updates regarding their children which he then used to make 'it seem like he was visiting and being an active parent when he hadn't been'.

67. Victoria Police assigned Detective Senior Constable (DSC) Sally Spalding to be the Coroner's Investigator (CI) for Bradley's death. The CI 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.

68. This finding draws on the totality of the coronial investigation into the death of Bradley Scott Liefvoort 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.[20]

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

Circumstances in which the death occurred[21]

69. Bradley moved into his unit in Dandenong around January 2021 after he separated from Linda. Anne was concerned that her son was residing on his own, and insisted that he text her every morning to check in. Bradley did not allow his family to visit him at his unit, preferring to meet them elsewhere or go to their homes instead.

70. On 3 April 2021 Bradley went to his mother's home to celebrate her partner's birthday with family and friends. On that day Anne noticed that her son mingled with the guests and family for about an hour, after which he retreated to his former bedroom at the home, emerging only to have coffee when all the other guests had departed. Bradley declined Anne's offer of dinner and returned to the bedroom.

71. On the following day at approximately 10.30 am Bradley left the bedroom and went directly to his car. While Bradley was outside, Anne went into the bedroom to search for any signs of drug use, but Bradley's unexpected return meant Anne was unable to conduct a thorough search. When Bradley voiced his displeasure about his mother 'looking' around in his bedroom, she told him that she came to remove the crockery he left behind after he had eaten there. Bradley remained in the bedroom for the rest of the day and only emerged at

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[20] 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.

[21] CB, statements of Anne Strengers and Linda Liefvoort.

about 5 pm for a sandwich and coffee. According to Anne, her son again declined her offer to have dinner with the family.

72. On 5 April 2021 at approximately 8.30 am Anne heard 'scuffling' and assumed that Bradley was awake. She later found he had departed the house at around that time. When Anne enquired by text message, Bradley told his mother that 'his headache was coming on and he wanted to get home before it got really bad'. This was the last time Anne saw her son, though she remained in contact with him via text message.

73. In May 2021 Anne and her partner went on a trip to New South Wales (NSW). Bradley and Anne texted one another during this trip. On 27 May 2021 at 10.47 am Bradley sent Anne a text message in which he wrote that he planned to ask Linda whether she would allow him to have a video chat with the triplets. The evidence indicates, however, that this video chat did not occur and Bradley's text message to Anne was the last known contact he had with anyone.[22] On the same day, at 6.08 pm, Anne sent her son a text message to enquire about his wellbeing and whether the video chat went ahead. Bradley did not respond. Over the course of the next two days, 30 and 31 May 2021, Anne continued trying to contact Bradley but did not succeed in reaching him.

74. Bradley's neighbour Matthew Bradfield (Matthew) saw him arrived at his unit on the morning of 31 May 2021 at approximately 8.30am-9.00am. Matthew stated that he saw Bradley's car drive into the unit complex but didn't speak to him. The evidence indicates that this was the last time anyone saw Bradley alive.[23]

75. On 1 June 2021, when her further attempts to contact Bradley failed, Anne (who was still in NSW at the time) alerted Linda to her concerns about her son's whereabouts.

"Welfare Check"

76. Following the 1 June 2021 telephone call from Anne, Linda tried to contact Bradley 'because he usually answered calls from her straight away'. When Bradley did not respond

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22 CB, statement of Linda Liefvoort. According to Linda, Bradley did not even take up her invitation to visit them on the day of the triplets' first birthday. Even though he indicated that he would visit them that day, he cancelled on the morning of their first birthday, 16 April 2021, telling Linda that 'he wasn't going to make it'.

23 CB, statement of Matthew Bradfield.

to Linda's call, she asked her father Graeme Matthews (Graeme) to go to Bradley's unit to check on him.[24]

77. According to Graeme, when he arrived at the unit he noticed Bradley's car but there was no response when he knocked on Bradley's door. He alerted police after attempting to make enquiries of Bradley's neighbours. Victoria Police members attended and could not gain entry to Bradley's unit, so they obtained a key from the real estate agent. Upon entering the unit at approximately 1.50 pm, the Victoria Police members discovered a person 'lying on his bed slumped over and clearly deceased'.[25]

78. Victoria Police did not identify any suspicious circumstances but noted 'numerous packets some being empty of what appeared to be prescription medication' at the scene. On closer inspection, Victoria Police also noticed that the deceased had some prescription medications still clutched in his hand.[26]

Identity of the deceased

79. On 1 June 2021, Bradley Scott Liefvoort, born 26 January 1975, was visually identified by his father-in-law, Graeme Robert Matthews who signed a formal Statement of Identification.

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

Medical cause of death

81. Forensic Pathologist Dr Brian Beer of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy upon the body of Bradley Scott Liefvoort on 7 June 2021. Prior to conducting the autopsy, Dr Beer reviewed the following material:

    i. The Victoria Police Report of Death for the Coroner ('Form 83');

    ii. The post-mortem computed tomography (CT) scan;

    iii. The VIFM Coronial Admission & Enquiries (CAE) contact log; and

    iv. The scene photographs.

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[24] CB, statement of Anne Strengers.

[25] CB, statement of First Constable (FC) of Police, Jayden Lee according to whom, the deceased 'was purple in the face' when the body was discovered.

[26] CB, statements of FC Jayden Lee, Constable Jake Nash and Senior Constable (SC) Justin Pigdon

82. Dr Beer provided a written report of his findings, the Medical Examiner's Report (MER) dated 26 July 2021.

83. Dr Beer's post-mortem examination revealed that the death likely occurred some time before the body was discovered. Toxicological analysis of post-mortem samples identified the presence of the following common drugs or poisons in blood:[27]

    i. Ethanol 0.05 g/100mL;

    ii. Oxycodone ~0.5 mg/L;

    iii. Tapentadol ~2.2 mg/L;

    iv. Diazepam ~0.1 mg/L and its metabolite nordiazepam;[28] and

    v. Mirtazapine ~0.02 mg/L.[29]

84. Dr Beer commented that the opioids oxycodone and tapentadol were detected 'at lethal range levels'.[30] Dr Beer concluded that, in the absence of any 'injuries or significant underlying natural disease that may have caused death', the medical cause of death was 1 (a) OPIOID TOXICITY (TAPENTADOL AND OXYCODONE).

PRELIMINARY INVESTIGATIONS

85. The initial investigation of the scene indicated that Bradley had access to many medications. Attending Victoria Police members catalogued the following:[31]

    i. 1 empty bottle of 1 mg prednisolone;[32]

    ii. 1 packet of Palexia SR 100 mg (a brand of tapentadol) with 3 tablets missing;

    iii. 4 sealed boxes of Endone (a brand of oxycodone);

    iv. 1 empty bottle of prednisolone 25 mg tablets;

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27 CB, Toxicology Report of Elizabeth Gould-Williams, VIFM Forensic Toxicologist, dated 15 June 2021.

28 Diazepam's minor metabolites oxazepam and temazepam were also detected in urine.

29 Mirtazapine is an antidepressant drug. In this case, it was detected in the urine.

30 CB, MER of Dr Beer.

31 Court File, Victoria Police Report of Death, Form 83.

32 Prednisolone is a steroid medicine used to treat allergies and autoimmune disorders, amongst other indications.

v. Panamax (a brand of paracetamol);

vi. Mirtazapine;

vii. Pana[f]cortelone;[33]

viii. Methoblastin (a brand of methotrexate);[34]

ix. Sandomigran (a brand of pizotifen);[35]

x. Somac (a brand of pantoprazole);[36]

xi. Megafol (a brand of folic acid);[37] and

xii. Valium (a brand of diazepam).

86. A later search of Bradley's vehicle revealed more packaging from medications prescribed by several different doctors, as well as bags from various pharmacies.

87. Having considered the Victoria Police Report of Death in conjunction with Dr Beer's MER and the circumstances within which the death occurred as outlined in the evidence gathered during the initial Victoria Police investigation, on 4 August 2021 I directed DSC Spalding to compile a Coronial Brief of Evidence that addressed:[38]

i. Bradley's background details including personal/social circumstances, medical and mental health history and any history of suicidality or family violence;

ii. Statements from family or friends to inform the background details sought;

iii. Statements from any medical clinicians involved in Bradley's care and details of treatment or medication prescribed;

iv. Bradley's history of drug or alcohol use;

v. Bradley's history of illicit or prescription drug use; and

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33 Panafcortelone is an oral corticosteroid anti-inflammatory medicine.

34 Methotrexate is indicated to treat sever psoriasis, rheumatoid arthritis and some types of cancer.

35 Pizotifen is indicated to treat recurrent migraine pain.

36 Pantoprazole is indicated to treat gastric reflux.

37 Folic acid is indicated to treat anaemia and folate deficiency.

38 Court File, Letter from the Court to Victoria Police, Crime Investigation Unit (CIU)—Greater Dandenong.

vi. Details of any contact with any services which Bradley may have accessed.

Coronial Brief of Evidence

88. On 26 October 2021 DSC Spalding delivered the Coronial Brief for my consideration, which contained statements from 14 doctors who prescribed medications to Bradley in the year leading up to his death. The Coronial Brief also contained Bradley's Medicare Patient History Report and his PBS Patient Summary. These records chronicled Bradley's consultations with doctors for the entire period as well as providing detailed information on the prescriptions issued and where those prescriptions were dispensed.

89. Having reviewed the evidence contained in the Coronial Brief, I was concerned about the quantity of medications prescribed and dispensed to Bradley. I was particularly concerned at how he was able to access these medications in circumstances where many were target drugs monitored by Victoria's *SafeScript* real-time prescription monitoring (RTPM) system.

The Victorian Government's *SafeScript* System

90. Briefly, the *SafeScript* system works as follows:

i. RTPM describes the process of gathering information on prescription medications immediately as they are prescribed and/or dispensed, and storing this information in a central electronic database where it can be accessed by clinicians when a patient attends for treatment, and by pharmacists when a patient presents a script for a pharmaceutical drug. By enabling both prescribers and dispensers to access a patient's history of prescribed medications, an RTPM system in turn enables them to understand what drugs the patient is obtaining in what quantities and from whom, so that they can make more informed decisions about treatment and also detect concerns such as medication over-use.

ii. Victoria's RTPM system *SafeScript* does not monitor all prescribed drugs in Victoria. Instead, it monitors drugs considered to present a particular risk of dependence and harms (including death). These target drugs include: (a) strong opioid analgesics such as buprenorphine, codeine, fentanyl, hydromorphone, methadone, morphine, oxycodone, pethidine, tapentadol; (b) benzodiazepines, which are prescribed primarily treat anxiety and sleeplessness; (c) zolpidem and zopiclone, which are also potent sedatives; (d) stimulants for attention deficit hyperactivity disorder or narcolepsy, being dexamphetamine, lisdexamphetamine and

methylphenidate; and (e) ketamine and quetiapine, which both present an elevated risk of misuse and harm.

iii. *SafeScript* was initially made available to prescribers and dispensers in the second half of 2018 on a voluntary opt-in basis. Since 1 April 2020, it has been mandatory for Victorian prescribers and dispensers to check *SafeScript* prior to prescribing or dispensing a medication monitored through the system.

iv. The only exceptions to checking the *SafeScript* platform prior to prescribing or dispensing are when clinicians treat patients in hospitals, prisons, police gaols, age care and palliative care settings.

91. At the time of Bradley's death, *SafeScript* had already been compulsory to use for more than a year when prescribing or dispensing either of the two drugs that contributed centrally to the death: oxycodone and tapentadol. Moreover, given the period of time elapsed since the *SafeScript* platform was first made available, I thought it very reasonable to expect that the clinicians involved in Bradley's care - particularly in the months leading up to his death - should have been very familiar with the functioning of the *SafeScript* platform and its stated objectives.

92. In this context, having considered the evidence before me at this stage of my investigation into Bradley's death, I was concerned that Bradley's ability to access multiple potent drugs of dependence in large quantities from multiple doctors might indicate the *SafeScript* system either was not working as intended, or was not being used as required by his prescribing clinicians.

93. Accordingly, I directed the Coroners Prevention Unit (CPU)[39] to review the circumstances in which Bradley's death occurred and advise whether the practices of his treating clinicians (including their use of *SafeScript*) were reasonable and appropriate in the circumstances. I sought this advice to assist my consideration of whether the prescribing practices were tantamount to an opportunity lost for preventing Bradley's death.

[39] The Coroners Prevention Unit is a business unit in the Coroners Court of Victoria, whose staff support coroners' investigations through activities such as collating data, reviewing evidence, compiling literature review, and consulting with relevant experts and organisation. The CPU's central purpose is to identify opportunities to reduce preventable deaths investigated by coroners.

FURTHER INVESTIGATIONS

94. Although Bradley's prescription medication dependence emerged more than a decade before his death, I directed the CPU to focus their review on the approximately six-month period leading to Bradley's death. One reason for this was to ensure that the prescribing behaviour being scrutinised was sufficiently proximal to be regarded as causal in the death. Another reason was, the evidence indicates that there was an escalation in Bradley's behaviours relating to drug seeking and drug dependence following his last separation from Linda in January 2021.

95. I directed that the CPU initially focus on review of available material in the Coronial Brief, such as the PBS Patient Summary and *SafeScript* report of drugs prescribed and dispensed, to identify the sources of the main opioid prescription drugs (tapentadol and oxycodone) implicated in Bradley's death. Additionally, noting that the Forensic Pathologist Dr Beer identified diazepam (a sedating benzodiazepine monitored through *SafeScript*) as a potential contributor to respiratory depression in the death, I asked the CPU to also include diazepam in their analysis.

INITIAL CPU REVIEW[40]

96. From review of the available material, the CPU identified numerous prescriptions issued to Bradley for tapentadol, oxycodone and diazepam in the months leading up to his death.

Tapentadol

97. Between 24 November 2020 and 29 May 2021, tapentadol was prescribed to Bradley on 41 occasions as follows:[41]

    i. Two occasions where the prescribers could not be identified;[42]

    ii. One occasion where tapentadol was prescribed by Dr Katie Liao, an intern at Monash Medical Centre, Clayton;

    iii. Fifteen occasions where tapentadol was prescribed by Dr Yang Song of the FMC;

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40 CPU Advice Memorandum dated 17 November 2021.

41 Ibid. According to the CPU, there were no repeat prescriptions issued.

42 The CPU suspected that these prescriptions may have emanated from Bradley's numerous visits to the ED at Dandenong Hospital and were issued by doctor(s) there.

iv. Six occasions where tapentadol was prescribed by Dr Gregory Field of the FMC;

v. Five occasions where tapentadol was prescribed by Dr Peter Trye of the FMC;

vi. Three occasions where tapentadol was prescribed by Dr Sybilla Fievez of the FMC;

vii. Three occasions where tapentadol was prescribed by each of Dr Kandasamy Vijaykumar, Dr Vijesh Soni and Dr Malgorzata Thomas at the Access Medical Group Knox (AMGK);

viii. Four occasions where tapentadol was prescribed by Dr Ayodele Ogunjobi of the Zenith Medical Centre (ZMC); and

ix. Two occasions where tapentadol was prescribed by Dr Yuyang Huang of the South Eastern Deputising Centre Dandenong (SEDCD).

98. According to the CPU's analysis of available prescribing and dispensing information, a total of 988 tapentadol tablets were prescribed to Bradley for the period under review in both 50 mg and 100 mg dosage strengths, with clinical directions for Bradley to take one tablet three times daily. The CPU concluded that the tapentadol was prescribed and dispensed to Bradley 'in amounts exceeding these clinical directions'.

Oxycodone

99. In the same period, between 27 November 2020 and 29 May 2021, oxycodone was prescribed to Bradley on 22 occasions as follows:[43]

i. One occasion where the prescriber could not be identified;[44]

ii. Nine occasions where oxycodone was prescribed by Dr Yang Song of the FMC;

iii. Five occasions where oxycodone was prescribed by Dr Gregory Field of the FMC;

iv. Four occasions where oxycodone was prescribed by Dr Peter Trye of the FMC;

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43 *Supra*, Fn 53. According to the CPU 19 out of the 22 prescriptions were issued through the PBS with no repeat prescriptions.

44 *Supra,* Fn 54

v. One occasion each where oxycodone was prescribed by Dr Sybilla Fievez of the FMC; Dr Lydia Sin of the FMC; and Dr Katie Liao when she was an intern at Dandenong Hospital.

100. The CPU calculated on the basis of the available material that a total of 1785 oxycodone tablets were prescribed to Bradley for the period under review in 5mg dosage strength with general clinical directions to take a total of eight tablets daily. The total number of oxycodone tablets prescribed and dispensed over the period was the equivalent of almost 10 tablets daily, which slightly exceeded these clinical directions.[45]

Diazepam

101. Diazepam was the only benzodiazepine drug prescribed to Bradley between 1 December 2020 and 29 May 2021. It was prescribed on 14 occasions as follows:[46]

i. Two occasions where the prescriber could not be identified;[47]

ii. Five occasions where diazepam was prescribed by Dr Yang Song of the FMC;

iii. Two occasions each where diazepam was prescribed by Dr Gregory Field of the FMC; and Dr Peter Trye of the FMC;

iv. One occasion each where diazepam was prescribed by Dr Sybilla Fievez of the FMC; Dr Ayodele Ogunjobi of the ZMC; and Dr Yuyang Huang of the SEDCD.

102. According to the available material, all the prescriptions were for 5 mg diazepam dosage strength. The CPU calculated that 556 diazepam tablets were prescribed to Bradley during this period, the equivalent to a daily dose of three tablets or 16 mg of diazepam. Bradley's clinical directions for most of this period were to take one half to one tablet twice daily until his last two consultations at the FMC on 24 May 2021 and 29 May 2021, when Drs Fievez and Trye respectively directed him to take two 5 mg diazepam tablets three times daily. The CPU concluded, on the information available, that the amount of the diazepam prescribed

45 CPU Advice Memorandum dated 17 November 2022.

46 *Supra*, Fn 53. According to the CPU there were no repeat prescriptions.

47 *Supra*, Fn 54

and dispensed to Bradley exceeded the clinical directions for consumption over the course of the period being examined.[48]

Use of *SafeScript* while prescribing

103. As noted above, oxycodone and tapentadol and diazepam are all target drugs monitored by the *SafeScript* system. While I do not intend to explain here in detail how *SafeScript* works, some background is needed to understand what information was available to the CPU when they conducted their initial review of material in this death.

104. The *SafeScript* system was implemented in Victoria to enable clinicians to ascertain a patient's past access to target medicines and to inform safe prescribing and dispensing practices. The *SafeScript* system is integrated with most software packages used for clinical note-taking, prescribing and dispensing, so there is usually no need to run *SafeScript* separately. However, if a doctor or pharmacist does not use software integrated with *SafeScript* this is not an issue; they can login directly on the online SafeScript portal (located at https://www.safescript.vic.gov.au/) before prescribing or dispensing a monitored drug to view the patient's medication history.

105. When a doctor intends to prescribe a target drug (or a pharmacist intends to dispense a target drug) to the patient and checks *SafeScript*, if the system's algorithms detect any potential issue the doctor (or pharmacist) is presented with an alert:

    i. An amber alert appears when the *SafeScript* system's algorithms identify a potential concern with the intended prescribing or dispensing. One criterion for an amber notification is that the target drug has been prescribed by more than one clinician in the past six months, or dispensed at four or more pharmacies during that period. Another criterion for amber notification is when the *SafeScript* system detects the patient has recently been dispensed opioids in the equivalent dosage of between 50mg and 100mg daily morphine.

    ii. A red alert appears when the *SafeScript* system's algorithms identify a particular concern with the intended prescribing or dispensing. Criteria for a red alert include that the patient has been prescribed target drugs by four or more doctors in the past 90 days; or is being prescribed or dispensed certain high-risk combinations of drugs

[48] CPU Advice Memorandum dated 17 November 2022.

(such as potent opioids in combination with benzodiazepines); or has recently been dispensed opioids in the equivalent dosage of more than 100mg daily morphine.

106. The alerts specify the potential issue detected (for example "patient has obtained prescription medicines from at least four different prescribers within the last 90 days") and prompt clinicians to consider the patient's recent history of prescribed drug use as part of their clinical decision-making. It is important to note that an alert does not require a clinician to take a particular course of action, and *SafeScript* does not seek in any way to replace the clinician's judgment.

107. Of particular relevance to this investigation, *SafeScript* centrally maintains a record of all target medications prescribed and dispensed to each patient. The record, which can be accessed and checked by any prescriber or dispenser treating the patient, includes the drug details, the name of the practitioner prescribing or dispensing the drug, the date, and the nature of any alert that accompanied the prescribing or dispensing event. The *SafeScript* record for each patient also includes the date on which any practitioner accessed *SafeScript* to check information regarding the patient.

108. As intimated above, I was able to obtain a copy of Bradley's *SafeScript* record from the Victorian Department of Health to assist my investigation. Given that from 1 April 2020 all Victorian doctors were required by law to check *SafeScript* before prescribing tapentadol, oxycodone or diazepam, it would be expected that any doctor prescribing these drugs to Bradley between 24 November 2020 and his death (the period that is the particular focus of my investigations here) should have checked *SafeScript*, and this checking would have been reflected in his access history.

109. The CPU analysed the *SafeScript* access history for Bradley during this period and noted that there were in total 77 prescriptions for the target drugs tapentadol, oxycodone and diazepam issued to him. Among these 77 prescribing events, there were only six corresponding access records demonstrating that prescribers checked the system before providing the prescription to him. Dr Trye checked the system three times, Dr Fievez checked twice, and Dr Huang checked once.

STATEMENTS FROM PRESCRIBING DOCTORS

110. With the CPU's initial analysis supporting my concern about the quantity of drugs prescribed to Bradley, the large number of doctors involved in this prescribing, and the

likelihood that these doctors did not always check *SafeScript* when required, I directed the CPU to obtain statements from relevant treating clinicians.[49] The three issues I sought to clarify were: (1) whether clinicians had any concerns about prescribing drugs to Bradley in excess of clinical need; (2) whether the clinicians considered using the SafeScript system to inform their prescribing decisions and improve medicines safety; and (3) whether clinicians who prescribed the opioids tapentadol and oxycodone to Bradley met the permit requirements that are in place for prescribing these drugs. (The permit requirements are explained in greater detail below.)

Clinicians' responses to concerns about prescribing drugs in excess of medical need

111. By and large the clinicians, some of whom Bradley consulted when his usual treating doctor was not available, individually offered what appeared to be clinically reasonable explanations for their prescribing. These included but were not limited to explaining that they were satisfied their prescribing practices were consistent with the existing established practices of Bradley's usual treating team.

112. Given the prescribers' explanations, and acknowledging that both pain management and addiction medicine are complex fields, I considered whether it would be appropriate to investigate their individual prescribing decisions any further either by commissioning the input of a clinical expert or by referring the matter to oral evidence. However, ultimately I determined that this would not substantially advance my investigation into Bradley's death and would therefore be to no purpose.

Clinicians' use of the *SafeScript* platform

113. Clinicians offered a wide variety of accounts in response to my inquiry about how they integrated (or not) the *SafeScript* platform into their practice:

    i. Dr Vijayakumar did not provide a response to my query. The *SafeScript* records show that on 28 December 2020, when Dr Vijayakumar prescribed tapentadol to Bradley, a red alert was generated in SafeScript but Dr Vijayakumar did not check the system.

[49] At my Direction, statements were obtained from the following clinicians:
i. Dr Kandasamy Vijaykumar, Dr Malgorzata Thomas and Dr Vijesh Soni of the AMGK;
ii. Dr Peter Trye, Dr Gregory Field, DR Sybilla Fieves, Dr Yang Song and Dr Lydia Sin of the FMC; and
iii. Dr Ayodele Ogunjobi of the ZMC.

ii. Dr Thomas stated that she did not 'recall any *SafeScript* warning at the time'. The *SafeScript* record shows that on 3 March 2021 (when Dr Thomas prescribed tapentadol to Bradley) two warnings were generated; Dr Thomas did not access the system on this date.

iii. Dr Trye prescribed monitored drugs to Bradley Liefvoort on six occasions between February and May 2021, but only checked SafeScript on three of those occasions. He stated that 'when many of [Bradley's] medications were prescribed the software system we use (Best Practice) would automatically direct us to *SafeScript*. […] Aside from the automatic redirection made by the clinical software I did consult *SafeScript* at other times when verifying drug use, for instance when doctor shopper notifications came through, or when there were unusual requests or such that needed verification.' This suggests a possibility that Dr Trye did not understand the difference between *SafeScript* notifications appearing in his clinic's prescribing software, and *SafeScript* alerts within the actual *SafeScript* system. In any event, this did not explain why he failed to check the system on three of the six occasions he prescribed target drugs to Bradley.

iv. Dr Soni stated that 'a warning like "Red Alert" from *SafeScript* does come on the screen when I prescribe such medication, if the patient is doctor shopping, but it did not occur at the time of that prescription'. However, this claim was directly contradicted by the *SafeScript* report showing multiple red alerts generated when Dr Soni prescribed tapentadol to Bradley on 2 January 2021. The *SafeScript* record showed Dr Soni did not access *SafeScript* on this date.

v. Dr Ogunjobi stated: '*SafeScript* is an auto alert, I am not expected to go and check anything. In this case, I am not sure there was any warning that precluded me from prescribing limited quantities Bradley Liefvoort who presented with severe pains.' This response indicated Dr Ogunjobi may not understand the requirement to check *SafeScript* on every occasion before prescribing a target drug.

vi. Dr Field stated that "*SafeScript* had been checked prior to prescribing for Bradley", but this was contradicted by the *SafeScript* report showing Dr Field never accessed the system prior to prescribing.

vii. Dr Fievez checked *SafeScript* when prescribing the target drugs tapentadol and diazepam to Bradley on 24 May 2021 but did not check it before prescribing 100

tablets of 5 mg Oxycodone and 84 tablets of 100 mg tapentadol on 4 May 2021 (multiple high-risk prescribing red alerts were generated by *SafeScript* in this instance). Dr Fievez explained that 'I believe I was not able to access SafeScript at the time of the consultation on 4 May 2021 and accessed *SafeScript* the following day'. The SafeScript record confirms she checked *SafeScript* on 5 May 2021. However, there was no explanation as to why Dr Fievez was unable to check the system on 4 May 2021, and this purported inability to check *SafeScript* was not recorded in Dr Fievez's progress notes for the 4 May 2021 consultation with Bradley. Victorian Department of Health Guidance states that prescribers and pharmacists should take 'all reasonable steps to check *SafeScript* when prescribing or supplying a high-risk medicine', and that in circumstances where doctors cannot check *SafeScript* but consider it necessary to prescribe or supply a high-risk medicine, they should attempt to take 'reasonable steps' such as contacting the Department or the patient's dispensing pharmacy to enquire about patient history, or prescribing limited quantities of drugs until the next available opportunity to check SafeScript.[50] I could find no evidence that Dr Fievez attempted to take any of these 'reasonable steps'.

viii. Dr Sin stated that Bradley 'was a regular patient with no history of doctor shopping. I have looked at his *SafeScript* history in the past but am unable to definitively recall if I did on this day.' This is contradicted by the report showing Dr Sin never accessed *SafeScript* before prescribing to Bradley.

ix. Dr Song stated: "Regrettably I did not check *SafeScript*. I acknowledge that I was required to do so from 1 April 2020 onwards. I cannot offer a reason for failing to check *SafeScript* other than I was falsely reassured that Bradley was following my instructions to only attend one clinic for these medications". I commend Dr Song's honesty in acknowledging that he erred by not checking the System.

114. Considering the responses together, I was struck by the disparity between many doctors' responses and the evidence from the *SafeScript* records.

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[50] Victorian Department of Health website, "Setting up and accessing *SafeScript*". https://www.health.vic.gov.au/drugs-and-poisons/setting-up-and-accessing-safescript

Permits to prescribe oxycodone and tapentadol

115. In addition to being target drugs monitored by *SafeScript*, the strong opioids oxycodone and tapentadol are subject to strict prescribing controls stemming from their being listed in Schedule 8 (S8) of the Commonwealth's *Poisons Standard*. Again, I do not intend to explain at length here the principles of drug scheduling in Australia, but some background is necessary to understand the issues emerging from my investigation.

116. Briefly, the drugs listed in S8 of the *Poisons Standard* include those drugs that have clinical uses but require restrictions on manufacture and supply and access because they present a serious risk of misuse and the development of dependence (addiction). In Victoria, access to S8 drugs is regulated via the *Drugs, Poisons and Controlled Substances Act 1981(Vic)* (DPCSA). Section 34 of the DPCSA provides as follows:

34 Requirement to apply for Schedule 8 permit

(1) A registered medical practitioner or a nurse practitioner who considers it is necessary to administer, supply or prescribe a Schedule 8 poison to or for one of his or her patients who is a drug-dependent person must apply to the Secretary for a Schedule 8 permit.

(2) Subject to subsection (3), a registered medical practitioner or a nurse practitioner who considers it is necessary to administer, supply or prescribe a Schedule 8 poison for a continuous period greater than 8 weeks to or for one of his or her patients who is not a drug-dependent person must apply to the Secretary for a Schedule 8 permit.

(3) A registered medical practitioner or a nurse practitioner must apply to the Secretary for a Schedule 8 permit if—

(a) the practitioner—

(i) has reason to believe that one of his or her patients who is not a drug-dependent person has been, or is currently being, administered, supplied or prescribed a Schedule 8 poison by one or more other practitioners; and

(ii) considers it is necessary to administer, supply or prescribe a Schedule 8 poison to or for that patient; and

(b) the total period of administration, supply or prescription of a Schedule 8 poison to that patient would be a continuous period greater than 8 weeks, taking into account any period of administration, supply or prescription referred to in paragraph (a)(i) together with the period of administration, supply or prescription of a Schedule 8 poison to or for that patient by the practitioner.

(4) An application for a Schedule 8 permit must be in the prescribed form.

117. Put more simply, a doctor who intends to prescribe an S8 drug to a patient for more than eight weeks continuously must apply for a permit to do so. Additionally, if a doctor intends to prescribe an S8 drug for any length of time (even on a single occasion) to a patient whom they believe to be drug dependent, the doctor must apply for a permit to do so. Applications are made to the Medicines and Poisons Regulation team at the Victorian Department of Health. An important reason for the permit requirement is to try to ensure that S8 drug prescribing to a patient is - as far as reasonably possible - coordinated by a single doctor, to reduce the risk of over-prescribing and dependence and poorly coordinated care.

118. From my enquiries, I established that on 8 November 2017 the Medicines and Poisons Regulation team issued an S8 permit to Dr Field to prescribe 45 mg oxycodone daily to Bradley. This permit was valid for a period of approximately two years and expired on 6 November 2019. There was no evidence of any clinician subsequently applying for another permit. Therefore, at my direction the CPU asked each doctor who prescribed oxycodone or tapentadol to Bradley during the period about whether they considered the requirement for a permit to support this prescribing.

119. The clinicians' responses were as follows:

i. Dr Vijayakumar and Dr Thomas provided no response as to whether they applied for an S8 permit.

ii. Dr Soni stated that he had 'no intentions of prescribing Schedule 8 drugs on a regular basis' and therefore he 'did not apply for the Schedule 8 permit'. Dr Soni stated further that Bradley's usual treating general practitioner should hold a permit for him and 'multiple GPs cannot have this permit for the same patient'. I noted that Dr Soni's explanation might be consistent with the permit application requirements

under the DPCSA, but only if Dr Soni believed Bradley was not drug dependent (Dr Soni did not explicitly indicate in the statement whether he held this belief).

iii. Dr Trye stated: 'The regulations state that permits can be obtained by the clinic, and permits were applied for, the previous one was on 14 April 2020 for 450mg Tapentadol daily.' This is contradicted by the information received from Medicines and Poisons Regulation, which did not include any reference to permits being sought after 6 November 2019. Dr Trye also stated: 'I understand that there was a moratorium on permits that was put in place as part of the COVID regulations which gave some exceptions to General Practice in the matter of drug permit requirements. These came into force on 1 April 2020 and expired on 27 March 2021.' However, while I note that Medicines and Poisons Regulation put in place such a moratorium, it only applied to patients who were not drug dependent; doctors were still required to apply for a permit to prescribe to drug dependent individuals such as Bradley.

iv. Dr Field stated: "I held a permit for Bradley for oxycodone from Nov 2017 until Nov 2019. An application for further permits were sent in late 2019 and April 2020 when he had been changed onto tapentadol. These permits were for treatment of chronic pain and no response was forthcoming as I think this was the time where COVID related changes to the system occurred." This was contradicted by the lack of evidence for any permit application after November 2019. Additionally, Dr Field's understanding of COVID-related changes to the permit system was incorrect.

v. Dr Fievez stated: 'I assumed that my colleagues who were Mr Liefvoort's usual practitioners had permits for the medications prescribed for Mr Liefvoort. I understood that my prescribing would be covered by the permits. I was also aware that the requirements for permits had been temporarily waived during the COVID pandemic.' Dr Fievez's colleagues did not hold valid permits, and (as with Dr Field and Dr Trye) she was mistaken in believing that permit requirements had been waived for Bradley under COVID measures.

vi. Dr Sin stated: "The clinic had sent an application for the permit." This was contradicted by the lack of evidence of a permit being sought by any clinician at Ferngate Medical Centre.

vii. Dr Ogunjobi's response hinged on his definition of a 'drug-dependent person' being 'one who has admitted to misuse or abuse of pharmaceutical medicines and/or illicit

drugs'. According to Dr Ogunjobi, the 'limited period of encounter with Bradley Liefvoort was not sufficient' to establish whether Bradley was a drug dependent person. On this basis Dr Ogunjobi may not have been required to apply for a permit under the DPCSA. However I was not entirely satisfied by this response because Dr Ogunjobi did not take the prudent and legally required step to check *SafeScript* before prescribing; this check would likely have given Dr Ogunjobi a better perspective on whether Bradley was drug dependent.

viii. Dr Song expressed regret for his actions, stating that he 'did not apply for a S8 permit' and acknowledged that it was his responsibility to check whether the requisite permit was held before he prescribed S8 drugs. Dr Song acknowledged that he wrongly assumed Dr Field held the relevant permit.

120. Considering the responses together, I was again struck by the recurring disparities between what clinicians stated and the nature of the evidence on record regarding S8 permit applications and requirements.

STATEMENT FROM DEPARTMENT OF HEALTH

121. Given the many disparities between the clinicians' statements and the evidence before me regarding both their use of *SafeScript* and their adherence to S8 permit requirements, I determined that to advance my investigation into Bradley's death I would need to seek advice from the Victorian Department of Health, to establish whether there was a reasonable explanation to account for the disparities before I drew any conclusions about the clinicians' conduct.

122. Ms Jacqueline Goodall, Director of the Medicines and Poisons Regulation team, provided a detailed and extremely helpful statement dated 12 January 2023. The salient points of her statement in relation to my concerns were as follows:

i. Jacqueline Goodall stated that none of Bradley's treating clinicians from whom statements were sought appeared to have complied with the obligation (articulated in section 30F of the DPCSA) that a registered medical practitioner is required to take all reasonable steps to check the monitored poisons database, *SafeScript*, before prescribing a monitored drug.

ii. Jacqueline Goodall confirmed that Medicines and Poisons Regulation did not receive any application for an S8 permit from any clinician after 6 November 2019 (the date on which Dr Field's permit to prescribe oxycodone to Bradley expired).

iii. Jacqueline Goodall explained that the Department of Health issued a Public Health Emergency Order (PHEO) during the COVID-19 Pandemic which temporarily waived the requirement for clinicians to obtain permits before prescribing S8 target medicines to patients who were *not* drug dependent. This temporary waiver of the permit requirement was subject to a requirement that the clinician check *SafeScript* each time before prescribing S8 medicines.[51]

123. Having considered Jacqueline Goodall's statement, I was satisfied to the standard applicable in my jurisdiction, *on the balance of probabilities*, that the nine clinicians did not use the *SafeScript* system on every occasion when prescribing target drugs as required under by the relevant provisions of the DPCSA. Further, I was satisfied on the balance of probabilities that at least some of the clinicians did not meet S8 permit application requirements under the DPCSA when prescribing S8 drugs to Bradley.

OTHER ORGANISATIONS' INVESTIGATIONS

124. On 13 October 2022, by way of electronic mail (email), the Australian Health Practitioner Regulation Agency (AHPRA) informed me that they 'received information in relation to two practitioners involved in the care of Bradley Scott Liefvoort',[52] and requested certain documents to assist in their assessment of the matter. On 6 December 2022, with my leave, AHPRA indicated their intention to commence their own investigation into certain clinicians' treatment of Bradley by examining the relevant patient records.[53] On 31 March 2023 AHPRA indicated that their investigation was still in progress.[54]

125. On 10 January 2023, by letter addressed to the Court, the Secretary of the Victorian Department of Health indicated the Department's intention to investigate the circumstances surrounding Bradley's death and filed an application to obtain copies of certain documents

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51 PHEO #6, Gazetted on 26 March 2020, subsequently amended on 10 June 2020 and to 10 September 2020.

52 AHPRA is a statutory body with investigative powers *vis-à-vis* its members. Since their first email, AHPRA has been following up on the progress of my investigation regularly in an effort not to compromise the coronial process by their own investigative processes.

53 Court File, email correspondence between APHRA and the Court dated 7 November 2022, 8 November 2022, 2 December 2022, 6 December 2022, 16 March 2023.

54 Court File, email from AHPRA to the Court.

relating to my investigation. On 16 March 2023, I granted the Department of Health's application for access to the coronial documents including the Advice Memorandum that the CPU had prepared for me. On 31 March 2023 I enquired about the progress of the Department of Health investigations, and the Department of Health confirmed that it 'is actively investigating the relevant medical practitioners'.[55]

COMMENTS

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

1. When delivering a finding, it is not my usual practice to include the degree of detail set out herein when recounting the events preceding the death. However, the story of how Bradley Liefvoort developed his dependence on pharmaceutical drugs, and how his dependence (particularly his dependence on opioid medications) was consolidated and exacerbated through his interactions with the health system, contains valuable insights from a public health and death prevention perspective. Further to this point, the impact of Bradley's dependence not only on his own health (ultimately resulting in his tragic death) but also on his relationships with his loved ones - partners, family members, children, friends - is a potent reminder that drug dependence related harms reach beyond the individual to the community, thus reinforcing the importance of prevention.

2. After receiving the initial coronial brief in Bradley's death, my subsequent investigation focused primarily on the doctors who prescribed oxycodone and tapentadol and diazepam to him in the six months leading up to his death. I explored their rationale for prescribing these drugs of dependence to him, and how they used two important Victorian medicines safety initiatives to inform their prescribing: the *SafeScript* RTPM system and the S8 permit application system, both of which are administered by the Victorian Department of Health. I established that despite having a legal requirement to check *SafeScript* before prescribing oxycodone and tapentadol and diazepam to Bradley in the six months leading up to his death, on most occasions the doctors failed to check *SafeScript*. I further established that several of the doctors prescribed the potent opioids oxycodone and tapentadol to Bradley without applying for S8 permits as required by legislation. I believe these failures were missed opportunities for doctors to understand the extent of Bradley's pharmaceutical opioid

[55] Court File, email to the Court from Stefan Tulloch, Acting Director, Medicines and Poisons Regulation -- Regulatory, Risk, Integrity and Legal Division, Department of Health.

use and intervene to help him; the doctors as a group instead continued to feed his dependence with ultimately fatal results.

3. In concluding my investigation, I have turned my mind to a broader systemic issue that arises from the facts of the case.

4. Both the *SafeScript* program and S8 permit application process are administered by the Victorian Department of Health, with its Medicines and Poisons Regulation team maintaining detailed records about *SafeScript* target drug prescribing and dispensing, S8 applications received and approved, and so on. In the six-month period that I closely scrutinised leading to Bradley's death, the Victorian Department of Health knew the following information in real time:

    iv. What target medicines (including oxycodone and tapentadol) were prescribed to Bradley when and in what quantities;

    v. What *SafeScript* alerts and notifications were generated in the course of this prescribing and dispensing;

    vi. The identity of the prescribers and the dispensers and whether they checked the *SafeScript* system; and

    vii. The identity of the prescribers who did and did not hold a permit to prescribe potent S8 opioids to Bradley.

5. The above information obtained from *SafeScript* was crucial to my investigation after Bradley's death, but it was available to the Department of Health well before Bradley's death. The Department did not act on the information while Bradley was alive, to intervene when doctors prescribed without S8 permits and when doctors prescribed drugs of dependence without checking *SafeScript*, and I would be remiss in my duty to contribute to a reduction in the incidence of reportable deaths if I did not ask whether the lack of intervention may have been another opportunity lost for Bradley.

6. In assisting my investigation, the CPU drafted the following recommendation for me to consider including in this finding:

    That Medicines and Poisons Regulation urgently review the circumstances of Bradley Liefvoort's death, including particularly what they knew via SafeScript about the drugs being prescribed and dispensed to him in the period leading up to

his death; and consider what measures they could put in place to intervene in similar clinical scenarios in future to reduce the risk of a fatal outcome.

7. This draft recommendation was contained in a CPU memorandum that I directed to be released to the Department of Health, in response to the Department's request for coronial documents to assist in their investigation into Bradley's death. I did not include the draft recommendation for purposes of inviting feedback, however Mr Stefan Tulloch, Medicines and Poisons Regulation Acting Director, responded in any event to express his view that if I were to adopt the CPU's draft recommendation in my findings, I may not achieve my desired prevention outcome because that recommendation 'may limit the options to prevent deaths in similar circumstances'.[56]

8. In support of his view, Mr Tulloch offered the following explanation:

> *Dispensing records alone do not provide sufficient information to intervene in the patient's care, as the department does not have complete clinical information available to the clinician to understand their decision making processes. Dispensing records can provide information that justifies the department seeking further information from a treat[ing] clinicians to understand their rationale for prescribing. Since the department does not have access to a clinician's records on a continual basis, clinical records and statements collected from clinicians represents a point in time.*
>
> *Unfortunately, it is not (. . .) feasible for the department to engage with all prescribers in Victoria on a continual basis that are caring for patients in similar high risk circumstances to Mr Liefvoort. It was for this reason that SafeScript was implemented as a clinical tool for clinicians, rather [than] a tool for Government to track dispensing of medicines and seek to prevent prescribing or otherwise intervene for all high risk patients on an individual basis.*

9. Mr Tulloch, on behalf of the Department of Health, suggested an alternative wording to the recommendation, changing the words "what measures they [Medicines and Poisons Regulation] could put in place" to "what measures could be put in place.

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[56] Court File, Second email from Mr Tulloch received by the Court on 31 March 2023. Mr Tulloch suggested that the CPU amend their Advice Memorandum to reflect that Medicines and Poisons Regulation and consequently the Department of Health may not have to consider any measure or recommendation which effectively means that the Department of Health itself would have to '*to intervene in similar clinical scenarios in future to reduce the risk of a fatal outcome.'*

10. Having carefully considered Mr Tulloch's suggested changes to the draft recommendation and the reasons for them, in the context of Bradley's death, I am not minded to accede to Mr Tulloch's request.

11. One reason for this is, I do not agree Mr Tulloch's concern that "the department does not have complete clinical information available to the clinician to understand their decision making processes" has any relevance here. The requirement for a clinician to check *SafeScript* before prescribing a target drug is a legal matter: it is established in legislation. The purpose of checking *SafeScript* may be clinical (ie to assist prescribers (and dispensers) with their decisions relating to treatment of a patient), but the Department of Health does not need to know the clinical reasons why a doctor prescribed a target drug in order to scrutinise whether that doctor checked *SafeScript* as part of the prescribing process.

12. The second reason why I am not minded to accede to Mr Tulloch's request is, it blunts the focus of the recommendation. As a rule the most effective coronial investigations are calls to action: they identify what need to be done and who must do it. The recommendation drafted by the CPU makes clear that the Department of Health (through its Medicines and Poisons Regulation team) needs to consider what measures it can put in place to reduce the risk of further deaths like Bradley's occurring in future. Mr Tulloch's subtle change of wording means that the Department of Health are no longer required to consider what they can do, but (rather more nebulously) what could be done by unspecified bodies or organisations or even individuals.

13. The third reason why I am not minded to accede to Mr Tulloch's request is based on my reading of the relevant legislation.

14. Having perused the submission made on behalf of the Department of Health, I was concerned by the implications that the proposed recommendation would hold for the "notional" interests of public health and safety. If, as the Department of Health suggested, I was to proceed from the premise that the mandatory *SafeScript* System was <u>not</u> a 'tool for Government to track dispensing of medicines and seek to prevent prescribing or otherwise for all high-risk patients on an individual basis' (sic), then if adopted, the revised recommendation may not have the desired effect to foster prevention opportunities, resonating with my role as a coroner.

15. Given that my investigation into Bradley's death turned on the ease with which he was able to access S8 drugs by merely consulting a medical practitioner who would issue a

prescription for target medicines despite the real-time *SafeScript* alerts to warn those medical practitioners that Bradley may have been prescription shopping at the time, and turned on the further issue that the prescriptions were issued in the absence of a valid S8 permit, which is also monitored by the Department of Health, I was not convinced that the Department of Health submission in this regard was tenable.

16. However, to determine whether the Department of Health submission before me would enhance my prevention role, I reconsidered Mr Tulloch's submission in the context of the body of evidence already before me including the previously obtained evidence of the Department of Health, the statement of Ms Goodall. Further, I considered the legislative framework within which the *SafeScript* System operates and more specifically, the prescripts of the relevant legislative provisions, sections 34 *et seq* of the DPCSA.

17. Having previously considered Ms Goodall's contribution to my investigation into Bradley's death to be satisfactory in that her evidence corroborated the evidence already before me, I determined that the probative value of Ms Goodall's evidence in conjunction with the existing body of evidence outweighed the responses to my enquiries as provided by Bradley's clinicians. Mr Tulloch's more recent submission on behalf of the Department of Health, is difficult to reconcile with Ms Goodall's corroborating evidence as it appears that Mr Tulloch's submission seeks to dissociate the Department of Health from any responsibility of monitoring the prescribing practices of medical practitioners in respect of S8 medicines and holding errant medical practitioners to account.

18. According to Mr Tulloch, the 'dispensing records do not provide sufficient information' to justify any intervention by the Department of Health because those records only represent 'a point in time'. While I acknowledge that patient records only represent 'a point in time' in a patient's clinical history, having previously reviewed the relevant provisions of the DPSCA, I am reluctant to accept, on the strength of Mr Tulloch's submission alone, that the Department of Health has no role to play in monitoring or regulating prescribing practices of medical practitioners or that it is 'not feasible for the department to engage with all prescribers in Victoria'. If I were to accept Mr Tulloch's submission that it is not practicable for the Department of Health to engage with medical practitioners on a 'continual basis that are caring for patients in similar high risk circumstances to' (sic) Bradley, then the Department of Health may never be in a position to contribute to a reduction in similar reportable deaths, which might obviate the need for any recommendation. It follows,

therefore, that Mr Tulloch's submission is not congruent with my prevention role as articulated in the Preamble and Purposes of the *Coroners Act 2008 (Vic)*.

19. Upon further review of Ms Goodall's evidence, I was satisfied that her evidence indicates with sufficient cogency that the Department of Health is notified as and when a medical practitioner has failed to observe any statutory obligations relating to S8 drugs. However, I am unable to distinguish any logical reason to explain why the Department of Health would take on the ostensible burden of being alerted to the conduct of errant medical practitioners if it is 'not feasible' for the Department of Health to follow up their own System warnings.[57]

20. Paying further deference to Mr Tulloch's submission, I turned to consider whether his submission could be supported by the relevant statutory provision or any interpretation thereof, observing the general principles of statutory interpretation.

21. In the context of the overwhelming evidence to support a conclusion that Bradley was drug-dependent, section 34 of the DPSCA makes it mandatory for a registered medical practitioner to apply to the Secretary[58] of the Department of Health for a 'Schedule 8 permit'. The provision does not empower any other person or entity to issue the requisite permit.

22. If the Legislature has specifically enjoined the Secretary as the designated person or entity to consider applications and further as the person or entity with the discretionary powers to issue S8 permits, then by observing the conventions of statutory interpretation, it falls to the Secretary to monitor errant medical practitioners. My interpretation is further informed and supported by subsequent provisions in the DPSCA in terms of which the Secretary has further discretionary powers to amend, suspend and revoke existing S8 permits. If the Secretary is empowered to 'amend, suspend and revoke', then by the Secretary merely holding those powers, it is implied that the Secretary has a correlative obligation to 'intervene' and to hold errant medical practitioners to account for their non-compliance with their own legislative obligations. It is my considered view that the Department of Health is

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[57] CB, statement of Jacqueline Goodall according to whom, the Department of Health held records which indicated that Bradley's prescribing clinicians had breached section 30F DPSCA by not taking reasonable steps to check the *SafeScript* database. The penalty clause in section 30F provides for a penalty of 100 penalty units for non-compliance, from which it can be inferred that the Secretary of the Department of Health has a role to play monitoring and ensuring compliance with the prescripts of the DPSCA.

[58] As defined by s 4(1) of the DPSCA.

i. Cf: s3(1) *Public Health and Wellbeing Act 2008 (Vic)*; and further

ii. Definition of Head of Department as per *Public Administration Act 2004 (Vic)*.

obligated to monitor medical practitioners and hold them to account where it can be established, as in the case with Bradley's medical practitioners, that they have breached their statutory obligations.[59]

23. I do, however, commend the initiative taken by both AHPRA and the Victorian Department of Health to independently investigate the circumstances in which Bradley's death occurred. In my view, the outcome of their investigations, may result in the adoption of further restorative and preventative measures which may in turn contribute to a reduction in overdose deaths by prescription medicines, resonating with my own prevention role.

24. Given that these entities have indicated their intention to conduct their own independent investigations, the output of which may complement my prevention role as a coroner and further, to curtail what appears to be an emerging culture amongst prescribers in the State of Victoria to ignore the *SafeScript* System or to disregard the statutory obligation to obtain S8 permits prior to prescribing target medicines, I am satisfied that the following Recommendation is apposite in the circumstances.

RECOMMENDATIONS

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

1. In the interests of promoting public health and safety and with the aim of reducing the number of deaths in similar circumstances, I recommend that the Medicines and Poisons Regulation Section of the Victorian Department of Health implement suitable measures to identify when prescribers are not complying with requirements to check *SafeScript* before prescribing target drugs, and impose suitable measures to deter prescribers from similar conduct in future.

FINDINGS AND CONCLUSION

1. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[60] Adverse findings or

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[59] *Vide*:
   i. Section 34A(3);
   ii. My interpretation was further informed the subsequent penalty provisions, ss 34B and 24C of the DPSCA.

[60] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the

comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

2. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

   a) the identity of the deceased was Bradley Scott Liefvoort, born 26 January 1975;

   b) the death occurred on 01 June 2021 at 5/7 Bulong Street, Dandenong, Victoria, 3175; and

   c) I accept and adopt the medical cause of death as ascribed by Dr Beer and I find that Bradley Scott Liefvoort died from opioid toxicity (tapentadol and oxycodone).

3. On a background of long-term ill health, the weight of the available evidence supports a conclusion that Bradley Scott Liefvoort developed an addiction to prescription medicines and I find that Bradley Scott Liefvoort actively sought out opioid drugs, amongst others, to satisfy his addiction to prescription medicines.

4. Having considered the factual matrix of this matter, the available evidence supports a conclusion that Bradley Scott Liefvoort's addiction to prescription medication was inextricably connected to his altered and peculiar opioid-seeking behaviour patterns particularly in the six-month period leading to his death and I find that Bradley Scott Liefvoort's death was the unintended consequence of his use and abuse of prescription medication.

5. I am satisfied, on the available evidence, that there is a causal nexus between Bradley Scott Liefvoort's death and the conduct of many of the medical practitioners[61] who Bradley Scott Liefvoort consulted and who prescribed tapentadol and oxycodone to him during the six-month period leading to his death. I am satisfied further that the availability of the fully functional *SafeScript* system supports a conclusion that those medical practitioners ought to have known Bradley Scott Liefvoort was accessing opioid drugs in excess of clinical need when they prescribed the tapentadol and oxycodone to him and I find that the conduct of

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reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

[61] The CPU did not examine the prescribing of Dr Katie Liao or Dr Yuyang Huang.

each one of those medical practitioners, in prescribing tapentadol and oxycodone without adhering to the *SafeScript* System practices and protocols or without heeding *SafeScript* alerts or warnings, is connected with Bradley Scott Liefvoort's death.

6. Having considered the circumstances in which his death occurred, I am satisfied further that many of the medical practitioners who prescribed opioid or other drugs to Bradley Scott Liefvoort in the six-month period leading to his death did so in excess of his medical need and I find that the conduct of Bradley Scott Liefvoort's treating medical practitioners who collectively prescribed opioid and other drugs in excess of his medical need, contributed to the chain of events leading to his death.

7. In the circumstances of this matter, it does not fall within purview of the coronial jurisdiction to make findings on the contribution of individual medical practitioners to the chain of events leading to Bradley Scott Liefvoort's death. However, for the sake of clarity, the available evidence is not sufficiently cogent to enable me to apportion weight to the conduct of each medical practitioner individually in prescribing the opioid drugs connected to Bradley Scott Liefvoort's death and I am therefore unable to make definitive findings to quantify the impact of each medical practitioner's individual contribution to the events that led to Bradley Scott Liefvoort's death.

8. The weight of the available evidence further supports a conclusion that many of the medical practitioners who prescribed tapentadol and oxycodone to Bradley Scott Liefvoort conducted themselves, at all relevant and material times, in a manner which did not meet the Victorian Department of Health clinical best practice requirements in respect of adhering to the prescripts of the Department's *SafeScript* system.

9. Similarly, the available evidence indicates further that clinicians who prescribed tapentadol and oxycodone did not comply with the statutory obligation to hold a valid Schedule 8 permit for this and I find, *on the balance of probabilities*, that in the approximate six-month period leading to his death, many of the medical practitioners who prescribed tapentadol and oxycodone to Bradley Scott Liefvoort did so in a clinically suboptimal manner because they did not check the *SafeScript* System, did not heed any *SafeScript* system warnings and did not hold a valid Schedule 8 permit.

10. FURTHER, the weight of the available evidence supports a conclusion that the outcome for Bradley Scott Liefvoort may have been different if his prescribing medical practitioners honoured the statutory obligation imposed upon all medical practitioners and I find , *on the*

balance of probabilities, that the failure of the individual medical practitioners, in the approximate six-month period leading to his death, to check the *SafeScript* System, in contravention of a statutory obligation imposed upon each one of them in their capacity as a medical practitioner, presented an opportunity lost for Bradley Scott Liefvoort each time a prescription was issued.

11. Similarly, the weight of the available evidence supports a conclusion that the outcome for Bradley Scott Liefvoort may have been different if the Victorian Department of Health and moreover, their Medicines and Poisons Regulation Section, in the approximate six-month period leading to his death, had exercised a vigilant oversight of the *SafeScript* system under their management and control. The weight of the available evidence supports a conclusion that the Victorian Department of Health did not take appropriate action to abate the risk of harm to Bradley Scott Liefvoort despite their awareness that multiple medical practitioners were issuing prescriptions to Bradley Scott Liefvoort for tapentadol and oxycodone in excess of his medical need and despite being aware that their own systems had generated notifications and alerts to warn against the impending danger of over-prescribing Schedule 8 target drugs to Bradley Scott Liefvoort and further, despite their awareness that the prescribing medical practitioners did not hold the requisite permit to prescribe Schedule 8 target drugs to Bradley Scott Liefvoort. Therefore, *on the balance of probabilities*, I find that the failure of the Victorian Department of Health to take appropriate remedial action in a timely way against the relevant medical practitioners to mitigate the effect of their non-compliance with their statutory obligations, presented an opportunity lost for Bradley Scott Liefvoort each time he consulted a medical practitioner in order to obtain opioid medications.

12. AND FURTHER, given the manner in which I had engaged with the relevant medical practitioners and the Victorian Department of Health in conducting my investigation into Bradley Scott Liefvoort's death, I am satisfied that the nature and extent of my enquiries were sufficiently indicative of the scope and content of my investigation and the potential for adverse comments and findings.

13. In light of the ongoing independent investigations of the Victorian Department of Health and the Australian Health Practitioners Regulation Agency and, moreover, the responses to my enquiries received from the medical practitioners and the submissions made by the Victorian Department of Health, I am satisfied further that the medical practitioners against whom my adverse comments and findings may operate as well as the Victorian Department of Health

have been afforded a reasonable opportunity, by presenting their responses and submissions, to advance any substantive and compelling reasons in mitigation of any adverse comments and findings I may make. Consequently, any further delay in handing down my Finding for this reason alone, would be to no purpose.

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

Pursuant to section 73(1B) 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:

Linda Liefvoort

Victorian Department of Health

Australian Health Practitioner Regulation Agency

Dr Gregory Field

Dr Yang Song

Dr Peter Trye

Dr Sybilla Fievez

Dr Lydia Sin

Dr Vijesh Soni

Dr Kandasamy Vijaykumar

Dr Malgorzata Thomas

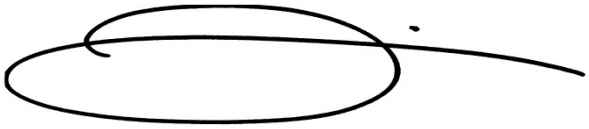
Dr Katie Liao

Dr Ayodele Ogunjobi

Dr Yuyang Huang

Detective Senior Constable Sally Spalding, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 25 May 2023

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.