IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 005440

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Daniel Joseph Herbert
Date of birth:	23 June 1981
Date of death:	Between 27 and 29 October 2018
Cause of death:	Combined drug toxicity (methadone, fentanyl, diazepam and pregabalin)
Place of death:	[redacted] Wodonga, 3690

INTRODUCTION

1. Daniel Joseph Herbert, born on 23 June 1981, was 37 years old at the time of his death. He lived in Wodonga with his parents [redacted], his brother [redacted] and his seven-year-old son [redacted].

2. Mr Herbert had a history of drug abuse which developed after being prescribed OxyContin for a work-related back injury approximately 17 years prior to his death.

3. Mr Herbert's parents described him as "a kind and gentle person" who was "never aggressive or moody" and never stole from the family.[1] He was a loving and "awesome" father to [redacted].[2]

4. On 29 October 2018, on returning from a weekend trip to Sydney, [redacted] found her son deceased on the floor in his bedroom.

THE CORONIAL INVESTIGATION

5. Mr Herbert'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 death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

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 Detective Leading Senior Constable Tracy Jarrott (**DLSC Jarrott**) to be the Coroner's Investigator for the investigation of Mr Herbert's death. DLSC Jarrott conducted inquiries on my behalf, including taking statements from witnesses and compiling a

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[1] Coronial Brief of Evidence (**CB**), Statement of [redacted], [5]; CB, Statement of [redacted], [9].

[2] CB, Statement of [redacted], [8]; CB, Statement of [redacted], [10]; CB, Statement of [redacted], [15].

coronial brief of evidence. The brief contains statements from Mr Herbert's family and ex-partner, treating clinician, the forensic pathologist who examined him, the Coroner's Investigator, as well as other relevant materials.

9. After receipt of the brief, the Court obtained a statement from Dr Julian Fidge, Mr Herbert's treating general practitioner (**GP**) at the time of his death.

10. As part of the coronial investigation, advice was also sought from the Coroners Prevention Unit (**CPU**)[3] concerning the appropriateness of prescribing pregabalin to Mr Herbert. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are not associated with the health professionals under consideration and are therefore able to give independent advice to coroners.

11. This finding draws on the totality of the coronial investigation into the death of Daniel Joseph Herbert including evidence contained in the coronial brief and information provided by the CPU. 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.[4]

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

Circumstances in which the death occurred

12. After leaving school at the age of 15, Mr Herbert worked for some years in maintenance and other trades.[5] When he was approximately 20 years old, he suffered a back injury while working in concreting and was prescribed OxyContin for pain relief and Valium for

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

[4] 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.

[5] CB, Statement of [redacted], [5].

depression.[6] His parents recalled that this "was the start of Daniel's drug problems as he became addicted to the OxyContin."[7] Shortly after this, Mr Herbert stopped working.

13. Sometime after the age of 21, Mr Herbert moved out of the family home and into his own residence in Snowden Street. His mother observed his drug addiction escalate at this time.[8]

14. In November 2018, Mr Herbert commenced a relationship with [redacted], and their child [redacted] was born in 2011.[9] From the time they met, their relationship revolved around the use of drugs.[10] According to [redacted], the couple smoked cannabis heavily on a daily basis.[11] She also said that Mr Herbert was addicted to opiates and would take "whatever drugs he could get his hands on".[12] They both used drugs intravenously.[13] For several years prior to his death, the relationship had become volatile and resulted in domestic violence incidents.[14]

15. In April 2018, Mr Herbert was sentenced to two months' imprisonment for various offences including family violence-related offending.[15] While in prison, without access to drugs, Mr Herbert became healthy and put on weight. However, upon his release, he returned to [redacted] and started using drugs again.[16]

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[6] CB, Statement of [redacted], [6].

[7] CB, Statement of [redacted], [6]; CB, Statement of [redacted], [5]-[6].

[8] CB, Statement of [redacted], [7].

[9] CB, Statement of [redacted], [1]-[2].

[10] CB, Statement of [redacted], [6]; CB, Statement of [redacted], [2] and [12].

[11] CB, Statement of [redacted], [12].

[12] CB, Statement of [redacted], [11].

[13] CB, Statement of [redacted].

[14] CB, Statement of [redacted], [15].

[15] CB, Appendix 3.

[16] CB, Statement of [redacted], [8]; CB, Statement of [redacted], [11].

Prescription medications

16. When Mr Herbert sustained his back injury, his treating GP was Dr Phillip Steele at Federation Clinic in Wodonga. According to Mr Herbert's father, Dr Steele "ended up kicking Daniel out of the clinic", however the reason for this is unknown.[17]

17. As no other doctors in Wodonga would prescribe the medications he sought, Mr Herbert started seeing Dr Julian Fidge at Docker Street General Medical Centre in Wangaratta.

18. Dr Fidge said that at the first consultation, enquiries were made and Mr Herbert was "identified as a doctor shopper". As such, a treatment plan was negotiated with Mr Herbert to help reduce harm from 'doctor-shopping' and illicit drug use.[18] Under Dr Fidge's care, Mr Herbert commenced opioid replacement therapy on 14 March 2018 with the prescription of methadone. He was also prescribed diazepam for anxiety and pregabalin for neuropathic pain. These medications were controlled through monthly consultations, which limited the quantities of medications prescribed and staged the supply of limited quantities of medication by the pharmacist.[19]

19. On 17 August 2018, Mr Herbert attended on Dr Cornelius Kruytbosch in Albury,[20] providing a "vague…reason why his Wodonga practitioner failed to meet his needs."[21] Mr Herbert said that he sustained a laceration to the right wrist in 2010 and continued to suffer nerve damage pain in his right ring and little fingers, which radiated to the right forearm. Dr Kruytbosch noted that this was "consistent with neuropathic pain". Mr Herbert also claimed to have suffered from anxiety and depression since childhood.

20. During this consultation, Dr Kruytbosch issued a script for 56 pregabalin tablets with five repeats, and two scripts for diazepam.[22] Dr Kruytbosch said that he received a telephone call from a pharmacy later that day informing him that Mr Herbert was "a known 'Doctor

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[17] CB, Statement of [redacted], [7].

[18] Statement of Dr Julian Fidge, [5].

[19] Statement of Dr Julian Fidge, [11]; CB, Statement of [redacted], [12]; CB, Statement of [redacted], [7]; CB, Statement of [redacted], [10].

[20] Mr Herbert only saw Dr Kruytbosch on one occasion, on 17 August 2018.

[21] CB, Statement of Dr Cornelius Kruytbosch, p1.

[22] CB, Appendix 5.

Shopper'". The pharmacist sought confirmation from the doctor as to whether the script was to be dispensed. Dr Kruytbosch said that he decided to cancel the script.

21. According to the Medicare and Pharmaceutical Benefits Scheme (**PBS**) claims history, however, all of the scripts issued by Dr Kruytbosch on 17 August 2018 for pregabalin and diazepam were dispensed to Mr Herbert at the Chiltern Pharmacy. How these scripts were dispensed when Dr Kruytbosch claimed to have cancelled them is unknown.[23]

Fentanyl

22. According to his mother and [redacted], Mr Herbert had been using fentanyl for years, purchased in the form of patches from someone called Rodger.[24]

23. The evidence suggests that on or around 26 October 2018, Mr Herbert obtained fentanyl from Rodger.[25]

27 to 29 October 2018

24. At approximately 6.00am on Saturday 27 October 2018, [redacted], her husband, [redacted] and [redacted] left the family home to travel to Sydney. Mr Herbert was awake and came out of his bedroom to say goodbye to them. It was not unusual for Mr Herbert to choose to stay at home instead of going to Sydney with the family.[26] As Mr Herbert did not have a mobile phone, the family could not contact him over the weekend.

25. At approximately 3.00am on 29 October 2018, the family returned home. [redacted] noticed that the house was still in the same state as when they left.[27] Seeing that the light was on in Mr Herbert's room, she went to check on him and saw him on his knees and lying face down on the floor, apparently deceased.[28]

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[23] The CPU was requested to contact Dr Kruytbosch for further comment but was advised that he had retired and that his patient records were, at the time of the attempted contact, being transferred to another clinic.

[24] Last name unknown.

[25] CB, Statement of [redacted], [5]; CB, Statement of [redacted], [11].

[26] CB, Statement of [redacted], [9].

[27] The kitchen and living room lights were on; the television was on the same cartoon channel; the money that [redacted] had left for Mr Herbert to get some milk was still on the bench. CB, Statement of [redacted], [10]; CB, Statement of [redacted], [14].

[28] CB, Statement of [redacted], [10]; CB, Statement of [redacted], [13].

26. Emergency services were called and ambulance paramedics arrived, but Mr Herbert was unable to be assisted. Paramedics pronounced him deceased a short time later.

27. Police, including the Coroner's Investigator DLSC Jarrott, attended the scene and commenced an investigation. Photographic evidence was collected and formed part of the coronial brief.

28. In Mr Herbert's bedroom, DLSC Jarrott observed empty medication packages of prescription medications, including diazepam, Valpam (diazepam), Clonidine, pregabalin and Lyrica (pregabalin). She also located two empty packets of 50mg fentanyl patches and three sharps containers containing used syringes. A used syringe was located on the floor between Mr Hebert's legs.

29. No suspicious circumstances were found. Police believe that Mr Herbert had extracted the contents of the fentanyl patches and used a syringe to inject his arm with an unknown quantity of the drug, passing out thereafter and slumping forward with his face hitting the floor.[29]

Identity of the deceased

30. On 29 October 2018, the body of Daniel Joseph Herbert, born 23 June 1981, was visually identified by his father, [redacted].

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

Medical cause of death

32. Specialist Forensic Pathologist Professor Noel Woodford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted a partial autopsy on 1 November 2018, reviewed a post-mortem computed tomography (**CT**) scan and referred to the Victoria Police Report of Death (Form 83), VIFM preliminary examination report, Victoria Police scene photographs and medical records from Docker Street General Medical Centre. Professor Woodford provided a written report of his findings dated 29 January 2019.

33. The autopsy revealed evidence of recent and more remote injecting drug use. There were no injuries identified of a type likely to have caused or contributed to death. There was also no natural disease identified of the type likely to have caused or significantly contributed to death.

[29] CB, Police Summary.

34. Toxicological analysis of post-mortem blood samples identified the presence of the following drugs in the following concentrations in blood:

    i. Methadone (~0.3 mg/L) and its metabolite;[30]

    ii. Fentanyl (~14 ng/mL);[31]

    iii. Diazepam (~0.1 mg/L) and its metabolites;[32]

    iv. Pregabalin (~13 mg/L);[33] and

    v. Cannabis metabolite delta-9-tetrahydrocannabinol (~3 ng/mL).

35. Analysis of the specimen of post-mortem urine showed the presence of methadone and its metabolite, fentanyl, diazepam and its metabolites, amphetamine,[34] methylamphetamine, and cannabis metabolite 11-nor-delta-9-tetrahydrocannabinol.

36. Professor Woodford noted that there is an additive central nervous system (**CNS**) depressive effect with concurrent use of methadone, neuromuscular blockers, tranquilisers and other CNS depressant drugs, resulting in exaggerated respiratory depression and sedation.

37. Professor Woodford found evidence of aspiration of gastric content, which is likely to have occurred due to an inability to protect the airway as a consequence of CNS depression, and has possibly contributed to the ultimate mechanism of death.

38. Professor Woodford provided an opinion that the medical cause of death was 'Combined drug toxicity (methadone, fentanyl, diazepam and pregabalin)'.

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[30] Methadone is a synthetic narcotic analgesic used for the treatment of opioid dependency or for the treatment of severe pain.

[31] Fentanyl is a narcotic (opioid analgesic) used as perioperative analgesic and as an adjunct to surgival anaesthesia.

[32] Diazepam is a sedative/hypnotic drug of the benzodiazepines class. Nordiazepam, temazepam and oxazepam are metabolites of diazepam.

[33] Pregabalin, an analog of the inhibitory neurotransmitter gamma-aminobutyric acid, is used clinically as an analgesic, anticonvulsant and anxiolytic agent. When taken in combination, pregabalin can increase the depressant effects of opioid analgesics, benzodiazepines and ethanol.

[34] Amphetamines is a collective word to describe CNS stimulants structurally related to dexamphetamine. One of these is methamphetamine, a strong stimulant drug that acts like the neurotransmitter noradrenaline and the hormone adrenaline. Amphetamine is also a metabolite of methamphetamine.

CORONERS PREVENTION UNIT REVIEW

39. The CPU was requested to review the appropriateness of prescribing pregabalin to Mr Herbert. As part of its review, the CPU referred to the coronial brief of evidence and medical records from Docker Street General Medical Centre, and noted that of the drugs identified as being contributory to Mr Herbert's death, methadone, diazepam and pregabalin were prescribed to him in the period proximal to his death, but fentanyl was not.

40. Putting aside fentanyl, the CPU examined Mr Herbert's Medicare and PBS claims history and medical records from Docker Street General Medical Centre to identify the source and amounts of methadone, pregabalin and diazepam prescribed and dispensed to Mr Herbert. It was noted that Dr Fidge had sole responsibility for prescribing methadone as part of an opioid replacement therapy program. The amount of methadone prescribed and dispensed fluctuated under the review of Dr Fidge, partly due to Mr Herbert not using methadone for three weeks in August 2018, necessitating his restart on methadone at a much lower daily dose, to be increased as time went on.

41. In relation to pregabalin, Mr Herbert was prescribed the drug a total of six times in the three months prior to his death. Dr Fidge prescribed pregabalin four times without repeat, his colleague at Docker Street General Medical Centre once without repeat, and Dr Kruytbosch once with five repeats. All of these were PBS scripts and all three doctors directed Mr Herbert to take one tablet twice a day. However, a total of 560 tablets of 300mg pregabalin were prescribed and dispensed to Mr Herbert across all of these scripts, averaging approximately 5.3 tablets per day.

42. In relation to diazepam, Mr Herbert was prescribed the drug a total of eight times in the three months prior to his death—four times by Dr Fidge, once by his colleague at Docker Street General Medical Centre, twice by Dr Kruytbosch, and once by Dr Muhammad Jawaid at Tristar Medical Group (Wodonga). All of these scripts were issued without repeat and, except for the four issued by Dr Fidge, all were PBS scripts. The directions for consumption specified by Dr Jawaid are unknown, but records indicate that Dr Kruytbosch directed Mr Herbert to take one tablet twice a day, and Dr Fidge and his colleague directed him to take one tablet three times a day. In total, 520 tablets of 5mg diazepam were prescribed and dispensed to Mr Herbert across all of these scripts, averaging approximately 4.9 tablets per day.

43. The CPU noted that the amount of pregabalin and diazepam prescribed and dispensed to Mr Herbert in the period proximal to his death exceeded the clinical directions for consumption

when considered as a whole. However, the CPU considered that the individual prescribing of each doctor was not excessive; rather it was the overlap of prescribing—particularly the overlap between Dr Fidge and Dr Kruytbosch—that allowed Mr Herbert to obtain excessive amounts of these drugs. The CPU acknowledged that both doctors do not appear to have been aware of each other prescribing the same drugs during the same time period to Mr Herbert.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

44. Mr Herbert was prescribed in amounts that significantly exceeded the clinical directions for consumption, particularly in the three months immediately prior to his death. The evidence suggests that he had a dependence on pregabalin.

45. Victorian Coroners have previously highlighted the harms associated with pregabalin.[35] This case is a further example that pregabalin is not a harmless drug.

46. This finding will be provided to the Royal Australian College of General Practitioners and consideration should be had in relation to warning their members that when prescribing pregabalin with repeats, they should treat it with the same caution as any other drug of dependence.

47. I note that in February 2021, the Therapeutic Goods Administration (**TGA**) introduced a new warning label on pregabalin boxes to advise doctors to assess a patient's risk of abuse before prescribing the drug and to monitor patients regularly during treatment. This change, unfortunately subsequent to Mr Herbert's death, represents an improvement and a growing awareness about the risks of pregabalin.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Daniel Joseph Herbert, born 23 June 1981;

    b) the death occurred between 27 and 29 October 2018 at [redacted] Wodonga, 3690; and

[35] E.g. Carlin R, Finding without inquest in the death of NJ (identity redacted), Coroners Court of Victoria, reference COR 2015 2127, delivered 4 July 2017; Gebert S, Finding without inquest in the death of Mr A (identity redacted), Coroners Court of Victoria, reference COR 2016 4886, delivered 18 October 2019; Bracken D, Finding without inquest in the death of Tate Ashley Hobbs, Coroners Court of Victoria, reference COR 2019 686, delivered 25 June 2021.

c) I accept and adopt the medical cause of death ascribed by Professor Noel Woodford and I find that Daniel Joseph Herbert died from combined drug toxicity (methadone, fentanyl, diazepam and pregabalin).

49. Having considered all of the circumstances, I am satisfied that his death was the unintended consequence of his intentional use and abuse of prescription medication in combination with illicit drugs.

Pursuant to section 73(1A) of the Act, I order that the redacted finding be published on the internet in accordance with the rules.

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

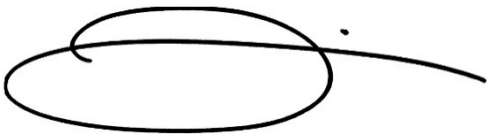
[redacted]

Dr Julian Fidge, Docker Street General Medical Centre

Royal Australian College of General Practitioners

Detective Leading Senior Constable Tracy Jarrott, Victoria Police, Coroner's Investigator

Signature:



AUDREY JAMIESON, CORONER

Date: 27 July 2021

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.