IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 005925

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Emma Louise Terrill
Date of birth:	7 May 1979
Date of death:	30 October 2020
Cause of death:	1a: Aspiration pneumonia in the setting of a mixed drug toxicity
Place of death:	2 Shawlands Avenue, Blackburn South, Victoria, 3130
Keywords:	Polypharmacy toxicity, pain management, prescribing practices, Schedule 8, Schedule 4

THE CORONIAL INVESTIGATION

1. On 30 October 2020, Emma Louise Terrill was 41 years old when she died at home. At the time of her death, Emma lived with her mother in Blackburn South.

2. Emma'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.

3. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Emma's death. The Coronial Investigator conducted inquiries on my behalf.

4. This finding draws on the totality of the coronial investigation into the death of Emma Louise Terrill. 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.

THE CORONIAL JURISDICTION

5. The jurisdiction of the Coroners Court of Victoria (**Coroners Court**) is inquisitorial. The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

6. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

7. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

8. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, promotion of public health and safety and the administration of justice through findings and recommendations made by coroners. This is generally referred to as the 'prevention role' of the coroner.

9. Coroners are not empowered to determine any civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence. It is not the role of the coroner to lay or apportion blame, but to establish the facts.

THE STANDARD OF PROOF

10. In the coronial jurisdiction, facts must be established on the balance of probabilities. The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336.

11. Coroners should not make adverse findings against, or comments about, individuals or entities as contributing to the death, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death. 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. Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences.

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

RELEVANT BACKGROUND INFORMATION

13. Emma had a lengthy and complex medical and psychiatric history. Her psychiatric history included diagnoses of Attention Deficit Hyperactivity Disorder (**ADHD**), eating disorder, personality disorder, major depression, severe anxiety, bipolar disorder and chronic insomnia. She had previous overdose attempts. Her medical history included fibromyalgia including pain in her hips and back, tachycardia, persistent stomach problems and chronic dental infections. She reported chronic pain and regularly took a range of prescribed medications to treat medical and mental health conditions. Emma was engaging with various general practitioners (**GPs**) and a psychiatrist at the time of her death, and she had sporadic contact with a psychologist. Emma did not disclose any suicidal ideation or thoughts of self-harm to any clinician in the period proximate to her death.

14. According to Emma's sister, their childhood was adversely impacted by incidences of alleged family violence and family dysfunction. As a teenager, Emma's living arrangements were transient, and she began using cannabis and alcohol and started to show signs of mental illness. Her behaviour became increasingly erratic and could be violent and abusive. Emma commenced self-harming and there were police and ambulance attendances due to her mental health issues. Her mental health deteriorated to the point that she was admitted for involuntary inpatient psychiatric care.

15. As a young adult, Emma's drug use escalated and included use of methylamphetamine, 'crack' and heroin. Emma disclosed suicidal thoughts, and her family sought mental health treatment for her. They perceived that there was difficulty accessing appropriate services due to overwhelming demand on the public mental health system. At some stage in her adult years, it became apparent to Emma's sister that Emma was misusing prescription medications.

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

Circumstances in which the death occurred

16. On the evening of 29 October 2020, Emma was at home with her mother, Angela, who did not report anything out of the ordinary regarding Emma's behaviour or demeanour. They were watching television together and Emma fell asleep on the couch.

17. Before Angela went to bed, she noted that Emma was snoring and it sounded "wet". However, she had heard Emma snore like that before and wasn't concerned. Angela went to bed, leaving Emma asleep on the couch.

18. The next morning, on 30 October 2020, Angela found Emma still in the same position on the living room couch and could not rouse her. Emma was also cold to the touch.

19. Emergency services were called and attended the scene. Ambulance Victoria members declared Emma deceased at 8:35 am. Police also attended the scene and conducted an examination in which they found numerous packages of prescription medication. No suspicious circumstances were reported.

Identity of the deceased

20. On 30 October 2020, Emma Louise Terrill, born 7 May 1979, was visually identified by her mother, Angela Terrill.

21. Identity is not in dispute and requires no further investigation. I am satisfied that the identity of the deceased is Emma Louise Terrill.

Medical cause of death

22. Specialist Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 5 November 2020 and provided a written report of her findings dated 19 January 2021.

23. At autopsy, Dr Parsons found evidence of aspiration pneumonia and mild hepatic steatosis.[1] Microbiological testing on lung tissue and a nasopharyngeal aspirate did not reveal any bacteria or viruses which may have caused the pneumonia. Foreign material in keeping with aspiration was seen.

24. Toxicological analysis of post-mortem samples found elevated concentrations of tramadol,[2] as well as the presence of alprazolam,[3] diazepam[4] and its metabolite nordiazepam, temazepam[5], oxazepam[6] and amphetamine[7].

25. Dr Parsons explained that the tramadol level was elevated and, in combination with the benzodiazepines detected, this would have had a synergistic effect leading to central nervous system depression, coma, respiratory depression and seizures, leading to aspiration pneumonia.

26. Dr Parsons provided an opinion that the medical cause of death was "1(a) aspiration pneumonia in the setting of a mixed drug toxicity".

27. I accept Dr Parsons' opinion.

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[1] Also known as fatty liver disease.
[2] Tramadol is a Schedule 4 opioid analgesic for moderate-to-severe acute or chronic pain. Tramadol is effective for moderate pain and useful in neuropathic pain, but not in severe pain.
[3] Alprazolam is a Schedule 8 benzodiazepine, is habit-forming and used in the treatment of anxiety and panic disorder.
[4] Diazepam is a long-acting benzodiazepine with anxiolytic, sedative, hypnotic, muscle relaxant and antiepileptic effects. It is indicated in the short-term management of anxiety, and agitation, acute alcohol withdrawal, muscle spasms, sedation, and status epilepticus.
[5] Temazepam is a benzodiazepine, is habit-forming and used in the short-term treatment of insomnia.
[6] Oxazepam is a medium acting benzodiazepine. It is indicated in the treatment of anxiety, panic disorder, sleep disorders, seizures acute behavioural disturbance and acute alcohol, barbiturate or benzodiazepine withdrawal.
[7] Amphetamines are stimulant drugs, which means they speed up the messages travelling between the brain and the body. Some types of amphetamines are legally prescribed by doctors to treat conditions such as attention deficit hyperactivity disorder (ADHD) and narcolepsy (where a person has an uncontrollable urge to sleep). Emma was prescribed lisdexamfetamine at the time of her death.

FAMILY CONCERNS

28. In correspondence to the Court, Emma's sister Charlotte Bartrum-Terrill submitted approximately 265 questions for consideration by the investigating coroner in a 15-page document. The questions in that document relate to a wide range of matters including the regulation of GPs and pharmacists, the prescription of benzodiazepines and opioids, National Disability Insurance Scheme (**NDIS**) funding, and many questions relating specifically to Emma's case, broadly questioning the appropriateness of her medication regime and medical management.

29. It is understandable that Emma's family have many questions about her untimely death. However, a coroner is an independent judicial investigator, and the role of the coroner is limited. A coroner is empowered to examine matters that are proximate and causative of, or contributory to, a death for the purposes of making the findings required by section 67 of the Act. The Act does not provide a general mechanism for an open-ended inquiry into the merits or otherwise of the performance of government agencies, private institutions or individuals.[8]

30. I have considered the correspondence from Emma's sister Charlotte and all the investigation materials, including the coronial brief. I have determined that the relevant issues in relation to Emma's death are whether her death was accidental or deliberate, and whether the medications she was prescribed by various medical practitioners (only some of which contributed to her death) were prescribed appropriately.

FURTHER INVESTIGATIONS

31. As part of the coronial investigation, Emma's Pharmaceutical Benefits Scheme (**PBS**) and Medicare records were obtained, as well as statements from seven prescribing doctors, all of whom Emma consulted at least once in the months leading up to her death.[9] The records indicate that Emma's regular prescribers in the period proximate to her death were all GPs located at Blackburn Clinic. Emma's treatment was also overseen by a consultant psychiatrist, Dr David Lim, from March 2020.

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[8] In *Harmsworth v The State Coroner*,[8] Nathan J referred to the limits of a coroner's power and observed that the power of investigation is not 'free ranging', commenting that unless restricted to pertinent issues, an inquest could become wide, prolix and indeterminate. The same principle applies to coronial investigations where no inquest is held.

[9] The GPs that she saw most often at Blackburn Clinic were Dr Yixan (Aaron) Zhang and Dr Terence Ting (who had been treating her since 2018 and 2017 respectively).

32. Emma's medication regime at the time of her death included tramadol (immediate release (**IR**) and sustained release (**SR**)), alprazolam, diazepam, lisdexamfetamine, pregabalin, reboxetine, olanzapine, propranolol, stilnox and topiramate.

33. To better understand the medication regime, I referred Emma's case to the Coroners' Prevention Unit (**CPU**) for review, and sought expert evidence from Professor Eric Visser, a specialist pain medicine physician and anaesthesiologist. Prof Visser was asked to review the available evidence in Emma's case and provide an expert opinion as to the appropriateness of her medication regime, including the types and quantities of medications prescribed.

34. I note that not all the medications included in Emma's medication regime were detected in the toxicology results. As the prescribing of those medications has not caused or contributed to her death, they are relevant only to the extent that they formed a part of her medication regime.

Medications prescribed to Emma

Tramadol

35. Emma had been prescribed tramadol since 2008 for chronic back/hip pain and joint pain. She last consulted with a rheumatologist in September 2017, and it does not appear that she pursued any further appointments. Dr Zhang stated that he had unsuccessfully attempted to transition Emma to norspan and durogesic patches and wean her from tramadol use, but these efforts were not successful. Emma was resistant to the suggestion of methadone or suboxone as an alternative to tramadol. There is also evidence that Dr Lim discussed tramadol weaning with Emma, who stated she was interested in reducing her dosage.

36. At the time of her death, Emma was prescribed tramadol IR 50 mg (three times daily) and tramadol SR 100 mg (three times daily) in quantities of 20 each prescription. Prof Visser commented that there was "long-term, high-dose, high frequency prescribing" of tramadol, and noted that the total daily dose is higher than the recommended total oral dose approved by the Therapeutic Goods Administration, but only by 50-100 mg per day. Prof Visser considered that this was unlikely to be excessively toxic per se, particularly if Emma had been prescribed these doses for at least a few months and was taking the medication as prescribed. Prof Visser explained that Emma was also likely to have developed a degree of pharmacological tolerance to tramadol after taking it for over a decade. However, if Emma accidentally or deliberately took more than prescribed, the tramadol dose would be

supramaximal, increasing the risk of adverse effects such as sedation, respiratory depression, seizure, or serotonin syndrome.

37. Prof Visser noted that attending police found blister sheets of 50 mg tramadol tablets at Emma's home, one with ten of ten tablets missing, another with seven of ten tablets missing, with a prescription date of 29 October 2024, the day before she was found deceased. Prof Visser also noted Emma's history of previous overdoses and recorded history of tramadol dependence. He opined that if Emma had taken 17 x 50 mg tramadol IR in one day, that would be a dose of 850 mg, whereas her maximum prescribed daily dosage was 450-500 mg. Prof Visser concluded that Emma had accidentally or deliberately taken more tramadol than she was prescribed.

38. Prof Visser considered that there was an unusually frequent prescribing/dispensing practice in relation to tramadol. However, it was noted that possible reasons for frequent dosing may have included that tramadol SR and IR are only available in quantities of 20, or it could reflect conscientious clinical monitoring of tramadol prescribing/dispensing by her medical practitioners, for dose control and safety. Prof Visser explained that tramadol is considered to have a lower respiratory depressant effect than equivalent doses of 'full' opioid analgesics, so is often considered a 'safer choice'. However, high doses, particularly when mixed with other sedatives, can still cause sedation and respiratory depression.

39. I note that there is ample evidence in the medical records and statements provided by the prescribers that the more frequent prescribing to Emma was deliberately utilised as a risk mitigation strategy. It occurred due to acknowledgement of the issue of dependence and a desire to regulate usage.

Alprazolam

40. Alprazolam was initiated as part of Emma's treatment by her psychiatrist, Dr Lim, in September 2020. This was for better management of her increasing anxiety. Two further scripts of alprazolam were dispensed on 15 October 2020 and 29 October 2020, prescribed by Dr Zhang and Dr Ting, in line with the medication regime recommended by Dr Lim.

Lisdexamfetamine

41. Lisdexamfetamine was prescribed by Emma's psychiatrist Dr Lim to treat her ADHD. Emma usually had a script of lisdexamfetamine dispensed once a month.

Diazepam

42. Diazepam was prescribed for Emma's anxiety. According to Dr Zhang and Dr Lim, there was a plan in place to introduce alprazolam for better management of Emma's anxiety symptoms whilst simultaneously slowly reducing the diazepam dosage. This was at the direction of Dr Lim, and I note that there was discussion between Dr Lim and Dr Zhang regarding this treatment plan.

Temazepam

43. Temazepam was not prescribed as part of Emma's medication regime prior to her death and, according to the PBS records, was last dispensed to her on 17 January 2020. I note that no evidence of temazepam use was found at the scene. However, it was detected in Emma's post-mortem toxicology results. This may be due to consumption of temazepam by Emma, or it may be present as a metabolite of diazepam.

Oxazepam

44. Oxazepam was also not prescribed as part of Emma's medication regime and there is no record of it being prescribed or dispensed to her. Nor was any evidence of this medication found at the scene. However, it was detected in Emma's post-mortem toxicology results. This may be due to consumption of oxazepam by Emma, or it may be present as a metabolite of diazepam.

Expert conclusions

45. Prof Visser provided an opinion that in Emma's case, the combination of multiple sedative and psychoactive medications most likely contributed to medication-induced over-sedation, aspiration and death. In reaching this conclusion, he noted the near-empty tramadol blister sheets found at the scene, from a script dispensed the day before, suggesting Emma took a larger dose of tramadol (up to 850 mg) in a short period, as was reflected in the high serum tramadol levels found in post-mortem toxicology. I note that this is consistent with the opinion of Dr Parsons regarding the mechanism of death.

46. With regard to the available evidence, Prof Visser was unable to provide an opinion regarding whether Emma's death was preventable, but concluded that where there is a complex history of chronic pain and concurrent pharmacological treatment of psychiatric conditions, best practice would include periodic (at least once every 18 months) review by a specialist pain medicine physician (**SPMP**) or equivalent specialist to assess the appropriateness and safety

of tramadol prescribing. He noted that the medical records do not document such a review taking place in the last 18 months of Emma's life. He commented that such a review in her case may have resulted in the recommendation of tramadol dose tapering or cessation if it was determined to be inappropriate.

CPU review

Rationale for prescribing

47. The CPU reviewed the statements provided by Emma's prescribing doctors and noted that each clinician provided an explanation for why they prescribed each drug. The GPs also referred to the advice and guidance received from Emma's psychiatrist Dr David Lim, and this reinforced that there was a defensible clinical rationale for the prescribing by the various GPs.

Quantities of medications dispensed

48. The CPU advised that the quantities of medications dispensed to Emma, including in the month prior to her death, were broadly in keeping with the doses of tramadol, alprazolam, diazepam and lisdexamfetamine prescribed by her doctors at the Blackburn Clinic. The CPU noted that whilst their calculations of the medication dispensed exceeded the quantities Emma was directed to take, daily average figures were somewhat skewed by the fact that several prescriptions were only dispensed the day before she died.

Management of medications and drug dependence

49. The CPU commented that the available records did not generally evidence Emma seeking to obtain medication in excess of what was prescribed to her. It was noted that when such concerns were raised, controls were put in place to regulate the prescribing and dispensing of medication to Emma. The PBS records generally demonstrated Emma being dispensed medication in accordance with her prescribed medication regime.

Permits for Schedule 8 medications

50. Emma was prescribed lisdexamfetamine and alprazolam, both of which are Schedule 8 drugs. In most circumstances, clinicians must apply for a permit from the Victorian Department of Health's Medicines and Poisons Regulation (**MPR**) before prescribing these medications, although there are exceptions.

51. The CPU noted that in certain cases, a clinician can initiate treatment with a Schedule 8 medication without a permit, provided they do not prescribe or contribute to treatment for a continuous period greater than eight weeks. However, GPs must still seek a permit or an authority from the relevant state or territory health department when prescribing a Schedule 8 drug to a patient who is drug dependent.

52. Both alprazolam and lisdexamfetamine are Schedule 8 drugs, and they were prescribed to Emma without a permit.

53. Emma was first prescribed alprazolam on 23 September 2020 by Dr Lim for anxiety. Dr Ting and Dr Zhang were the only doctors at Blackburn Clinic who also prescribed alprazolam to Emma. This was introduced into her treatment regime by Dr Lim, and the GPs prescribed the medication on the basis of Dr Lim's treatment plan, with Dr Zhang discussing with Dr Lim the introduction of alprazolam alongside a reduction in diazepam. In their statements to the Court, the clinicians provided explanations for the absence of a permit, but the CPU questioned their rationale on the basis that the CPU regarded Emma as being drug dependent.

54. The CPU also provided an opinion that in prescribing lisdexamfetamine, Dr Lim could not have taken advantage of the exemption to the permit requirement, again on the basis that Emma was drug dependent, and the exemption therefore did not apply.

55. I note that Dr Lim did not believe that Emma was exhibiting drug seeking behaviour and was not concerned about her use of medications. Dr Ting did not hold significant concerns regarding aberrant behaviour regarding medication misuse. Whilst Dr Zhang did hold concerns regarding drug dependence, which was the rationale for using prescribing and dispensing restrictions on a weekly basis, he had no concerns about intentional overdose.

56. Dr Zhang stated that the reason he did not apply for a Schedule 8 permit for alprazolam was because it was "very early in the treatment prescribing" and "It was unclear at the time whether this was going to be an ongoing treatment". Dr Lim's rationale was that he understood a permit was not required as he was treating Emma with the medication for a duration of less than eight weeks. Dr Lim's rationale for the absence of a permit for lisdexamfetamine related to what he understood to be incoming changes regarding psychiatrists no longer having to apply for permits for stimulant medication.

CPU conclusions

57. The only prescribing issue identified by the CPU was the absence of Schedule 8 permits for alprazolam and lisdexamphetamine. However, the CPU opined that this was not a causal factor in the fatal incident and therefore did not recommend further investigation of the issue.

58. The CPU observed that the medications prescribed to Emma were drugs of dependence, which inherently carried a risk of Emma developing iatrogenic drug dependence. It was acknowledged that her history of drug abuse would have complicated the doctors' attempts to navigate between the clinical need for certain medications and her dependence upon them.

REGULATION OF PRESCRIBING PRACTICES

Department of Health and SafeScript

59. In view of the family's questions about the regulation of prescribing practices, I sought further information from the Victorian Department of Health (**the Department**) in relation to the operation of SafeScript and its capacity to provide oversight of prescribing.

60. The SafeScript system was officially launched by the Victorian Government in July 2018 for health professionals working in the Western Victoria Primary Health Network catchment area, was extended to the rest of Victoria in early 2019, and its use became compulsory in 2020. SafeScript monitors the following drugs:

    (a) strong opioid painkillers: buprenorphine, codeine, fentanyl, hydromorphone, methadone, morphine, oxycodone, pethidine, tapentadol;

    (b) strong medicines for anxiety or sleeping tablets (benzodiazepines): alprazolam, flunitrazepam, bromazepam, clobazam, clonazepam, diazepam, lorazepam, midazolam, nitrazepam, oxazepam, temazepam;

    (c) other strong sleeping tablets: zolpidem, zopiclone;

    (d) stimulants for attention deficit hyperactivity disorder or narcolepsy: dexamphetamine, lisdexamfetamine, methylphenidate; and

(e) other high-risk medicines: ketamine, quetiapine.[10]

61. Under the SafeScript system, any clinician intending to prescribe any of the drugs monitored by the system will first be required to perform a check to see which – if any – of the monitored drugs have been or are being prescribed to the patient. This allows clinicians to immediately identify potential prescription shopping patients and makes them aware of other practitioners who are treating the same patient. SafeScript monitors all prescriptions for the medicines listed above regardless of whether they receive a PBS subsidy or are private, non-PBS prescriptions.[11]

62. The Department explained that SafeScript does not capture (or have functionality to capture) the symptoms with which a patient presents or a patient's medical history. Accordingly, the decision as to whether a medicine is overprescribed or contraindicated is outside the scope of SafeScript's function and of the Department's powers.

63. The Department added that departmental officers who are able to review SafeScript data do not possess the patient knowledge to make an assessment as to whether a medication is overprescribed or contraindicated. 'Overprescription' or 'prescribing medication which is contraindicated' are instead regulated in Victoria by measures intended to uphold professional standards of health practitioners, namely, as matters of professional misconduct or unprofessional conduct under the *Health Practitioner Regulation National Law (Victoria) Act 2009*. This is part of a national scheme governed by the national health practitioner boards and the Australian Health Practitioner Regulation Agency.

Royal Australian College of General Practitioners (RACGP)

64. To understand the role and obligations of GPs in prescribing opioids and Schedule 4 or 8 medications for pain management, I sought further information from the RACGP as the national professional organisation responsible for setting standards for general practice and accreditation.

65. In response to questions posed, Ms Anita Muñoz, Chair of the RACGP Victoria Faculty, explained that drugs with the possibility of dependence are not first line treatment for non-

[10] Victorian Department of Health and Human Services, "Medicines monitored in SafeScript", <https://www2. health.vic.gov.au/public-health/drugs-and-poisons/safescript/medicines-monitored>, accessed 29 October 2019

[11] Victorian Department of Health and Human Services, "What medicines are monitored through SafeScript", <https://www2. health.vic.gov.au/public-health/drugs-and-poisons/safescript/health-professionals>, accessed 29 October 2019.

cancer chronic pain, but can have a role for some patients as part of a multimodal management plan. Ms Muñoz acknowledged that the risk of harm from such medications increases as the dose increases, and each individual patient will have their own unique risk profile based on their history and other morbidities.

66. I note the RACGP has published extensive clinical guidelines on prescribing drugs of dependence in general practice which can be viewed on the RACGP website. The GP's role includes taking appropriate steps to ensure patient safety, such as:

    a) assessing risk related to co morbidities, dose and other medication use;

    b) formulating treatment plans with measurable outcomes;

    c) where possible, establishing a single prescriber and single pharmacist;

    d) facilitating staged/supervised supply; and

    e) provision of naloxone and training in administering naloxone for family members/housemates; and

    f) regular review to assess treatment outcomes.

67. Ms Muñoz also outlined some of the challenges that GPs face in practising community medicine, including that the Medicare system is designed to give effect to principles of patient choice, autonomy and availability of doctors when accessing general practice care. This means that all rebates applied to patient care require the patient to be present in the room. This system was designed at a time when most health conditions were related to acute injuries or illnesses. Doctors practising today must now try to fit this framework to complex and chronic diseases, which often require ongoing coordination and consultation between doctors. This model is rigorously pursued in tertiary care settings in hospitals but is impractical in general practice, given the current funding model.

68. Emma's case therefore reflects some of the challenges faced with polypharmacy treatment in the context a complex and chronic presentation where a patient is being treated by more than one doctor.

69. Reflecting on Emma's case, Ms Muñoz suggested two measures that may have assisted her treating GPs to provide coordinated medical care and oversight:

a) Better support for case conferencing: increasing the rebate for mental health case conferencing Medicare Benefits Scheme (**MBS**) item numbers and expanding what is covered by these item numbers to include complex psychiatric conferencing between the GP and the psychiatrist without the patient being present. This would allow adequate funded time to conduct this conferencing and for in-depth conversations between the medical specialists that may not be appropriate with the patient present; and

b) GPs having access to advice from a pharmacology expert to advise on the interactions of various drugs. Currently the Victorian Drug and Alcohol Clinical Advisory Service provides this support to practitioners treating those with drug and alcohol use issues, but it could be expanded to support practitioners when prescribing pain medications.

Victorian Drug and Alcohol Clinical Advisory Service response

70. In consideration of the second suggestion made on behalf of the RACGP, I sought the views of the Victorian Drug and Alcohol Clinical Advisory Service (**DACAS**) as to the possibility of expanding their services to include advice from a pharmacology expert.

71. DACAS provides telephone consultation on clinical issues related to alcohol and other drugs. The service is managed by Turning Point, which receives State Government funding. Any Victorian clinician can use the service at no cost, and can do so 24 hours a day, all year round. DACAS is staffed by call takers, administrative support staff and a team of specialist medical practitioners or consultants, who are qualified addiction medicine specialists and addiction psychiatrists.

72. The service provided by DACAS is aimed at supporting clinical practice and the calls received are invariably in the form of a case or patient treated by the caller. The service aims to provide practical addiction medicine and psychiatry knowledge to clinicians. All DACAS consultants are actively employed in direct patient care roles as specialists outside their DACAS role, which is a part-time, casual sessional commitment.

73. In a statement made on behalf of the service, Turning Point Clinical Directors Dr Matthew Frei, A/Prof Shalini Arunogiri and Prof Dan Lubman explained that a key area of expertise of

all DACAS consultants is knowledge of drug effects and drug interactions. They added that while knowledge of drug interactions generally relates to drugs of dependence, it also encompasses drug interactions relevant to alcohol and other drug medicine. Addiction psychiatrists have particular exposure to interactions where psychiatric drugs are a component. Addiction medicine specialists often come from a general internal medicine background, and their training may focus more on drugs used for pain and other medical conditions and their interactions.

74. In these circumstances, the service considered that the addition of specialist pharmacologists to their consultant cohort would be unlikely to improve the content of DACAS advice.

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 Emma Louise Terrill, born 7 May 1979;

    b) the death occurred on 30 October 2020 at 2 Shawlands Avenue, Blackburn South, Victoria, 3130, from 1(a) aspiration pneumonia in the setting of a mixed drug toxicity; and

    c) the death occurred in the circumstances described above.

76. Having considered all the circumstances, I am satisfied that Emma's death was the unintended consequence of the ingestion of multiple drugs. Having regard to all the available evidence, it is likely that Emma consumed an amount of tramadol far in excess of the amount directed by her treating clinicians. This has led to an elevated tramadol level which, when combined with her use of benzodiazepines, has caused her death. However, I have been unable to determine why Emma took an excessive amount of tramadol, or whether she was aware that she had done so.

COMMENTS AND RECOMMENDATIONS

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

77. Emma had a complex history of mental health issues, illicit drug use, and polypharmacy in the context of reported issues with her physical health. Her issues were chronic in nature and spanned more than two decades. In the coronial context, having regard to principles of causation, remoteness and proximity, it is simply not feasible to now disentangle how this

situation came to be. It is also questionable whether such an endeavour could be successfully undertaken in a case of this type and complexity.

78. The management of Emma by clinicians treating her in the period proximate to her death must be viewed within that context and without hindsight bias. As noted by Ms Muñoz on behalf of the RACGP, Emma's case demonstrates the challenges confronted by GPs when providing care to a patient with a history of polypharmacy treatment in the context of a complex and chronic presentation, where patients exercise choice in accessing general practice care. In my view, the same may be said in relation to the provision of psychiatric care.

79. Emma had been prescribed and was taking large amounts of prescription medication for pain and her mental health issues for an extended period of time. The risk of harm from such medications, most notably accidental overdose, increases as the dose increases. However, even in smaller therapeutic doses, this Court routinely investigates deaths that occur in the context of polypharmacy, where a combination of prescription medications prescribed by even a single medical practitioner has led to accidental or deliberate overdose, and where even short periods of prescription medication use results in iatrogenic drug dependency and abuse. Clinicians prescribing these drugs do so for the benefit of their patients in the management of physical and mental illness, and not every patient is the same. Each patient's risk profile will be assessed based on their history as it is known to the prescriber.

80. In my view, the available evidence does not establish that the prescribing practices of Emma's GPs or psychiatrist were inappropriate. I am satisfied that there was a reasonable clinical basis for the medications prescribed to Emma, with acknowledgement of the risk involved, and mitigation strategies in place to manage that risk. Whilst there was no recent review by a pain management specialist, which would have been best practice, Dr Zhang did attempt to reduce Emma's tramadol usage but was unsuccessful. Dr Lim also discussed reduction of medication dosage with Emma. These discussions were complicated by Emma's resistance to using methadone or suboxone.

81. I note that there were no Schedule 8 permits for the prescribing of alprazolam and lisdexamfetamine, and no applications for such permits were submitted. However, I have not made a final determination as to whether these were required, as the evidence does not suggest that Emma's death would have been avoided if those drugs were not prescribed. As a comment, it would be prudent for the prescribers involved to make their own enquiries and

ensure they correctly understand the legislative requirements for prescribing Schedule 8 drugs to a person regarded as 'drug dependent'.

82. Prescription drug deaths are a growing problem in Australia. It is apparent that management of a patient with polypharmacy treatment in the context of a complex and chronic presentation can be a challenging area of medical practice. Whilst I have not identified any specific prevention opportunities in relation to Emma's case, anything that can be done to provide greater support and resourcing to GPs and other medical practitioners managing such patients would be of benefit, particularly in the management of patients with mental health issues where there are multiple prescribers. In this case, I note there was some consultation between Emma's treating GP and psychiatrist, and this is to be encouraged.

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

(i) That the Australian Government Department of Health, Disability and Ageing consider increasing the rebate for mental health case conferencing Medicare Benefits Scheme (MBS) item numbers and expanding what is covered by these item numbers to include complex psychiatric conferencing between a GP and psychiatrist in the absence of the patient.

ORDERS

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

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

Angela Terrill, Senior Next of Kin

Blackburn Clinic

Dr Andrew Rawlin (c/- MDA National)

Senior Constable Natali Gregov, Victoria Police, Reporting Member

The Australian Government Department of Health, Disability and Ageing

The Royal Australian College of General Practitioners (RACGP), Victoria Faculty

The Victorian Drug and Alcohol Clinical Advisory Service

Signature:

Coroner Catherine Fitzgerald

Date: 07 August 2025

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.