STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Alissa Campbell
Hearing dates:	21-25 May 2018
Date of findings:	27 July 2018
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – accidental drug overdose, Real Time Prescription Monitoring (RTPM)
File numbers:	2015/206715
Representation:	Ms D Ward, Counsel Assisting, instructed by Ms J Geddes and Ms T Bird, Crown Solicitor's Office Mr N Regener of Makinson d'Apice, for Dr Hoque and Dr Moore Mr C Jackson, instructed by Ms L Kearney of Avant Law, for Dr Hurst and Dr Grammat Ms J Gatland, for Mr Kanchan Mr R Gambi with E Anderson, instructed by Mr D Brown of Brown's Legal & Consulting, for Dr Foo Mr T Saunders, instructed by Ms N Brown of Meridian Lawyers, for Dr Rust

Findings:

The findings I make under section 81(1) of the Coroners Act 2009 (NSW) are:

Identity
The person who died was Alissa Campbell.

Date of death
She died on 14 July 2015.

Place of death
She died at 29 Judge Street, Woolloomooloo, NSW.

Cause of death
She died from multiple drug toxicity.

Manner of death
Alissa Campbell died from an accidental drug overdose. Those around her did not immediately recognise the danger she was in and for that reason medical intervention was tragically delayed.

Recommendations:

To the Minister for Health
I recommend that urgent consideration is given to raising the priority for the introduction of Real Time Prescription Monitoring (RTPM) in NSW. I recommend that the Ministry plan and publish a timetable for the scheme's commencement.

Non publication orders:

1. Pursuant to section 74 of the *Coroners Act 2009* (NSW) I make the following non-publication orders:

   a. Name, date of birth and image of AT;
   b. Tab 21;
   c. Tab 22;
   d. Tab 23;
   e. Tab 62 (page 637);
   f. Current residential address of Mithun Kanchan; and
   g. Exhibit 2 (sensitive material folder).

2. Pursuant to section 65 of the *Coroners Act 2009* (NSW), I make an order that access not be provided to the contents of the following unless with the specific leave of the Coroner:

   a. Exhibit 2 (sensitive material folder); and
   b. Exhibit 1, Tab 96.

Table of Contents

Introduction 1
The role of the coroner 1
The evidence 1
Brief background 2
The last 24 hours of Alissa's life 3
Cause of death 4
Was Alissa's death preventable? 6
How did Alissa get access to prescription drugs? 7
Dr Foo 8
Dr Hurst 9
Dr Moore 13
Dr Rust 14
Dr Grammat 14
The General Practitioners from the DoctorDoctor service 15
Dr Hoque 15
Dr Ayad 15
Dr Haddad 15
Other doctors seen by Alissa 15
The need for recommendations 16
Real Time Prescription Monitoring (RTPM) 16
Tackling unsafe or unnecessary prescription and overuse of opioids 19
Findings 20
Identity 20
Date of death 20
Place of death 20
Cause of death 20
Manner of death 20
Recommendations pursuant to section 82 Coroners Act 2009 20
Referral of matter to NSW Medical Council 20
Conclusion 21

Introduction

1. Alissa Campbell died in her own home on 14 July 2015. Toxicological testing would later indicate that her death was caused by an overdose of prescription medication. Initially her partner and family members thought she was sleeping or had “passed out”. After an ambulance was eventually called it became clear that Alissa was dead.

2. Alissa was only 26 years of age. She had a young son, a partner and many family members who loved her. Her aunt described her as “a wonderful loving young woman, a loving mother and daughter and a best friend to her mother”.[1] Her father described the joy she and her son brought to the family and her partner described Alissa’s purity and contagious smile. Although the family was fractured, it is clear that each family member has suffered their own great pain and tremendous loss.

3. Alissa’s death is a terrible tragedy that continues to cause enormous grief and distress to those who loved her.

The role of the coroner

4. The role of the coroner is to make findings as to the identity of a nominated person and in relation to the place and date of death. The coroner is also to address issues concerning the manner and cause of the person’s death.[2] The place and date of Alissa’s death is straightforward. For this reason the inquest focused on the circumstances surrounding her death and on whether it could have been prevented.

5. A coroner may also make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[3] While the expert evidence in this inquest was fairly narrowly contained to the immediate circumstances of Alissa’s death, those circumstances drew attention to the need for greater transparency and monitoring of the prescription of potentially dangerous drugs.

The evidence

6. The court took evidence over four days and heard final oral submissions from the parties on the fifth. The court also received extensive documentary material in five volumes. The material included witness statements, medical records, photographs, audio and video recordings and expert reports.

7. Two medical experts gave oral evidence. Dr Hester Wilson, who has expertise in general practice and addiction medicine, reviewed the medical records of a number of general practitioners who had seen Alissa over the years and provided her views on the adequacy of their care[4]. Professor Alison Jones reviewed Alissa’s post mortem toxicological results and assisted the court with understanding the process of Alissa’s death.

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[1] Alissa’s maternal family did not attend the inquest but their thoughts were read onto the record. Counsel assisting’s submission, Transcript 24/5/18, page 31, line 15 onwards.
[2] Section 81 *Coroners Act 2009* (NSW).
[3] Section 82 *Coroners Act 2009* (NSW).
[4] Report of Dr Hester Wilson, Exhibit 1, Tab 10.

8. A list of issues was prepared before the proceedings commenced[5]. However, as the inquest progressed, the focus became the manner in which Alissa was able to obtain prescription drugs, the nature and adequacy of the medical care that Alissa received in the months before her death and on the events of 14 July 2015. The court was also concerned with trying to identify ways in which Alissa's death could have been prevented.

Brief background

9. Alissa had lived in Judge Street, Woolloomooloo most of her life. Her mother and grandmother had been there even longer, sharing the house with various other family members who came and went. At the time of Alissa's death, her partner, Mithun Kanchan and their son were also living at the premises, along with her brother Jake and his girlfriend.

10. Alissa's parents had separated when she was about five years of age, but Alissa had remained in contact to some degree with her father over the years and their relationship had strengthened recently. Michael Franke spoke of his joy at the birth of his grandchild and his happiness in reconnecting with Alissa.

11. There is little doubt that there was often a turbulent atmosphere in the Judge Street house. In recent times Alissa's family had prevented her from seeing her grandmother before she died and apprehended violence orders were in place.[6] There had been numerous fights between various relatives and frequent episodes of discord in the home. A number of doctors that Alissa had seen had recorded her ongoing anxiety about her living situation. Nevertheless, it is clear that Alissa and her mother had a close relationship and often did things together.

12. One clear point of tension in the home was that Alissa's maternal family did not support her relationship with Mithun, which they characterised as abusive. They suggested he belittled Alissa and treated her poorly. Mithun stated that Alissa's family "hated him" and that the family had previously told her that she must choose between with him and the rest of the family. He told the court that around the time of her death he and Alissa were planning to leave Woolloomooloo and set up a home of their own, with their son.

13. In other words, both Mithun and the maternal family saw each other as negative influences on Alissa's wellbeing. Whatever the truth of the situation, it is clearly documented in medical records that Alissa felt anxious about the atmosphere at home and reported, at different times, a lack of support from them all.

14. Alissa had a substantial medical history. Over the years she had experienced a variety of medical conditions and complaints. These included recurrent back pain, sciatic nerve problems, iron deficiency anaemia, seizures, migraines, Graves' disease, obesity, anxiety, self-harm, suicidal ideation, post-natal depression and depression. There is no doubt that she was a complex patient, with a range of needs. Over the years she attended numerous doctors and received a wide range of medication. As well as any physical and mental health problems she experienced, Alissa was also troubled by extreme interpersonal trauma and the effects of family dysfunction.

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[5] List of Issues. Attached to Court file.

[6] COPS Event, Exhibit 1, Tab 46; Statement of S/C Jennar, Exhibit 1, Tab 8 and annexures; Statement of Michael Franke, Exhibit 1, Tab 19, [14].

The last 24 hours of Alissa's life

15. According to Mithun, he and Alissa had gone to Kings Cross very late in the evening to get food. On their return he had gone to bed. It appears that Alissa woke Mithun in the early hours of 14 July 2015 to ask for his credit card so that she could go with her mother to the local petrol station to get some coca cola. It seems to have been common that members of the household slept and woke at odd hours and had disrupted eating patterns. However, Mithun, who was a shift worker, was angry at being woken for money and there was an argument between them.

16. Alissa's mother, Pauline states that she was woken by the argument.[7] Mithun states that he was angry and hit the headboard, accidently breaking it.[8] He then gave Alissa $10 and went back to sleep.[9]

17. Alissa and Pauline left the house soon afterwards and walked the short distance to the petrol station. They had Alissa's baby with them in the pram.[10] At the petrol station, they met, by chance, some police officers who were getting petrol. Those officers thought it strange for the family to be out in the cold at that time in the morning and engaged Alissa and Pauline in conversation. According to their statements it was shortly after 4.15am.[11] Pauline told them she wanted Mithun removed from the house. After hearing that Mithun had punched the headboard of the bed, police decided to attend and speak with him.[12] Police recorded the event but after a brief investigation they were satisfied that no imminent danger existed.

18. Alissa and Pauline returned to the house shortly afterwards. The baby went back to bed with Mithun. According to Mithun, Alissa kissed him and then went back downstairs, while he slept. She later returned and asked for the credit card to get breakfast.[13] He said that they planned to go to a restaurant that evening.[14]

19. Alissa made some food and sat on the sofa to eat it. At some point in the morning Pauline reports that she was aware Alissa had taken five Valium tablets. It is not known when Alissa may have taken other drugs. Alissa appears to have last used the internet on her mobile phone at around 7.35 am.[15] Pauline states that she saw her daughter at 8.12am and then about 9am when Alissa was feeding her baby.[16]

20. Mithun came downstairs at about 10.30am and saw Alissa on the lounge. Her upper body was slumped over and she seemed to be in a deep sleep. He called her name and gave her a little shake but she did not wake up. He told the court that he assumed that she had just "passed out".

21. Mithun explained that he had been becoming increasingly concerned with Alissa's use of prescription drugs. He took a number of photographs and a short video of her on the lounge.

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[7] Statement of Pauline Campbell, Exhibit 1, Tab 13, [6].
[8] Statement of Sergeant Scott Mostran, Exhibit 1, Tab 40, [13], [15].
[9] Statement of Mithun Kanchan, Exhibit 1, Tab 11, [15] onwards.
[10] Statement of Sergeant Scott Mostran, Exhibit 1, Tab 40, [6].
[11] Statement of Sergeant Scott Mostran, Exhibit 1, Tab 40, [4].
[12] Statement of Sergeant Scott Mostran, Exhibit 1, Tab 40, [10].
[13] Statement of Mithun Kanchan, Exhibit 1, Tab 11, [18]-[19].
[14] Evidence of Mithun Kanchan, Transcript 24/5/18, page 27, line 1 onwards.
[15] Evidence of S/C Jennar, Transcript 21/5/18, page 19, line 1.
[16] Statement of Pauline Campbell, Exhibit 1, Tab 13, [9].

These were taken between 11.05am and 12.17 pm.[17] In some of these recordings Alissa's child can be seen and heard. Mithun explained that he wanted to show Alissa how she actually looked and acted when she used prescription medicine, as in the past she had not believed him. Alissa had apparently previously taken video footage of her mother Pauline for a similar purpose on an earlier occasion.[18]

22. When he couldn't wake Alissa, Mithun put their child in the stroller and went to visit Alissa's doctor, Dr Moore. He didn't have an appointment but Dr Moore agreed to see him in her lunchbreak. Quite properly, Dr Moore emphasised that she could not breach Alissa's patient confidentiality but she was willing to listen to Mithun. At the time of the inquest, Dr Moore could not remember if she had seen the photograph or video Mithun had taken that morning.[19] However, she remembered that Mithun was concerned about Alissa's well-being and the number of prescription drugs that she was using. He explained that it had been getting worse since the death of her grandmother, a few weeks earlier. The tenor of the conversation was that Mithun was concerned in a general way and not that he had any acute or urgent sense of danger.

23. Dr Moore had previously seen Alissa's child as a patient as well as Alissa. She offered to book Alissa in for an appointment for the following Thursday. She also suggested that Mithun should make a separate appointment as a new patient as he appeared to her to need support himself. It was during this discussion that Mithun received a phone call telling him that an ambulance had been called for Alissa back at the house. He left immediately. After Mithun was gone, Dr Moore was so concerned about the interaction that she spoke to a colleague and made a report to the FACS Helpline. She did this well before finding out the tragic result of the ambulance attendance.

24. It appears that after Mithun had left the house to visit Dr Moore, Alissa had been left by herself for a period of time. It may be that nobody was up and about downstairs or just that nobody recognised that there was anything wrong. At about 1.30pm, Alissa's brother's girlfriend, Akina Button got a call from her grandmother who was coming over to collect some car keys. Akina saw Alissa on the lounge and assumed that she was asleep. However, she was concerned enough to go back upstairs and tell Alissa's brother, Jake that "you should check on your sister, she's sleeping in a weird position."[20]

25. Akina went outside to meet her grandmother. A short time later Jake came running out and asked for someone to call an ambulance. An ambulance was called at 1.40pm and Akina's grandmother and uncle followed directions for CPR,[21] given to them by the Triple 0 operator. Unfortunately, when ambulance officers arrived soon afterwards Alissa was pronounced dead, despite their further attempts at CPR.

Cause of death

26. An autopsy was conducted by forensic pathologist, Dr Johan Duflou at the Department of Forensic Medicine, Glebe on 15 July 2015.[22] Dr Duflou lists the direct cause of death as

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[17] Sensitive Exhibit, Exhibit 2, Tab 1, 2,3, 4.
[18] Sensitive Exhibit, Exhibit 2,Tab 6.
[19] Dr Moore, Transcript 21/5/18, page 36, line 30.
[20] Statement of Akina Button, Exhibit 1, Tab 14, [24].
[21] Ambulance records, Exhibit 1, Tab 56.
[22] Autopsy Report, Exhibit 1, Tab 5.

"multiple drug toxicity". There were no obviously suspicious markings or injuries. There was "negligible minor injury" to the surface of the body and a peri-mortem bruise to the back of her head which was visible on dissection. Taking into account other evidence it is likely that this may have been sustained when Alissa's mother, Pauline was cradling Alissa's head after her death. There was no evidence of a traumatic injury or acute disease.

27. A number of medicinal tablets were found in Alissa's stomach. Toxicological blood testing which occurred post mortem revealed a number of prescription drugs were present, including various opioids (codeine, morphine and oxycodone), various benzodiazepines and two anti-depressants (doxepin and sertraline), among other substances.

28. The toxicological results were later analysed by specialist general physician and toxicologist, Professor Jones.[23] It was her view that Alissa's death was caused predominantly by the combination of codeine and doxepin. Taken individually the levels of each drug remained within the toxic range, but taken in combination these two drugs would have caused profound respiratory depression and coma. She also noted that doxepin, which is a tricyclic antidepressant, can cause cardiac arrhythmias, the risk of which is "exacerbated by hypoxia due to any respiratory depression."[24] The effect of these two drugs would have been further exacerbated by the presence of diazepam and oxycodone. It should also be noted that Alissa had been prescribed pregabalin, however as this drug is not currently included in testing regimes in Australia, it is impossible to know if it was present or played a part in Alissa's death.

29. Professor Jones was unable to say, on the basis of a single blood sample exactly when the fatal doses had been taken. However, she stated "the presence of active metabolites of many of the drugs indicates that Ms Alissa Campbell was alive for at least a few hours after ingestion of the overdose".[25]

30. Professor Jones also had the opportunity to view the video footage of Alissa taken by Mithun on his telephone. It appears that the footage was taken at around 11.06am.

31. At the outset, Professor Jones stressed that the only way to definitively diagnose death is through careful clinical examination. However, she noted that there were factors demonstrated in the video which suggest that Alissa may have been in a coma at the time the footage was taken. She is clearly unresponsive to touch or voice. She is not moving spontaneously. While she appears "pink" rather than cyanosed or blue in colour, there are no obvious movements indicating that she is breathing.[26] It is impossible to grade the coma on the Glasgow Coma Scale, but Professor Jones indicates that the coma is likely to have been serious or significant. On balance, Professor Jones thought it more likely that Alissa was in a coma, rather than dead at the time the footage was taken.

32. It is important to state that there is no evidence to suggest that Alissa's death was intentionally self-inflicted. Rather, it appears to have been an accidental overdose that occurred while she was eating or resting.

[23] Report of Dr Alison Jones, Exhibit 1, Tab 9.
[24] Report of Dr Alison Jones, Exhibit 1, Tab 9, page 256.
[25] Report of Dr Alison Jones, Exhibit 1, Tab 9, page 257.
[26] Supplementary report of Dr Alison Jones, Exhibit 1, Tab 9A, page 1.

Was Alissa's death preventable?

33. It appears that Mithun took his footage of Alissa at around 11.06am. The Triple 0 call occurred at 1.40pm. While it is impossible to know how long Alissa had been incapacitated prior to Mithun's discovery of her, it is certainly possible that she may have been in a coma for some hours before she died. This is consistent with toxicological analysis of her blood which showed the breakdown of some of the drugs within her system.

34. It was necessary to examine whether earlier medical treatment could have saved Alissa's life. Dr Wilson noted that people present at the house did not recognise the danger Alissa was in. They appeared to be somewhat used to members of the household, "passing out" for periods of time and nevertheless surviving.

35. Professor Jones stated that the failure to get early medical treatment was critical. Had Alissa received early referral to proper medical intervention, she would have been expected to survive the codeine and doxepin toxicity which killed her.

36. One of the drugs which Professor Jones would have administered if Alissa had been in her care was naloxone[27]. While naloxone would not have overcome the effects of the anti-depressant, it would have had some effect on the opioid drugs in her system and may have assisted a positive outcome. In Professor Jones's view, Alissa needed to be taken to a hospital where she could have received breathing assistance and other treatment as necessary.

37. The court heard evidence from Mithun about his decision to leave Alissa unattended when she could not be roused. I accept that he did not appreciate the imminent danger his partner was facing. He certainly had no understanding that she was at risk of death when he left her at the house that morning. The film he takes of Alissa has Alissa's child sitting nearby. I had the benefit of hearing Mithun give evidence and to observe his grief closely. It is inconceivable that he would have been so callous as to continue filming in those circumstances had he known his inaction could have contributed to her death. Equally, he would not have taken the video to show the doctor if he realised that it might disclose that he had filmed his partner dying. Mithun had no actual knowledge of what drugs Alissa had taken or when she had taken them. He understood her prescription drug use was problematic, but he did not understand it was life threatening in that moment.

38. Mithun gave oral evidence where he tried to explain the atmosphere and culture of the house at Judge Street, Woolloomooloo. He said words to the effect of, "everything abnormal" was normal in [that] house.[28] People slept and woke at all hours of the day, people took pills and passed out with regularity. There was shouting and even violence. He had seen both Pauline and Alissa's brother extremely drug affected and it no longer surprised him.

39. Mithun was specifically questioned on whether he had considered calling the ambulance when he saw Alissa that morning. He said,

> " No, I didn't think calling – I need to call the ambulance
> because I didn't think it's anything out of – unusual what I have
> already seen. I have seen Pauline in the same way, passing out

[27] Professor Jones,Transcript 23/5/18, page 47, line 26 onwards.
[28] Mithun Kanchan Transcript 24/5/18, page 11, line 50 onwards.

> and I have seen Alissa, a few times, the same way passing out, so, I didn't think it's anything different than other times, or the danger she was in."

40. I accept his evidence is truthful and although it may seem surprising, given the context of the house and its inhabitants, it is a plausible explanation of his lack of action. I accept that he was genuinely concerned about his partner and that is why he left the house to visit Dr Moore. What he failed to understand was that the danger was not just chronic, it was urgent.

41. Mithun told the court that he was originally from a farming community in the Punjab. He said he had very limited understanding and experience of depression and psychiatry. He gave evidence that his own life and cultural experience meant that he "never thought a person can die by the medicine prescribed by doctor".[29] While I accept that Mithun did not understand the perilous situation Alissa was in on the morning of 14 July 2015, I find that his supposed innocence about prescription drug use is likely to have been somewhat overstated. He had lived in a house awash with drugs for some years. He worked as a security guard at a Kings Cross night club. There were large numbers of steroids found in his bedside drawer. While I accept that he did not understand that Alissa was close to death that morning, one can safely assume that he knew something of the potential dangers of drug use, even if he failed to recognise the danger that morning.

42. Tragically, it is clear that Alissa's death was preventable. In my view, had she received urgent medical attention, it is likely that she would have survived the overdose. No one person is to blame for her death. Her growing anxiety and drug dependence was exacerbated by the turmoil and discord in which she appeared to be living. At times she felt unsupported by members of her maternal family and by Mithun. Unfortunately she found it easy to obtain a range of drugs without, it seems, much education about the real dangers that mixing them could bring.

How did Alissa get access to prescription drugs?

43. Before reviewing the drugs which were actually prescribed to Alissa, it is necessary to point out that it is clear that there was a general acceptance in the house that medications once obtained could be shared. They were not stored safely or securely[30]. It is also worth noting that while there is no record of Alissa having been prescribed doxepin, her mother was.

44. Mithun was keen to make it known that Alissa had "not always been like this". He gave evidence that at times Alissa was "okay" or "normal", but increasingly as 2015 wore on she was under the influence of drugs. When she was "normal" she was a caring and attentive mother. However Mithun became concerned because when she was "out of it" she could fall asleep, even when holding the baby. Mithun told the court that when he first knew Alissa she was "always against her mum using medication" and used to hide her mother's pills and confront Pauline about her problematic use. However, more recently he had seen Alissa's own use increase and it concerned him.[31] He said that he was aware that at times Alissa got Valium tablets from her mother, Pauline.

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[29] Mithun Kanchan Transcript 24/5/18, page 25, line 26.
[30] Statement of Dr Jennifer Raymond, Exhibit 1, Tab 43, [12].
[31] Transcript 24/5/18, page 4, line 35 onwards.

45. Counsel assisting created a useful spreadsheet which summarises the known prescriptions obtained by Alissa and her mother from January and February 2015.[32] It is a startling document outlining a very large number of prescription medications obtained from different doctors and filled at a variety of chemists, sometimes even on the same day.

46. In the six months prior to Alissa's death she saw 13 general practitioners.[33] However, as the inquest progressed it became increasingly clear that no one practitioner had a complete picture of her health needs or indeed her current medications. While some of the doctors prescribed a range and volume of medication which was acceptable in isolation, the total picture that emerged was disturbing.

47. It is also clear that Alissa chose to discuss specific issues with certain practitioners. Her relationship with Dr Moore, for example appears to have been one of very genuine therapeutic value and Dr Moore prescribed cautiously. However, she did not know that Alissa had apparently had a long history of migraine or a known history of troubling benzodiazepine use. It would not have been clear to Dr Moore, using her own records, that Alissa appeared to be developing a significant dependence on prescription medication as 2015 wore on. Alissa clearly understood that by visiting different doctors she could obtain the medication she needed. She was then careful to get it dispensed at different pharmacies, sometimes even on the same day. Alissa appears to have visited doctors who were prepared to use private prescriptions and she asked for them directly.

48. It is important to note that none of the doctors identified Alissa as "a typical drug user." This is because there is no "typical drug user." It is increasingly clear that problematic opioid and benzodiazepine use can affect any person within the community. Alissa had real and varied medical problems. Her requests for drugs would have been compelling and genuine.

49. Dr Wilson, in her expert review, was sympathetic to some of the real problems facing general practitioners. Given the time constraints on doctors, it is sometimes difficult to contact other treating practitioners during the course of a normal consultation to corroborate history. This is especially the case in bulk billing practices where patients frequently attend on a one-off basis.

50. The inquest focussed on examining the conduct of the doctors who had seen Alissa in the six months prior to her death[34]. While I do not intend to examine each consultation in detail, it is necessary to review the important relationships she developed and to understand the kind of care that she received.

Dr Foo

51. Dr Foo practised at Woolloomooloo and had treated Alissa and her family since Alissa was a child. At the time of her death he had seen her on and off for 22 years. I accept that this helps to explain the brevity of some of his later clinical notes.

52. Dr Foo gave oral evidence before the court. He appeared to be a principled and caring practitioner. He told the court that as well as conducting his own practice in Woolloomooloo, he works as a visiting general practitioner at Foster House, a facility for homeless men in the

[32] See "2015" GP Attendances document. Attached to Court file.

[33] Report of Dr Hester Wilson, Exhibit 1, Tab 10.

[34] It should be noted that in the records obtained troubling prescribing was also revealed in earlier years. See for example the appendix to Dr Wilson's report.

area. For this reason he had some considerable experience working closely with patients who may have problematic use of prescription medications and alcohol. He also demonstrated knowledge of the local drug and alcohol services.

53. Dr Foo was aware that Alissa had a longstanding problem with migraine, which appeared to be an issue that both her mother and grandmother also suffered. It had apparently been diagnosed in childhood and Dr Foo had referred Alissa for neurological assessment at the Sydney Children's Hospital. In adolescence and later life, Dr Foo felt there were also psychological components to the problem and he felt that family stress and conflict may have been causing increased anxiety and triggering attacks.[35]

54. Dr Foo explained that at times Alissa was reluctant to take up medical support offered and he gave the example of her resistance to attending antenatal support, psychological counselling or psychiatric appointments. She had also failed to follow up referrals for neurological review or CT scanning for back pain. In that respect she was not always an easy patient to help.

55. Dr Foo told the court that in 2010 he had become aware that Alissa had an addiction to benzodiazepines. After confirming this with her psychiatrist, he had always been circumspect in prescribing any drug of addiction to Alissa.[36] For this reason, on occasions when she presented in pain he chose to give her a tramadol injection, rather than a prescription for painkiller tablets. He felt that it gave him more control over the prescribed drug and for that reason was a safer option for Alissa. Dr Wilson was not critical of that approach.

56. Dr Foo prescribed Alissa temazepam for insomnia after the birth of her child and later after the death of her grandmother. However, he was careful to limit the length of the prescription and recorded "last script" in his notes to remind himself. He never wrote a private script for this medication, noting that "first of all, it was too large a quantities [sic]. I didn't feel safe to prescribe in that way."[37]

57. I accept that Dr Foo was never aware that Alissa was obtaining benzodiazepines from other doctors and that he did not ever see her when she was obviously drug affected or intoxicated.

58. The court is not critical of Dr Foo's involvement in Alissa's care.

Dr Hurst

59. Alissa had initially seen Dr Hurst at a practice in Kogarah in 2013. He recalled that he had seen her at that time in relation to thyroid problems and anaemia.[38] However, he did not recall knowing that Alissa had an issue with benzodiazepine dependency, although 2013 correspondence to the Kogarah practice from St Vincent's Clinic referred to an "issue of benzodiazepine dependency".[39]

60. He explained that in 2015 Alissa appeared to have somehow discovered that he was working in Sutherland and sought him out because they had previously had a good rapport. He did

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[35] Dr Foo Transcript 22/5/18, page 41, line 25 onwards.
[36] Dr Foo Transcript 22/5/18, page 45, line 21 onwards.
[37] Dr Foo Transcript 22/5/18, page 52, line 10 onwards.
[38] Dr Hurst Transcript 22/5/18, page 5, line 24.
[39] St Vincent's Hospital records, Exhibit 1, Tab 91a, page 1096-1097.

not question why a young mother would travel, sometimes on public transport from Woolloomooloo to Sutherland to see him.

61. A comprehensive review of his contact with Alissa is set out in Dr Wilson's report and I do not intend to detail each consultation here. A number of problems were identified, including inadequate consultation notes and "unwise" use of private prescriptions.

62. Having regard to Dr Hurst's contemporaneous notes,[40] prescribing records[41] and statement prepared for these proceedings[42] it is evident that Alissa often presented to him with a range of problems. She complained of physical pain (in the hip, back, or leg), anxiety, sleeplessness and other symptoms associated with a depressive illness.

63. Alissa saw Dr Hurst in Sutherland for the first time on 12 January 2015. She requested Valium on the first occasion she saw him, but that did not ring a warning bell and he did not prescribe it. Dr Hurst stated in oral evidence that Alissa was teary and extremely upset when she visited. Dr Hurst explained that he felt that she was depressed and that an anti-depressant would be more effective than Valium on that occasion.

64. After that consultation she returned on 19 January, 28 January, 30 March, 24 April, 26 May and finally on 13 July 2015, the day before she died. Most of the attendances resulted in a mix of PBS and "private scripts". The private scripts were typically used for diazepam (and also for paracetamol + codeine on 24 April 2015 and 13 July 2015[43]). Private prescribing allowed Dr Hurst to prescribe in amounts exceeding the maximum quantity able to be prescribed at one time on the PBS.

65. Dr Hurst used PBS scripts for other medications he prescribed for Alissa across the first seven months of 2015 (dothiepin, prochlorperazine, oxycodone + naloxone, tramadol, sertraline).[44]

66. Although Professor Jones attributes Alissa's death predominantly to the accumulative effect of codeine and doxepin, toxicology results showed a range of prescription medications were involved. Focusing below on the benzodiazepine prescribing by Dr Hurst highlights the way in which Alissa was able to access large amounts of prescription medication without triggering effective help to reduce her apparent dependence. For example, when Alissa returned to Dr Hurst on 19 January 2015 and requested Valium for anxiety, Dr Hurst was on this occasion prepared to prescribe it for her. He wrote two scripts for diazepam, both private scripts. One script provided for 100 x 5mg tablets, the other script provided for 100 x 2 mg tablets.[45] If the medications had been prescribed on the PBS the script would typically have been limited to a maximum quantity of 50.

67. Dr Hurst says he was concerned to help Alissa and to limit her need to travel back to Sutherland to see him, hence the amounts he prescribed. Based upon his recommendation

[40] Records from Dr Hurst, Exhibit 1, Tab 63.
[41] Medicare History and PBS records, Exhibit 1, Tab 57-58.
[42] Statement of Dr Hurst, Exhibit 1, Tab 100.
[43] PBS records, Exhibit 1, Tab 58.
[44] Medicare History, Exhibit 1, Tab 57.
[45] Records from Dr Hurst, Exhibit 1, Tab 63, page 843; records from Woollomooloo Pharmacy, Exhibit 1, Tab 80, page 1060; records from Chemist Warehouse Darlinghurst, Exhibit 1, Tab 74, page 1042.

that Alissa try half a tablet but could take up to one tablet per day if needed[46] the 5 mg script should have lasted 100 days (that is, over three months) if Alissa took one full tablet a day. Obviously if Alissa was able to limit her use to half a tablet per day, was able to go without the medication some days, or was able to use the lesser 2mg dose, the medication could have lasted much longer than 100 days. Instead, the next script for diazepam issued on 28 January 2015, but with a direction that it not be filled prior to 10 February.[47]

68. When asked why he had issued a new script given he'd written ones for 200 tablets 9 days before, Dr Hurst says ""[Alissa] may have told me that she'd lost them or that, I, I do not recall."[48]. He conceded this was speculation. This is not corroborated by the contemporaneous records and it seems to me that Dr Hurst may have been reaching for an excuse that cannot be checked with a deceased patient. It does him no credit. The explanation was pure speculation in relation to this script, although Alissa had previously advised Dr Hurst on 14 January 2015 that she had lost a script for Brufen and requested another one, which he gave her.[49]

69. In the period from 19 January 2015 – 13 July 2015 Dr Hurst wrote private scripts for Alissa that amounted to prescribing 800 diazepam tablets. Of these, 700 were at the 5mg dose and 100 were at the 2mg dose.

70. Alissa was consistently complaining of stress and anxiety and the evidence establishes that she was experiencing a range of very stressful events in her family life across this time. Nevertheless, the level of diazepam prescribing is very concerning.

71. This is so even allowing for Alissa's genuine distress, Dr Hurst's stated belief that there was a reasonable period between some consultations[50] and that Alissa was trying things like exercise to help lose weight and improve her mood.[51] Given the number of diazepam Dr Hurst was prescribing on private scripts there was no sound basis to rely upon the period between appointments as being "reasonable". The amounts he was prescribing should have easily covered the period between appointments if Alissa was taking the medication in accordance with directions.

72. By the appointment of 26 May 2015 Dr Hurst accepts that he was aware that Alissa was taking many more diazepam each day than he had prescribed. He indicated that he thought it likely she was taking six a day.[52] When Dr Hurst realised that Alissa was taking more diazepam than had been prescribed, he states that he counselled "cutting back." As Dr Wilson points out this demonstrates a poor understanding of dependence and addiction.[53]

73. Dr Hurst claims that he did not suspect that Alissa had a developing problem with prescription medication at least until the 26 May 2015 appointment when Alissa was counselled to limit use. He did not offer any referral to counselling or therapy for the anxiety, depression and post-natal depression he identified, nor did he identify or contact other

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[46] Records from Dr Hurst, Exhibit 1, Tab 63, page 843.
[47] Records from Dr Hurst, Exhibit 1, Tab 63, page 842.
[48] Dr Hurst Transcript 22/5/18, page 20, line 41 onwards.
[49] Statement of Dr Hurst Exhibit 1, Tab 100, [19].
[50] Statement of Dr Hurst, Exhibit 1, Tab 100, [38], [48].
[51] Statement of Dr Hurst, Exhibit 1, Tab 100, [38].
[52] Statement of Dr Hurst, Exhibit 1, Tab 100, [54].
[53] Report of Dr Hester Wilson, Exhibit 1, Tab 10, pages 13-14.

doctors Alissa may have been seeing. He does not appear to have explored non-pharmacological options to manage her pain.

74. In my view it is impossible to believe Dr Hurst missed all the clear warning signs of a developing problem. Alissa was travelling a long distance, sometimes by public transport to see him. She was requesting certain drugs by name and requesting large quantities. The fact that she was apparently requesting that they were prescribed privately should in itself have caused him to wonder if she was receiving similar medication on the PBS from other doctors. In the circumstances, Dr Hurst should have considered what other practitioners she may also have been attending.

75. During the inquest Dr Hurst conceded that the requests for private scripts should have rung an alarm bell. He agreed that some of the medications were ill-advised, especially in the quantities he prescribed. He agreed that he had "more than enough information to suggest that Alissa was at risk of some sort of problematic prescription drug use."[54] His only explanation for missing it was that he was "very caught up in her emotional state and clinically…I felt that depression was her major problem". He later agreed that he was prescribing according to Alissa's report of usage rather than "exercising independently [his] medical judgment as to what would be appropriate for her".[55] Similarly he stated that he had "continued" a prescription for Targin that he understood had been commenced in hospital, without exercising his independent clinical judgement.

76. In my view, Dr Hurst properly conceded some of the problems with the care he provided.[56] Nevertheless I found some of his explanations were still difficult to accept. He told the court that Alissa had requested a private script, "saying it was cheaper that way for her and it would enable her to come less frequently."[57] Dr Hurst later conceded that a private script for 100 x Antenex tablets is marginally more expensive than two PBS scripts for 50 x Antenex tablets.[58] This explanation strikes me as highly implausible and one that a skilled doctor would question. His explanation for prescribing Targin, without any real exploration of the pain was that another doctor had given it to her originally. His failure to exercise his own clinical judgment is troubling. The fact that he was prepared to write a PBS script for some medications and a private script for other medications on the same day and during the same consultation is also worthy of note (30 March 2015, 24 April 2015, 13 July 2015)[59].

77. On 28 January 2015, Dr Hurst received a telephone call from a pharmacist questioning when dispensing should occur. Dr Hurst had intended a script for diazepam written that day should not be filled until 10 February 2015. He later received a call from the pharmacist because Alissa was apparently asking for it to be filled earlier. Even this did not make him question what was going on. Alissa's mother then rang to see if she could access the medication for her daughter. Dr Hurst sensibly refused but even this behaviour apparently did not ring alarm bells for him.

78. Counsel assisting submitted that the pattern of care and prescribing demonstrated by Dr Hurst warrants a referral to the Medical Council pursuant to section 151A (2) of the *Health*

[54] Dr Hurst Transcript 22/5/18, page 22, line 25.
[55] Dr Hurst Transcript 22/5/18, page 27, line 41 onwards.
[56] Statement of Dr Hurst, Exhibit 1, Tab 100 [78].
[57] Dr Hurst Transcript 22/5/18, page 15, line 10 onwards.
[58] Dr Hurst Transcript 22/5/18, page 16, line 37 onwards.
[59] See "2015" GP Attendances document. Attached to Court file.

Practitioner Regulation National Law (NSW) so that body can consider whether further investigation into Dr Hurst's prescribing and patient care is necessary.

79. Counsel for Dr Hurst argued strongly and eloquently against referral. He suggested that the concessions already made were significant and demonstrated an appropriate and fulsome acceptance of his errors of judgment which was commendable.[60] He suggested that at least some of these errors of judgment were understandable due to the complexities of Alissa as a patient. Her issues were complex and varied and included physical pain and mental pain. She did not appear to be drug affected on consultation. Counsel for Dr Hurst submitted that if one averaged out the overall volume of Valium prescribed over the months, it was not inconsistent with a reasonable dose. Dr Hurst did not know what others may have been prescribing and was thus not able to factor it in.

80. It was submitted that Dr Hurst had a good therapeutic relationship with Alissa, based on her willingness to talk with him about the problems she was facing. In my view, while it may have been supportive in some respects, it became an unhealthy therapeutic relationship, where Alissa dictated to the doctor the quantities and kinds of medications she wanted.

81. It is difficult to know if Dr Hurst's pattern of care with Alissa was an anomaly. It may be that a fuller review of his prescribing patterns is warranted. I remain troubled by his prescribing practice and I intend to refer him to the Medical Council.

Dr Moore

82. Dr Moore had first seen Alissa in October 2013. Dr Moore is a general practitioner at Potts Point Family Medical Practice. She appears to have had a long-term, positive therapeutic relationship with Alissa, providing care for her over two pregnancies (one of which tragically ended in a miscarriage).[61] Alissa had no real pattern to her attendance on Dr Moore, but she would come from time to time in relation to her own care and that of her son. It was Dr Moore that Mithun went to see, seeking help for Alissa on the day of her death.

83. Alissa came to Dr Moore initially for "shared care" in relation to her pregnancy as Dr Foo did not provide that service. However, she appeared after a while to have settled in to seeing Dr Moore more regularly and sought advice about a number of issues. When asked in court if she regarded herself as Alissa's primary general practitioner, Dr Moore explained, "It was a little bit unclear but I had understood that throughout the pregnancy we had developed a rapport that would mean that she would come to the practice principally to see us."[62] When Dr Moore was not available, Alissa had seen one of her colleagues. Towards the end of January 2015, Dr Moore became aware that Alissa had sought treatment from a doctor in Sutherland (Dr Hurst). She was aware that this doctor had prescribed Alissa Valium and it was "a warning signal of sorts". It was not a medication that Dr Moore would commonly prescribe in the circumstances.

84. Dr Moore had tried on more than one occasion to get Alissa to engage with a psychologist and had referred her to Karitane for parenting support. An initial mental health plan had been commenced in November 2014. Dr Moore was aware that Alissa had a history of Graves'

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[60] Submissions of Mr Jackson, Transcript 25/5/18, page 19, line 20 onwards.
[61] Dr Moore, Transcript 21/5/18, page 21, line 44 onwards.
[62] Dr Moore, Transcript 21/5/18, page 24, line 14 onwards.

disease and had provided a specialist referral in relation to this issue. She had treated her for wrist pain and sciatica on one occasion.

85. Alissa appears to have trusted Dr Moore with many of her problems at home. Dr Moore told the court that her overall impression was that Alissa was "an anxious young woman but she had significant psychosocial stressors which really contributed to her burden of anxiety."[63] She agreed that Alissa had limited capacity due to her life experiences, temperament and personality to juggle the trials and tribulations of life.

86. Dr Moore gave evidence before this court and she impressed as a caring and thoughtful practitioner. Her medical notes and management plans appeared detailed and appropriate. Dr Wilson notes that her prescribing was judicious and careful.

87. This court has no criticism of the care offered by Dr Moore.

Dr Rust

88. Dr Rust saw Alissa in February, April and June 2015. He prescribed a range of medications, including Panadeine Forte, tramadol and diazepam. Dr Wilson was not critical of the amounts he prescribed, but once again he was working in isolation and therefore he was unable to properly assess the risk overall.

89. Counsel for Dr Rust correctly pointed out that the first prescription for Panadeine Forte was made in relation to a painful labial cyst that Dr Rust examined and corroborated. The second two prescriptions were in accordance with Schedule 4 prescribing levels and were made for sciatic pain.

90. I accept his counsel's submission that Dr Rust's involvement in the inquest has been a great learning experience for him and that he is now more careful and vigilant in his practice. His conduct is not worthy of referral elsewhere in those circumstances.

Dr Grammat

91. Dr Grammat saw Alissa on a single occasion in February 2015. He notes that she had a benzodiazepine dependency.[64] He appears to accept that Alissa was then taking 20mg a day and he "continued" a prescription with that in mind. The supply he gave her should have lasted 25 days, if taken at that rate.

92. Two aspects of his care are troubling. Dr Wilson describes his use of a private script in these circumstances as "not best practice". There appears to be no legitimate reason for it. Equally if Dr Grammat accepts that she had a regular general practitioner, as he appears to have done, there was really no need to prescribe the quantity that he did.

93. I note that Dr Grammat was undergoing medical treatment during the inquest and for that reason did not appear, however, he expressed through his legal representative an acknowledgement that with hindsight his prescribing was "not best practice" on this occasion. I accept that he has had the opportunity to reflect upon it. On the evidence available to this court, his care during a single consultation would not attract further criticism or referral.

[63] Dr Moore, Transcript 21/5/18, page 25, line 8 onwards.
[64] Exhibit 1, Tab 67.

The General Practitioners from the DoctorDoctor service

94. From time to time Alissa and her mother used doctors from the DoctorDoctor service. DoctorDoctor is an after-hours medical service that Alissa and her family relied upon for home visits from time to time. A number of doctors visited the house over the years and three of them were reviewed during the course of the inquest.

Dr Hoque

95. Dr Hoque was one of the doctors working with the DoctorDoctor service. Dr Hoque saw Alissa on one occasion only. While Dr Hoque told the court that Alissa was encouraged to see her own doctor[65], Dr Wilson nevertheless was critical of a prescription of 14 days worth of oxycodone on the basis of a single consultation. I share her concern. Services such as DoctorDoctor should be especially careful in prescribing to patients on the basis of single consultation. A patient should always be encouraged to see their regular doctor and a 14 day prescription would usually be unnecessary. However, on the basis of a single consultation I accept counsel assisting's submission that referral is not appropriate.

Dr Ayad

96. Dr Ayad also saw Alissa on a two occasions. During the inquest it became clear that she had visited Alissa at home in relation to migraine like symptoms and provided Stemetil and relatively small quantities of painkillers. Dr Wilson was not critical of her treatment, having had the opportunity to review Dr Ayad's statement and her more detailed explanation of the care provided.[66]

Dr Haddad

97. Dr Haddad was informed of these proceedings, but decided not to take part. On the face of it his conduct is troubling and without further explanation it remains so. He saw Alissa on five occasions and prescribed various drugs. He gave intramuscular injections on three occasions, morphine on 28 January 2015 and pethidine on 19 April 2015 and again on 26 May 2015. His medical records are lacking and the choice of medication is likely to have been inappropriate.

98. Given this doctor's lack of cooperation with the court, it is impossible to know if the doctor would attempt to justify his treatment decisions. In my view it is appropriate to refer him to the Medical Council.

Other doctors seen by Alissa

99. There were a number of other doctors that Alissa saw over the years[67]. One such doctor was Dr Summers, who also treated Alissa's mother, Pauline. From Medicare data it appears that Alissa saw Dr Summers seven times from March 2013 until June 2015. In the period proximate to Alissa's death Dr Summers prescribed diazepam using the PBS on two occasions. In addition to that he prescribed 100x 5mg diazepam tablets on 30 March 2015 and a codeine combination, both on a private script. In the same period he prescribed various drugs to Pauline on many occasions.

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[65] See Statement of Dr Hoque, Exhibit 4.
[66] See Statement of Dr Ayad, Exhibit 3.
[67] See the Report of Dr Hester Wilson, Exhibit 1, Tab 10 and also the "2015" GP Attendances document prepared by counsel assisting and attached to Court file for details of each consultation.

100. The court was keen to receive Dr Summer's consultation records to review the content and quality of his various consultations, however despite numerous attempts it was unable to make contact with him.[68] The court was later informed that he had retired from practice. For this reason his material does not form part of the brief and the court has not considered whether or not his conduct is worthy of further review.

The need for recommendations

101. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focusses on the specific lessons that may be learnt from the particular death.

102. The evidence arising from this inquest once again draws into focus the pressing need for the NSW Government to do more about the frequency of accidental overdose in this state. There is an urgent need to develop an overall strategy to reduce the number of citizens dying each year from drug overdose. While this inquest did not explore in any detail the range of work which needs to be done,[69] one clear issue emerged for further consideration.

Real Time Prescription Monitoring (RTPM)

103. It was extremely difficult to get an accurate picture of the medical care and prescriptions being provided to Alissa prior to her death. While it is possible to obtain PBS records and Medicare records for the purpose of this inquest, it is very difficult to know if Alissa was also attending any doctor on a non-Medicare basis or if unidentified doctors may have been prescribing on private scripts. While local general practitioners and chemists that Alissa was known to attend were subpoenaed, there is always the chance that private scripts were dispensed that we have not captured in the investigative phase of the inquest. In any event, even with hindsight the process was time-consuming and possibly incomplete.

104. The PBS system was not designed to monitor the use of Schedule 8 drugs and as a consequence its usefulness is extremely limited in this regard. The tragic evidence in this inquest, once again demonstrates the need for improved monitoring of the prescribing of certain types of drugs. A system that has the capacity to immediately identify a patient's current prescriptions would clearly assist doctors and pharmacists to prescribe and dispense more safely. Doctors and pharmacists would be able to identify patients who may be struggling with their medicine use. As Dr Wilson most properly points out, such a system should not be used to stigmatise or deny people medical care, but rather as a way of opening up honest conversations between doctor and patient in relation to risk and potential addiction. It would be particularly useful in caring for complex patients like Alissa who accessed a number of doctors and pharmacies at any one time.

105. The benefit to someone like Alissa is obvious. If her trusted medical advisors, Dr Foo or Dr Moore, for example, had been able to see the number of pills that Alissa was being

[68] See correspondence from Florey Clinic, Exhibit 1, Tab 66.

[69] An unfinished inquest running parallel to this one explores in greater detail the need for an overdose strategy. That matter, "Inquest into Six Opiate Deaths", recommences in August 2018 for further expert evidence. It is anticipated that a range of recommendations in relation to drug overdose will flow from that inquest.

prescribed overall, I have no doubt that both practitioners would have attempted to discuss the issue with Alissa and made recommendations in relation to her safety.

106. It is easy to identify specific examples.[70] On 30 March 2015, Dr Hurst prescribed sertraline, Targin (oxycodone and naloxone) on a PBS script and a large quantity of diazepam on a private script. The same day Dr Foo prescribed tramadol and prochlorperazine on the PBS. Each prescription was taken to a different pharmacy: the Dr Hurst PBS script to Chemist Warehouse Darlinghurst, the Dr Hurst private script to Blakes Pharmacy and the Dr Foo script to Woolloomooloo Pharmacy.

107. Only two days later Dr Rust prescribed Panadeine Forte and twenty further tramadol. Again this prescription was filled at a different pharmacy, this time in Bondi. This demonstrates how no one person had enough information to give Alissa the support and assistance she needed.

108. Currently in NSW there is a regulatory framework designed to control the misuse of Schedule 8 drugs. Under the provisions of section 28 of the *Poisons and Therapeutic Goods Act* 1966, a medical practitioner may not prescribe a drug of addiction to a drug dependent person without proper authority from the Ministry of Health. However, according to Dr Wilson it is likely that many doctors find the authority regulations confusing and difficult to understand[71], and others are likely to have limited skills in identifying "a drug dependent person".

109. A doctor may also contact the Commonwealth Prescription Shopping Information Service (PSIS)[72] However there are real limits to that service. Only people who satisfy the strict criteria of a "Prescription Shopper" will be identified. The criteria are limited to 25 PBS target medications. Private scripts will not be identified. Patients must visit six prescribers within a set period of time. The limits to the system are obvious. Large numbers of privately scripted oxycodone tablets or fentanyl patches will not be identified. Similarly many drugs which are problematic when used in combination, but are Schedule 4 drugs will not show up. Alissa would not have qualified as a "Prescription Shopper" on the records we have been able to obtain. Further difficulties with the service tend to arise for busy doctors who find the process of contacting the hotline number cumbersome and frustrating.

110. Coroners and many general practitioners have been advocating for a fully functional real time prescribing system for many years.[73] At the commencement of this inquest the court sought advice from the NSW Ministry of Health about the implementation of Real Time Prescription Monitoring (RTPM) in NSW.

111. The Federal Government announced the Electronic Recording and Reporting of Controlled Drugs (ERRCD) initiative in 2012, but implementation across Australia has been frustratingly slow. In September 2016, the NSW Ministry of Health replaced the Pharmaceutical Drugs of Addiction System used to manage authorisations to prescribe controlled drugs with the

[70] See "2015" GP Attendances document. Attached to Court file.
[71] Report of Dr Wilson, Exhibit 1, Tab 10, page 20.
[72] Letter from Judith Mackson, Chief Pharmacist, Exhibit 1, Tab 97.
[73] In NSW see *Inquest into the deaths of Christopher Salib, Nathan Attard,and Shamsad Aktar*, 27 June 2014 Deputy State Coroner Forbes. The first Australian Coronial recommendation in relation to Real Time Prescription Monitoring may have occurred as early as the *Inquest into the Death of James*, 15 February 2012, Coroner Olle.

ERRCD system.[74] However, while the ERRCD software is said to have the capability to support RTPM, significant software upgrades are necessary to provide the integration that is necessary for the system to be fully operational.

112. According to the NSW Ministry of Health "a timetable for implementation has not been developed and the costs to NSW to implement real-time prescription monitoring have not been determined."[75] In evidence tendered in these proceedings Judith Mackson, Chief Pharmacist and Director of the Chief Pharmacist Unit within NSW Ministry of Health, stated the NSW system was still in the design stage.[76] In her view the eventual roll out was "years" away.[77] Ms Mackson stated that NSW Ministry of Health was committed to waiting on the Commonwealth system rather than implementing a NSW "stand alone" system. When questioned about the Victorian Government's implementation of the SafeScript system, which it is foreshadowed will be up and running this year, she stated that in relation to NSW, she "[did not] believe that the timeframe would be any earlier if it was done on a state level as opposed to nationally."[78] She made this comment noting that Victoria's "commitment and build occurred…commenced some time ago."[79] She was unaware of any evaluation of the Tasmanian system, and reiterated that NSW did not plan to follow the "stand alone" path.

113. This evidence was both frustrating and depressing. While the problem has been identified by experts for years, it does not seem that the issue is being addressed with real urgency in terms of developing this potentially life-saving tool. The question must be asked, where is NSW's commitment to this important issue? Preventable deaths from opioid and other drugs are ever increasing. While I accept that there is no one simple answer to these rising death rates, clearly RTPM is a sensible and achievable part of an overall strategy to reduce drug overdose. It will increase the tools available for doctors to ensure they are prescribing safely, it will provide better oversight of prescribers who need guidance, it will open the way for more honest consultations. RTPM has the support of the Royal Australian College of General Practitioners[80] and the peak bodies of NSW pharmacists. Its implementation was supported by each of the doctors who appeared at the inquest.

114. It is important that any future roll out of ERRCD goes further than Schedule 8 drugs. There are numerous examples of Schedule 4 drugs which create serious problems for consumers like Alissa, especially when used in combination with Schedule 8 drugs. Diazepam, codeine combination drugs and drugs such as tramadol would not be captured if the system only records Schedule 8 drugs.[81] It must be a compulsory system that picks up private scripts.

115. Tragically, in 2018 it is necessary to once again call for the urgent introduction of RTPM in NSW. It is no longer good enough for Governments to express commitment to the process. It is astounding that the NSW Ministry of Health was not even able to give a firm timetable for the introduction of this important system, after years of stated commitment.

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[74] Letter from Judith Mackson, Chief Pharmacist, Exhibit 1, Tab 97.
[75] Letter from Judith Mackson, Exhibit 1, Tab 97, page 1188.
[76] Exhibit 6, Evidence of Judith Mackson, taken on 10/5/18, page 8, line 1 onwards.
[77] Exhibit 6, Evidence of Judith Mackson, taken on 10/5/18, page 8, line 8 onwards. See also page 36, line 50 onwards for discussion of timelines.
[78] Exhibit 6, Evidence of Judith Mackson, taken on 10/5/18, page 8, line 43 onwards.
[79] Exhibit 6, Evidence of Judith Mackson, taken on 10/5/18, page 8, line 48 onwards.
[80] Exhibit 1, Tab 98.
[81] See discussion of this point in Dr Wilson's report. Report of Dr Hester Wilson, Exhibit 1, Tab 10, page 18.

116. At the conclusion of the inquest, a draft recommendation was provided to the NSW Ministry of Health, advising the Ministry that consideration was being given to recommending the prioritisation of RTPM and to the development and publishing of a timetable for the scheme's commencement. In response, the Ministry reiterated that the development of a national scheme is "very much in its infancy" and that it would be "premature at this initial planning stage to publish a timetable for implementation".[82] I have considered the response carefully, but remain of the view that the issue requires urgent attention and that the development of a public timetable may assist in keeping this important issue squarely on the agenda of the NSW Ministry of Health.

Tackling unsafe or unnecessary prescription and overuse of opioids[83]

117. Alissa's death raised a number of other complex issues, some of which go well beyond the scope of the evidence received in this inquest. While Alissa complained to various doctors of chronic pain and was prescribed opioid medication, according to Dr Wilson there is little evidence to suggest that this was likely to have been effective for her back pain. While it is attractive to imagine a pill will solve pain, it is rarely that simple. However, general practitioners are often working under enormous pressure and the "fee for service model" currently in place means that they are often unable to give more complex patients the attention and time they may need. Pain management is a complex issue for general practitioners and public pain clinics are currently under-resourced.[84] More information and training for general practitioners in relation to evidence based non-pharmaceutical treatments for non-malignant pain is clearly called for.[85] It is also clear that the law surrounding the regulation and prescription of drugs of dependency is complex and confusing.[86] There would be merit in simplifying processes and further educating doctors in this regard.

118. Interestingly it is not clear on the evidence that Alissa ever accessed drug and alcohol treatment, although her dependence was noted on medical records as early as 2010. Her medical records indicate that there was little consistent recognition of the possibility of a troubling dependence. It follows that it is unlikely her medical practitioners talked openly with her about the dangers of mixing medications and taking ever larger quantities.

119. Alissa died when those around her failed to recognise the danger she was in, notwithstanding the fact that some of those living in the house were themselves apparently struggling with a long term dependence upon prescription medication. Simply calling for an ambulance at an earlier time could have saved Alissa's life. Dr Wilson suggested that all doctors prescribing opioids should explicitly discuss the dangers of overdose with their patients.

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[82] See correspondence from the NSW Ministry of Health, dated by email 24 July 2018, attached to the court file

[83] A significant amount of evidence in relation to these issues has been received in an unfinished inquest running parallel to this one. It explores in greater detail the need for a comprehensive overdose strategy. That matter "Inquest into Six Opiate Deaths" recommences in August 2018 for further expert evidence. It is anticipated that a range of recommendations in relation to drug overdose will be considered in that inquest, including recommendations in relation to the provision, cost and availability of naloxone and the need for increased availability of pain clinics, among a number of other issues. For this reason I have decided to limit the recommendations which could potentially arise on the facts of this inquest for later, more detailed consideration.

[84] See Report of Dr Hester Wilson, Exhibit 1, Tab 10, page 20.

[85] See Report of Dr Hester Wilson, Exhibit 1, Tab 10, page 23.

[86] Dr Wilson, Transcript 23/5/18, page 6 onwards.

120. Both Dr Wilson and Professor Jones stated that naloxone could have been administered and may also have had a positive effect on Alissa. There is a pressing need to support increased awareness of naloxone within the community and to agitate for its wider distribution.[87] I note that an intra-nasal form is currently before the TGA for approval.[88] Its introduction should be supported and funded for wide availability.

121. These are just some of the issues that require further consideration if we are to reduce the number of drug overdose deaths in NSW. Until there is a multi-faceted and comprehensive approach to some of these complex issues, our prescription overdose rate will continue to rise.

Findings

122. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity
The person who died was Alissa Campbell.

Date of death
She died on 14 July 2015.

Place of death
She died at 29 Judge Street, Woolloomooloo, NSW.

Cause of death
She died from multiple drug toxicity.

Manner of death
Alissa Campbell died from an accidental drug overdose. Those around her did not immediately recognise the danger she was in and for that reason medical intervention was tragically delayed.

Recommendations pursuant to section 82 Coroners Act 2009

123. For reasons stated above, I make the following recommendations

To the Minister for Health

1. I recommend that urgent consideration is given to raising the priority for the introduction of Real Time Prescription Monitoring (RTPM) in NSW. I recommend that the Ministry plan and publish a timetable for the scheme's commencement.

Referral of matter to NSW Medical Council

124. Having decided that there are reasonable grounds to believe the evidence given may indicate a complaint could be made about persons registered in a health profession (Dr

[87] See for example Professor Jones comments about overseas programs. Transcript 23/5/18, page 46, line 45 onwards.
[88] Dr Wilson, Transcript 23/5/18, page 34, line 10 onwards.

Richard Hurst and Dr Raed Haddad) I intend to give a transcript of the relevant evidence to the Executive Officer of the NSW Medical Council pursuant to section 151A(2) of the *Health Practitioner Regulation National Law*.

Conclusion

125. Finally, I once again express my sincere condolences to Alissa's family. While they are sadly divided among themselves, I acknowledge the enormous grief they share. My sincere condolences go to Alissa's child. He was clearly greatly loved by his mother and the tragedy of his loss is heartbreaking.

126. I thank Alissa's family for their participation in this inquest.

127. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
27 July 2018
NSW State Coroner's Court, Glebe