IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2022 001217

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	LT
Date of birth:	26 July 1987
Date of death:	4 March 2022
Cause of death:	1(a) Combined drug toxicity (gabapentin, oxycodone, tramadol, diazepam, citalopram, desmethylvenlafaxine, ondansetron, paracetamol)
Place of death:	5 Ford Court, Mill Park, Victoria
Key words:	*Combined drug toxicity, prescribed medication, multiple prescribers, SafeScript monitoring and compliance*

INTRODUCTION

1. On 4 March 2022, LT was 34 years old when she died at home after ingesting a combination of prescription drugs. At the time, Ms LT lived in Mill Park with her partner, KR, and Ms KR's two children.

2. Ms LT had a complex medical history and reported a history of trauma from childhood into later life. Her mother stated that Ms LT suffered from asthma, Hashimoto's disease,[1] sleep disorder, anxiety, panic attacks, hypermobility syndrome, chronic fatigue syndrome, and fibromyalgia. The hypermobility was associated with several injuries to Ms LT's joints and, together with fibromyalgia, resulted in chronic pain. At the time of her death, Ms LT was in receipt of the disability support pension.

3. Ms LT's general practitioner, Dr Michael Desouza at Appletree Hill Medical Centre, stated that Ms LT also had longstanding depression and anxiety. He also noted her history of childhood trauma and that she had lost a previous partner to suicide.

4. Ms LT met Ms KR in late 2020. At the time, Ms LT was separated but still resided with her former partner and their children. Ms LT moved into the house in about March 2021. Ms LT and Ms KR later moved in together in late 2021.

5. In the year preceding her death, Ms LT was prescribed a large amount of medication, including significant quantities of medications (later) implicated in her death. Ms KR had found empty packets of medication around the house and noticed that other medication had gone missing. When Ms KR questioned her, Ms LT denied that she had an addiction and stated she did not need to go to hospital.

6. Dr Desouza reported that Ms LT had been referred to Dr David Cunnington, sleep physician, Dr Tim Hucker, pain specialist, and Dr Srirekha Vadasseri, consultant psychiatrist, to help manage Ms LT's various conditions.

THE CORONIAL INVESTIGATION

7. Ms LT'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.

[1] Hashimoto's disease is an autoimmune disorder leading to hypothyroidism.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

9. 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.

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

11. This finding draws on the totality of the coronial investigation into Ms LT's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Identity of the deceased

12. On 4 March 2022, LT, born 26 July 1987, was visually identified by her partner, KR, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

14. Forensic Pathologist, Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 8 March 2022 and provided a written report of his findings dated 7 July 2022.

[2] 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.

15. The post-mortem examination did not reveal any significant natural disease that may have caused or contributed to death. The bone marrow was normal and there was no evidence of haematological malignancy. Hashimoto's thyroiditis was confirmed.

16. The brain was swollen and there was a foam plume in the airways, indicative of a comatose period prior to death often seen in setting of drug related deaths.

17. There was no significant injury that may have caused or contributed to the death.

18. COVID-19 was not detected.

19. Routine toxicological analysis of post-mortem samples detected gabapentin,[3] oxycodone,[4] tramadol,[5] diazepam and nordiazepam,[6] citalopram,[7] desmethylvenlafaxine,[8] ondansetron,[9] and paracetamol.[10]

20. It was noted that there is an additive central nervous system (**CNS**) depressive effect with the concurrent use of number CNS depressant drugs which may lead to sedation and possible respiratory depression.

21. Dr Bouwer provided an opinion that the medical cause of death was *"1(a) Combined drug toxicity (gabapentin, oxycodone, tramadol, diazepam, citalopram, desmethylvenlafaxine, ondansetron, paracetamol)"*.

22. I accept Dr Bouwer's opinion.

[3] Gabapentin is clinically used for treatment of partial seizures and neuropathic pain.
[4] Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine used clinically to treat moderate to severe pain.
[5] Tramadol is a synthetic opioid analgesic indicated for moderate pain.
[6] Diazepam is indicated for anxiety, muscle relaxation and seizures. Nordiazepam, temazepam, and oxazepam are metabolites. Adverse effects of diazepam include confusion, incoordination, physical dependence, sedation, and seizures in withdrawal. Overdose can cause ataxia, drowsiness, and muscular weakness.
[7] Citalopram is indicated for major depression and panic disorders. Escitalopram is indicated for the treatment of major depression, social anxiety disorders, panic disorder, generalised anxiety disorder, and obsessive-compulsive disorder.
[8] Desmethylvenlafaxine is the major active metabolite of venlafaxine indicated for major depression.
[9] Ondansetron is indicated for post-operative nausea and vomiting cancer chemotherapy.
[10] Paracetamol is an analgesic drug.

Circumstances in which the death occurred

Sleep disorder

23. In 2017, Ms LT consulted Dr Cunnington, specialist sleep physician at the Melbourne Sleep Disorders Centre, for disturbed sleep, daytime tiredness, nightmares, and parasomnias.[11] Sleep studies performed in early 2018 identified hyperarousal issues and Ms LT was prescribed gabapentin[12] 100mg (which could be increased up to a maximum of 400mg).

24. Ms LT responded well to gabapentin but in December 2018, Dr Cunnington ceased the medication due to side effects and commenced amitriptyline (Endep). This new medication was subsequently unsuccessful, and Ms LT resumed gabapentin (up to 400mg daily) and commenced melatonin in March 2019.

25. In June 2019, Ms LT reported to Dr Cunnington that she was taking 400mg gabapentin and melatonin with good effect and was soon to travel to the United Kingdom (**UK**).

26. The next month, Ms LT reported misplacing a repeat script for gabapentin and requested a replacement script.

27. In October 2019, Ms LT emailed Dr Cunnington saying she had returned early from the UK[13] as her mother had been involved in a serious accident and had accidentally left the medication behind in the UK. Dr Cunnington provided replacement scripts. At the next appointment in December 2019, Dr Cunnington recommended Ms LT see Dr Allie Peters, psychologist.

28. In June 2020, Ms LT informed Dr Cunnington she was being treated for complex post-traumatic stress disorder (**C-PTSD**),[14] had recently returned from a trip to the United States, and been involved in court proceedings in relation to a previous incident of abuse.

29. On 28 July 2020, Ms LT told Dr Cunnington her goddaughter had died in an accident and her sleep had worsened; the dose of gabapentin was increased to 600mg with good effect.

[11] Parasomnias are a group of sleep disorders characterised by abnormal, unpleasant motor, verbal or behavioural events (e.g., sleepwalking, nightmares) that occur during sleep or wake to sleep transitions.
[12] Gabapentin is not approved for treatment of sleep disorders in Australia but there is some evidence of its efficacy and it is prescribed for this use. Gabapentin can be misused for its euphoric and sedative effects and the Australian Medicines Handbook (2025) advises monitoring for signs and symptoms of misuse and dependence such as requests to increase the dose and drug-seeking behaviour. The Handbook provides recommended dosage for use with focal seizures (0.9 – 1.8 g/daily) and neuropathic pain (0.9-2.4 g/daily) up to a maximum of 3.6g daily). eMIMS also provides warnings about the central nervous system depressant effects of gabapentin, particularly when used concomitantly with opioids, and the increased risk of suicidal thoughts or behaviour.
[13] The Australian Border Force reported Ms LT had never held a passport nor travelled internationally.
[14] It was unclear who provided the diagnosis of C-PTSD or what treatment Ms LT was receiving for the disorder.

30. In April 2021, Ms LT complained of *"more sleep issues"* to Dr Desouza. He discussed sleep hygiene with Ms LT and provided one script for temazepam 10mg after warning her of the risks associated with using this medication.

31. In June 2021, Ms LT consulted Dr Desouza and reported anxiety and sleep disturbance in relation to the behaviour of Ms KR's former partner. Dr Desouza prescribed temazepam 10mg and provided further scripts for gabapentin.

32. On 10 August 2021, Ms LT told Dr Desouza she had been sexually assaulted by Ms KR's former partner. He provided counselling and a further script for temazepam.

33. Ms LT next saw Dr Cunnington on 18 August 2021 where she reported struggling with multiple stressors, symptoms of PTSD, and worsening screaming at night-time that was disturbing Ms KR's children. She reported that she was still taking 600mg gabapentin; Dr Cunnington recommended she gradually reduce the dose and supported her decision to see a psychiatrist/pain specialist.

34. On 16 September 2021, Ms LT again requested replacement scripts for gabapentin from Dr Cunnington, stating they had been stolen. Dr Cunnington re-prescribed gabapentin and melatonin with four repeats.

35. In October 2021, Ms LT requested diazepam from Dr Desouza which was declined. The reason for this decision was unclear.

36. Ms LT first saw a new general practitioner, Dr Sureka Vyravipillai at Lalor Plaza Medical Centre, on 27 October 2021. She noted a history of C-PTSD, and anxiety and panic attacks, but said she had been too anxious to see a psychologist. Dr Vyravipillai recorded that Ms LT's previous doctor (Dr Desouza) had refused to provide her with any more scripts for gabapentin. Dr Vyravipillai explained breathing exercises to Ms LT and recorded her current medications as escitalopram 80mg,[15] gabapentin, oxycodone (as per pain specialist), ondansetron, and rizatriptan for migraines.

37. At the subsequent appointment with Dr Vyravipillai (8 November 2021), Ms LT reported being anxious and waking through the night then hyperventilating. They discussed short term use of benzodiazepines and diazepam PRN (as needed) up to 4mg daily. The plan was to

[15] eMIMs states the recommended adult dose of escitalopram is 10mg, which can be increased to a maximum of 20mg, though it is sometimes used clinically at higher doses. Dr Desouza stated that in June 2021, Ms LT told her that Dr Vadasseri (psychiatrist/pain specialist) had increased her escitalopram to 80mgs and was considering an admission for inpatient treatment with ketamine. Dr Vadasseri stated she only saw Ms LT once, on 24 February 2022.

conduct a range of blood pathology tests, and if no abnormalities were found, to refer Ms LT to a mental health clinician.

38. When reviewed by Dr Vyravipillai on 17 November 2021, there were no abnormalities with the blood tests, and the diazepam was ceased. Dr Vyravipillai raised concerns with Ms LT about her high dose of gabapentin (and escitalopram) and the risk of serotonin syndrome.[16] Ms LT believed escitalopram was no longer effective and so was advised to slowly wean down the dose.

39. On 22 November 2021, Dr Vyravipillai referred Ms LT to a psychologist. At this consultation, Ms LT stated that two months prior she had been diagnosed with *"AML",*[17] Dr Vyravipillai documented that he had not been informed of this by Ms LT's previous doctor (Dr Desouza) and planned to follow-up.

40. Ms LT saw Dr Desouza on 10 and 25 January 2022 and reported poor sleep and migraines. She was prescribed temazepam. When reviewed by Dr Desouza on 7 February 2022, he declined further scripts for temazepam, prescribed melatonin, and provided education around sleep hygiene.

41. Dr Cunnington last saw Ms LT on 21 February 2022 where she reported ongoing sleep issues including nightmares. He checked SafeScript, noting recent prescriptions for temazepam and oxycodone from other prescribers, and provided another script for gabapentin. Dr Cunnington was aware Ms LT was seeing a psychologist and planning to see psychiatrist/pain specialist, Dr Vadasseri. Dr Cunnington maintained the dose of gabapentin at 600mg.

Chronic pain

42. Ms LT was referred to Dr Tim Hucker, pain medicine specialist, for assistance with hypermobility and joint pain. Dr Desouza had also suggested to Ms LT that her dose of gabapentin could be reduced and that she discuss this with Dr Hucker.

43. When she saw Dr Hucker in October 2020, Ms LT reported a history of chronic pain dating back to the 2000s and at the time, said she was housebound and struggling to function. She

[16] Serotonin syndrome is a potentially lethal condition that can occur when certain antidepressants (such as the SSRI escitalopram) are taken concurrently with other drugs that modulate synaptic serotonin levels (such as gabapentin).
[17] The acronym may be referring to acute myeloid leukemia. In her statement, Ms KR indicated that Ms LT had told her she had *"acute myeloid cancer".* Further, Ms KR reported to psychologist, Anastasi Pourliakas, that Ms LT had been diagnosed with leukemia approximately one year ago but had been too anxious to raise this with Ms Pourliakas. The forensic pathologist reported no evidence of leukemia on autopsy.

reported significant mood disturbance on a background of multiple traumas[18] since childhood; the anxiety was so debilitating that although she had been referred to mental health clinicians, Ms LT had been unable to enter their practice. Dr Hucker appropriately explained to Ms LT the link between mood and pain and referred her to Dr Sri Vadasseri (psychiatrist/pain specialist).[19]

44. In March 2021, Dr Desouza commenced Ms LT on tramadol for ongoing pain, but due to side effects, this was subsequently changed to Panadeine Forte.

45. Ms LT consulted Dr Hucker in May 2021 for acute pain associated with a fractured ankle. At this time, Ms LT was reducing the dose of gabapentin and Dr Hucker recommended that once she had reduced the dosage to 600mg at night, Ms LT could use 300mg during the day for pain relief. In order to reduce the amount of opioids Ms LT was taking, he advised one box of 20 oxycodone tablets to be used over one month, in conjunction with paracetamol. Dr Hucker urged Ms LT to see a pain specialist to develop a plan to manage her chronic pain.

46. On 9 June 2021, Ms LT requested and was given a script for oxycodone (no repeats) from Dr Desouza for migraine. According to Dr Desouza, Ms LT reported that Dr Hucker had increased her gabapentin dose to 1200mg (300mg in the morning and 900mg at night), likely due to a fractured ankle, and he provided a new script for this new dose.

47. At some point in September 2021, Ms LT reported to Dr Desouza that she had been abused by Ms KR's former partner. Ms LT requested oxycodone while she was awaiting an appointment at the dental hospital. Later that month she told Dr Desouza she was still awaiting dental care and requested further oxycodone that was declined. The PBS report suggests Ms LT did obtain dental care around this time as she was prescribed oxycodone by Dr Marina Ghobrial, dentist, on 25 September 2021, and subsequently tramadol by Dr Ghobrial on 27 September 2021 and Dr Patrishia Bordbar, dentist, on 5 and 11 October 2021. Ms LT was also prescribed oxycodone (15 October 2021) and tramadol (16 October 2021) by Dr Anthony Singh, anaesthetist. It is unclear what dental procedure/s were performed.

48. Ms LT saw Dr Vyravipillai on 10 December 2021. She reported constant pain (back, hips, legs, chest, shoulder) and requested tramadol rather than oxycodone. Dr Vyravipillai checked

[18] Dr Desouza referred to Ms LT losing an ex-partner to suicide and being sexually abused by a police officer in the past.
[19] Ms LT did not follow up with Dr Vadasseri until 2022.

SafeScript and prescribed oxycodone as it was the recommendation of Ms LT's pain specialist. Dr Vyravipillai urged her to see Dr Vadasseri.

49. On 22 December 2021, Ms LT requested Dr Vyravipillai prescribe pregabalin for foot pain following a fall, stating her script had been taken by Ms KR's former partner. Dr Vyravipillai explained she had received a letter from the Australian Government Prescription Shopping Programme (**PSP**), dated 2 December 2021, advising Ms LT may have received medicines in excess of medical need and thus advised her that she could not provide the script earlier than expected and would only prescribe on specialist advise. At this consult, Ms LT reported weaning off escitalopram more rapidly than Dr Vyravipillai had recommended. Dr Vyravipillai was concerned this may have been the cause of her current heightened anxiety. Dr Vyravipillai recommended restarting at low dose and urged Ms LT to see Dr Vadasseri. It was documented that no appointment was available with Dr Vadasseri until May 2022, so Dr Vyravipillai planned to phone the psychiatrist for medication advice if escitalopram was not tolerated. This was Ms LT's last appointment with Dr Vyravipillai before her death.

50. Dr Desouza also received a letter from the PSP in December 2021. In his statement he indicated he phoned Ms LT to discuss medications, but she did not attend the practice until 30 December 2021, at which point she informed him that her pain was well managed with Panadol Osteo.

Mental health

51. Dr Desouza referred Ms LT to clinical psychologist Anastasi Pourliakas on 29 June 2021.[20] The referral was for treatment of anxiety and C-PTSD. Ms LT attended four sessions with the psychologist: 13 December 2021, 24 January 2022, and 9 and 23 February 2022. On each occasion, Ms KR accompanied Ms LT.

52. Ms LT presented as severely anxious with psychomotor agitation and a history of interpersonal trauma beginning in childhood that contributed to her difficulties in trusting others. She reported therapy was anxiety-provoking and she needed Ms KR to accompany her. Ms LT denied suicidal ideation and thoughts of self-harm and reported her partner and the children to be protective factors.

[20] Dr Vyravipillai also referred Ms LT to Ms Pourliakas on 10 December 2021.

53. Ms Poulakis' treatment plan included psychoeducation and strategies to manage distress and agitation while trust developed to enable more specific trauma-focused therapy.

54. Ms Poulakis was informed Ms LT was seeing a psychiatrist but had not yet obtained contact details or consent to contact them.

55. After Ms LT's death, Ms KR informed the psychologist that Ms LT had been having distressing *"visual hallucinations"* that involved seeing her ex-boyfriend's body whom she had found after he hanged himself. The psychologist was unaware of the hallucinations, but Ms LT had previously referred to wanting to talk about an ex-boyfriend when her anxiety levels were more manageable.

56. Ms LT's only consultation with consultant psychiatrist/pain specialist Dr Vadasseri occurred on 24 February 2022. Ms LT, who was accompanied by Ms KR, reported constant body pain (self-rated as 4/10 to 9/10) and headaches, longstanding anxiety (self-rated as 10/10), PTSD, two-year history of mood disturbance and sleep disorder. Ms LT denied suicidal plans or intent and stated that her partner and her children were protective factors. Ms LT told Dr Vadasseri that her mother had died one month earlier and that her father had died one week later.[21]

57. The plan was to commence desvenlafaxine 50mg (five repeats) with gradually increasing dose; taper then cease escitalopram as it was no longer effective; use diazepam 2.5-5mg PRN (50 tablets with no repeats) during the changeover from escitalopram to desvenlafaxine; and continue fortnightly appointments with her psychologist. Dr Vadasseri requested Ms LT compete a number of assessments for depression, anxiety, PTSD, and borderline personality disorder and attend for review in two weeks.

Immediate circumstances preceding death

58. At about 6.00pm on 2 March 2022, Ms LT slipped on wet tiles and fell in the bathroom. Ms LT sustained a cut to her forehead, to which Ms KR tended.

59. At about 6.30pm, Ms LT fell again in the kitchen area, landing on her back and striking her head on the ground. According to Ms KR, she lost consciousness for a short period of time.

[21] Ms LT's parents were both alive. Ms KR also reported that Ms LT had told her that her parents were dead.

60. Ms LT subsequently went to lie down in the bedroom. When Ms KR checked on her later, she found Ms LT had vomited with reduced responsiveness. Ms KR subsequently contacted emergency services at about 7.15pm.

61. Ambulance Victoria paramedics arrived at about 7.27pm, finding Ms LT lying in bed and alert but with shallow breathing. Ms LT told paramedics she was experiencing significant pain in her right rib area and tenderness on the right side of her forehand to the back of her head. She was also nauseated. Paramedics administered 200mcg fentanyl and 3ml methoxyflurane for pain, and 8mg ondansetron for nausea. Ms LT was then transported to Northern Hospital Emergency Department where she arrived at about 8.35pm.

62. In hospital, Ms LT reported losing consciousness for about one minute following the first fall but not the later fall. She provided a medical history of possible Post Orthostatic Tachycardia Syndrome (**POTS**), PTSD, and depression. There was no reference to chronic pain nor to a sleep disorder. The only current medication recorded was desvenlafaxine. CT scans of the chest, abdomen, and pelvis showed no abnormalities. Ms LT was reportedly eager to be discharged as she reported considerable anxiety.

63. She was subsequently discharged in the early hours of 3 March 2022 with a script for oxycodone 5mg and advised to return if symptoms worsened. Ms LT returned home via taxi.

64. Upon her return home, Ms LT made the children's lunches and slept for a few hours. After waking, Ms LT went about her normal activities throughout the day. She and Ms KR later collected the children from school and took them to taekwondo at about 5.00pm that evening.

65. Ms KR stated that Ms LT insisted she was feeling fine and drove the car. However, she veered off the road once or twice and declined Ms KR's offer to drive.

66. During the taekwondo class, Ms LT remained in the car, exchanging text messages with Ms KR. At this time, Ms LT disclosed she taken large amounts of temazepam over several previous nights but denied this was done with an intention to die. She said she was terrified of losing Ms KR and the children over this incident and promised she would never hurt Ms KR *"like this again"* and she would *"do better"*.

67. When they returned home, the children went to bed at about 8.00pm. According to Ms KR, she noticed Ms LT *"acting strange"* at about 8.30pm. She appeared *"clingy"* and anxious. They subsequently fell asleep on the couch watching television.

68. Ms KR woke up at about 1.00am, 4 March 2022. She roused Ms LT, telling her that she was going to bed. Ms LT went to the bathroom and then to the kitchen, bringing some lollies and biscuits to bed. They then fell asleep.

69. Ms KR awoke again at about 3.00am at which time Ms LT was in the bathroom, crying because she was unable to urinate. Ms LT returned to the bedroom, saying she had hurt her ankle and Ms KR helped her back to bed. Ms KR then took her pillow and went to the couch where she fell asleep.

70. Ms KR woke again about an hour later at 4.12am and returned to the bedroom where she found Ms LT unresponsive. She telephoned emergency services at 4.13am and began administering cardiopulmonary resuscitation (**CPR**) until Ambulance Victoria paramedics arrived at 4.23am.

71. Upon examination, paramedics found Ms LT lifeless, cold, and with no cardiac output. Both pupils were dilated and non-reactive and Ms LT had a temperature of 34.7°C. CPR continued and defibrillator pads were applied which found an asystole rhythm. CPR was then ceased, and Ms LT's was formally verified 4.40am.

72. Responding Victoria Police members searched Ms LT's bedroom and found the following medication in a safe:

    (a) Pristiq (desvenlafaxine) 50mg (21 tablets out of 28 in the packet);

    (b) Lamotrigine 25mg (18 tablets out of 28 in the packet);

    (c) Circadin (melatonin) 2mg (11 tablets out of 15 in the packet);

    (d) Desvenlafaxine 100mg (27 tablets out of 28 in the packet);

    (e) Ritalin (methylphenidate) 10mg (61 tablets out of 80 in the packet);

    (f) Ibuprofen tablets (51 tablets out of 72 in the packet);

    (g) Ritalin 10 – empty;

    (h) Curam Duo Forte (amoxicillin and clavulanic acid) 875mg (2 tablets out of 10 in the packet);

    (i) APX-Escitalopram 10mg (0 tablets out of 15 in the packet);

(j) Panamax (paracetamol) 500mg (11 tablets out of 20 in the packet).

73. A large number of empty packets of additional medication were found in the boot of Ms LT's car.

FAMILY CONCERNS

74. Ms LT's parents wrote to the court on multiple occasions. Most of those concerns were about Ms KR's appointment as senior next of kin for coronial purposes, the nature of Ms LT's relationship with Ms KR, and Ms KR's behaviour following Ms LT's death. I also received written concerns from Ms KR about the behaviour of Ms LT's parents following the death.

75. Section 3 of the Act defines who should be considered 'senior next of kin' for all coronial purposes by providing a mandatory hierarchy of people who should be treated as such by the court. At a practical level, the significance of senior next of kin is that they are the person who may raise any religious or cultural objections to autopsy, will generally apply for release of the deceased's body for burial/cremation in the absence of a will appointing an executor, and have a right under the Act to be informed about progress with a coronial investigation. When it became apparent that Ms LT's parents were at odds with Ms KR, I directed that they also be kept informed of progress with the coronial investigation. In this finding I will only address those concerns which fall within the reasonable scope of a coronial investigation of Ms LT's death.

76. Ms LT's parents also questioned whether a third party was involved in Ms LT's death and whether her head injury had contributed to her death. Regarding this concern, I am satisfied that the post-mortem examination did not detect any significant injury that may have caused or contributed to Ms LT's death. There was no evidence that another person contributed to Ms LT's death.

REVIEW OF CARE

77. The police search of the scene and Ms LT's car revealed a large amount of prescription medication. As part of my investigation, I obtained statements[22] from her treating practitioners in addition to those already obtained by Senior Constable Lachlan Learmonth, the Coronial Investigator in this matter. I also obtained records from these clinicians, and Ms LT's Medicare and Pharmaceutical Benefits Scheme (**PBS**) and SafeScript records.

[22] Information from these statements has been incorporated above where relevant.

78. Advice was also obtained from the Coroners Prevention Unit (**CPU**)[23] about the clinical management and care provided to her in the period leading to Ms LT's death, in particular the prescribing practices of the medical practitioners consulted by Ms LT.

Ms LT's medical and mental health treatment

79. The CPU considered there was no doubt that Ms LT experienced chronic pain associated with hypermobility and fibromyalgia, with a potentially undiagnosed underlying disorder. Her experience of pain occurred on a background of complex mental health symptoms (primarily anxiety and mood disturbance), significant sleep disturbance, and reported lifelong history of trauma.

80. While Ms LT was appropriately referred to sleep and pain specialists, it was apparent that the complex interplay between chronic pain, mood, anxiety and sleep warranted a multidisciplinary care team that included specialist mental health care. The CPU noted that there is a robust body of research indicates the limited efficacy of opioids for chronic pain and the value of coordinated interdisciplinary management strategies.[24]

81. All of Ms LT's specialists and general practitioners recognised that her mental health issues were maintaining and exacerbating her chronic pain and consistently encouraged her to engage with a psychologist and psychiatrist. However, Ms LT did not seek appointments with any mental health clinicians until late 2021 to early 2022 but then did not fully disclose her symptoms, medical history or current medications.

82. Dr Cunnington commenced Ms LT on gabapentin in 2017, and his statement indicated that in the year before her death, he provided multiple scripts for the medication. These scripts are not reflected in the PBS report for the 12 months immediately preceding her death, presumably because they were private scripts as the medication was not approved under the PBS for the treatment of sleep disorders. Dr Cunnington appeared to appropriately communicate the dose of gabapentin to Ms LT's general practitioners, who provided her with multiple PBS-subsidised scripts. It is unclear why the general practitioners opted for PBS-subsidised

[23] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[24] *National Strategic Action Plan for Pain Management (*2021). Pain Australia/ Australian Government Department of Health. Available at: https://www.health.gov.au/resources/publications/the-national-strategic-action-plan-for-pain-management?language=en

prescriptions for gabapentin, but it may have been because Ms LT was experiencing chronic pain, the cause of which was still under investigation.

83. The medical records from Appletree Hill Medical Centre and Dr Cunnington demonstrated good communication. Dr Cunnington provided letters to Dr Desouza after each review, as well as to Dr Hucker and Dr Vadasseri. However, the effectiveness of the communication was hindered by Ms LT providing varied (although plausible) narratives and inaccurate lists of her current medications. This made it difficult for members of the treating team to recognise her potential drug-seeking behaviour and to assess the risks associated with taking multiple medications with central nervous system depressant effects.

84. Additionally, at that time, there was no real-time clinical tool in place at the time to monitor the prescribing and dispensing of gabapentin.[25] This meant there was no way individual prescribers (or dispensers) would have been aware of the extent to which the medication was being prescribed unless their patient was providing accurate information.

85. Dr Cunnington stated he was never concerned that Ms LT was misusing her medication, However, he also had no awareness of the extent to which gabapentin was being prescribed by Ms LT's general practitioners.

86. On several occasions, Ms LT requested replacement scripts from Dr Cunnington. The CPU considered it reasonable that he did not question what likely appeared plausible reasons for the requests. However, the coronial investigation has since revealed that some of the reasons provided by Ms LT were spurious, such as her two complaints of increased anxiety and disturbed sleep following returning from overseas travel when she had not travelled overseas at all.

87. There were also other occasions when Ms LT was not entirely truthful with health professionals, reporting that both her parents had recently died and that she was diagnosed with leukaemia in 2021. Ms LT told Dr Vyravipillai that she had recently seen Dr Vadasseri who had increased the dose of escitalopram to 80mg. When Ms LT did see Dr Vadasseri on 24 February 2022, she told her she was not taking gabapentin. The investigations conducted following Ms LT's death found no evidence to support any of these claims. In contrast, it does appear that Ms LT's September 2021 requests for analgesia associated with a dental condition may have been factual.

[25] Gabapentin was not included in SafeScript until July 2023.

88. In summary, the CPU advised that Ms LT provided varied narratives to the different members of her treating team, some of which, in hindsight, lacked veracity, but generally appeared plausible clinicians at the time.

89. Ms LT was prescribed oxycodone 12 times during 2021. Some of these occasions were accounted for by dental procedures and the episode of care at Northern Hospital in March 2022. Dr Desouza provided six scripts for oxycodone between 9 June 2021 and 15 November 2021 and was a major prescriber of gabapentin to Ms LT.

90. Dr Desouza has since provided a very reflective statement in which he considered whether he had not given sufficient thought to Ms LT becoming drug dependent due to her *"innocent"* presentation and whether he might have provided a different management approach had there been less reliance on telehealth consults due to the pandemic restrictions. Dr Desouza's statement was compelling, and he noted that since Ms LT's death he no longer prescribes opioids or benzodiazepines over telehealth and rigorously checks SafeScript, which will be discussed below.

91. Of note, there were several occasions when treating professionals appropriately refused to provide ongoing scripts for the high-risk benzodiazepines temazepam and diazepam. Additionally, both Dr Desouza and Dr Vyravipillai appropriately responded to the letter they received from the PSP in December 2021 flagging possible misuse of medication.

92. There was no evidence to suggest Ms LT had the intention to die on 3 and 4 March 2022, but it was apparent she was anxious about being taken to hospital and distressed about Ms KR knowing she had taken a large amount of temazepam in the lead-up to the falls.

93. Ms LT had access to an extensive array of prescribed medication, and this was boosted by the diazepam prescribed on 24 February 2022 by Dr Vadasseri and the oxycodone prescribed by Northern Health on discharge.

94. While it is not known if Dr Vadasseri checked SafeScript, nor if it would have flagged any concerns at the time, the CPU considered his prescription of diazepam appeared reasonable given the need to support Ms LT during the changeover from escitalopram to desmethylvenlafaxine. Importantly, Ms LT had not told Dr Vadasseri she was also taking gabapentin.

95. With regard to the prescription of oxycodone, it was apparent that Ms LT did not disclose the full extent of her medical history nor that she was taking high dose gabapentin to Northern

Health staff; thus, there was no reason for medical staff to query the appropriateness of prescribing an opioid analgesic.

SafeScript prescription monitoring

96. At the time of Ms LT's death, it was mandatory to check SafeScript prior to writing or dispensing a prescription for a medicine monitored through the system. However, of the drugs implicated in her death, only oxycodone and diazepam were monitored by SafeScript.[26]

97. In the year prior to Ms LT's death, there were a total of 66 occasions on which the SafeScript system generated notifications for prescribers and dispensers, letting them know that there was a current SafeScript alert relating to Ms LT. On 18 occasions the notifications related to red high-risk alerts, and on 48 occasions the notifications related to amber medium-risk alerts. All alerts indicated: "*LT has obtained prescription medicines from at least 4 different prescribers within the last 90 days. Take action to coordinate treatment to ensure patient safety.*"

98. All 18 notifications relating to current high-risk alerts occurred in the last six months of Ms LT's life, with only one prescribing episode[27] in this period not resulting in a notification being generated. Focusing on this six-month period, the CPU noted the following:

    (a) on seven occasions prescribers received notifications that a current high-risk alert was in place on SafeScript, and on each occasion the prescriber did not access SafeScript to learn more about the alert. High-risk notifications were generated for Dr Desouza on five occasions, and twice for Dr Vyravipillai;

    (b) four notifications regarding a current medium-risk alert were generated for prescribers (Dr Desouza and Dr Vadasseri) and on each occasion, the prescriber did not access SafeScript;

    (c) 11 notifications regarding a current high-risk alert were generated for dispensers and on all but one occasion[28] the dispenser did not access SafeScript;

[26] Pregabalin and tramadol were not added to SafeScript until 2023.
[27] This prescribing was by Dr Desouza for temazepam on 22 February 2022.
[28] The pharmacist who checked SafeScript on this occasion (the day before Ms LT's death) proceeded to dispense oxycodone despite the red alert. It is not known what interaction, if any, took place between the pharmacist, the prescriber, and Ms LT prior to dispensing.

(d) seven notifications regarding a current medium-risk alert were generated for dispensers, and on each occasion the dispenser did not access SafeScript; and

(e) Ms LT had scripts dispensed by 11 different pharmacies, including attending two different pharmacies on the same day to obtain oxycodone (13 October 2021).

99. According to the SafeScript Access History report, during this six-month period, no prescriber checked the system when prescribing monitored drugs to Ms LT despite this being required under the *Drugs Poisons and Controlled Substances Act 1981* (Vic). This contrasts with the statement of Dr Desouza, who indicated he regularly consulted SafeScript. This discrepancy may be due to Dr Desouza mistakenly believing that he had had consulted SafeScript whenever a SafeScript notification was generated inside his clinical practice software. However, the Victorian Department of Health has confirmed that viewing a notification inside clinical practice software does not equate to checking SafeScript; rather the notification is a prompt that a current alert exists in the system, and in no way obviates the requirement for the clinician to access SafeScript itself.[29]

100. This knowledge gap likely led to Dr Desouza mistakenly believing he was checking SafeScript. His statement also did not indicate how he used the notification to inform his clinical decision-making. Rather, it appears Dr Desouza's decision-making was informed by the fact no consultant raised concerns with him about the amount of high-risk medication prescribed to Ms LT. Dr Desouza later informed the Court that he was also reassured that Ms LT was regularly attending the clinic, which he believed demonstrated her transparent behaviour.

101. In Ms LT's case, Dr Desouza's failure to appropriately check SafeScript may also have at least partially been due to the way Ms LT presented. For example, Dr Desouza stated that he wondered if:

> *... the fact she was quite 'innocent', in that she did not drink alcohol or smoke or have other addictions, made me assume that she could not be drug dependent ... she does not seem to squarely fit the 'doctor shopping' profile.*

[29] SafeScript is integrated with most medical software and produces notifications within the medical software when a clinician goes to prescribe or dispense a monitored drug. Some clinicians may interpret these notifications as a SafeScript 'check' and proceed with prescribing / dispensing after acknowledging the notification. This is not the correct course of action as the notification contains very little information and its function is to prompt the clinician to go into SafeScript and review the far more detailed information contained therein before prescribing or dispensing.

102. He also later stated that he wanted to remain supportive of Ms LT and maintain her trust of their therapeutic relationship given her significant trauma and ongoing complex issues.

103. Both Dr Desouza and Dr Vyravipillai responded to correspondence from the Australian Government PSP stating that Ms LT had received monitored medications from a number of prescribers in the period 1 September to 30 November 2021 that may be in excess of medical need. However, the PSP is not a 'real-time' monitoring system. Nevertheless, it generated a subsequent proactive response from these prescribers. That is, Dr Vyravipillai informed Ms LT she would no longer prescribe without consultant advice, and at a telehealth consultation on 13 December 2021, Dr Desouza noted that he spoke to Ms LT about interaction of opioids with her other medications.

104. The CPU considered that had SafeScript been accessed by clinicians as mandated, there *may* have been more informed risk management such as greater communication between Ms LT's multiple prescribers. As noted above, the first step in realising the benefits of real-time prescription checking is for clinicians to use it as mandated. However, there is no way of predicting how clinicians would have responded to any alerts, hence no certainty that enhanced communication would have occurred nor led to altered prescribing habits.

105. Dr Desouza acknowledged that the better and more accurate data from SafeScript allows medical practitioners to consider all relevant clinic information before prescribing.

The role of dispensers in prescription monitoring

106. It appears that dispensers were also generally poor at checking SafeScript prior to Ms LT's death. However, when some dispensers noticed anomalies in the amount of high-risk but non-monitored medication (specifically pregabalin that Ms LT sought), they did communicate this to prescribers which in turn led to changes in prescribing practices.

107. From 22 January 2021 until her death, Ms LT obtained both PBS and non-PBS[30] scripts that gave her access to very large amounts of gabapentin of varying strengths. For example, Ms LT's last PBS script for gabapentin was provided by Dr Desouza on 16 June 2021, at the prescribed dosage of 300mg (1 tablet) per day. All five repeats were dispensed by 28 July

[30] Dr Cunnington provided Ms LT with non-PBS (or private) scripts for gabapentin, most likely because the medication was not approved by PBS for the treatment of sleep disorders. In contrast, Dr Desouza and Dr John Reid (also of Appletree Hill Medical Clinic) prescribed gabapentin as a PBS script.

2021, meaning that across six weeks (42 days), Ms LT obtained 600 tablets of gabapentin, far exceeding the prescribed dose.[31]

108. Perusal of Dr Desouza's medical record circa mid-2021, indicates that he may have ceased providing gabapentin due to contact from pharmacies. At a telehealth consultation with Ms LT on 3 May 2021, Dr Desouza noted a phone call from a pharmacist at Chemist Warehouse in Epping indicating that Ms LT was seeking six x 600mg gabapentin tablets per day. Ms LT described the matter as *"a big kerfuffle"* but Dr Desouza and the pharmacist agreed to decline the script.

109. On 29 June 2021, Dr Desouza documented *"letter from pharmacy noted"*; he was likely referring to a fax from Quality Pharmacy Epping (received 28 June 2021). The fax indicated concern about Ms LT recently reporting lost scripts for escitalopram and gabapentin and confusion about doses. At the consultation, Dr Desouza noted that Ms LT explained that she had seen "... *pain specilaist* [specialist] *SHREE Vesaria … she has mixed around with my meds ... that is why I have gone to the pharmacy so many times…".* The documented reference to '*Dr Shree Vesaria'* was likely in relation to pain specialist/psychiatrist Dr Srirekha Vadasseri. However, according to Dr Vadasseri her only consultation with Ms LT occurred in the following year (24 February 2022).

110. On 14 July 2021, Dr Desouza wrote, "*Pharmacist v. concerned re gapapentin* [gabapentin] *intake to contact sleep speicalit* [specialist] *on avge* [average] *getting 2l tablet of 600 mg a day. Reason for contact: tele-call from Full life pharmacy Mill park".*

111. There was no record of Dr Desouza contacting Dr Cunnington but as noted above, Dr Desouza did not provide any further scripts for gabapentin.

112. The responsiveness of Dr Desouza to pharmacist feedback highlights the likely value of pharmacies checking SafeScript and communicating concerns to practices.

[31] Between 18 August 2021 and 21 February 2022, Dr Cunnington provided Ms LT with scripts for 300mg pregabalin (with five repeats this totalled 350 tablets), and 100mg pregabalin (with nine repeats this totalled 1100 tablets) with the advice to reduce her current dose of 600mg per day in 100mg increments. Even if Ms LT was not reducing the dose as recommended, this exceeded the prescribed dose. When Ms LT last saw Dr Cunnington (21 February 2022), she reported still taking 600mg pregabalin per day; Dr Cunnington provided a script for 600mg pregabalin (with one repeat, which totalled 200 tablets). As these were non-PBS scripts, it is not known if Ms LT had both scripts dispensed in the 11 days before her death.

Recent efforts to improve SafeScript

113. I note that the SafeScript compliance issues I identified are not restricted to Ms LT's case. The experience of Victorian coroners is that in many cases they investigate, medical professionals failed to check SafeScript when prescribing or dispensing monitored medications. This non-compliance was a central issue examined in Coroner Ingrid Giles' inquest into the death of LI (name redacted),[32] a young male who was prescribed medications by 31 different doctors in the 12 months leading up to his overdose death. At inquest, Coroner Giles heard evidence from Department of Health Director of Regulatory Services Laura Mulligan that:

> *[…] while 99 percent of 'in-scope' clinicians are registered to use SafeScript, which is clearly positive, the rate of compliance – namely clinicians actually checking SafeScript prior to prescribing or dispensing monitored medications – is only 70 percent.*
>
> *Ms Mulligan identified that the reasons for this might be that clinicians do not wish to be monitored or have their clinical practice overseen by the state. She also noted that there are different rates of compliance amongst different cohorts, and that 'those that have done their medical degree overseas and come and get registered in Victoria sometimes don't always understand that they need to register and use the system.*

114. In her finding delivered 24 May 2024, Coroner Giles accordingly recommended as follows:

> *… I further recommend that the Victorian Department of Health develop, as a matter of priority, additional strategies to enhance its oversight and compliance role in relation to the checking of SafeScript, as well as to consider increasing the scope of application across the state, including by:*
>
> *a) Working with the Royal Australian College of General Practitioners, Medical Board of Australia and the Pharmacy Board of Australia, along with medical indemnity insurers and any other identified stakeholders, to develop education and training tools for clinicians that focus on and promote the positive benefits of SafeScript, reinforce its role as a clinical tool for the clinician's own decision-making,*

[32] Finding into Death with Inquest regarding LI, dated 24 May 2024, available at: https://www.coronerscourt.vic.gov.au/sites/default/files/Finding%20into%20death%20with%20Inquest%20-%20COR%202019%200537%20-%20for%20publication.pdf

and address the perception among some clinicians that SafeScript usurps their clinical judgment;

b) Continuing to consider the ways in which to surmount technological barriers to implementing SafeScript throughout hospitals in Victoria; and

c) Continuing to work with the Commonwealth Department of Health and Aged Care to implement cross-border data-sharing of real-time prescription monitoring

115. Department of Health Secretary Professor Euan Wallace responded to this recommendation by letter dated 19 August 2024. Professor Wallace indicated inter alia that the recommendation would be implemented, and described a range of initiatives including the Australian Commission on Safety and Quality in Healthcare commencing a project to develop educational resources for users of real-time prescription monitoring systems nationally; consultation with the Australian Digital Health Agency on addressing technical barriers to using real-time prescription monitoring systems in hospitals; and exploratory work relating to sharing prescription monitoring data across state and territory borders. Professor Wallace also wrote:

> *On 29 April 2024, the department released a Consultation Paper recommending further reforms to health regulation in Victoria. These proposed reforms include the introduction of an additional suite of compliance and enforcement tools for the regulator to enable a graduated, risk-based and proportionate approach. If enacted by Parliament, these tools would be available for the regulator in monitoring SafeScript compliance and encompass measures such as improvement and prohibition notices, infringement notices, enforceable undertakings and notices to produce information or documents. The proposed reforms would provide the regulator with additional regulatory compliance tools, with which it can better target its enforcement approach commensurate with the circumstances of alleged non-compliance.*

116. The Consultation Paper explicitly sets out the compliance issues that the Department has been struggling with on SafeScript.[33] In summary, these are:

(a) currently, the Health Regulator has limited options where non-compliance with SafeScript requirements is identified;

[33] Department of Health, Reforms to health regulation in Victoria, https://www.health.vic.gov.au/legislation/reforms-to-health-regulation-in-victoria.

(b) the *Drugs, Poisons and Controlled Substances Act 1981* establishes offences for when health practitioners fail to comply with requirements to check SafeScript;

(c) while prosecution is sometimes warranted, it is not always the most proportionate or timely means of addressing non-compliance;

(d) under the proposed reforms, additional compliance and enforcement options will be available, enabling the Health Regulator to take graduated, timely, and proportionate action to ensure compliance and minimise harm. These options included issuing an improvement notice or an infringement notice to the practitioner.

117. Following the Consultation Paper and associated consultation, the Department then published its Consultation Summary[34] which indicated support for improved compliance powers and a risk-based graduated approach to compliance and enforcement. The Department noted that if the proposed legislative amendments were made, the Health Regulator would:

> *Publicly report on implementation of the improved compliance and enforcement powers in the Department of Health's 2024-25 and 2025-26 annual reports, and report on the Health Regulator's activities in all future department annual reports.*

118. Subsequently the *Health Legislation Amendment (Regulatory Reform) Bill 2024* (Vic) was drafted and on 29 October 2024 received Royal Assent, creating the *Health Legislation Amendment (Regulatory Reform) Act 2024* (Vic). According to the Department of Health, the commencement date for improved compliance and enforcement powers under this Act was 1 March 2025.

119. Part 4 of the *Health Legislation Amendment (Regulatory Reform) Act 2024* relates to amendments to the *Drugs Poisons and Controlled Substances Act 1981* and inserts a new Division 18 into the latter Act, establishing powers to give improvement notices,[35] prohibition notices,[36] and infringement notices.[37] The Secretary may also accept an undertaking from a medical practitioner to take certain action, or not take certain action, to comply with that Act.[38]

[34] Department of Health, Reforms to health regulation in Victoria, https://www.health.vic.gov.au/legislation/reforms-to-health-regulation-in-victoria.
[35] Section 55AA of the *Drugs, Poisons and Controlled Substances Act 1981.*
[36] Section 55AAG of the *Drugs, Poisons and Controlled Substances Act 1981.*
[37] Section 55AAZ of the *Drugs, Poisons and Controlled Substances Act 1981.*
[38] Section 55AAM of the *Drugs, Poisons and Controlled Substances Act 1981.*

Conclusion

120. Ms LT had a long and complex medical history and experienced significant challenges with sleep, chronic pain, and mental health. In the last year of her life, Ms LT had a relatively consistent treating team who largely adopted pharmacological approaches to manage her multiple conditions. All clinicians involved in Ms LT's care recognised the interrelated nature of her symptoms and appropriately encouraged her to see mental health clinicians, something Ms LT was reluctant to do until the last few months of her life.

121. Ms LT's consultants provided appropriate feedback and communication to her general practitioners, though this was confounded by Ms LT providing varying narratives to clinicians and not always fully disclosing her medications. Ms LT's provision of incomplete information about her medication usage was also evident when she attended Northern Hospital Emergency Department following the fall at home the day before her death. There is no doubt that the provision of inaccurate but plausible narratives and partial information about her medication usage impacted the treating clinicians' ability to identify Ms LT's apparent dependence on gabapentin, and potentially other medications and to take into consideration the risks associated with taking multiple medications with central nervous system depressant effects.

122. A review of Ms LT's medical history shows long-standing drug-seeking behaviour and extensive prescribing, particularly of gabapentin.

123. While gabapentin was not monitored by SafeScript at the time, in the last six months of Ms LT's life, SafeScript generated multiple alerts that indicated she was receiving monitored drugs from multiple prescribers. However, in all but one instance, SafeScript was not checked by the prescribing or dispensing clinician. The reasons for this are unclear but in relation to Dr Desouza, it may have been due, at least in part, to misunderstanding how SafeScript worked and unconscious bias. However, I acknowledge Dr Desouza's statement that he did genuinely reflect on his practice, and undertook further training in the use of SafeScript, and changed his standard way of practising in relation to high-risk medications. These acts are to be commended.

124. The CPU did not identify any clear opportunities to prevent Ms LT's death. However, there were many occasions in the months leading up to her death where her treating clinicians did not comply with legal requirements to check SafeScript before prescribing or dispensing drugs to Ms LT, which led to missed opportunities to understand what drugs she was obtaining were and contact one another to ensure they were coordinating the treatment they provided to her.

If they had done so, this may have triggered a further exploration of Ms LT's access to and use of multiple high-risk medications, though of course it is not possible to know whether this in turn would have averted the fatal incident.

FINDINGS AND CONCLUSION

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

(a) the identity of the deceased was LT, born 26 July 1987;

(b) the death occurred on 4 March 2022 at 5 Ford Court, Mill Park, Victoria;

(c) the cause of Ms LT's death was combined drug toxicity (gabapentin, oxycodone, tramadol, diazepam, citalopram, desmethylvenlafaxine, ondansetron, paracetamol); and

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

126. Having considered all of the evidence, I am satisfied that Ms LT's death was an unintended consequence of the deliberate ingestion of several prescription drugs, commonly referred to as an accidental or inadvertent overdose.

127. I convey my sincere condolences to Ms LT's family and friends for their loss.

COMMENTS

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

128. Previous coronial investigations have found clinician non-compliance with legal requirements under the *Drugs, Poisons and Controlled Substances Act 1981* to check SafeScript before prescribing or dispensing monitored drugs to a patient to be a systemic issue across Victoria's health system.

129. The Victorian government has recognised this issue with clinician non-compliance with SafeScript and has taken action including through the introduction of new compliance and enforcement powers under the amended *Drugs, Poisons and Controlled Substances Act 1981*.

130. It is likely to be too early still to understand what impact these new compliance and enforcement powers will have on clinicians' use of SafeScript. Therefore, I do not make any further recommendation directed at SafeScript at this time. Instead, noting that the Department

of Health has undertaken to report publicly on implementation of the powers, I will await this report to understand whether the new powers are effective in encouraging more prescribers and dispensers to access SafeScript to inform their clinical decisions.

131. I will otherwise direct this finding to be distributed to the Royal Australian College of General Practitioners, the Pharmaceutical Society of Australia, and the Pharmacy Guild, with encouragement that they consider incorporating this case in de-identified form in their professional development programs as illustrative of the need to challenge stereotypes and assumptions about drug-seeking behaviour and/or doctor shopping.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

KR, senior next of kin

BT, senior next of kin

Anastasia Pourliakas (care of Barry Nilsson Lawyers)

Dr David Cunnington (care of Meridian Lawyers)

Dr Michael Desouza (care of Kennedys Law)

Dr Sureka Vyravipilla

Dr Srirekha Vadasseri

Northern Health

Jenny Atta PSM, Secretary of the Victorian Department of Health

Royal Australian College of General Practitioners

Pharmaceutical Society of Australia

Pharmacy Guild of Australia

Senior Constable Lachlan Learmonth, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 08 January 2026

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.