



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005176

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Ingrid Giles
Deceased:	Laurence Mark O'Brien
Date of birth:	28 November 2000
Date of death:	Between 15 and 16 September 2023
Cause of death:	1(a) Mixed drug toxicity (tapentadol, clonazepam, citalopram, amphetamine, olanzapine, oxazepam, pregabalin, ketamine)
Place of death:	Lilydale Victoria 3140
Keywords:	SafeScript, real-time prescription monitoring, drug toxicity, 'prescription shopping', 'doctor-shopping', monitored medicine, overdose.

INTRODUCTION

1. On 16 September 2023, Laurence Mark O'Brien¹ was 22 years old when he was found deceased at his home. At the time of his death, Laurence lived at his family home with his parents, Michael and Josephine O'Brien (**Mr and Ms O'Brien**).
2. Laurence reportedly had a normal childhood and upbringing. In 2011, he was in a motor vehicle being driven by his father when they were involved in a serious collision with a logging truck. Mr O'Brien and Laurence sustained head injuries and were conveyed to hospital. As a result of the collision, Laurence required a craniotomy to elevate a depressed right skull and was later diagnosed with an acquired brain injury (**ABI**). Laurence was supported by the Transport Accident Commission (**TAC**) and the National Disability Insurance Scheme (**NDIS**) following the collision. Laurence regularly complained of headaches and pain to the back of his head and was prescribed pain medication to manage same.
3. Following the collision, Laurence struggled with memory loss and forgetfulness, which appeared to affect his schooling and academic results. Laurence left school after completing part of Year 10 or Year 11, then completed a TAFE course in plumbing. Laurence did not enjoy this work and later volunteered at a charity shop; however, he also did not enjoy this job. He ceased working in the years prior to his death and Mr O'Brien noted that Laurence "*lived like a bit of a hermit*".
4. In 2018, Laurence's (then) longstanding general practitioner (**GP**), prescribed him with sertraline for depression and referred him to psychiatrist, Dr Alan Blandthorn. Laurence told his GP that he was often depressed and anxious and regularly drank alcohol and smoked cannabis. Laurence told his father that he smoked cannabis to "*relieve his head pain*" as he believed it was a natural pain remedy. Mr O'Brien noted that Laurence smoked cannabis and vapes daily.
5. According to Laurence's clinical neuropsychologist, Dr Simone Field (**Dr Field**), Laurence started experimenting with illicit drugs and alcohol as an adolescent, and over time he developed a drug dependence disorder. In addition to recreational drugs such as cannabis and methylamphetamine, Laurence reportedly also obtained and consumed medication that was not prescribed to him.

¹ Referred to throughout my finding as 'Laurence' unless more formality is required.

6. In November 2021, Laurence was admitted to The Melbourne Clinic due to psychosis secondary to cannabis and alcohol use. Following his discharge, psychiatrist Dr Ed Theologis (**Dr Theologis**) trialled Laurence on lisdexamphetamine for attention deficit hyperactivity disorder (**ADHD**) and escitalopram, olanzapine and clonazepam. Dr Theologis noted that Laurence suffered from a dependence/addiction disorder which involved substance dependence and a gaming addiction. Laurence's gaming addiction resulted in him spending excessive hours gaming online and consequently neglected self-care, sleep and exercise.
7. In 2022, Laurence became a "*very demanding patient*" according to his then-GP. He requested scripts for Mersyndol Forte, tramadol, clonazepam and pregabalin and started "*doctor shopping*". His GP noted that he would provide a prescription to Laurence, however Laurence would return within a day to advise that he "*lost a script*". His GP eventually refused to provide further prescriptions. On 19 October 2022, the GP discovered via SafeScript that Laurence was obtaining multiple prescriptions from multiple doctors, however Laurence denied same. The GP refused to continue to prescribe/treat Laurence any longer and Laurence transferred his care to Dr Han San Aw Yeang (**Dr Yeang**), who was a different GP at another clinic.
8. In April 2023, Laurence was admitted to The Melbourne Clinic again for a drug detoxification admission. This admission primarily focused on his nitrous oxide dependence, which had developed over the preceding 12 months. Laurence was able to achieve abstinence from nitrous oxide, however, was unable to overcome his addiction to analgesics and benzodiazepines.
9. Following the April 2023 admission, Laurence repeatedly requested an increase in his lisdexamphetamine dose from Dr Theologis, however he declined to prescribe same. Dr Theologis last reviewed Laurence in person on 11 July 2023 and via telehealth on 10 August 2023. Dr Theologis noted that Laurence's mental state and substance cravings were reduced, and he otherwise appeared stable.
10. At the time of his death, Laurence's prescription medication regime included escitalopram, tapentadol, pregabalin, clonidine, olanzapine and lisdexamphetamine. Olanzapine and lisdexamphetamine were prescribed by Dr Theologis, while the other medications were prescribed by Dr Yeang.
11. Laurence's longstanding GP until the end of 2022 noted that Laurence had no history of suicidal ideation, however Dr Yeang noted that he had a history of suicidal ideation prior to

their first appointment in 2017. Mr O'Brien reported that his son had never attempted to take his own life, however about a year prior to his passing he stated that he did not think he would "*live much longer*". Mr O'Brien stated that at the time, Laurence was "*down in the dumps*". When Mr O'Brien asked what he meant, Laurence did not elaborate. Mr O'Brien stated that shortly before Laurence's death, he did not say anything to indicate that he was suicidal or wanted to harm himself.

12. Laurence's long-term friend, Brandon, reported that in the months prior to Laurence's death, he appeared "*quite happy*" and did not appear depressed. Brandon noted that Laurence was taking a lot of medication at the time of his death and believed that Laurence may have taken his own life, although noted that Laurence's parents disagreed. Brandon also noted that Laurence "*took too many drugs because he was becoming tolerant and just wanted to feel good*".

THE CORONIAL INVESTIGATION

13. Laurence'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.
14. 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.
15. 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.
16. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Laurence'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.
17. This finding draws on the totality of the coronial investigation into the death of Laurence Mark O'Brien 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

Circumstances in which the death occurred

18. Laurence last consulted with Dr Yeang on 14 September 2023 where they discussed several issues. Laurence reported “*feeling bites on his scalp*” and advised that he would attempt scalp lice treatment. Dr Yeang noted that there was an “*irregular prescription of pregabalin*” identified on SafeScript. Laurence reportedly had an old pregabalin prescription held at a pharmacy and decided to make use of same. Laurence asked Dr Yeang if he could change his opioid from tapentadol tablets to buprenorphine patches. Dr Yeang declined to make the change as Laurence had previously informed him that his psychiatrist was planning an opioid dose tapering regime and Dr Yeang did not want to disturb this plan. Dr Yeang referred Laurence to consult with his psychiatrist or consider seeing a pain management specialist. Dr Yeang provided a repeat prescription for tapentadol which Laurence filled that day.
19. Later that afternoon, Mr O’Brien was at home with his son and spoke to him about having an early night, as he had an appointment the next day with Dr Field. Dr Field visited their home weekly as part of the TAC supports Laurence received. Mr O’Brien noted that this was going to be an important meeting as Laurence was due to discuss commencing employment. Despite Mr O’Brien telling Laurence to go to bed that afternoon and evening, he noted that Laurence stayed up playing Xbox all night instead.
20. At about 4.00am on 15 September 2023, Mr O’Brien heard his son was still awake, so he went into his bedroom and told him to go to sleep. Laurence responded that “*I won’t be long*”, however when Mr O’Brien returned to his son’s bedroom at 6.00am, he was still playing Xbox.
21. At 10.30am, Dr Field met with Laurence and his NDIS support worker at the WCIG Disability Support Services offices in Lilydale. They met with Laurence’s employment officer to discuss Laurence’s interests and cognitive ability to commence work. The group discussed various

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.

options including Laurence obtaining a forklift licence, which he was reportedly keen to pursue. During this meeting, Laurence presented as “*very drowsy*”, however Dr Field noted that as Laurence often played online games through the night and slept in the morning, she did not think his presentation was unusual.

22. After the employment meeting, Dr Field visited Laurence at his home with the NDIS support worker. The trio discussed the plans made during the WCIG meeting and the steps that were required for Laurence to commence a forklift driving course, for example, having a working phone and obtaining photo identification. Dr Field facilitated a phone call with the State Trustees Victoria (Laurence’s financial administrator) to discuss how they could organise a meal delivery service for Laurence. Dr Field also discussed some behavioural goals for the coming week which included constructing shelves in the family garage and selling items which were cluttering up the garage.
23. Due to his drowsiness, Dr Field asked Laurence if he had consumed anything. Laurence advised that he took Phenergan (promethazine) during the night as he was having difficulty sleeping, after playing games that night. Despite being drowsy, Dr Field noted that Laurence presented with appropriate affect and was excited about the prospect of getting his forklift licence. Dr Field did not observe any concerns with Laurence’s presentation, nor any indication that he was suicidal.
24. After Dr Field left their house, Mr O’Brien spoke to Laurence about getting some sleep. Mr O’Brien recalled that as he walked up the stairs to his bedroom, his “*eyes were almost closed*”. Mr O’Brien could not recall what time Laurence returned to his bedroom, but assumed he went to sleep, so he did not disturb him.
25. During the afternoon or evening, Mr O’Brien entered Laurence’s bedroom and observed him lying on his stomach on his bed with his head resting on his right forearm. Laurence commonly slept on his stomach as sleeping on his back caused pressure to the back of his head, however it was unusual for him to sleep with his head on his arm. Mr O’Brien did not think this was strange at the time, and as Laurence was so tired, he left him to sleep.
26. At about 8.15am on 16 September 2023, Mr O’Brien checked on Laurence in his bedroom and observed that he had not moved from the position he was in the night before. Mr O’Brien assumed Laurence was tired and therefore did not attempt to wake him. Mr O’Brien was out of the house for most of the day, however when he returned, he asked Ms O’Brien whether

Laurence had left his room or eaten anything. When Ms O'Brien advised that Laurence had not left his bedroom, Mr O'Brien became concerned and decided to check on him.

27. When Mr O'Brien returned to Laurence's bedroom, he observed that Laurence was in the same position as he was that morning. Mr O'Brien tried to find a pulse, however found that Laurence was cold to touch and felt stiff when he attempted to shake him. Mr O'Brien called out to Ms O'Brien and asked her to call Triple Zero. Mr O'Brien followed the call-taker's instructions to move Laurence from the bed and commence cardiopulmonary resuscitation (CPR).
28. Paramedics attended and took over CPR, however they were unable to revive Laurence, and he was declared deceased at the scene.
29. Police also attended the home and investigated Laurence's death. In Laurence's bedroom, police located an almost-empty Webster pack (with a start date of 13 September 2023). There were one or two tablets left inside the 'lunch' section; however, all seven days were opened. There was another Webster pack (start date 6 September 2023) which had breakfast tablets for three days missing (four days still present), lunch tablets for five days missing (two days still present) and bedtime tablets for six days missing (one day still present).
30. Additionally, there was a box of tapentadol IR (immediate release) 50mg (dispensed 14 September 2023) with four tablets missing and one blister packet of tapentadol (sustained release) 50mg with all tablets missing. There was also one box of Allersoothe (promethazine) with all tablets missing. Police observed three clear Ziplock plastic bags in amongst Laurence's possessions. Police did not identify any suspicious circumstances or evidence of third-party intervention in connection with Laurence's death.

Identity of the deceased

31. On 16 September 2023, Laurence Mark O'Brien, born 28 November 2000, was visually identified by his father Michael O'Brien.
32. Identity is not in dispute and requires no further investigation.

Medical cause of death

33. Forensic Pathology Registrar Dr Michael Duffy, supervised by Dr Brian Beer from the Victorian Institute of Forensic Medicine (VIFM), conducted an examination on 19 September 2023 and provided a written report of his findings dated 4 December 2023.

34. The post-mortem examination revealed anterior lividity.
35. Examination of the post-mortem computed tomography (CT) scan showed no intracranial haemorrhage or skull fracture, intact hyoid bone and thyroid cartilages, a remote right parieto-occipital craniectomy and a full bladder.
36. Toxicological analysis of post-mortem samples identified the presence of tapentadol,³ amphetamine,⁴ clonazepam and its metabolite 7-aminoclonazepam,⁵ diazepam metabolite oxazepam,⁶ pregabalin,⁷ citalopram,⁸ olanzapine,⁹ promethazine,¹⁰ ketamine¹¹ and cannabis metabolite delta-9-tetrahydrocannabinol.¹²
37. Dr Duffy noted the detection of multiple substances which, in combination, can cause death by central nervous and respiratory depression. Dr Duffy noted tapentadol was detected at a significantly elevated level that can cause considerable respiratory depression.
38. Dr Duffy provided an opinion that the medical cause of death was 1(a) Mixed drug toxicity (tapentadol, clonazepam, citalopram, amphetamine, olanzapine, oxazepam, pregabalin, ketamine).
39. I accept Dr Duffy's opinion.

FURTHER INVESTIGATIONS AND CPU REVIEW

40. As part of my investigation, I determined to obtain further material, including SafeScript records and a statement from the Department of Health regarding SafeScript operations and compliance, due to evidence in my brief of prescription-shopping on Laurence's part. I also referred this matter to the Coroners Prevention Unit (CPU)¹³ for an independent review of the medical treatment Laurence received proximate to his passing.

³ Tapentadol is a centrally acting synthetic analgesic indicated for moderate to severe pain.

⁴ Dexamphetamine is the d-isomer of amphetamine indicated for attention deficit hyperactivity disorder (ADHD) and narcolepsy.

⁵ Clonazepam is a nitrobenzodiazepine indicated for the treatment of seizures.

⁶ Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.

⁷ Pregabalin is clinically used for treatment of partial seizures and neuropathic pain.

⁸ Citalopram and escitalopram are selective serotonin reuptake inhibitors (SSRIs) that increase serotonin neurotransmitter action in the synapse.

⁹ Olanzapine is an antipsychotic drug with a similar structure to clozapine. It is also indicated for mood stabilization and as an anti-manic drug.

¹⁰ Promethazine is an anti-histamine.

¹¹ Ketamine is an anaesthetic normally used for short and medium duration operations as an induction agent.

¹² Delta-9-tetrahydrocannabinol (THC) is the active form of cannabis (marijuana).

¹³ The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations.

What is prescription-shopping?

41. As described by an expert in the Inquest into the death of LI, over which I presided in early 2024,¹⁴ ‘doctor-shopping’ or ‘prescription-shopping’ is one of the most common and simplest methods to obtain prescription medication for non-medical use. There are people who utilise the ‘open nature’ of the Australian health care system to visit multiple practitioners to obtain desired medication. They usually have a substance use disorder and are seeking drugs.
42. A drug-seeking patient is likely to be a ‘new patient’ of a general practice when their usual doctor is described as being ‘unavailable’, they may indicate they have lost a prescription, or they may present to an emergency department feigning a painful condition requiring analgesia such as a migraine, kidney stones, back pain or chest pain. They tend to ignore medical advice on managing their pain or addiction.
43. Clinicians have professional and clinical responsibilities to ensure that every medicine prescribed and dispensed is safe in all of the circumstances, and avenues to address prescription shopping such as SafeScript (described below) are intended to assist clinicians to exercise their judgment having regard to the clinical situation at hand, whether that be in the doctor’s consulting room or at the pharmacy counter.

What is real-time prescription monitoring?

44. Commencing in 2012, several Victorian coroners made recommendations for the Victorian Department of Health and Human Services (now Department of Health) to implement a real-time prescription monitoring (**RTPM**) system for the state. A RTPM system involves gathering information on target prescription medications immediately as they are 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.
45. Through the RTPM system, both prescribers and dispensers can identify and intervene to prevent excessive use of prescribed drugs, use of contraindicated drug combinations, prescription shopping, and other issues that underpin pharmaceutical drug harms. The dispensing information also can be centrally monitored by health authorities to identify

CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

¹⁴ See [Finding into death with inquest – LI](#), at paragraphs 104 to 113 per evidence of Professor Edward Ogden.

prescribing and dispensing of concern and deliver targeted countermeasures to improve clinical practice.

46. The agitation for RTPM in Victoria culminated in an April 2016 announcement from the Victorian government that a state-wide system would be implemented. The system, named 'SafeScript', was made available to all Victorian pharmacies and medical practices in October 2018, initially on a voluntary opt-in basis with a focus on the western Victoria primary health network, but with some 'early' adopters signing up beyond the western region. Access to SafeScript was formally announced and promoted by the Victorian Government from 1 April 2019.
47. From April 2020 it has been mandatory to check SafeScript prior to writing or dispensing a prescription for a medicine monitored through the system. Clinicians who fail to take all reasonable steps to check SafeScript prior to prescribing or dispensing a monitored medicine can incur (according to the legislation) a penalty of 100 penalty units.¹⁵ Exceptions to the mandatory use of SafeScript include for prescribing and dispensing when treating patients in hospitals, prisons, police gaols, aged care facilities and palliative care settings.
48. SafeScript monitors all Schedule 8 medicines as well as some Schedule 4 medicines. They include:
 - a) opiates / opioids (including codeine, oxycodone)
 - b) benzodiazepines (including alprazolam, oxazepam, temazepam)
 - c) hypnotics and sedatives (zolpidem, zopiclone)
 - d) stimulants for ADHD or narcolepsy (such as dexamphetamine)
 - e) other high-risk medications (quetiapine, ketamine)
49. On 3 July 2023, pregabalin, gabapentin and tramadol were added to the list of medicines monitored in SafeScript.

¹⁵ See sections 30E (dispensing) and 30F (prescribing) of the *Drugs, Poisons and Controlled Substances Act 1981*. One penalty unit at the present time is \$191.31, meaning a maximum possible penalty of \$19,120.

SafeScript response to prescribing/dispensing to Laurence

50. Olivia Goodman, Executive Director, Health Regulator, People Operations Legal and Regulation Division at the Department of Health (**Ms Goodman**) provided a statement to the Court. Ms Goodman noted that between 16 September 2022 and 16 September 2023, the following SafeScript information was available:
- a) One GP prescribed monitored medicines (tapentadol IR and tapentadol SR) to Laurence on 17 August 2023 which were dispensed that same day. The GP did not check SafeScript on that occasion.
 - b) Laurence's former longstanding GP (who cared for him up until the end of 2022) prescribed monitored medications on five separate dates and did not check SafeScript prior to issuing the prescriptions. He did check SafeScript on 19 October 2022 and did not issue any further prescriptions from this date; and
 - c) A third GP issued two prescriptions in October 2022 and did not check SafeScript.
51. Ms Goodman noted that the Department has not taken action to date in relation to these three prescribers. The Department explained that it has implemented measures to ensure that medical practitioners meet their obligation to take all reasonable steps to check SafeScript, including via proactive and reactive compliance monitoring.
52. Ms Goodman explained that proactive compliance monitoring with SafeScript is used to detect medical practitioners who are not fulfilling their obligation to take all reasonable steps to check SafeScript before prescribing or supplying a monitored medicine. This involves running a report and reviewing profiles of patients who have seen multiple prescribers in a short period of time. From this set of patients, the department reviews the SafeScript database to confirm that the treating medical practitioners have checked SafeScript before prescribing or supplying the medicine.
53. Where medical practitioners have not checked SafeScript before issuing a prescription, the Department sends them correspondence (a Compliance Letter) advising them of their obligation to do so and requesting their response confirming understanding of this requirement.

54. Ms Goodman further noted that the Department also undertakes reactive investigations and interventions when a complaint has been received or when the department has been informed of harm or death of a patient.
55. The CPU noted its surprise that the Department has not taken action in relation to the three prescribers listed above regarding their non-compliance with SafeScript checks. I share the CPU’s concerns about the lack of action in relation to this issue.

General compliance with SafeScript

56. I note that the use of SafeScript was canvassed extensively in the inquest into the death of LI.¹⁶ At the inquest, the Acting Director of Medicines and Poisons Regulations at the Department of Health gave evidence (as at 2024) that while 99% of ‘in-scope’ clinicians are registered to use SafeScript, the rate of compliance is only 70%. That is, only 70% of clinicians are actually checking SafeScript prior to prescribing or dispensing monitored medication.¹⁷
57. The Acting Director suggested reasons for non-compliance included:
- a) Clinicians do not wish to be monitored or have their clinical practice overseen by the Government.
 - b) Different levels of compliance depending on where the clinician obtained their qualification.
58. The Acting Director stated that the Department’s compliance strategy has focused on writing to all registered clinicians to remind those who have not checked SafeScript to do so before prescribing or dispensing monitored medications. If they are not responsive to the letter, the Department will refer them to the Australian Health Practitioner Regulation Agency (**Ahpra**). However, this compliance “*relates only to the very worst offenders*” and equated to between 10 and 30 practitioners per month.
59. Following conclusion of the inquest into LI’s death, the Court followed up with Ahpra and requested de-identified details of any action taken from April 2020 to May 2024 in relation to Victorian medical practitioners/pharmacists for non-compliance with SafeScript. Ahpra noted as follows:

¹⁶ [Finding into death with inquest – LI](#).

¹⁷ Ibid, 39.

- a) 11 practitioners in relation to 14 notifications had regulatory action taken under section 178 of the National Law and their notifications were closed; and
 - b) Three medical practitioners had interim action taken (immediate action under section 156 of the National Law) and their notifications remain under investigation or before the tribunal (as of May 2024).
60. As I noted in my finding into LI's death, these numbers demonstrated that there is a significant difference between the number of practitioners being referred to Ahpra and the number of practitioners Ahpra has taken action against. In my view, there was (and still is) broad scope for improvement in ensuring compliance with SafeScript.
61. The expert evidence in the LI inquest was that there was an opportunity for the Department to communicate more effectively with clinicians who are subject to the obligations under the *Drugs, Poisons and Controlled Substances Act 1981* to check SafeScript in a non-punitive manner. The expert evidence was to “*walk alongside those clinicians and reframe ‘the very formal legalistic letters that they send out which do sound like you’re being naughty when they’re actually seeking more information’*”.
62. The Department gave evidence that while a penalty of 100 penalty units exists for failing to check SafeScript, the Department has “*not ever administered that penalty. [Their] understanding is due to the way the legislation has been drafted [they are] not actually able to implement that penalty. However, legislative change is happening at the moment so that [they] are able to penalise people*”.
63. Following the inquest into LI's death, I recommended (amongst other matters):
- [T]hat 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, and address the perception among some clinicians that SafeScript usurps their clinical judgment.

64. In response, the Department noted that in late-2023, the Australian Commission on Safety and Quality in Healthcare (ACSQH) commenced a project to establish a suite of educational written resources for users of real-time prescription monitoring systems in Australia (e.g., SafeScript). While the project is led by the ACSQH, the Australian Digital Health Agency and all States and Territories are part of the working group. The written resources being developed (as of August 2024) are as follows:

- a) Practice guidance on real-time prescription monitoring for safety (fact sheet format).
- b) Risk assessment quick reference guide.
- c) Visual aids, conversation prompts and modifiable posters for general practitioners and pharmacists.

65. Furthermore, the Department noted that on 29 April 2024, it released a Consultation Paper recommending further reforms to health regulation in Victoria.¹⁸ 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, including:

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

¹⁸ Department of Health, Reforms to health regulation in Victoria, <https://www.health.vic.gov.au/legislation/reforms-to-health-regulation-in-victoria>.

66. Following the Consultation Paper and associated consultation, the Department then published its Consultation Summary¹⁹ 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.

67. 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.

68. 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,²⁰ prohibition notices,²¹ and infringement notices.²² 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.²³

PROCEDURAL FAIRNESS RESPONSES

69. As a matter of procedural fairness, the Court wrote to the three GPs who did not check SafeScript (and who are not named in this finding), to provide them with an opportunity to respond to the proposed adverse comments. Their responses are summarised below.

Former GP until end-2022

70. As noted above, Laurence's former GP until the end of 2022 issued prescriptions to Laurence on five occasions without checking SafeScript first. In response, the GP advised that he did not have any further comment to make to the Court.

¹⁹ Department of Health, Reforms to health regulation in Victoria, <https://www.health.vic.gov.au/legislation/reforms-to-health-regulation-in-victoria>.

²⁰ Section 55AA of the *Drugs, Poisons and Controlled Substances Act 1981*.

²¹ Section 55AAG of the *Drugs, Poisons and Controlled Substances Act 1981*.

²² Section 55AAZ of the *Drugs, Poisons and Controlled Substances Act 1981*.

²³ Section 55AAM of the *Drugs, Poisons and Controlled Substances Act 1981*.

Tapentadol IR and SR prescribed on 17 August 2023

71. The GP who consulted with Laurence on 17 August 2023 noted that she worked in the same clinic as Laurence's usual GP. She explained that she saw Laurence on 17 August 2023 and recorded a complaint of ongoing headaches. Laurence requested repeat prescriptions for his usual medications, which the GP provided. The GP did not say anything in response to the concern that she did not check SafeScript prior to prescribing SafeScript monitored medications and only provided a summary of her treatment on that occasion.

Prescriptions in October 2022

72. As noted above, a GP prescribed Laurence with SafeScript monitored medications on two occasions in October 2022 without checking SafeScript first. The GP explained that he has predominantly practised in Australia as a GP, and briefly moved to New Zealand in 2021, before returning in late-2021. He explained that at the time Laurence presented to him, he was new to the clinic and was experiencing technical issues when accessing SafeScript. He reported that he brought this up several times with his clinic's IT team, who were unable to resolve the issue. He further noted that he did not know that SafeScript was mandatory in Victoria as he was in New Zealand around the time when it became mandatory.
73. The GP noted that he eventually found a workaround for his technical issues and discovered that he could log onto his practice software via Google (Chrome) and SafeScript in Microsoft (Edge) and could leave both programs open all day and access both without difficulty. He acknowledged that he is now vigilant in prescribing SafeScript monitored medications and informs patients that he is unable to prescribe some without checking SafeScript first.
74. The GP's response was considered and thoughtful. He explained that he had since reflected upon his treatment of Laurence and noted that Laurence usually presented to him on weekends reporting severe headaches and neuropathic pain when his usual GP was unavailable. In prescribing SafeScript monitored medications to Laurence, the GP stated his intention was to only provide him with short-term symptom relief until Laurence could see his regular GP. However, once it became clear that these requests were becoming more frequent, the GP refused to prescribe them and referred Laurence to his usual GP.

FINDINGS AND CONCLUSION

75. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was Laurence Mark O'Brien, born 28 November 2000;
 - b) the death occurred between 15 and 16 September 2023 at Lilydale Victoria 3140, from mixed drug toxicity (tapentadol, clonazepam, citalopram, amphetamine, olanzapine, oxazepam, pregabalin, ketamine); and
 - c) the death occurred in the circumstances described above.
76. Having considered all of the circumstances, I consider that there is a possibility that Laurence intentionally took his own life. I note that tapentadol was detected at a significantly elevated level, suggestive of excessive use, and potentially, of intention to suicide. I also note that the Webster pack from 13 September 2023 was almost completely empty, however if taken as prescribed, should have only had tablets from 13, 14 and 15 September 2023 removed. This supports the contention that Laurence intentionally took more medication than prescribed and that he may have done so with an intent to end his life.
77. On the other hand, there was no positive evidence of intent in the form of (for example) a 'suicide note' or contemporaneous utterances to clinicians or loved ones as to suicidal ideation or plan. It is therefore possible that Laurence's death was the unintended consequence of the deliberate ingestion of drugs. In this connection, it is possible that Laurence consumed more of his prescribed medication than recommended and combined this with non-prescribed medications (ketamine; oxazepam) to achieve a heightened effect. His friend noted that he was sometimes reckless with his medications and became tolerant to them over time, so he opined that Laurence may have taken more than prescribed in order to "*feel good*".
78. It is not possible, on the evidence, and after an extensive investigation, to make a finding either way.
79. Consistent with the advice provided to me by the Coroners Prevention Unit, while there is evidence of Laurence 'prescription shopping' in the year prior to his death, his regular team of clinicians (named in this finding) treated Laurence appropriately, coordinated their care, and took steps to mitigate the risks of the suite of prescribed medications Laurence was on, including directing the use of Webster Packs and the checking of SafeScript.

COMMENTS

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

80. The general practitioners who wrote *ad hoc* prescriptions for monitored drugs to meet Laurence's demands in the year before his death, without checking SafeScript, perpetuated the cycle of his addiction and his 'prescription shopping'.
81. Further, while Laurence's long-time regular GP was engaged with Laurence up until the end of 2022 in a caring and patient-centred approach, even he failed on five occasions to check SafeScript and was thus poorly-placed to detect prescription-shopping at an earlier point in the face of Laurence's known substance dependency issues, escalating demands, and tales of 'lost prescriptions'. This represented a missed opportunity to engage Laurence earlier in an honest discussion about his drug dependency and treatment options while maintaining a therapeutic relationship, which the GP considered was not ultimately possible when he eventually detected – via SafeScript – the extent of Laurence's prescription-shopping.
82. Having so commented, this occurred some months before Laurence passed, and it cannot now be said that the tragic outcome could have been avoided.
83. Notwithstanding, I have elected to notify my finding to the Department of Health (**Department**) to inform its ongoing work in monitoring compliance with SafeScript, which is critical to its success and to improving the safety of medication prescribing and dispensing to members of the Victorian community. The historic focus of enforcement action on the '*very worst offenders*' (of those not checking SafeScript) does not account for the fact that even 'one-off' prescribing and dispensing of monitored medicines without checking SafeScript can compromise patient safety, care and outcomes.
84. As noted by Deputy State Coroner Spanos (**DSC Spanos**) in the finding into the death without inquest of LT, delivered last month,²⁴ the Victorian government has recognised this issue with clinician non-compliance with SafeScript and, commendably, has taken action including through the introduction of new compliance and enforcement powers under the amended *Drugs, Poisons and Controlled Substances Act 1981*, which is highly positive.
85. I echo the comments of her Honour DSC Spanos that it is likely to be too early still to understand what impact these new compliance and enforcement powers will have on

²⁴ COR 2022 001217, 8 January 2026, available [here](#).

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.

I convey my sincere condolences to family and friends for the profound loss of their much-loved and much cared-for Laurence. I would also like to commend the Coronial Investigator for the detailed and diligently compiled coronial brief prepared for this investigation.

ORDERS AND DIRECTIONS

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

Michael and Josephine O'Brien, Senior Next of Kin

General Practitioner (C/- Wotton Kearney)

Transport Accident Commission

Victorian Department of Health

Australian Health Practitioner Regulation Agency

Royal Australian College of General Practitioners

Detective Sergeant Paul Edyvane, Coronial Investigator

Signature:



**INGRID GILES
CORONER**



Date: 17 February 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.
