IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 003783

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Aboriginal and Torres Strait Islander readers are advised that this finding contains names, words and descriptions which may be distressing.

Findings of:	Coroner Simon McGregor
Deceased:	Jayden Kain Wright
Date of birth:	1 November 1997
Date of death:	10 July 2022
Cause of death:	1(a) Combined drug toxicity (clonazepam, diazepam, methadone, tramadol, pregabalin)
Place of death:	34 Orme Street, Edenhope, Victoria, 3318

INTRODUCTION

1. On 10 July 2022, Jayden Kain Wright, an Aboriginal man, was 24 years old when he died at home. At the time of his passing, Jayden lived at 34 Orme Street, Edenhope, Victoria.

2. On 31 August 2020, Jayden was involved in a motor vehicle collision and suffered a lower back and right hip injury. He also suffered from Post-Traumatic Stress Disorder, severe anxiety, schizophrenia, and drug abuse. At the time of his passing, Jayden was prescribed tramadol, pregabalin, clonazepam, and quetiapine by his general practitioner, Dr Vijai Gupta.[1]

3. Jayden's partner, Ebony Taylor, stated that Jayden developed an addiction to pain killers following the collision and would often engage in doctor-shopping to obtain extra medication. She stated that she would give half of her medication to Jayden to help with his pain, a practice of which Dr Gupta was unaware. Ebony also sent Jayden methadone when he moved to Edenhope,[2] a bottle of which was later discovered in Jayden's room following his passing.[3]

4. In May 2022, Jayden began staying with Suzie and her partner, David Whisker, in Edenhope.[4] Suzie stated that Jayden was aware of his substance abuse issues and "wanted to clean himself up…to be a good dad to his kids". During this time, David stated that he noticed that Jayden appeared drowsy and uncoordinated from the medication he was taking for his pain.[5] [6]

THE CORONIAL INVESTIGATION

5. Jayden'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.

6. 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 passing. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

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[1] Coronial brief, statement of Dr Vijai Gupta (undated).
[2] Coronial brief, statement of Ebony Taylor dated 12 October 2022, page 3.
[3] Coronial brief, statement of David Whisker dated 8 September 2022, pages 1-2.
[4] Coronial brief, statement of David Whisker dated 8 September 2022, pages 1-2.
[5] Coronial brief, statement of David Whisker dated 8 September 2022, pages 1-2.
[6] In his supplementary statement dated 1 February 2023, Dr Gupta noted that Jayden attended telephone consultations in May, June, and July 2022. During this consultations, Dr Gupta stated that Jayden "sounded like his usual self" and was not "slurring his words or failing to articulate himself or understand [Dr Gupta]".

7. 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.

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

9. This finding draws on the totality of the coronial investigation into the passing of Jayden Kain Wright 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.[7]

10. In considering the issues associated with this finding, I have been mindful of Jayden's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the passing occurred

11. On 9 July 2022, Jayden shared dinner with Suzie and David before retiring to his room. At approximately 2.00am, David woke to the sound of breaking glass and investigated, finding Jayden in the kitchen in a "groggy" state after having accidentally broken a glass cabinet door.

12. Jayden told David that he "didn't feel well" and went to the bathroom before going back to bed. Suzie then checked on her son, noting that he had been sick on the train whilst travelling down to Edenhope. Jayden assured his mother that he was okay, however, and Suzie returned to bed with David.[8]

[7] 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.

[8] Coronial brief, statement of David Whisker dated 8 September 2022, page 2; statement of Susie Jay dated 17 September 2022, page 2.

13. On 10 July 2022 at approximately 10.00am, David and Suzie woke. Suzie checked on Jayden in his room and discovered that he was unresponsive. David contacted 000 and moved Jayden to the ground, beginning cardiopulmonary resuscitation under the call taker's directions.[9]

14. Ambulance Victoria paramedics attended the address and continued resuscitation efforts however Jayden was unable to be revived and was verified as deceased at 11.05am.[10]

Identity of the deceased

15. On 10 July 2022, Jayden Kain Wright, born 1 November 1997, was visually identified by his mother, Susie Melissa Jay.

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

Medical cause of death

17. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 13 July 2022 and provided a written report of his findings dated 11 August 2022.

18. The post-mortem computed tomography scan revealed increased lung markings and a distended urinary bladder. No unexpected signs of trauma were noted.

19. Toxicological analysis of post-mortem samples identified the presence of clonazepam and its metabolite 7-aminoclonazepam, diazepam and its metabolite nordiazepam, methadone and its metabolite EDDP,[11] tramadol, pregabalin, and delta-9-tetrahydrocannabinol (cannabis).[12] [13]

20. Dr Young provided an opinion that the medical cause of death was from 1 (a) combined drug toxicity (clonazepam, diazepam, methadone, tramadol, pregabalin).

21. I accept Dr Young's opinion.

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[9] Coronial brief, statement of David Whisker dated 8 September 2022, pages 2-3.

[10] Ambulance Victoria Verification of Death form dated 10 July 2022.

[11] Information obtained from the Department of Health indicates that there was no permit to treat the deceased with methadone and buprenorphine.

[12] There is considerable overlap between therapeutic concentrations of methadone and concentrations attributed to overdose. Tolerance to opiates and prescribing history must be considered. In addition, there is an additive central nervous system (CNS) depressive effect with the concurrent use of other CNS depressant drugs such as clonazepam, diazepam, tramadol and pregabalin.

[13] The drugs detected were at levels consistent with excessive and potentially fatal use. The combination of these drugs may cause death in the absence of other contributing factors.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Jayden Kain Wright, born 1 November 1997;

    b) the passing occurred on 10 July 2022 at 34 Orme Street, Edenhope, Victoria, 3318, from *combined drug toxicity (clonazepam, diazepam, methadone, tramadol, pregabalin)*; and

    c) the passing occurred in the circumstances described above.

23. Having considered the available evidence, including Jayden's previous history of substance abuse, I am satisfied that Jayden's passing was unintended consequence of the deliberate consumption of drugs and was not due to any suicidality on his part.

COMMENTS AND RECOMMENDATION

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

24. The potential dangers of the use of pregabalin have previously been recognised by this Court[14] with several recommendations made regarding the addition of pregabalin to medications monitored by SafeScript to reduce the likelihood of pregabalin-related overdoses.

25. In early 2019, an updated literature review was commissioned by the Victoria Department of Health to determine whether there was any new evidence of harm associated with medications not currently monitored by SafeScript. In the case of pregabalin, the review concluded that pregabalin was only potentially harmful when used in combination with opioids or benzodiazepines and was not considered to be at the "same level compared to medicines currently monitored in SafeScript".[15]

26. In February 2021, the Therapeutic Goods Administration introduced a new warning label on pregabalin medications to advise doctors to assess a patient's risk of abuse before prescribing the drug and to monitor patients regularly during treatment.[16]

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[14] COR 2015 2127; COR 2016 4886; COR 2018 5440; COR 2019 0686; COR 2020 2828.

[15] Department of Health, 'Medicines monitored in SafeScript' (2022) https://www.health.vic.gov.au/drugs-and-poisons/medicines-monitored-in-safescript

[16] COR 2018 5440.

27. Additionally, whilst SafeScript currently only targets Schedule 8 medications under the Poisons Standard[17], on 31 October 2022 Coroner Sarah Gebert recommended in her investigation into the death of Master S[18] that the Victorian Department of Health expand the scope of drugs monitored by SafeScript to include all prescription medications that are prescribed and dispensed throughout Victoria without exception.

28. Given that so many pregabalin-related overdoses investigated by this Court involve the presence of multiple additional sedating medications, it is reasonable to conclude that pregabalin should be dispensed with the same level of caution afforded other medications currently included on SafeScript. This precaution, in concert with the warning label, would prompt general practitioners and other prescribing clinicians to be aware of the potential for adverse effects and possible aberrant behaviour, thereby reducing the risk of further pregabalin-related overdoses.

29. Therefore, pursuant to section 72(2) of the Act, I make the following recommendation:

    I recommend that the Therapeutic Goods Administration include pregabalin in the scope of medications currently monitored by the SafeScript real-time prescription monitoring scheme.

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

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

[This section has been left intentionally blank]

[17] *Therapeutic Goods (Poisons Standard – February 2023) Instrument 2022* (Cth).

[18] COR 2019 006224 (name redacted).

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

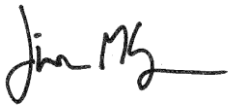
Ebony Taylor, Senior Next of Kin

Dr Vijay Gupta (care of Fraser Oakley, Avant Law)

The Hon. Mary-Anne Thomas, Minister for Health.

Leading Senior Constable Phill Shiells, Victoria Police, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 27 February 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.