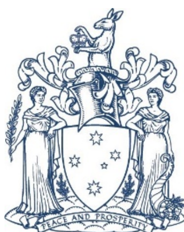

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3865

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**MANDY JANE HAWKEY**
Date of birth:	18 FEBRUARY 1967
Date of death:	5 AUGUST 2018
Cause of death:	MIXED DRUG TOXICITY
Place of death:	6 RALEIGH ROAD, MELTON VICTORIA 3337

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- Cause of death, pursuant to section 67(1)(b) of the Act
- Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

Comments pursuant to section 67(3) of the Act

Findings and conclusion

<u>HIS HONOUR</u>:

BACKGROUND

1. Mandy Jane Hawkey was 51 years old when she died on 5 August 2018 from mixed drug toxicity. Immediately prior to her death, Mrs Hawkey lived at 6 Raleigh Road, Melton with her husband of 29 years, Peter Hawkey. Mr and Mrs Hawkey had four children together, Douglas (29), Samuel (27) and twins, Sarah and Anthony (24).

2. Mr Hawkey provided a statement to the coroner's investigator (**CI)** in which he explained that Mrs Hawkey suffered from chronic pain caused by hip replacement surgery some fifteen years before her death from which "*…she never really recovered physically.".* He described her as suffering from issues with her back and other hip "*…but after numerous tests over the years they couldn't find anything wrong."*.

3. Mr Hawkey said his wife suffered from mental health issues too, depression (which he attributed to her chronic pain) particularly during the 18 months prior to her death. He explained that:

   "She talked to me about her struggles with depression and she talked about taking her own life two or three times by taking too many pills. I think she was referring to the sleeping pills.".

4. Despite his wife's problems, Mr Hawkey said that:

   "*At the time of her death we were renovating the family home, the kids had moved out and we were looking forward to the next phase of our lives. Mandy seemed like she was planning ahead and looking forward to the next phase.".*

5. The CI obtained a statement from Dr Mark Robson, Mrs Hawkey's treating general practitioner of 18 years at the Station Medical Centre in Melton South. Dr Robson stated that:

   "[Mrs Hawkey] *had an extremely long history of generalised anxiety disorder, treatment resistant depressive illness with suicidal ideation and chronic pain".*

6. Mrs Hawkey's medical history included hypothyroidism, irritable bowel syndrome, gastro-oesophageal reflux disease and a total hip replacement for osteo-arthritis (2009).

7. Dr Robson explained that in 2004, Mrs Hawkey was taking a number of pain medications and was referred to the Barbara Walker Pain Management Clinic where she commenced a multidisciplinary medication reduction and education program through which she managed to wean off most of her medications. However, she developed a severe depressive illness for which she was prescribed a variety of antidepressant medications.

8. Mrs Hawkey's mental health state included depressive symptoms precipitated in the context of difficulty at work in 2011 and family stressors. Between 2012 and 2016 she became the full-time carer for her granddaughter, a situation which she described herself as being "*thrown into*". Mrs Hawkey also reported that she subsequently lost contact with her granddaughter due to conflict with her son's partner, a situation which she felt keenly.

9. In June 2017, Dr Robson referred Mrs Hawkey to Harvester Private Consulting Clinic, which provides mental health services. On 14 June 2017, Mrs Hawkey saw psychiatrist Dr Dimuthu Hettiarachchi who assessed her as suffering from a moderate to severe major depressive disorder with comorbid generalised anxiety disorder. Dr Hettiarachchi noted hypothyroidism and cannabis use were potential contributing factors to Mrs Hawkey's mental health. At this time Mrs Hawkey was taking the antidepressants desvenlafaxine (for which she subsequently substituted venlafaxine) and endep; she experienced a poor response.

10. In August 2017, Mrs Hawkey began to see psychologist, Dr Angelo Pagano of Western Psychological Services. Mrs Hawkey attended Dr Pagano on ten occasions during 2017 and seventeen occasions during 2018, with the last consultation being on 27 July 2018. She was next due to see him on 7 August 2018. Mrs Hawkey formed a good therapeutic relationship with Dr Pagano who promoted relaxation, mindfulness and cognitive behavioural intervention.

11. Dr Pagano described Mrs Hawkey as:

> "*…a delightful, humorous, loving person, wife, mother and grandmother* [who] *cared deeply about her family. She also struggled with depression for much of her life and in the 18 or so months before she died, experienced a deep depression that she fought hard to overcome with the strong support from her loving husband Peter*".

12. Dr Pagano noted that Mrs Hawkey described her family as a strong protective factor in relation to self-harm and that she persistently denied intent and clear plans to harm herself or suicide.

13. In December 2017, Dr Robson referred Mrs Hawkey back to Dr Hettiarachchi for review because of "*…poor tolerability of medication and recent suicidal self-harm thoughts of wanting to take an overdose".* Dr Hettiarachchi saw Mrs Hawkey on 19 December 2017 when she recommended a gradual weaning from venlafaxine and that Mrs Hawkey commence taking (and gradually increase the dose of) mirtazapine. She also recommended, inter alia, that Mrs Hawkey continue to see her psychologist. Dr Hettiarachchi did not see Mrs Hawkey after this consultation.

14. Mrs Hawkey continued to see Dr Robson regularly who noted that she had ongoing problems with sleeping and, at her last consultation with him on 3 August 2018, he referred her to the Sleep Clinic at the Royal Melbourne Hospital. Dr Robson noted that Mrs Hawkey's medications at that time included dothiepin 25mg 1 tablet at night; flunitrazepam 1mg 1-2 tablets at night, fluvoxamine 100mgs 1 tablet at night, lamotrigine 25mg 1 tablet at night, levothyroxine 0.05mg on alternate days and Panadeine Forte 2 tablets 3 times daily as required.

THE CORONIAL INVESTIGATION

Coroners Act 2008

15. Mrs Hawkey's death was a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**) because her death occurred in Victoria, was unexpected and was not from natural causes.

16. The Act requires a coroner to investigate reportable deaths such as Mrs Hawkey's and, if possible, to find:

    (a) The identity of the deceased

    (b) The cause of death; and

    (c) the circumstances in which death occurred.[1]

[1] *Coroners Act 2008* (Vic) preamble and s 67.

17. For coronial purposes, "*circumstances in which death occurred*",[2] refers to the context and background to the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death relevant circumstances are limited to those which are sufficiently proximate to be considered relevant to the death.

18. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[3] It is not the Coroner's role to determine criminal or civil liability,[4] nor to determine disciplinary matters.

19. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through comments made in findings and by making recommendations.

20. Coroners are also empowered to:

    (a) Report to the Attorney-General on a death;[5]

    (b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[6] and

    (c) Make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[7]

Standard of Proof

21. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[8] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[9] The principles enunciated by the

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[2] *Coroners Act 2008* (Vic) s 67(1)(c).
[3] *Keown v Khan* [1999] 1 VR 69.
[4] *Coroners Act 2008* (Vic) s 69 (1).
[5] *Coroners Act 2008* (Vic) s 72(1).
[6] *Coroners Act 2008* (Vic) s 67(3).
[7] *Coroners Act 2008* (Vic) s 72(2).
[8] (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
[9] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

Chief Justice in *Briginshaw* do not create a new standard of proof; there is no such thing as a "*Briginshaw Standard*" or "*Briginshaw Test*" and use of such terms may mislead.[10]

22. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[11] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[12] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved and the content of the finding based on those facts.[13]

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

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

23. On 5 August 2018, Peter Hawkey identified the deceased as his wife, Mandy Jane Hawkey, born on 18 February 2018.

24. Mrs Hawkey's identity is not in dispute and requires no further investigation.

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

25. On 9 August 2018, Dr Matthew Lynch, a Senior Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted a post-mortem examination upon Mrs Hawkey's body. Dr Lynch provided a written report, dated 17 October 2018, in which he opined that the cause of Mrs Hawkey's death was "*Mixed drug toxicity"*. I accept Dr Lynch's opinion.

26. Toxicological analysis of post-mortem samples detected the presence of codeine, morphine, tramadol[14], paracetamol, 7-aminoflunitrazepam[15], lorazepam[16], fluvoxamine[17], reboxetine[18],

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[10] *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].
[11] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[12] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[13] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.
[14] Narcotic analgesic used to treat moderate to severe pain.
[15] Sedative/hypnotic of the benzodiazepine class.
[16] Benzodiazepine used to treat insomnia and anxiety associated with depressive symptoms.
[17] An anti-depressant for use in treatment of major depression.
[18] An anti-depressant for use in treatment of major depression.

dothiepin[19], mirtazapine[20], nortriptyline[21], metoclopramide[22], lamotrigine[23], caffeine and prednisolone[24].

27. The toxicology report drawn by Ms Gould-Williams commented that:

> "*The drugs detected are consistent with excessive and potentially fatal use. The combination of drugs detected may cause death in the absence of other contributing factors. There is an additive CNS[25] depressive effect with the concurrent use of number of CNS depressant drugs"*.

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

28. Mr Hawkey stated that on 4 August 2018, he and his wife had dinner together before he went out to the shed to watch football. As he kissed Mrs Hawkey goodnight, she told him she loved him and would see him in the morning.

29. At approximately 12.00am, Mr Hawkey came in from the shed and went to bed in his room, noting, as he walked past Mrs Hawkey's bedroom that her door was closed. The couple had slept in separate rooms for the previous five years because of Mr Hawkey's snoring and restlessness. He remarked that it was normal for her to sleep with the bedroom door closed as she kept the dog with her.

30. At approximately 7.30am the following morning, Mr Hawkey got up and, as he passed his wife's bedroom, the door was open indicating she got up some time during the night. When he looked into the room, he saw the dog at the end of the bed and Mrs Hawkey lying on her side. Thinking she was still asleep, he tried to be quiet.

31. Following a shower and breakfast, Mr Hawkey started preparations for painting the walls of the hallway. He looked into his wife's bedroom a few times while he was painting. At approximately 1.30pm Mr Hawkey, concerned that "*it was getting a bit late"*, went in to check on Mrs Hawkey and discovered that her lips were blue, and she was unresponsive.

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[19] Antidepressant.
[20] Indicated in treatment of depression.
[21] A tricyclic antidepressant.
[22] An anti-emetic drug used for the treatment of nausea and vomiting.
[23] An anticonvulsant medication.
[24] A synthetic corticosteroid with anti-inflammatory action.
[25] Central nervous system.

He called emergency services and commenced cardiopulmonary resuscitation in accordance with the instructions of the call-taker until the arrival of a team from Ambulance Victoria. Mrs Hawkey could not be resuscitated, and paramedics declared her there deceased.

32. Police who attended the scene located a large quantity of prescription medication in boxes and loose blister packs many of which had been opened. A drinking glass containing a spoon with a quantity of crushed and partially dissolved white tablets was found in the bathroom. These items were not seized at the time. No suicide note was located.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

33. Given the number and levels of drugs detected in Mrs Hawkey's post mortem blood samples, I asked the Coroners Prevention Unit (**CPU**)[26] to review her medical management, including prescribing practises, of doctors treating Mrs Hawkey and advise me about whether the prescriptions provided to her were appropriate and consistent with therapeutic use.

Sources of contributory drugs and prescribed and dispensed amounts

34. Following its review of the coronial brief and Mrs Hawkey's medical records from Station Medical Centre, a Pharmaceutical Benefits Summary (**PBS)** and Medicare Report, the CPU advised me that, with the exception of tramadol, the medications which contributed to Mrs Hawkey's death were each prescribed to her at least once in the three months immediately prior to her death, apart from mirtazapine which was last dispensed on 19 March 2018. This suggests that Mrs Hawkey may have retained medication that had been dispensed to her for quite some time. Additionally, the CPU advised me that, with the exception of flunitrazepam, the (prescribed) contributory medications appeared to have been prescribed in amounts that were in keeping with the clinical directions for consumption.

35. The CPU was unable to find any evidence of the source of tramadol found in Mrs Hawkey's post-mortem blood samples. Although it is possible that she may have kept some tramadol from an earlier period when it was prescribed to her (i.e., following her hip surgery for example), the CPU considered this unlikely and opined that the tramadol found in Mrs Hawkey's system was most likely obtained by diversion.

[26] CPU was established in 2009 to assist coroners to perform their prevention role – that is to fulfil their legislative obligation to contribute to a reduction in the number of preventable deaths. CPU is staffed by qualified and experienced clinicians who are independent of the health professional and institutions involved in the clinical management and care provided to Mr Chandler.

36. The available records from Station Medical Centre (from September 2016 onwards) reveal that Dr Robson prescribed flunitrazepam to Mrs Hawkey from at least September 2016, a period of almost 2 years prior to her death. The medication was prescribed outside the PBS and the number of tablets prescribed to her was not noted in the medical records, making it difficult for the CPU to identify exactly how many flunitrazepam tablets were dispensed to Mrs Hawkey. The label on a bottle of flunitrazepam tablets located at the scene of her death revealed it had originally contained 60 tablets and was dispensed on 13 July 2018. Only 3 tablets remained in the bottle. The CPU calculated that, if this were the amount of flunitrazepam ordinarily prescribed and dispensed to Mrs Hawkey, then immediately prior to her death she was given 360 flunitrazepam tablets in a 78 day period, equivalent to four and a half tablets a day: twice the directed daily dose.

37. The CPU concluded that, in the 24 hours prior to her death, Mrs Hawkey took 74 Panadeine Forte (each containing 500mg paracetamol and 30mg codeine) (100 tablets were dispensed to her on 4 August 2018 but only 26 were located at the scene after her death); an estimated 19 Panadol Osteo tablets; 45 dothiepin (50 capsules were dispensed to her on 4 August 2018 but only 5 were found at the scene following her death).

38. The CPU ultimately concluded that the contributory drugs were in some cases taken to excess by Mrs Hawley but, with the exception of flunitrazepam, did not appear to have been excessively prescribed.

Issues arising from prescribing of contributory drugs

39. The CPU advised me that, the fact that a large range of medications was prescribed to Mrs Hawkey and subsequently detected on post-mortem toxicology is not, in and of itself, problematic. It was clear to the CPU from the medical records that Dr Robson regularly reviewed and amended Mrs Hawkey's medications based on her progress and the feedback she provided when reviewed by himself, Dr Hettiarachchi or Dr Pagano. The CPU noted for example that, on 28 December 2017, Dr Robson noted Mrs Hawkey changed from venlafaxine (which she reported to Dr Hettiariachchi she found "*intolerable*") to mirtazapine. On 27 April 2018, Mrs Hawkey complained to Dr Robson that she felt mirtazapine was ineffective and made her drowsy prompting a change to reboxetine; which in turn was replaced by fluvoxamine on 31 May 2018.

40. Similarly, nortriptyline was prescribed and dispensed to Mrs Hawkey on 18 May 2018, apparently with a view to reducing the amount of flunitrazepam she was taking. However, when reviewed on 22 May 2018, Dr Robson noted that Mrs Hawkey was "*Not sleeping on nortriptyline – cease and continue flunitrazepam 1-2 nocte*[27] *and* [reboxetine] *4mg bd*[28]*"*.

41. That Mrs Hawkey retained some of these medications after they were no longer prescribed to her and then took them at a time more proximal to her death does not mean that they were inappropriately or excessively prescribed in the first instance. It would have been difficult for Dr Robson to know that she was hoarding medication; she did not present as drug dependent or drug seeking. Accordingly, the CPU opined that (again with the exception of flunitrazepam) Dr Robson's prescribing was not inappropriate.

42. The CPU advised me that flunitrazepam is classified as Schedule 8 drug of dependence in Victoria and requires the prescribing clinician to obtain the relevant permit from the Medicines and Poisons Branch (**MPB)** of the Department of Health and Human Services if it is to be prescribed for a period longer than 8 weeks. The CPU made enquiries of the MPB which confirmed that no permit had been issued in respect of Mrs Hawkey, leading the CPU to consider that Dr Robson's prescribing of flunitrazepam to Mrs Hawkey without a permit was in contravention of the existing regulations.

43. In addition, the CPU referred me to the guidelines from the Royal Australian College of General Practitioners[29] (**RACGP)** regarding the prescribing of drugs of dependence (specifically benzodiazepines) in general practice which states:

> "*Guidelines and formularies typically give durations of 1-4 weeks for benzodiazepine therapy, depending on the indication. Short term therapy is generally advised to reduce the risk of dependence and withdrawal, as well as other potential harm such as cognitive impairment.*
>
> *Dependence is recognised as a risk in some patients who receive treatment for longer than 1 month and health professionals should be conscious of this when considering the relative benefits and risk of treatment.*

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[27] At night.
[28] Twice daily.
[29] Royal Australian College of General practitioners, prescribing drugs of dependence in general practice, Part B: *Benzodiazepines, 4.1 Optimal duration of therapy*, June 2015.

While the optimum duration of therapy is not clear from the evidence, there are very few specific indications for the chronic use of benzodiazepines. The decision to prescribe benzodiazepines longer term should be uncommon and made with caution. Assume that all patients are at risk of dependence.

The principles of universal precautions apply. Ensure a clear diagnosis is formed, comprehensive assessment is undertaken, clear treatment plan is discussed with the patient and information is provided to the patient to enable informed consent. The negotiated treatment plan will have a clearly defined time limit and goals of treatment".

44. The CPU advised me it was not clear from the available medical records that the continued use of flunitrazepam was appropriate.

45. The CPU noted that the prescribing guidelines for benzodiazepines issued by the College of Psychiatrists are less strict than those of the RACGP as they accept that patients being treated by a psychiatrist generally have more complex treatment needs and may require longer-term prescribing. However, Dr Robson was prescribing flunitrazepam to Mrs Hawkey well before she attended on Dr Hettiarachchi for the first time. From a review of the medical records, it appears that Dr Hettiarachchi was aware that Mrs Hawkey was prescribed flunitrazepam but does not appear to have assumed oversight for this medication or prescribed it herself to Mrs Hawkey. Further, according to Dr Hettiarachchi's statement, following her first consultation with Mrs Hawkey she noted she was on two benzodiazepines (flunitrazepam and alepam) recommended she stay on endep stating:

> "*Increasing Endep can be beneficial for sleep and anxiety and she would be able to reduce benzodiazepine in the future".*

46. In relation to her second contact with Mrs Hawkey, Dr Hettiarachchi does not refer to flunitrazepam at all, focussing instead on the antidepressant medication she was taking. It would appear that she did not consider herself as overseeing the prescribing of this medication to Mrs Hawkey.

47. There is evidence in the coronial brief that Mrs Hawkey acted intentionally to end her own life.

48. First, there is evidence that Mrs Hawkey had taken a large number of Panadeine Forte and dothiepin tablets in 24 hours prior to her death – quantities which correlate with the high levels of paracetamol and dothiepin detected in the post-mortem blood samples.

As the VIFM toxicology report notes, blood concentrations in recorded fatalities attributed to paracetamol toxicity range from 160mg/L, less than half the amount (405mg/L) detected in Mrs Hawkey's system; fatalities associated with dothiepin had blood concentrations of 0.3mg/L or higher, less than the 0.4mg/L detected.

49. Second, the presence of crushed tablets inside a glass along with a spoon evidently used to crush them, indicated she had deliberately tried to make it easier to ingest a large quantity of tablets. This conclusion was further supported by the finding of 38 dothiepin capsules which Mrs Hawkey had apparently emptied of their contents to obtain the powder they contained.

50. Third, Mrs Hawkey had a long history of suicidal ideation and approximately 8 months prior to her death had been the subject of a suicide risk safety plan prompted by her signalling that she had suicidal ideation without intent along with a plan to suicide by way of overdose. Mr Hawkey indicated that, on several occasions, Mrs Hawkey had discussed taking her own life by overdose in the 18 months prior to her death.

51. Fourth, the post-mortem toxicology analysis revealed the presence of five antidepressant medications (mirtazapine, reboxetine, nortriptyline, fluvoxamine and dothiepin), three of which had not been prescribed to her for some months, lending weight to a conclusion that Mrs Hawkey had been hoarding medication proximate to her death.

52. Fifth, in a consultation with Dr Hettiarachchi on 14 June 2017, Mrs Hawkey admitted she had deliberately overdosed on medication some years previously as a result of pain and stress at work.

53. Finally, Mrs Hawkey faced significant ongoing stressors in her personal life, both from chronic pain and treatment resistant depression as well as historical stressors including a fractious relationship with her son's partner, having to care for her granddaughter between 2012 and 2016 and the subsequent loss of contact with that granddaughter.

54. A finding that a person died as a result of suicide is a finding of great moment which can impact upon the memory of a deceased person. It can also reverberate throughout a family for generations. Such a finding should only be made on compelling evidence, not indirect inferences or speculation.

55. It is often difficult to determine what may have precipitated a person's decision to end their own life. The decision is sometimes influenced by issues known only to the deceased person; sometimes events in the person's life suggest a reason. Identifying a precipitating event or

events can be difficult. The evidence indicates that Mrs Hawkey struggled with severe depression and chronic pain for many years.

56. Having considered all the evidence, and despite the lack of a suicide note, I am satisfied that Mrs Hawkey acted intentionally to take her own life.

57. I have noted the CPU's specific concern regarding the prescribing of flunitrazepam to Mrs Hawkey by Dr Robson. However, the investigation did not identify any prevention opportunities to be pursued, as clear rules already exist about the prescribing of Schedule 8 medicines and guideline offering advice on the prescribing of benzodiazepines in general practice (and psychiatry) were available for some years prior to Mrs Hawkey's death.

58. I directed my solicitor to write to Dr Robson to request an explanation for his prescribing of flunitrazepam to Mrs Hawkey in the absence of a permit. In his response Dr Robson advised me that he overlooked the obtaining of a permit. He did not proffer an explanation as to exactly how long he prescribed it to her, why he prescribed it by "*private*" [i.e., not PBS] prescription and whether it was ever prescribed under the oversight of a psychiatrist.

59. In the circumstances I propose to refer Dr Robson to the Australian Health Practitioners Regulation Agency for that agency to consider helping him to review his prescribing practices.

60. I also propose to refer Dr Robson to the MPB of DHHs.

RECOMMENDATIONS

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

(1) That the Australian Health Practitioner Regulation Agency (**AHPRA)** consider these findings in relation to Dr Robson's prescribing practices and assist Dr Robson to improve his prescribing practises and understand the significance of obtaining relevant permits to prescribe Schedule 8 medications.

(2) That the Medicines and Poisons Branch of the Department of Health, Victoria consider these findings in relation to Dr Robson's failure to comply with the regulations relating to permits.

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

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

FINDINGS AND CONCLUSION

61. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act* (*2008*):

    (a) The identity of the deceased was Mandy Jane Hawkey, born on 18 February 1967.

    (b) Mrs Hawkey's death occurred;

        i. on 5 August 2018 at 6 Raleigh Road, Melton,

        ii. from mixed drug toxicity; and

        iii. in the circumstances described above.

62. I direct that a copy of this finding be provided to:

(a) Mr Peter Hawkey, senior next of kin.

(b) Medicines and Poisons Branch, Victoria;

(c) The Australian Health Practitioners Regulation Agency; and

(d) Detective Leading Senior Constable Jacinta Elliott, Coroner's Investigator, Victoria Police.

Signature:

DARREN J BRACKEN

CORONER

Date: 20 May 2022.