STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of DB 2016/00139604 JD 2016/00160794 DC 2016/00165840 RG 2016/00157715 AH 2016/00160053 AB 2016/00165840
Hearing dates:	7-10 May 2018, 31 October – 1 November 2018, 26 November 2018
Date of findings:	1 March 2019
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – opiate overdose, opioid overdose Fentanyl, naloxone, multi-drug toxicity, methadone, recommendations to prevent opioid or opiate deaths, oxycodone, real time prescription monitoring,
File numbers:	DB 2016/00139604 RG 2016/00157715 AH 2016/00160053 JD 2016/00160794 DC 2016/00165840 AB 2016/00165840

Representation:	Dr P Dwyer, Counsel Assisting, instructed by Mr R McIlwaine and Ms Janet de Castro Lopo, Office of the General Counsel, Department of Justice Mr R Sergi, instructed by Ms Jacinta Smith, Crown Solicitor's Office for Northern Sydney Local Health District, Ministry of Health (NSW Health) and NSW Ambulance Service Mr P Rooney, instructed by Mr J Vijayaraj, of Avant Mutual for Dr Malhotra

Non-publication orders:

Pursuant to section 74(1)(b) of the *Coroners Act 2009* I direct that the following material is not to be published.

Any information which would tend to identify the deceased persons who are the subject of these proceedings. (The pseudonyms used in these findings may be published). Information which may tend to identify family members and those sharing residential addresses with the deceased persons at the time of death are also covered by these orders. The residential addresses of deceased persons may not be published.

A further non-publication order was made in relation to the identity of PF and to a formal objection he made.

A non-publication order was made in relation to a the formal objection made by Dr Deepika Malhotra

Table of Contents

Introduction 1
Background – why was this inquest called? 2
The evidence 3
The deaths under investigation 5
The death of DB 5
The death of RG 6
The death of AH 9
The death of JD 11
The death of DC 12
The death of AB 13
Scope for recommendations arising from the evidence 16
The need to acknowledge the current failures and to develop a comprehensive future strategy 17
The urgent need for increased drug treatment in NSW 19
The urgent need for increased support for harm minimisation strategies and facilities 22
The need to further roll out naloxone 24
The need to develop strategies to reduce the shame and stigma currently associated with drug use 30
The need to better manage the prescription of opiates and opioids in the community 31
Response to draft recommendations from the interested parties 37
Findings 38
Identity 1 (DB) 38
Date of death 38
Place of death 38
Cause of death 38
Manner of death 38
Identity 2 (RG) 38
Date of death 38
Place of death 38
Cause of death 38
Manner of death 39
Identity 3 (AH) 39
Date of death 39
Place of death 39
Cause of death 39
Manner of death 39
Identity 4 (JD) 39
Date of death 39
Place of death 39
Cause of death 39
Manner of death 39
Identity 5 (DC) 40
Date of death 40
Place of death 40
Cause of death 40
Manner of death 40

Identity 6 (AB) 40
Date of death.....40
Place of death 40
Cause of death.....40
Manner of death 40
Recommendations pursuant to section 82 *Coroners Act 2009*.....40
Conclusion.....45

Part One

Introduction

1. It is likely that between one and two thousand people in Australia will die of an opiate or opioid[1] induced cause this year.[2] Most of those deaths will occur in New South Wales[3].

2. New South Wales has a significant and growing problem with opiate and opioid overdose. While figures are notoriously difficult to interpret, it is clear that the number of deaths is continuing to increase.[4.] 2016 recorded the highest number of drug deaths in twenty years. Many of these deaths were caused by a combination of drugs, including prescribed opioids, heroin and benzodiazepines[.5]

3. If the death rate continues to trend upwards, as it has in the United States, the annual death toll could reach many thousands over the next five years.[6]

4. While we recognize the trend, we appear to have few coordinated strategies to address this problem. This is particularly frustrating when one examines the positive effect of coordinated, whole of government approaches in other policy areas. Any examination of road death statistics, for example, will show how effective a coordinated approach can be at reducing harm and death.[7] And yet, in relation to opioid overdose, creative thinking at a government level appears to have stalled.

5. During the inquest it became alarmingly clear that many opioid deaths are genuinely preventable. Policies could be implemented immediately which would begin to reduce the

---

[1] There is often confusion in relation to the terms 'opiate' and 'opioid'. The term 'opioid' refers to a substance which acts on opioid receptors in the brain. It is used by some to refer to any such substance whether synthetic, semi-synthetic or naturally occurring. Opiates are substances that are derived from the poppy plant or synthesised from a substance derived from that plant. Opiates are thus strictly speaking a subset of opioids. Opiates are drugs such as morphine, codeine and heroin. Fentanyl, for example is an opioid, not an opiate. However during the inquest the court was aware that there is considerable slippage and overlap in the way the terms are used in the media, in policy documents and even by the experts. The distinction is not an important one for the purpose of these findings and the court has generally repeated the word as used in the evidence. It should always be apparent which drug is being referred to.

[2] In the year that the deaths examined during this inquest occurred (2016) NDARC recorded 1045 **opiate** deaths. NDARC 'Opioid, Amphetamine and cocaine induced deaths in Australia' Report Aug 2018. Research Brief Exhibit 1 Tab 97. The Australian Bureau of Statistics (ABS) records that there were 1808 drug overdose deaths in 2016 See: Statement of Dr Alex Wodak AM Exhibit 1, Tab 3, [17]

[3] Australia's Annual Overdose Report 2017 Penington Institute p19 Tab 1a Research Brief Page 20-19

[4] Penington Institute Report based on ABS data says 2023 drug deaths in NSW in 2015, up from 1313 in 2001. NDARC 2018 report at Tab 95 states: Increase over last ten years in opioid related deaths from 3.8 /100,000 in 2007 t0 6.6/100,000 in 2016. The ABS 1808 figure quoted by Alex Wodak for 2016 is for Drug Induced deaths including Benzodiazepam, Antipsychotics and antidepressants as well as heroin and opioids.

[5] Unfortunately, up-to-date figures are slow to emerge, making it difficult to track trends at an early stage.

[6] For discussion of projections and the relative death rates of the two countries, see Dr Alex Wodak, Exhibit 1, Tab 3 [16-18]

[7] Dr Alex Wodak, Statement Exhibit 1, Tab 3 [6-9]

shocking numbers of deaths which already occur every year in NSW. However, significant change will require reframing the way we regard drug use in the community. Lowering the rate of opioid overdose is clearly achievable but it will require a government willing to listen to health experts and to act decisively on their advice. As former Commissioner of the Australian Federal Police, Michael (Mick) Palmer told the inquest, it will require us to rethink our drug policy, "we can't 'prohibition' our way out of the current problem."[8]

6. The court heard directly from the family and friends of some of the deceased. I acknowledge their pain and frustration in the face of such tragic and unnecessary loss. At the outset I offer them my sincere and personal condolences. The court was deeply moved by the grief expressed by the parents and loved ones who gave evidence or who participated in the investigative phase of this inquest. It is unfortunate that the stigma associated with drug use can sometimes cause families additional pain. As Dr Wodak so eloquently told the court, "these are members of our community, they are our sons and daughters, brothers and sisters, mothers and fathers and if life is something we cherish, the lives of these people should be cherished just as much…as anybody else."[9]

Background – why was this inquest called?

7. In late April to early June 2016, there appeared to be a noticeable increase in heroin or opiate related deaths processed at the Glebe Morgue. The court was notified of this increase at an early stage, prior to receiving the full autopsy and toxicological results. Statistical spikes occur from time-to-time and are sometimes thought to be explained by the inherently risky nature of uncontrolled black market supply, where short bursts of apparently stronger heroin enter the market. However, there is rarely a sustained investigation of these anomalies.

8. One reason for the lack of investigation is because inquests are rarely held in relation to illicit drug deaths. In NSW, inquests are routinely dispensed with in the vast majority of overdose deaths, where the focus is usually on the proximal factors only. This is because the questions a coroner must determine pursuant to section 81 of the *Coroners Act 2009* (NSW) can be construed fairly narrowly. 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.[10] When interpreted narrowly, these questions may be answered quite simply. The cause of death can be recorded as "drug toxicity" and the manner of death as "accidental drug overdose". While a coroner also has powers to make recommendations in relation to matters that have the

[8] Oral evidence of Mick Palmer, Transcript 1.11.18 Page 24, line 15. Elsewhere, Mr Palmer referenced a similar comment to Former Commissioner Ken Lay, "we cannot arrest and imprison our way out of our present dilemma" Exhibit 1, Tab5L [15]

[9] Oral evidence of Dr Alex Wodak, Transcript 31.10.18, Page 16, line 34 onwards

[10] Section 81 *Coroners Act 2009* (NSW).

capacity to improve public health and safety in the future,[11] those powers only come into play if the matter is ultimately listed for inquest. For this reason, coroners in NSW have rarely looked carefully at the big picture when faced with an overdose death.

9. In June 2016, the then NSW State Coroner, Magistrate Michael Barnes was concerned enough by the apparent spike in overdose deaths to issue an urgent public warning about the possibility of "an unusually strong or contaminated supply" of heroin.[12] 13 relevant files were then grouped together for further investigation. As inquiries continued, it became clear that there was in fact no single cause for these tragic deaths. There was certainly no simple explanation such as an unusually strong or contaminated supply. What emerged was a tragic snapshot of opioid related death in NSW. Some of the deaths were caused by prescription opiates, some from multi-drug toxicity and street heroin. The ages of the deceased were varied, as were their drug using histories, sex, and social background. This prompted the need to look beyond the simple medical cause of death and interrogate the wider circumstances that allow these kinds of deaths to continue to increase each year.

10. After some deliberation and consultation with family members, six of the 13 were chosen for inquest. It was determined that these matters should be grouped together for a single inquest[13], which as well as examining each individual death, could attempt to grapple with some of the broader public health and death prevention issues that might arise from the evidence.

The evidence

11. The court took evidence over seven hearing days. The court also received extensive documentary material in two volumes. This material included witness statements, medical records, photographs and expert reports.

12. As well as the brief of evidence, a four volume collection of research material was tendered. It included learned articles from a variety of research bodies including the Penington Institute, the National Drug and Alcohol Research Centre (NDARC), material from the Pharmacy Guild of Australia, extensive parliamentary, academic and media commentary both local and international, looking at naloxone usage, naloxone trials in Australia, Fentanyl use, oxycodone use and various other prescription and illicit drug issues.

---

[11] Section 82 *Coroners Act 2009* (NSW).

[12] "Bad Batch of Heroin kills 13 in Sydney" Sydney Morning Herald, 20 June 2016 Exhibit 1, Research Volume 1, Tab 5

[13] In the context of these findings I refer to the proceedings as an inquest, however in reality six separate proceedings have occurred.

13. The court was greatly assisted by the numerous health professionals and a range of experts who willingly gave up their time to share their expertise with the court. There was a sense of urgency in some of the testimonies. Oral evidence was taken from friends and family of the deceased citizens, involved doctors, police and paramedics and from a variety of experts including:

- Dr Hester Williams (expert General Practitioner and Chair of Royal Australian College of General Practitioner's Specific Interests Addiction Medicine network)
- Dr Marianne Jauncey (Director, Medically Supervised Injecting Centre, Kings Cross)
- Dr Phillip Reed (Director Kirketon Road Clinic)
- Associate Professor Nicholas Lintzeris (Director, Drug and Alcohol Services, South Eastern Sydney Local Health District)
- Ms Mary Ellen Harrod (CEO, NSW Users and AIDS Association)
- Ms Judith Mackson (Chief Pharmacist and Director, Chief Pharmacists Unit, NSW Health)
- Dr Brian Muller (Medical Affairs Director, Mundipharma)
- Dr Alex Wodak (President, Australian Drug Law Reform Foundation)
- Mr Angelo Pricolo (Presentation Manager, Pharmacy Guild of Australia)
- Dr Caitlin Hughes (Criminologist and Senior Research Fellow at the National Drug and Alcohol Research Centre)
- Mr Michael (Mick) Palmer (Former Commissioner, Australian Federal Police)
- Ms Joanne Mitchell (Executive Director, Centre for Population Health, NSW Health)
- Dr Issabella Brouwer (Forensic Pathologist, Department of Forensic Medicine, NSW Health Pathology)
- Mr Tony Trimingham (CEO, Family Drug Support)
- Dr Nuno Capaz (Vice President of the Dissuasion Commission of Lisbon, Portuguese Ministry of Health)
- Mr Kingsley Waterson (Director, Drug and Alcohol Service, Northern Sydney Local Health District)

14. A list of issues was prepared before the proceedings commenced. It included :

- What were the reasons for the cluster of deaths reported to the Coroner, which are reviewed at this inquest?

- How effective and appropriate is naloxone in preventing deaths from opiate use?

- Is naloxone as available as it should be in the community to assist first responders, professional and non-professionals, to prevent deaths? If not, what are the barriers to making it more available?

- Are there alternative means of delivering naloxone other than by injection that should be made available, for example, nasal spray?

- Should naloxone be made more accessible to former prisoners when they depart NSW Correctional Centres, and if so, how should this be facilitated?

- Where are drug users accessing illicit Fentanyl and is there any evidence of Fentanyl analogues being available in Australia on the illicit market? Is there a need for "Sentinel Surveillance" to detect illicit Fentanyl?

- Is there a need for 'Real time Monitoring of Prescriptions' and if so, what are the barriers to it being introduced?

- If Real Time Monitoring of Prescriptions is introduced, would this identify prescriptions that are not subsidized by the Pharmaceutical Benefits Scheme (PBS), and if not, how could this problem be addressed?

- Are there any harm reduction measures not yet introduced, or not fully supported, that would limit the risk of deaths from Fentanyl or other opiate products?

- Are there any recommendations that should flow from this Coroner's review of the cluster of opiate deaths?

With respect to the death of AB (in addition to matters outlined above)

- Was it appropriate for Dr Malhotra to prescribe Fentanyl to AB on 12 May 2016, and if not, what were appropriate treatment options?

15. There are many in the community who work tirelessly to enhance our understanding of these complex issues. It became increasingly clear that the broad subject matter under consideration was well beyond the scope or resources available to this court to adequately review. Nevertheless, after dealing briefly with each of the individual deaths, I intend to draw together some of the broad themes that emerged directly from the evidence I heard.

Part 2

The deaths under investigation

The death of DB

16. DB was 51 years of age at the time of his death. He lived in Armidale, NSW with a de facto partner. He had two adult children and is survived by them and his brother. At the time of his death, he was described as being in relatively good health, apart from some back pain and anxiety[14]

17. DB had a history of drug use and is reported to have travelled to Sydney every few weeks to buy heroin, as it was cheaper than in the country. He usually stayed in Sydney for a few days, before returning home by train.

18. At 1pm on 5 May 2016, Police received a telephone call from an unidentified male using a payphone. He reported that a man was dead in a kitchen at a residence in Liverpool. He

[14] Statement of Constable Guy Gilarte, Exhibit 1, Tab 13

gave the address, but no other details were provided. The caller refused to attend the scene to meet Emergency Services.

19. NSW Ambulance officers arrived a short time later at the address and entered through an unlocked door. They confirmed that DB was dead. DB was in a crouched position leaning onto the kitchen cabinetry. Directly above him on the kitchen bench was a capped syringe containing a liquid. Next to the syringe was a plastic spoon. Aside from DB, the house was empty. Detectives arrived and examined the scene. No suspicious circumstances were identified.

20. Around 6.30pm, the usual resident of the house arrived home from work and contacted police in response to a message that had been left. CT informed police that DB was a friend, who came to stay from time to time. He was aware that DB had used heroin for many years. Police also confirmed from DB's criminal record that DB had previously come to police attention in relation to the use and supply of heroin and prescription drugs and had served time in prison for drug and traffic offences

21. An autopsy was conducted on 10 May 2016. Dr Van Vuuren recorded the cause of death as multi-drug toxicity. DB had a toxic to lethal level of heroin in his blood. As well as this, he had codeine (non toxic level), Fentanyl (therapeutic to toxic level), Alprazolam, cannabis and diazepam.

22. DB's death is a terrible tragedy. There is no evidence of suicide. His death appears to have been an accidental overdose. There is clear evidence that many overdoses are reversible if treated quickly. One must wonder if DB had been treated immediately by experienced paramedics with naloxone and airway management, whether he could have survived. Given that his death was reported by an unknown person, it is impossible to know how long he remained in a recoverable state. Had that person been equipped and trained to use naloxone, there may also have been a different result. It appears likely that fear of legal consequences may have operated in his refusal to give more information to emergency services or stay with DB. It is noteworthy that although Fentanyl may have contributed to DB's death, there is no record of him having been prescribed that drug.

The death of RG

23. RG was only 22 years of age at the time of his death. He had recently made some positive changes in his life, including commencing a TAFE course in accountancy. His sister

described him as “smart, funny and frustratingly charismatic.[15]” He could play any sport and debate anything. At the time of his death he was trying to improve himself and his life. RG’s mother and sister attended the inquest and the court was deeply moved by their love for RG.

24. RG had experienced a number of life challenges from childhood, having been diagnosed with ADHD at a young age. More recently RG had experienced drug and alcohol issues over a number of years. He began to experiment with drugs around the age of 14 and had tried alcohol, cannabis, cocaine, MDMA, heroin and crystal methamphetamine.

25. RG had some insight into his problematic drug use and had sought treatment on numerous occasions to reduce or discontinue it. He had an enormously caring family who supported and assisted him. Shortly prior to his tragic death he had expressed a strong desire to leave the methadone program and attend residential rehabilitation.[16]

26. On 20 May 2016 RG was released from Royal North Shore Hospital (RNSH) where he had been treated for a serious head injury that had occurred on 9 May 2016. He had suffered a skull fracture and subdural haematoma. Prior to this admission, RG had been using crystal methamphetamine. Medical records indicate that he was at times unsettled and chaotic whilst at RNSH.

27. RG had been prescribed methadone by Dr Thalagala since January 2015. He collected his dose from a community pharmacy. RG appears to have continued to use drugs including methylamphetamine, benzodiazepines and cannabis while on the methadone program. While in RNSH, health workers from the Drug and Alcohol Unit were concerned about his “erratic behaviour” and changed his methadone collection point from a community pharmacy to Sydney Road Clinic so that there would be increased supervision of his compliance.

28. RG’s mother was concerned about RG being discharged from hospital without support. I accept that she advised the hospital that she would not be able to care for RG until her return to Sydney on 21 May 2016. She was told by a social worker that RG would be released to her care or directly to a rehabilitation centre.[17] I accept her evidence that she spoke to his treating professionals about her concerns for his psychiatric state, recent head injury and need for rehabilitation[18]. She was an active support for her son and was trying to get him the care he needed.

---

[15] Oral evidence of sister of RG Transcript 8.5.18, page 20, line 47 onwards
[16] Oral evidence of mother of RG, Transcript 8.5.18, page 10, line 25 onwards
[17] Statement of Senior Constable Davenport, Exhibit 1, Tab 53, page 1
[18] Oral evidence of mother of RG, Transcript 8.5.18, page 11, line 45 onwards

29. All the evidence points to the fact that entry to a rehabilitation unit was also RG's preference for release and it was clearly warranted. However, no facility was available and he returned home, alone. At the time of his release he appeared unstable and angry in relation to his care. There appears to have been little coordinated assistance given to RG to assist him in finding a rehabilitation bed. The Court had the opportunity to read correspondence sent to RG's mother in relation to this issue, from Mr Frank Bazik, Acting Director Operations, Northern Sydney Local Health District[19]. Among other issues, Mr Bazik acknowledged RG's desire for a residential rehabilitation placement at this crucial time. He stated "as part of providing a coordinated and effective health care service, the treating team tries to ensure that these support services are available to the patient immediately following discharge. Unfortunately despite the best efforts of medical staff, it is acknowledged that there can be significant delays to access beds in a residential rehabilitation treatment setting across NSW."[20] The lack of residential beds was in this case somewhat more than unfortunate; it meant that RG was discharged in unsafe circumstances.

30. His sister stated that she had spoken to RG the evening of his release from RNSH. He sounded "very alert" and was looking forward to catching up with family members the following evening.[21]

31. On the evening of 21 May 2016, RG's mother tried to contact him. He was expected to attend a regular Sunday night family dinner. When he did not arrive as expected she attended his residential block and tried to contact him over the intercom. The light was on, but given there was no reply, rather than invade her son's privacy, she left.

32. The following morning, around 9.48am, RG's parents returned to RG's townhouse. They found him on the floor of the lounge room, in front of a chair, slouched over in a kneeling position. Ambulance and police officers arrived, but it appears that it was too late to attempt revival. There was drug injecting paraphernalia nearby.

33. An autopsy was conducted on 27 May 2016. Dr Issabella Brouwer recorded the cause of death as "Multi-drug toxicity"[22]. Toxicological testing revealed therapeutic/non-toxic levels of benzodiazepines Alprazolam, Diazepam, Nordiazepam and Temazepam. Potentially

---

[19] Letter From Mr Frank Bazik, Acting Director Operations, Northern Sydney Local Health District, Exhibit 1, Tab 54

[20] Letter From Mr Frank Bazik, Acting Director Operations, Northern Sydney Local Health District, Exhibit 1, Tab 54, page 258

[21] Statement of Senior Constable Davenport, Exhibit 1, Tab 53, page 6

[22] Autopsy Report for the Coroner, Exhibit 1, Tab 51

toxic/lethal levels of Fentanyl and methadone were also detected. A clinically insignificant amount of paracetamol was discovered, as was evidence of cannabinoid use.

34. RG's death is a terrible tragedy. There is no evidence of suicide. He appeared to have been preparing some food on the stove. There was washing in the machine. His mother reports his last recorded Google search was "how to fix a hoverboard" and his tools and hoverboard were nearby.[23]

35. His death occurred soon after he had been discharged from Royal North Shore Hospital. He had expressed a wish to attend a rehabilitation centre, but no places were available. One can only wonder whether more adequate resourcing of the sector could have meant that he was released to a safe and supported environment, and that his tragic death could somehow have been prevented. It is noteworthy that although Fentanyl may have contributed to his death, there is no record of him having been prescribed that drug. Like others, he had used drugs alone on this occasion. It is a significant risk factor in opiate death.

The death of AH

36. AH was 48 years of age at the time of his death. AH's friend and former de facto partner gave evidence at the inquest. She described, with great tenderness, her extraordinary, intelligent and kind friend. He was an independent and intelligent thinker. He was gentle, fun and charismatic. He loved his family deeply[24]. She described him as "just the nicest man". As well as all this, she told the court he had a chronic relapsing struggle with drugs and alcohol.

37. I was moved by her testimony and by his parents' daily attendance at the inquest and I acknowledge their enormous loss. He remained in close contact with his parents and often had dinner with them. They were aware of his drug use and his many efforts to overcome it.

38. AH used drugs over many years. He had significant periods where he was abstinent, but tended to return to drug use. He had tried various treatment modalities, having attended long term rehabilitation with WHOS (We Help Ourselves), Narcotics Anonymous (NA) and 12 step meetings. He had been on a methadone program.

39. AH's friend spoke with great insight into AH's ongoing journey with drugs. She came to consider him unlikely to ever stop using drugs and alcohol. He was in her view "a lifelong

[23] See annexure A to the Statement of Senior Constable Davenport, Exhibit 1, Tab 53,
[24] Oral Evidence friend of AH, Transcript 1.11.18, page 35

addict". What he required was better services and treatment options than were available to him.

40. AH's friend spoke of the difficulties someone like AH has surviving financially. He struggled along without access to social housing or a disability support pension, even though he was at times unable to work. She also spoke eloquently about the way abstinence-based treatment broke his spirit, with each "failure" and return to drug use. He needed a wider range of treatments than were offered to him. She said "I firmly believe that if treatments other than abstinence had been available, along with legal and safe supply of drugs to prevent AH from buying street drugs, he would not only be alive he would be a productive member of society, with a job, a house, providing joy to his family and friends. Specifically, I believe AH should have been given injectable, prescribed heroin as an option in place of the methadone program"[25].

41. The court heard that AH had contacted his regular GP the day before his death. He prescribed temazepam to assist AH, who was once again awaiting entry to a drug and alcohol facility.[26] Others describe AH as positive and focussed on this imminent admission.

42. AH had limited prior contact with police and it appears to have been related only to minor property offences to fund his drug and alcohol use. He had also been dealt with for the possession of cannabis. Legal sanctions had not stopped his craving for drugs or assisted his rehabilitation.

43. AH had been staying sporadically with a friend in Waterloo in the months before his death. On 24 May 2016, AH was present at Waterloo with a friend, PF. PF states that during the morning he heard AH trying to arrange entry to the Langton Centre. Later, at around 11.52 pm, PF found AH slumped over, on the floor of the bedroom with a used syringe and other drug paraphernalia nearby. His breathing was laboured and he had recently vomited. PF went to the bathroom to get a tissue to wipe his mouth and when he returned AH had stopped breathing. PF called Triple 0 for assistance and commenced CPR. Unfortunately, AH could not be revived despite paramedics administering adrenalin, naloxone and Hartmann's solution.[27]

44. PF gave evidence at the inquest. He was an experienced and long term drug user himself. He told the court that in 2016 he was not aware that naloxone was available without a

[25] Oral evidence of friend of AH, Transcript 1.11.18, Page 43, line 30 onwards
[26] Statement of Senior Constable Matthew Lane, Exhibit 1, Page 476
[27] Transcript 8/5/18, page 42, line 45 onwards

prescription. He stated that had he had access to naloxone he would not have hesitated in using it, just as he had not hesitated to commence CPR and call for an ambulance.

45. An autopsy was conducted on 27 May 2016 by Dr Liliana Schwartz. She recorded the cause of death as "mixed drug toxicity (opiates, alcohol and benzodiazepines)". Toxicological testing showed toxic levels of morphine and a low level of monoacetylmorphine indicating recent heroin use. There were low levels of codeine, moderate levels of alcohol and low levels of paracetamol. He had track marks on both arms and some liver damage.

46. AH's death is a terrible tragedy. There is no evidence or indication of suicide. It appears to have been a tragic accidental overdose. One can only wonder whether, with the assistance of training and the availability of naloxone, his death might have been prevented. AH was also someone who had actively pursued a variety of drug treatment methods over the years, without lasting success. He was someone who may have been suitable for a heroin replacement program of the type that operates for certain drug users overseas. The evidence suggests that there is an apparent need for users in this category to have access to programs not currently available in NSW.

The death of JD

47. JD was 41 years of age at the time of his death. He lived with his partner in Werrington, NSW. He is survived by her and his mother.

48. He had a long history of drug use. His partner stated that he had been using heroin for around 20 years and was on a methadone program. His partner reported that he had also been prescribed Xanax and suboxone. JD had struggled with his heroin use over many years and had suffered various health issues as a result. His contact with the criminal justice system was primarily related to his use of drugs. He was financially insecure and was in poor health with cardiac and liver issues.[28]

49. On 24 May 2016, JD was found in an unresponsive state by his partner. He was lying face down in the lounge room. There was a black plastic box of syringes and a small plastic water bottle nearby. When police arrived, his partner was distraught. She told them he had taken heroin.

[28] Statement of Constable Rodney Adams 5 Dec 2016 Exh 1 Tab 46

50. A limited autopsy was conducted on 30 May 2016. Dr Van Vuuren recorded the cause of death as "heroin toxicity".[29] Toxicological testing revealed Alprazolam, clonazepam and its metabolites, diazepam and its metabolites in non-toxic levels. Morphine was present in a range overlapping toxic to lethal levels. Metabolites found indicate that there had been recent heroin use. Buprenorphine was detected in the urine. No alcohol was detected.

51. JD's death is a terrible tragedy. There is no evidence or indication of suicide. JD's long term use had caused him legal and ongoing health difficulties and periods of despair, but his craving for opiates had nevertheless continued. He had been using for many years and had previously overdosed. Nevertheless, his death was a shock to those who loved him. The court was greatly affected in reading of his partner's grief and shock at finding him dead. She was inconsolable and in terrible distress. Like many family members involved in such a tragedy, she did not initially request or want an inquest. The stigma still associated with opiate related death means that many grieving families wish to avoid the publicity an inquest can bring.

The death of DC

52. DC was 41 years of age at the time of his death. DC's father told the Court through a statement that DC was diagnosed with a mental illness at the age of 23. He had been on a disability pension for many years. His passion in life was travelling. He took great care to saves small amounts of this pension so that he could pursue this activity. He had visited Bali, Thailand and Sweden. He was greatly supported by his parents, mother, sister, aunt and uncle.

53. On 25 May 2016 DC checked into a hotel in Bayswater Road, Kings Cross. He had booked the hotel on the internet on 19 May 2016 and had paid with his credit card for a period of three nights.

54. CCTV footage shows DC entering the room alone at 9.16 am on Thursday 26 May 2016. About 1pm he left and then returned to the room shortly afterwards with a female. They left together about 2.25pm. At 2.33pm DC returned to the room alone.

55. At 3.52 pm, a cleaner opened the door to the room to clean, but closed it again quickly when she observed a male crouched over in the corner. She later told police she presumed that he was drunk. With hindsight, it is clearly possible that DC was alive and potentially saveable at this point. We will never know.

[29] Limited Autopsy Report for the Coroner, Exhibit 1, Tab 42

56. The same cleaner attended the following day at around 2.30pm. Finding DC in the same position, she realised something was seriously wrong and immediately alerted the manager. Police and ambulance officers attended but he had, by then, been dead for some time and could not be revived.

57. An autopsy was conducted on 31 May 2016. Dr Liliana Schwartz recorded the cause of death as “mixed drug toxicity (opiates, olanzapine and benzodiazepines)[30]. Toxicological testing identified toxic levels of morphine and olanzapine, low levels of monoacetylmorphine (indicating recent heroin use), codeine, and benzodiazepines. Alcohol was also found, but it is difficult to quantify as it may also be the result of the decomposition process.

58. DC’s death is a terrible tragedy. There is no evidence or indication of suicide. On the contrary there is evidence that, having paid for the room for three nights, he intended to stay alive. One can only wonder whether better community education about the signs of potential overdose and the easy provision of naloxone could have prevented his death. It is noteworthy that he died in close proximity to the Medically Supervised Injecting Centre. He died in circumstances known to be dangerous, having used a variety of drugs, alone.

The death of AB

59. AB was 44 years of age at the time of her death. She was studying graphic design at TAFE and was a loving mother of two. She lived with her husband and children on the North Shore of Sydney. AB was studying at TAFE at the time of her death. A fellow student described her as having been in “good spirits” on the day of her death, having just completed an assignment.

60. AB had been diagnosed with schizophrenia in early adulthood and at the time of her death was engaged in treatment with Royal North Shore Community Health Centre at St Leonards. She had been receiving anti-psychotic medication since 2014.

61. AB had a known history with drugs. Her husband was aware of her sporadic drug use and did not condone it. It is likely that she did her best to hide it from him and her family.

62. On the morning of 13 May 2016, AB prepared her children for school and left the house to attend TAFE. A friend from TAFE told investigators that AB seemed in a good mood that morning, but had left early to care for her husband.[31]

---

[30] Autopsy Report for the Coroner, Exhibit 1, Tab36
[31] Statement of Constable Nicholas Burnell, Exhibit 1, Tab 21 [28-30]

63. Her husband, who was recovering from a recent operation, remained at home. His recent procedure meant that he was unable to move freely.

64. Staff at Royal North Shore Community Health Centre were able to confirm that AB attended between 11am and midday. She appeared to have been "in a good mood" and told staff that she had not been using drugs.[32]

65. At 3.34pm, AB's husband woke and went to the bathroom door. He was unable to open it fully, but could see that AB was face down and appeared to be in need of help. When his children returned from school, he got his daughter's assistance. She squeezed through a small gap and pulled her mother away from the door so that he could enter. AB's husband called Triple 0, but immediately noticed that his wife's lips were blue and that she was unresponsive. Ambulance officers arrived and commenced CPR, however they were unable to revive her. AB had a needle mark on her right arm.

66. Police arrived. In the bathroom where she had been they located an empty, used syringe in the bathroom sink. On top of the medicine cabinet they located a spoon with a dried white residue. In the kitchen police found a syringe cap near the stove, next to it was a small metal tin with a crystal substance in the corner and medication packaging, marked Fentanyl.

67. An autopsy was conducted on 18 May 2016. The cause of death was recorded by Dr Liliana Schwartz as "methylamphetamine, Fentanyl and opioids toxicity"[33]. Toxicological testing showed toxic levels of methylamphetamine and its metabolite amphetamine and Fentanyl. The analysis also showed therapeutic levels of aripiprazole (an antipsychotic agent), oxycodone, oxymorphone and low levels of cannabinoids.

68. There was evidence of a track mark, indicating recent intravenous drug use.

69. Investigations revealed that AB had been prescribed Fentanyl by a local general practitioner, Dr Deepika Malhotra on 12 May 2016 in her rooms at the Forum Medical Centre at St Leonards. AB had never visited that doctor before.

70. Dr Malhotra gave evidence at the inquest. She did not have a strong independent recollection of her consultation with AB. However, she recalled that AB had presented, claiming a long history of back pain. Dr Malhotra had a vague recollection that AB told her that the pain was connected to a fall that AB had sustained several years earlier. AB apparently told Dr Malhotra that she was usually prescribed Durogesic (brand name for Fentanyl) for the pain. She stated that her usual GP was away.

[32] Statement of Constable Nicholas Burnell, Exhibit 1, Tab 21 [28]
[33] Autopsy Report for the Coroner, Exhibit 1, Tab 19

71. Dr Malhotra did not attempt to contact AB's usual GP or even record who that person may have been. She prescribed one box of Durogesic 100 MCG/hr patches (five patches). Dr Malhotra states that she discussed "potential side effects" and told AB that she must see her regular GP for future scripts. Dr Malhotra had no further involvement in AB's care.

72. Records indicate that AB filled the prescription she had received from Dr Malhotra at the North Shore Hospital Pharmacy shortly after the consultation.[34]

73. It should be noted that AB's usual GP, Dr Holdaway was working on the day in question. She gave evidence that she had never prescribed Fentanyl to AB. She recalled that AB had requested strong analgesics for back pain on 11 February 2016, and that the request had been refused.[35] After examination, Dr Holdaway was unsure if the pain was genuine. Dr Holdaway suggested core strengthening and other non-pharmaceutical options. She was aware of AB's history of illicit drug use and this increased her caution.

74. The court was assisted by the expert evidence of Dr Hester Wilson.[36] She raised concerns about Dr Malhotra prescribing Fentanyl to a new patient, without corroborating evidence or further background. She also had concerns about the lack of detail recorded in the medical notes. Dr Wilson indicated that there were red flags that Dr Malhotra had missed, including that she was a new patient asking for a very strong drug, by name.

75. Dr Wilson's analysis was balanced. She agreed that many GPs, while well placed to be the locus of care, are not supported, skilled or well remunerated to do this in patients with chronic complex needs.

76. Dr Malhotra gave candid and thoughtful evidence at the inquest. She acknowledged that her medical notes of the consultation were insufficient. This caused her difficulties, as she had only a vague independent recollection of events. Although she believed that she would have physically examined AB, in line with her usual practice, there was no record of that having taken place.

77. Dr Malhotra appears to have had little experience with drug seeking patients. She told the court that she did not at that time realise that Fentanyl patches could be washed and used intravenously.

78. Dr Malhotra indicated that with the benefit of hindsight she would approach the consultation very differently today. She stated that she would not prescribe Fentanyl (Durogesic) in those

---

[34] Exhibit 1, Tab 24
[35] Oral evidence of Dr Holdaway, Transcript 7.5.18, Page 29 , line 6 onwards
[36] Expert report of Dr Wilson, Exhibit 1, Tab 30

circumstances. In fact her practice now has a policy that new patients will not be prescribed schedule 8 drugs during a first consultation. She has undertaken education and training courses to assist her with the management of drug dependent patients and to improve her record keeping generally.[37] She told the court that the extra training had been beneficial to her work as a general practitioner. In my view she appeared to have genuinely reflected on the care she provided that day. A single episode of poor prescribing should not in these circumstances attract a referral to a professional body.

79. AB's death is a terrible tragedy. Her death draws into sharp focus some of the difficulties faced by doctors when called upon to prescribe opiate medication. It demonstrated the benefit of extra training for general practitioners. Like many drug users, AB kept her drug use secret to those close to her and as a result she used alone. This greatly reduced her chance of survival.

Part 3

Scope for recommendations arising from the evidence

80. 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 circumstances of each death.

81. The evidence arising from this inquest, involving six deaths, draws into focus the pressing need for the NSW Government to do more about the frequency of accidental overdose in this state. The reasons for the growing death toll are complex and multi-factored and it becomes necessary to look beyond the immediate circumstances of each death and examine some of the underlying factors which create the environment where these kinds of deaths are continuing to rise. A number of important issues emerged during the course of the inquest which require brief discussion.

[37] Course details are set out in Dr Malhotra's written submissions, attached to the court file.

The need to acknowledge the current failures and to develop a comprehensive future strategy

82. As the number of opioid related deaths appears to be continuing to rise, there is a need to acknowledge that the current approach to the regulation of drugs is not working if it is measured either by its ability to prevent drug use or its ability to reduce drug deaths.

83. There is extensive research to support the view that prohibition policies are rarely successful and are highly likely to cause harm to many in the community.[38] Where a product is prohibited, but demand remains, it is likely an unregulated and inherently dangerous black market will flourish. When law enforcement intensifies, history shows us that suppliers will create new products that may be more concentrated and more easily transported[39]. Citizens wanting drugs will continue to buy from a dangerously unregulated market. Their use of drugs is criminalised and their behaviour stigmatised. This in turn affects their place in the community and their ability to seek treatment, should they desire it. Once we stigmatise a section of the community, it follows that their needs are less likely to be adequately prioritised by government services.

84. While successive governments have placed the majority of government resources in the drug policy area into tackling the illegal drug market with law enforcement strategies, they have been unsuccessful in curbing supply[40]. Former Federal Commissioner of Police, Mick Palmer, spoke eloquently of the increasing efficiency of police in conducting significant seizures and arrests, and yet he pointed out "at the end of the day the reality is we don't make any difference, we don't do any more than scratch the surface. The price doesn't move very much, supply is never diminished. If it is, it's only for a very short period of time and we continue to demonise and marginalise young people who are involved in using and possessing drugs…"[41] His respected background in law enforcement made his comments about the futility of the current approach all the more compelling.

---

[38] See references for example in the statement of Dr Alex Wodak, Exhibit 1, Tab 3, [10-15], including Dr Alex Wodak Addiction Society for the Study of Addiction,113 1224-1230 'From failed global drug prohibition to regulating the drug market', 7 June 2018.

[39] See discussion of "Iron Law of Supply" by Dr Alex Wodak , oral evidence, T31.10.18, at 14.40. and annexures to his statement at Exhibit 1, Tab 3

[40] Dr Hughes quoted a figure that suggested around 66% of resources are put to law enforcement, leaving a much smaller proportion to harm reduction strategies. See Transcript Dr Hughes 1/11/18, page 7, line 44 onwards

[41] Oral evidence of Mick Palmer, Transcript 1.11.18, Page 22, 46 onwards

85. The inquest heard from a variety of respected experts in the field of drug treatment and drug policy who also advocated for the need to reframe the nature of public debate[42]. If the use of drugs is characterised primarily as a health and social welfare issue, rather than a criminal law issue, the focus becomes demand reduction with an emphasis on a wide range of harm minimisation and protective strategies.

86. Other jurisdictions have completely reframed their approach to illicit drugs in response to an overdose crisis, with great success[43]. The court heard, for example, from Dr Nuno Capaz, Vice President of the Dissuasion Commission of Lisbon, Portuguese Ministry of Health, about the decriminalisation of all personal drug use in Portugal.[44] That change has only been successful because it came about with a corresponding massive injection of funds into drug treatment programs of all kinds. It is a legislative reform worthy of close scrutiny[45]. Their law reform process is also instructive. Prior to introducing the changes in July 2001, Portugal brought together experts from a variety of fields including medical doctors, judges, university lecturers and drug users to grapple with the problem in a comprehensive manner[46]. The point of examining the Portuguese experience is not to suggest that it can be directly transported to the Australian context, but rather to study how a willingness to reframe the entire debate in response to an opiate crisis, with an evidence-based approach, has successfully achieved better overall community outcomes.

87. Australian experience has also demonstrated the benefits of drawing together experts from across disciplines to strategize and prioritise for change in the area of drug policy. Dr Alex Wodak and Dr Hughes both spoke of the importance of the last NSW Drug Summit, held in 1999, in triggering significant change. There is a clear need to bring people together again in response to the circumstances we now face.

88. The benefit of holding another NSW Drug Summit was supported by many of the professional witnesses who gave evidence.[47] Any summit held should bring together experts from a variety of fields including health, social policy and law enforcement. Importantly the

---

[42] See for example, Dr Nicholas Linzteris Transcript 9 May 2018; Dr Marianne Jauncey; Dr Nuno Capaz Transcript 26 Nov 2018; Kingsley Waterson, the Service Director of Drug and Alcohol at Royal North Shore Hospital

[43] Hughes C.E. and Stevens A (2010) *What can we learn from the Portuguese decriminalisation of illicit drugs*? British Journal of Criminology 50(6):999-1022 and other material in Research Brief

[44] Statement of Nuno Capaz, Exhibit 1, Tab 5I Vol 1 Evidence at Inquest

[45] I accept the rigorous evaluations of the Portuguese experience completed over many years by researchers such as Dr Caitlin Hughes. See her statement at Exhibit 1, Tab 5F. I accept the conclusion set out in her jointly authored paper "What can we learn from the Portuguese decriminalization of illicit drugs" that contrary to predictions the reforms did not lead to major rises in drug use, in fact it led to reductions in rates of infectious disease and overdose and the burden on the criminal justice system.

[46] Oral evidence of Dr Nuno Capaz, Transcript 26.11.18, page 11, line 2 onwards

[47] See for example evidence of Dr Alex Wodak, Mr Mick Palmer, Dr Caitlin Hughes

voices of drug users and their families must also be heard[48]. The summit should aim to give full consideration to any evidence based suggestions and be prepared to rethink the way we approach these issues at a fundamental level, rather than be content to just tinker around the edges of the debate. It will take courage to face the failure of our current drug policies to keep citizens safe. As Dr Hughes stated, a summit can provide a "safe space" for politicians, experts and interested citizens to come together and examine issues in depth.[49]

89. Any summit should be broad enough to look beyond the proximal causes of the increasing number of opiate deaths and examine not just harm minimisation strategies but also protective measures that may be based in social policy. One issue which cannot be ignored is the fact that while problematic drug use spans the entire socio-economic spectrum, a significant risk for dangerous opioid use is poverty, social inequality and disadvantage.[50] Dr Wodak spoke eloquently of the pattern we currently see in the United States of America[51], where "deaths of despair," principally deaths from opioid overdose, alcohol and suicide have increased to such an extent that overall life expectancy rates are now in decline in that country. These deaths can be linked to the desperation that growing social inequality and declining incomes in poorer communities can bring. In our own country, we also see increased pressure on our lower income communities. We see intergenerational poverty and despair. We need to be prepared to examine the role of social inequality in some opioid deaths and to commence talking about protective social strategies that could reverse the trend. We need to find ways of including citizens who use drugs in creating solutions. The rising death toll will not be solved without breaking down the stigma and shame that silences those most directly involved.

The urgent need for increased drug treatment in NSW

90. One of the clearest themes to emerge from the evidence at this inquest is the urgent need for increased drug treatment in this state. Any person with experience in the health or criminal justice system will confirm this proposition on an anecdotal basis and is likely to have their own stories of failure in trying to secure treatment for a patient or client in need.

91. Frustratingly, it is difficult to adequately assess the true size of the unmet need. Professor Alison Ritter, considered by many to be the most qualified to answer this question, told the court that despite the importance of the question, there is no research available on the

[48] The court heard directly from NUAA, a NSW peer based user group as well as from Family Drug Support. However, other drug user organisations such as Unharm and others exist. The expertise of these groups should be drawn upon at any drug summit.
[49] Oral evidence of Dr Hughes, Transcript 1.11.18 Page 14, line 9 onwards
[50] See Dr Wodak's discussion of this issue, Exhibit 1, Tab 3 [47] and Transcript
[51] Dr Wodak indicated that the latest available figures (for 2017) place annual opiate overdose deaths in the USA at ~73 000.

demand for drug treatment in NSW.[52] Professor Ritter's own research on national unmet need for both alcohol and illicit drug treatment demonstrates the unmet need in Australia is very high. Her figures show that treatment need is likely to be double what is currently available. Even if one assumes the unmet need for alcohol treatment is higher than the unmet need for illicit drug treatment, she sees no reason why the figure in NSW would differ greatly from the national demand.

92. Joanne Mitchell, the Executive Director of the Centre for Population Health, gave evidence on behalf of NSW Health on this and other issues. She stated that it was "well accepted across the board" that between 40-60% of the number of people wanting treatment, are unable to access it.[53]

93. Such a statistic is frankly horrifying, particularly if one characterises problematic drug use as a medical issue. If up to 60% of patients[54] needing treatment for cancer or some other potentially fatal condition were routinely refused service or given delayed service, there would be an enormous public outcry. It is only if we continue to stigmatise drug users as somehow lesser citizens that such a glaring lack of service can possibly be tolerated. It is known that at least one of the deaths examined during this inquest occurred at a time when treatment had been sought but was not available at that time.[55] I was somewhat surprised that final submissions made by NSW Health merely commented that the need to study and commit further resources to treatment "was a matter for NSW Government"[56].

94. The court heard evidence that the services we currently offer are sub-standard in some respects. Abstinence based facilities are often overcrowded and uncomfortable. Dr Wodak suggested we need to make drug treatment centres "more attractive" by improving the quality of the services they offer. Too often they are seen more like adjuncts to the criminal justice system, when they should be "front and centre of the health system".[57] We continue to treat those requesting drug treatment as though they are criminals, rather than as health services consumers. Some of the therapy services offered are narrowly construed[58].There are few

---

[52] Statement of Professor Alison Ritter, Exhibit 1 Tab 5N [4]
[53] Oral evidence of Joanne Mitchell, Transcript 1.11.18, Page 62, line 32 onwards
[54] I note Dr Wodak estimates we currently cater for about 40% of demand for drug treatment services. Statement of Dr Wodak, Exhibit 1, Tab 3 [36]
[55] Inquest into the death of RG
[56] Submissions on behalf of NSW Ministry of Health, Northern Sydney Local Health District, NSW Ambulance Service and NSW Police, paragraph 36
[57] See his discussion of this issue Transcript 31.10.18 Page 23, line 11 onwards
[58] See Gillian Cohen's discussion of the limitations of Alcohol Anonymous (AA) and Narcotics Anonymous (NA) and how unsuitable those solutions may be for some drug users: Transcript 1.11./18 Page 34, line 10 onwards.

options for residential treatment for people on methadone[59] or who have other pressing concurrent health needs, including mental health issues.

95. The court was also alerted to significant issues in relation to the cost of methadone and other substitution services for many wanting to enter treatment, especially those on low incomes. A number of experts raised this point. According to Dr Wodak, the dispensing or co-payment fee can take a significant proportion of the income of a person on a low income or government benefit. This can have the effect of delaying a patient's entry into treatment or cause their early exit from programs. Ms Mitchell conceded that, if provided through the private system, a substitution program could cost up to $80 a week.[60] This is unacceptable. The court heard that in New Zealand, where the program is free there were much higher retention rates and less delay in entering treatment.[61]

96. In submissions at the conclusion of the proceedings NSW Health expressed the view that the funding of medication dispensing via community pharmacies is primarily a matter for the Commonwealth. While the court accepts the difficulties that are sometimes involved operating within a federal system, there are well established avenues for states to pursue these issues with the Commonwealth if they are considered a priority.

97. It also became clear that there is a need to provide a much wider range of treatment services than we currently do. One example is the need for a heroin prescription trial for treatment resistant heroin use. Despite the advice of health experts there is an apparent reluctance to investigate this option in NSW[62]. The prescription of substitution drugs such as methadone and buprenorphine has become a well-accepted mainstream, first-line treatment for opiate dependent users throughout the world. However, research suggests a small minority of entrenched users fail to respond to this program, despite a willingness to try. There is evidence to suggest that the supervised use of medicinal heroin can be an effective second line treatment for this small, previously unresponsive group and yet NSW will not commence a trial[63]. At least one of the deaths examined at this inquest was for a person who might have benefitted from this form of treatment.[64]

---

[59] Statement of Dr Wodak, Exhibit 1, Tab 3[36]
[60] Oral evidence of Joanne Mitchell, Transcript 1.11.18 page 50
[61] Statement of Dr Wodak, Exhibit 1, Tab 3[37]
[62] Ms Mitchell noted in her evidence there was no discussion of a heroin trial since she had been in her role at the Ministry Transcript 1.11.18, Page 49, line 45 onwards. For discussion of the background to heroin trials in Australia see Dr Wodak, Transcript 31.10.18, page 24, line35 onwards
[63] For discussion of this issue see Dr Jauncey, Transcript 8.5.18, page 97, line 20 onwards. For further discussion also see "New Heroin-assisted treatment. Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond" Research Brief, Volume 2, Tab 36
[64] Death of AH

98. In submissions provided at the end of proceedings, NSW Health stated that it will "continue to monitor Australian and International research with respect to enabling novel opioid treatment access to people who (*sic*) circumstances are not amenable to traditional opioid substitution treatment programs."[65] Programs dispensing medicinal heroin are now well established and have been operating overseas for many years.[66] There is, in my view, already ample evidence to support commencing a trial in NSW. Extremely senior and experienced experts gave evidence to this effect during the inquest. Given that the stated aim of NSW Health is harm reduction, it is hoped that any remaining obstacles can be quickly overcome and greater support for a wider range treatment services can be forthcoming.

99. There is no one simple solution to reversing the trend of opioid overdose, but clearly a massive injection of funding into treatment services must be part of the solution. There needs to be increased treatment capacity and a wider range of treatment options.

The urgent need for increased support for harm minimisation strategies and facilities

100. The court heard extensive evidence about harm reduction strategies currently in place in NSW. Many of these programs are successful and appropriate. However, numerous service and treatment gaps were also revealed.

101. Dr Marianne Jauncey, the Medical Director of the Uniting Medically Supervised Injecting Centre (MSIC) at Kings Cross gave compelling evidence. She told the court that "put simply no one ever dies of an opiate overdose in a supervised injecting centre. This is because staff are trained to recognise and respond appropriately to overdose. No deaths have been associated with any of the 1.1 million supervised injections…in the Sydney service and all the 7438 overdoses in our 16.5 years of operation have been managed without injury or death."[67] This kind of success is mirrored at facilities around the world. All evaluations of the service have been positive.[68] The service and its staff are to be commended for the work they do.

102. Given the clear success of the MSIC, it is difficult to understand why further facilities of this sort have not been developed to suit other areas of need across NSW. This is not to suggest that the exact Kings Cross model should be transferred elsewhere without modification. However, ambulance call-out rates, hospital admissions, possession arrests and deaths

[65] Submissions on behalf of NSW Ministry of Health, Northern Sydney Local Health District, NSW Ambulance Service and NSW Police, paragraph 32
[66] Oral evidence of Dr Phillip Read, Transcript 9.5.18 page 27; Statement of Associate Professor N Lintzeris; Transcript 9.5.18 page 52; Statement of Dr Wodak page 9-10, See also various academic reports in research brief.
[67] Statement of Marianne Jauncey, Exhibit 1, Tab 2, [39]
[68] The success of the MSIC was also accepted by Ms Mitchell in evidence as a highly successful initiative

should clearly be reviewed to identify other geographic areas of need. New facilities should be specifically targeted to meet the particular needs of any local areas identified. Various locations have previously been suggested including Surry Hills, Redfern and various locations out west and in the south west of Sydney.[69] Any new service could be developed in consultation with local communities and with their specific needs in mind.

103. Ms Mitchell was questioned on the existence of future plans within the Ministry of Health for such facilities. Given the success of the MSIC, Ms Mitchell was specifically asked to comment on whether the lack of a further medically supervised injecting centre in NSW was a political problem rather than the result of a policy based properly in health data. She replied "…the reason for having it in Kings Cross are a very particular set of circumstances. It is a particular part of Sydney, which isn't replicated in other areas as well, but you know in the end it is – the situation that we have is the single MSIC and that's the policy environment within which we're working".[70] At the end of proceedings, a submission from NSW Health[71] stated that consideration of further medically supervised injection rooms (MSIR) in areas where there are many drug overdoses and where the community supports the establishment of MSIR, "is a matter for NSW Government."[72] Given that the stated philosophy of NSW Health is harm reduction, it was disappointing not to receive a response that actually grapples with the now uncontroversial evidence of the success of the MSIC and the need for similar services throughout NSW. It is hoped that the NSW Health will engage in those frank discussions in the context of a NSW Drug Summit, which is the first recommendation I intend to make.

104. The court heard startling comparisons about the way medically supervised injecting services have developed in other jurisdictions. In Canada, for example the first medically supervised injecting room opened in 2003, after the MSIC in NSW. While we have stalled with one service in NSW and one recently opened in Victoria, Canada now has 28, with other peer run services also available[73].

105. Dr Wodak gave evidence about the "drug consumption rooms" that have developed in parts of Europe, where there is increased emphasis on non-injecting routes of administration as a harm reduction measure.[74] He gave an example of an innovative centre auspiced by the Frankfurt City Council that he had visited. The centre provides facilities where people "can inject drugs, they can inhale drugs, they can go to the cafeteria, they can play pool, they can

[69] Oral evidence of Marianne Jauncey, Transcript 8.5.18, page 72, line 30
[70] Oral evidence of Joanne Mitchell, Transcript 1.11.18, Page 62, line 5 onwards
[71] Footnote 64 supra
[72] Submissions on behalf of NSW Health, Northern Sydney Local Health District, NSW Ambulance Service and NSW Police, paragraph 33
[73] Oral evidence of Marianne Jauncey Transcript 8.5.18, page 71, line 1 onwards
[74] Oral evidence of Dr Wodak Transcript 31.10.18, page 21, line 25 onwards.

watch television, they can have a shower, they can wash their clothes. If they walk across the road they can learn some skills to enter the employment market"[75]. Those who used the centre were treated with dignity and respect. Dr Wodak spoke with great knowledge about the need to change the way we think about the harm reduction services we offer.

106. Numerous other innovative harm minimisation schemes, currently unavailable in NSW were canvassed in the evidence. For example the court was interested to hear about the range of methadone treatments in Portugal. While treatment in NSW relies on a certain level of compliance to remain on a program, Portugal has found success with a subset of users for whom a regular lifestyle and medication compliance is difficult. Dr Capaz explained "to enlist in the program you basically only need an identity card and there is a maximum amount of methadone that can be dispensed to you without the medical prescription on that program."[76] Methadone is dispensed from mobile vans that cater for regular compliant clients but can also dispense a low dose for a "drop-in" population. As a harm reduction measure, it is certainly worthy of study.

The need to further roll out naloxone

107. The court heard extensive evidence in relation to the benefits of further increasing the availability of naloxone in NSW. Naloxone is a life saving medicine that can reverse opiate overdose. There was general agreement among all the medical experts that naloxone is a very safe drug, with few, if any, risks. It clearly saves lives.[77]

108. Currently most naloxone is administered in a medical or paramedical context. However, research shows that the provision of naloxone more widely in the community has also been very successful. There have been no reports of adverse incidents and it does not appear to deter people from calling an ambulance, it may even increase that chance.[78] There appear to be no disadvantages to further increasing its availability. Nevertheless the court heard that there were still a number of barriers to wider provision of the drug.

109. Ambulance officers in NSW are trained to administer naloxone in one of two ways, intravenously or intramuscularly. Naloxone is part of the standard kit carried by paramedics attending a job. Although it used to be available as a preloaded syringe, it is currently provided in ampules that have to be drawn up into a syringe[79]. I heard evidence from a number of ambulance officers who spoke positively about the life saving qualities of

---

[75] Oral evidence of Dr Wodak Transcript 31.10.18, Page 22, line 32 onwards
[76] Oral evidence of Dr Nuno Capaz, Transcript 26.11.18, Page 25, line 37 onwards
[77] See, for example, Statement of Dr Jauncey
[78] Statement of Dr Phillip Read, Exhibit 1, Tab 4 [16]
[79] Oral evidence of Christopher Townsend, Intensive Care Paramedic, Transcript 8.5.18, at p 55.

naloxone. Liam McDermott, for example, is an experienced intensive care paramedic who responded to the call in relation to AH. Although it was too late to save AH by the time he arrived, Mr McDermott has used naloxone to reverse an overdose and save lives on numerous occasions[80]. Paramedic McDermott gave evidence that he had "not experienced any problems with the administration of naloxone", nor had he "had a patient have an adverse outcome due to administration of naloxone[81].

110. The Court also heard from Christopher Townsend, who is an Intensive Care Paramedic working with the NSW Ambulance Service for 13 years at the time he gave evidence. Paramedic McDermott gave evidence that "time is of the essence" in getting the drug to the patient, because the patient still needs to have some cardiac output for naloxone to work effectively. He agreed that naloxone was an extremely successful and useful tool to reverse overdose and he had not had any problems with its administration[82].

111. NSW Ambulance uses the Medical Priority Dispatch System (MPDS) to triage Triple 0 emergency calls. This triage tool is in use in Australia, America, and many countries in Asia and Europe. It uses scripted questions and answers which have been prepared by international medical expert panels. A software upgrade is to take place in 2019 which will include changes to Protocol 23 – Overdose /Poisoning. This will address Fentanyl and opioid overdose. New key questions will establish the availability of naloxone when the patient has overdosed on narcotics[83].

112. At the conclusion of proceedings, NSW Ambulance submitted that the most appropriate treatment for suspected overdose is transport to hospital but in certain cases where transport to hospital is refused, that it may be appropriate to leave naloxone with the person[84]. I embrace that submission.

113. The court also heard that naloxone can currently be prescribed directly to a patient by a medical doctor and then purchased at a community pharmacy subsidised by the Pharmaceutical Benefits Scheme. Dr Wilson supported increased education for general

---

[80] Oral evidence of Liam McDermott, Intensive Care Paramedic, Transcript 8.5.18, at p 45, from line 33 onwards.
[81] Oral evidence of Liam McDermott, Intensive Care Paramedic, Statement, par [11] and Transcript 8.5.18, at p 46.
[82] Oral evidence of Christopher Townsend, Intensive Care Paramedic, Transcript 8.5.18, at p 54.
[83] Letter to Deputy State Coroner Grahame dated 21 February 2019 from Scott Deeth, A/Director Clinical Governance, NSW Ambulance
[84] Submissions on behalf of NSW Health, Northern Sydney Local Health District, NSW Ambulance Service and NSW Police, paragraph 17

practitioners about the benefits of discussing naloxone whenever prescribing opioid drugs, 'to signal the risk of opioids to both prescriber and patient'[85].

114. Naloxone may also be purchased directly from a pharmacist at full price.[86] A PBS prescription can only be written for a patient, not to a person, such as a family member who may be likely to witness an overdose. Various experts discussed the practical benefit of widening availability to family and friends. Angelo Pricolo, Pharmacy Guild of Australia, was one such expert, he stated that the availability of this drug over the counter at PBS price would 'markedly increase uptake and is a logical progression'.[87]

115. Unfortunately, although legally available, pharmacy 'take up' rates have been disappointing. The court heard that only 5-10% of pharmacies stock naloxone. In the last 12 months fewer than 100 naloxone kits were sold through pharmacies in the whole of Australia.[88] There is a clear need to educate and encourage pharmacists about the importance of providing this drug.

116. The court heard from Mr Pricolo that since May 2015, when the Therapeutic Goods Association announced its intention to down schedule naloxone from a schedule 4 to a schedule 3 drug, pharmacies have been able to sell naloxone without a prescription.[89] However, pharmacists have not been quick to stock and support naloxone. The stigma that attaches to drug use may also prevent users and their families from purchasing the drug from local pharmacies, especially in rural areas. Anecdotal evidence also suggests that some pharmacists, particularly in rural areas, do not want to encourage drug users to enter their pharmacies. Others are still ignorant of naloxone and its usefulness. Some users may even be loath to discuss the issue with their local doctor. There are a variety of other barriers identified, including cost, fear of legal consequences should something go wrong and fear that having naloxone could give police a basis to search.[90] Some people who may be well placed to assist would be reluctant to inject another person without medical training.

117. Most of the naloxone that has been distributed in the community to date has been through one of the excellent Take Home Naloxone programs that have been developed following earlier pilot studies which commenced as early as 2012. The Kirketon Road Centre (KRC), in conjunction with the Langton Centre has been a leader in developing methods of delivering

[85] Dr Wilson Report to Coroner Exhibit 1 Tab 5E page 12
[86] Letter to Coroner from Daniel Madeddu, Director Alcohol and Drugs, NSW Ministry of Health, Exhibit 1, Tab 5C
[87] Statement of Angelo Pricolo Exhibit 1 Tab 5H
[88] Professor Lintzeris, Exhibit 1, Tab 4A [18]
[89] Statement of Angelo Pricolo, Exhibit 1. Tab 5H and Transcript 3.10.198
[90] Statement of Dr Phillip Read, Exhibit 1, Tab 4 [17]

training and naloxone to relevant organisations over the last five or so years.[91] A number of agencies have been involved and the success of the Overdose Prevention and Emergency Naloxone (OPEN) project and the subsequent Overdose Response and Take Home Naloxone (ORTHN) project has provided a firm basis for the view that a further roll out of naloxone is warranted as a sound death prevention strategy.[92]

118. The court was impressed greatly with schemes such as ORTHN. The court heard about successful peer based support programs where other users, neighbours or parents could be trained to administer the drug. In submissions provided at the end of proceedings NSW Health commented that further feasibility studies in relation to education and distribution of naloxone are currently taking place. [93] These schemes must be supported as a matter of urgency.

119. The court learnt of the compassion and hard work of one particular community member, Ms Sarah Adey, from viewing a video on ABC Lateline with the title 'Heroin Hero – Sarah Adey's story'[94]. Acting in a voluntary capacity, Sarah Adey carries naloxone and responds to overdose emergencies for heroin users at Northcott towers in Surry Hills in inner city Sydney, where she lives. She has saved the lives of a number of heroin users through her actions.

120. Dr Phillip Read gave evidence at the inquest and was one of a number of witnesses who supported the extended provision of naloxone. He also specifically supported a consideration of providing naloxone to police, who are often the first responders to overdose, especially in rural areas[95]. He spoke of various innovative programs operating elsewhere, such as those that encouraged emergency services to leave naloxone at the scene of an overdose in some states of the USA and a successful Scottish program where naloxone was provided to newly released prisoners who are at heightened risk of overdose.

121. Intensive Care Paramedic McDermott gave evidence that based on his positive experiences with naloxone saving lives, it would be a good thing to have more people properly trained to administer the drug[96]. Intensive Care Paramedic Townsend agreed that members of the community who are likely to come into contact with drug users could be trained in the use of naloxone[97]. There are potential side effects of the drug, when used to reverse the effects of

---

[91] Statement of Dr Phillip Read, Exhibit 1, Tab 4 [4-5]
[92] Overdose Prevention and Emergency Naloxone (OPEN) project evaluation Exhibit 1 Tab 16, Tab 18, Tab 19 and Tab 20 Transcript of 9 May 2018 at page 13
[93] Submissions on behalf of NSW Health, Northern Sydney Local Health District, NSW Ambulance Service and NSW Police, paragraph 15
[94] Exhibit 8
[95] Statement of Dr Phillip Read, Exhibit 1, Tab 4 [17]
[96] Oral evidence of L McDermott, Transcript, 8.5.18, at p 46.
[97] Oral evidence of L McDermott, Transcript, 8.5.18, at p 55.

opioid overdose, (eg tachycardia and vomiting[98]) that should be monitored. He and other ambulance NSW employees gave evidence that a nasal spray would be much easier to administer than an injection[99], and less risky[100]. Training other service providers or even members of the public to administer naloxone is not a substitute for calling the ambulance to assist in the overall treatment, but it may certainly provide a life saving measure while the ambulance is travelling to the scene.

122. It is noteworthy that individual police officers told the inquest that they would be comfortable in administering naloxone if training and approval were forthcoming.[101] However, while the Commissioner expressed "in principle support" to having naloxone more widely available, he felt that NSW police officers were "not the most effective conduit to administer naloxone."[102]

123. The Commissioner stated that he did not support the provision of naloxone to police officers to administer at incident scenes because "intervention by Police in the treatment of persons potentially suffering from opioid overdose would detract from a Police officer's ability to maintain basic situational awareness at any scene" and "Police officers are not trained in medical diagnosis and treatment"[103]. I have given consideration to those issues, but am still of the opinion that appropriate training could be given to provide police with the basic skills to administer naloxone, particularly in a nasal spray form, provided the scene is sufficiently under control.

124. With respect to the recommendation that police leave naloxone at the scene of an overdose, it was submitted on behalf of the Commissioner that there is also a long standing agreement, developed in conjunction with health authorities, that discourages Police from attending overdose incidents unless required by ambulance services. This is to encourage people to call the ambulance without fear of prosecution for minor drug use and possession offences by police.[104] I would not wish to interfere with this longstanding agreement, which seems entirely appropriate, but the recommendation relates only to circumstances where police have attended, in spite of any agreement.

125. At the commencement of the inquest, the court heard about the current formulations of take home naloxone. One form is delivered via intramuscular injection. Prenoxad is a pre-filled syringe with 5mls, and each ml contains 400 micrograms of naloxone solution. These injections must be given on particular locations on the body to be effective and safe – upper

---

[98] Oral evidence of L McDermott, Transcript, 8.5.18, at p 49.
[99] Oral evidence of L McDermott, Transcript, 8.5.18, at p 47.
[100] Oral evidence of L McDermott, Transcript, 8.5.18, at p 52; oral evidence of Townsend at p 57.
[101] See for example the evidence of Senior Constable Burnell, Transcript 7.5.18, page 23, line 11 onwards
[102] Correspondence from the Commissioner of Police, Exhibit 1, Tab 5D
[103] Written Submissions on behalf of NSW Health, NSLHD, NSW Ambulance and NSW Police Force, at [41].
[104] Letter dated 19 Feb 2019 from Commissioner of Police MJ Fuller APM; Written Submissions on behalf of NSW Health, NSLHD, NSW Ambulance and NSW Police Force, at [41].

thigh, outer buttock being two examples. Prenoxad is available on the PBS.[105] A newer intranasal formulation, available in the USA and Canada, was still pending approval in Australia. However it was clear as the evidence emerged that an intranasal formulation might overcome the reluctance from some non-medical people to administering naloxone by injection in a crisis. Angelo Pricolo of the Pharmacy Guild was of the view that a nasal delivery system for naloxone will 'change the landscape'[106] as it is minimally intrusive for the user.

126. Dr Brian Muller, Medical Affairs Director at Mundipharma[107] gave evidence which highlighted the benefits of naloxone nasal spray. In the countries where it is available, it is being used by first responders like ambulance officers. There has been research conducted overseas that shows that the nasal spray is something that people feel more comfortable using to assist others who have overdosed. He suggested that their product research demonstrated nasal spray is an easier and more welcome mode of delivery than intramuscular or intravenous injection.

127. The court was informed that at the time of the hearings, that nasal naloxone spray was being registered with the Therapeutic Good Administration (TGA) but was yet to be released in Australia[108]. A clinical study of the intranasal formula was carried out in seven major Sydney and Melbourne hospitals with the Nyxoid product being provided ahead of licencing by Mundipharma[109]. By the time of publishing these findings, the Court had received information that Nyxoid Nasal Spray is commercially available in Australia and can be purchased at wholesalers by pharmacies, subject to stock availability. The Pharmaceutical Benefits Advisory Committee is to consider PBS listing of Nyxoid, with a review due in March this year[110].

128. Naloxone is not the simple solution for rising overdose death, but its wider provision in the community must be supported as a practical and life-saving initiative. Professor Nicholas Lintzeris estimated that between 2000 and 3000 packages of naloxone should be supplied to at risk users a year. The cost of this would be between $120 000 and $180 000 per annum.

---

[105] Statement of Angelo Pricolo Exhibit 1 Tab 5H
[106] Footnote 90 ibid
[107] Oral evidence of Dr Brian Muller, Transcript of proceedings 10.5.18 at p 10ff
[108] Oral Evidence of Dr Brian Muller Transcript of proceedings 10.5.18 at p 10ff
[109] Oral Evidence of Professor Lintzeris Transcript 9.5.18 page 38.
[110] That information was not available at the time of hearing but is publicly available and accurate at the time of publishing these findings.

He estimates that this could save 60-70 lives a year, making it one of the most cost effective interventions possible.[111]

The need to develop strategies to reduce the shame and stigma currently associated with drug use

129. Examination of the various reasons that drive people to use drugs is well beyond the scope of this inquest. However, drug use surveys suggest that many more people will experiment and use drugs over a lifetime than will experience problematic drug use requiring medical treatment. Just as many use the legal drug, alcohol for a variety of reasons including enhancing social interaction and having fun, it is likely many Australians use illicit drugs for similar reasons. In the current NSW regulatory framework, talking about this kind of use is still somewhat of a taboo. In the Portuguese model, drug users who are not at risk of significant or imminent harm are removed from the equation as “recreational users” requiring little immediate attention, leaving those who require intervention, treatment or support at the forefront of public policy and expenditure. This approach has the benefit of allowing more resources to be directed to those who are most at risk.[112]

130. Clearly a coroner’s focus is limited and concerned specifically with drug use ending in death. However, the evidence before the court demonstrated that blanket illegality contributes to making all drug use potentially more dangerous. Many of the expert witnesses spoke of the way criminal sanctions increase shame, secrecy and stigma across the board, driving drug use further underground where the risks of unsafe use will always increase[113].

131. Mick Palmer told the Court [114] that the illegality of drugs means that people who purchase them have no idea what they are buying, and maintaining quality control over these substances is virtually impossible.[115] Further, he agreed that stigmatisation and shame stood in the way of drug users telling their families and seeking treatment and help when they need it. This view was shared by medical practitioners such as Dr Jauncey, who are at the forefront of service provision in this area.

132. The court heard evidence from Ms Mary Harrod, the CEO of the NSW Users and Aids Association (NUAA), a peer based drug users association which has been active in harm

---

[111] Statement of Professor Lintzeris, Exhibit 1, Tab 4A. For brief discussion of his modelling see [24]
[112] Oral evidence of Dr Nuno Capaz, Transcript 26.11.18 page 13 ff
[113] Oral evidence of Mick Palmer, Transcript 1.11.18 page 26 ff
[114] Oral evidence of Mick Palmer, Transcript 1.11.18 at p24ff
[115] Others also commented on the benefit of regulating more of the currently illegal drug market to better control what is consumed. See for example Oral evidence of Dr Wodak

reduction for thirty years.[116] NUAA's focus is on harm reduction through a range of programs including needle and syringe exchange, provision of naloxone and peer education across New South Wales. NUAA recognises the need to treat fellow citizens who use drugs, not as second class citizens, but as having the same rights to quality health care and dignity enjoyed by all citizens.

133. The court also heard from Tony Trimingham, CEO of Family Drug Support[117]. His organisation supports families affected by drug use. He explained that the loss and grief felt by families after an opiate overdose is heightened by the shame and stigma they may feel. He spoke eloquently of the need for increased treatment, having seen at first hand the waiting lists and incomplete services currently available.

134. Mr Trimingham came back to give his evidence at Glebe Coroners Court, 21 years after he had identified his own son, Damian in the mortuary downstairs. He spoke with heartbreaking candour of his emotions following Damian's death. Like many parents he was totally blindsided. He had never considered opiates would affect his family. He spoke of the feelings of fear, guilt and grief, clouded by anger that were present on that day[118]. He has dedicated his working life to education and family support. It is compelling, that having lost a much loved child, he does not call for prohibition. Instead, he says "quite simply, governments need to recalibrate their response to drug and alcohol issues in the community and focus on demand and harm reduction strategies".[119]

The need to better manage the prescription of opiates and opioids in the community

135. Some of the six deaths before the court were as a result of heroin overdose, but most were likely the result of multi-drug toxicity, including the use of prescription drugs (either prescribed for the deceased, or prescribed for others and obtained by the deceased[120]).

136. Prescription of pharmaceutical opiates has been increasing in Australia since 2009, from 10 million prescriptions per year in that year, to 14 million prescriptions written in 2018[121].

137. NSW Health estimates that there may be 750,000 Australians currently dependent on pharmaceutical opiates, the overwhelming majority of whom are not recognised as having a dependency problem but who nevertheless receive repeat prescriptions.

---

[116] Oral evidence of Mary Harrod, Transcript 9.5.18 Page 57
[117] Exhibit 1 Tab 5K and Oral evidence of Tony Trimingham, Transcript of 26.11.18
[118] Oral evidence of Tony Trimingham Transcript 26.1.18 page 35
[119] Footnote 118 ibid
[120] Deaths of AB, RG, DB, DC. JD
[121] Penington Institute 'Saving lives: Australian Naloxone Access model' Research Brief page 42 Tab 1A

138. While well below the number of opioid overdose deaths in the United States (72,000 deaths in 2017), Australia's drug induced mortality is rising. Opioid overdose continues to overshadow accidental overdose from other drug types. Opioid deaths in Australia in the period 2011-2015 totalled 3,601 – a 1.6 fold increase from 2001-2005 (1,952 deaths).[122] Experts agree that the majority of opioid deaths in Australia are now related to pharmaceutical opioids[123]. The research shows that increases in the rate of fatal opioid overdose correlates to increases in opioid prescription.[124] In the 1990s fatal opioid overdoses were predominantly caused by heroin, often combined with alcohol and benziodiazepines ('poly drug use'). While poly drug use is still the norm, it is now pharmaceutical opioids – whether prescribed or obtained by other means – that account for some 70% of the fatal opioid overdoses.[125] These deaths feature particularly in the over 30 years age group.[126] Illicit heroin now accounts for approximately 30% of opiate overdose fatalities.

139. Because a number of prescription opioids including Fentanyl and oxycodone, as well as benzodiazepines, were implicated in several of the six deaths being examined in this inquest, it was necessary to look closely at the way these drugs are being prescribed. Evidence was received that suggests many general practitioners may not possess the requisite skills and training, or have all the information they need (including, for example, about naloxone and alternative pain management measures), to ensure that safe opioid prescribing takes place.

140. Fentanyl has recently received much attention in the media. It is a Schedule 8[127] prescription medication generally restricted for end of life care and severe long standing pain. In the case of the deceased AB, Fentanyl had been legally, but unwisely prescribed. The source of the Fentanyl in the other two deaths (RG and DB) is difficult to determine, but it may have been purchased illegally. It is a potent drug, up to 100 times stronger than morphine and thus causes a particular risk for overdose.[128] Fentanyl deaths are on the increase.

141. Fentanyl is commonly prescribed in transdermal patch form[129]. These patches are meant to be attached to the skin to allow for a steady titrated dose to be released. However, the inquest heard that it is relatively easy to buy Fentanyl patches on the black market.[130] The

---

[122] Penington Institute 'Australia's Annual Overdose Report 2017' Exh 1 Research Vol 1 Tab 1A Introduction
[123] NDACRC 'Majority of opioid deaths in Australia are related to pharmaceutical opioids' Exh 1 Research Vol 4 Tab 95
[124] Note 121 ibid
[125] Pennington Institute 'Australia's Annual Overdose Report 2017' Exh 1 Research Vol 1 page 41 ff
[126] NDARC report 'Powerful painkiller linked to 136 deaths in middle aged Australians' March 2013 Exh 1 Research Brief Tab 48
[127] *Poisons and Therapeutic Goods Regulation* 2008
[128] Statement of Dr Jauncey, Exhibit 1,Tab 2 [10]
[129] Durogesic patches 5 pack was prescribed in the case of AB
[130] Oral Evidence of PF, Transcript 8.5.18

active drug is then extracted from the patches and injected.[131] This method of delivery means that it is extremely difficult for the user to gauge or control the dose being administered[132]. This presents a major risk of overdose and death to users.

142. NSW Police have specifically raised the misuse of Fentanyl as an issue of real concern. Correspondence from the Commissioner's Office[133], notes that Fentanyl's high potency, rapid onset and accessibility make it a significant public health risk from a police perspective. The Commissioner noted that, on information available to him, between the period March 2016 and February 2018, 32.29% of all opiate based drug overdose deaths, (that is, 62 deaths), were directly attributable to Fentanyl.

143. It is always difficult to ascertain whether an individual has obtained a drug legally. While one can obtain PBS records and Medicare records for the purpose of an investigation such as this, there is no central register and it is difficult to know if an individual has been attending a doctor on a non-Medicare basis or has obtained private scripts. NSW Health supports, in principle, the introduction of a national system of Real Time Prescription Monitoring (RTPM) for the control drugs listed in Schedule 8 of the *Poisons and Therapeutic Goods Regulation* 2008 (NSW). It recognises that a system of RTPM of this drug group would enhance the regulatory framework for prescription medication in NSW[134].

144. The PBS system was not designed to monitor the use of Schedule 8 drugs and as a consequence its usefulness is extremely limited for this purpose. The evidence at this inquest indicates a 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 could 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[135]. Discussion could even trigger a co-prescription of naloxone and and honest discussion about the risks involved. It would also be useful in caring for complex patients like AB who claimed to be receiving a particular medication from her regular doctor, but who was not.

---

[131] "Deaths Related to Fentanyl Misuse – An Update" NCIS Fact Sheet, October 2013 Research Brief Volume 2, Tab 41

[132] "Powerful opioid Fentanyl poses serious risk of fatal overdose" NDARC , Research Brief, Volume 2, Tab 43

[133] Letter from Commissioner of Police MJ Fuller dated 27 March 2018, Exh 1 Tab 5D

[134] Submissions from the Department of Health were received on 22 February 2019 and are attached to the court file.

[135] Oral evidence of Hester Wilson Transcript 7.5.18 page 42-44

145. 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[136,] and others are likely to have limited skills in identifying "a drug dependent person. There appears to be limited oversight of this scheme.[137]

146. Associate Professor Lintzeris also noted that it was once the case in NSW that if opioids were prescribed for more than eight weeks, a doctor had to obtain approval to write further prescriptions. The Ministry of Health removed this restriction over a decade ago because it lacked the resources to monitor the requirement. In his view this increased the risk of patients accessing opiates from multiple doctors, a fact about which the Ministry of Health was warned at the time.[138]

147. A doctor can contact the Commonwealth Prescription Shopping Information Service (PSIS) [139.] 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 Schedule 4 drugs (including low dose codeine formulations) will not show up. The court heard evidence that further difficulties with the service tend to arise for busy doctors who find the process of contacting the hotline number cumbersome and frustrating.[140]

148. Coroners and many general practitioners have been advocating for a fully functional real time prescribing system for years.[141] Many of the experts who gave evidence in this inquest also supported its introduction. On the other hand, Dr Wodak, a previous supporter of the scheme, alerted the court to the lack of rigorous evaluation evidence currently available in

---

[136] Report of Dr Hester Wilson, Exhibit 1, Tab 30
[137] See also discussion of the regulatory scheme in oral evidence of Ms Mackson, Transcript 10.5.18 page 20-35
[138] Assoc Professor Lintzeris Statement Exhibit 1, Tab 4a page 4
[139] "Prescription Shopping Program" Australian Government, Department of Human Services Information. Research Volume 2, Tab 40
[140] It is interesting to note that it has been reported that findings in the Victorian Coroners Court show that in seven out of ten pharmaceutical drug overdose deaths, the deceased had only been to see one doctor. "Opioid prescription crisis; Everyday Aussies, not "doctor shoppers" at heart of crisis, experts say" ABC Law Report, Research Brief, Volume 1, Tab 8
[141] 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.

relation to the functioning of the Tasmanian system. He warned that supply restrictions can sometimes create serious unintended negative consequences and fewer benefits than had been hoped for. In this case, one might fear that turning off the supply of prescription Fentanyl might encourage the illegal market in Fentanyl or indeed Carfentanil manufactured on the black market.[142] Nevertheless, he agreed that many members of the medical profession too readily prescribe opiates for chronic pain at high doses and without review.[143] In my view, a functional real time prescribing system could be an important part of a safer prescribing system, if introduced in conjunction with other broad measures.

149. In any event, it looks a long way off. In evidence 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.[144] In her view the eventual roll out was "years" away.[145] 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 was foreshadowed to be up and running in 2018, 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."[146] She made this comment noting that Victoria's "commitment and build occurred…commenced some time ago."[147] She was unaware of any evaluation of the Tasmanian system, and reiterated that NSW did not plan to follow the "stand alone" path.

150. It does not seem that the issue is being addressed with real urgency in terms of developing this potentially life-saving tool. 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, in my view 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 could open the way for more honest consultations.

151. It is important that any future roll-out of any monitoring scheme goes further than Schedule 8 drugs. There are numerous examples of Schedule 4 drugs which create serious problems for consumers, especially when used in combination with Schedule 8 drugs. Diazepam, codeine

[142] See also "Today's fentanyl crisis;Prohibitions Iron Law, revisited" Research Volume 2, Tab 49
[143] See his discussion of this issue, Statement of Dr Wodak, Exhibit 1, Tab 3 [48-50] and in oral evidence.
[144] Oral evidence of Judith Mackson, taken on 10.5.18, page 8, line 1 onwards.
[145] Oral 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.
[146] Oral evidence of Judith Mackson, taken on 10.5.18, page 8, line 43 onwards.
[147] Evidence of Judith Mackson, taken on 10.5.18, page 8, line 48 onwards.

combination drugs and drugs such as tramadol would not be captured if the system only records Schedule 8 drugs.[148] It must be a compulsory system that picks up private scripts.

152. The kind of risky prescribing that can lead to patient death can arise from ignorance, carelessness and possibly greed. Many of the experts spoke about the need to provide doctors with further education in relation to prescribing and in relation to further treatment options.

153. Dr Wilson[149] advocated for further education for GPs, noting that education was needed at all stages of a doctor's professional development. Dr Wilson suggested that all doctors who wished to prescribe opioids and benzodiazepines should be required to do training as part of continuing professional development (CPD) so they are aware of the risks of prescribing these medications and are more skilled at assessing risk, setting boundaries, assessing dependency and in placing appropriate time limits on prescriptions. This training should be provided to all prescribers, including and especially those in rural and remote areas (via webinar).

154. Dr Wilson also advocated for an expanded role for multi-disciplinary comprehensive pain clinics which feature non-pharmacological treatments for patients The alternative pain relief strategies to medication include talk therapy with skilled psychologists, which is shown to be effective and evidence based but which is expensive and can be particularly hard to organise especially for many patients in rural and regional areas. Other options include hydrotherapy and physiotherapy.[150] The use of meditation and mindfulness techniques should be explored.

155. Submissions received from NSW Health made no comment in relation to the need to increase the availability and accessibility of non-pharmaceutical pain management strategies or in relation to research into the use of medicinal cannabis in chronic non-cancer pain as an overdose strategy. It appears to regard these issues as a Commonwealth responsibility.[151]

156. There is evidence that more needs to be done in educating doctors when prescribing opioids for pain relief. Patients may also leave hospital with a prescription that is later re-filled by a general practitioner without sufficient thought. [152]

157. It should be noted that it appears that almost all the Fentanyl currently being used illicitly in NSW is legally prescribed to the user or is pharmaceutical Fentanyl diverted into the black

---

[148] Report of Dr Hester Wilson, Exhibit 1, Tab 30
[149] Report of Dr Wilson, Exhibit 1 Tab 30 page 10ff
[150] Oral evidence of Dr Wilson, Transcript 7.5.18 page 64
[151] Submissions on behalf of NSW Ministry of Health, Northern Sydney Local Health District, NSW Ambulance Service and NSW Police, paragraph 37-38
[152] For discussion of this issue, see "Prescription opioids are killing more Australians than heroin: Australian Bureau of Statistics" SMH, Research brief, Volume 1, Tab 9, "St Vincent's Hospital intervenes to cut opioid prescriptions given to patients on discharge" Research brief, Volume 2, Tab 34

market by individuals who obtain a legal prescription. This differs greatly to other countries where most of the Fentanyl (and its analogues) in the market is illegally produced[153]. A number of witnesses gave evidence about the dire consequences should non-pharmaceutical Fentanyl or Fentanyl analogues such as Carfentanil take hold in NSW as they have in the United States[154].

158. Dr Jauncey described the importance for public health workers to monitor the supply for planning and treatment purposes. While there have been some reported seizures of illicit Fentanyl by Australian Border Force,[155] limited sentinel surveillance done at the MSIC to date has not detected the use of illicit Fentanyl among its users. Nevertheless I am of the view that monitoring programs such as this should be supported to provide as much information as possible about the market and to ensure the safety of users.

159. The Commissioner of Police supported a draft recommendation which concerned the capturing of data on overdose deaths including those attributable to Fentanyl. The Commissioner was of the view that the NSWPF best placed to assist NSW Health by providing information which it collects at overdose deaths, including whether illicit Fentanyl was implicated in the death.

Response to draft recommendations from the interested parties

160. From the evidence discussed briefly above came a list of draft recommendations for government consideration. These draft recommendations were provided to the Department of Premier and Cabinet, NSW Health, and the NSW Police Force (NSWPF) in December 2018. Given the six tragic deaths under consideration and the importance of the issues raised, it was genuinely hoped that feedback and comment would be provided.

161. Submissions in response to the draft circulated recommendations have been received on behalf of NSW Health, Northern Sydney Local Health District, NSW Ambulance Service, NSW Department of Premier and Cabinet NSW Police Force[156]. The court has reviewed them carefully.

162. I accept that the complexities of the federal system mean that some of the recommendations under consideration would require NSW leadership and advocacy in Commonwealth forums and I urge them to consider that path. I acknowledge the fine work that many employed by NSW Health, some of whom gave such compelling evidence before me, are currently doing

---

[153] "Fentanyl and its analogues- 50 years on" Research Brief Volume 2, Tab 42
[154] For example, oral evidence of Dr Wodak, Transcript 31.10.18 page 15, 28
[155] "Warning about elephant sedative drug Carfentanil seized in Canberra" Canberra Times Research Volume 2, Tab 56
[156] Submissions were received at 5pm on 22 February 2019 and are attached to the court file.

in the fields of harm reduction, drug treatment and the provision of naloxone. I remain hopeful that a Drug Summit will harness their expertise and have the capacity to help trigger significant change.

Findings

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

Identity 1 (DB)

The person who died was DB

Date of death

He died on 5 May 2016.

Place of death

He died at Liverpool in the State of NSW

Cause of death

He died from multi-drug toxicity.

Manner of death

DB died following the injection of a liquid substance believed to be heroin. DB's death was the result of an accidental drug overdose.

Identity 2 (RG)

The person who died was RG

Date of death

He died on 22 May 2016.

Place of death

He died at Brookvale in the State of NSW

Cause of death

He died from multi-drug toxicity.

Manner of death

RG died in his home following the injection of a substance or substances which included Fentanyl. RG's death was the result of an accidental drug overdose.

Identity 3 (AH)

The person who died was AH

Date of death

He died on 24 May 2016.

Place of death

He died at Waterloo in the State of NSW

Cause of death

He died from multi-drug toxicity

Manner of death

AH died following the injection of an opiate substance, believed to be heroin and the consumption of alcohol and benzodiazepines. AH's death was the result of an accidental drug overdose.

Identity 4 (JD)

The person who died was JD

Date of death

He died on 24 May 2016.

Place of death

He died at Werrington in the State of NSW

Cause of death

He died from heroin toxicity.

Manner of death

JD died following the injection of heroin. JD's death was the result of an accidental drug overdose.

Identity 5 (DC)

The person who died was DC

Date of death

He died on 27 May 2016.

Place of death

He died at Bayswater Road Kings Cross in the State of NSW

Cause of death

He died of multi-drug toxicity.

Manner of death

DC died following the injection of an opioid substance, believed to contain heroin. DC's death was the result of an accidental drug overdose.

Identity 6 (AB)

The person who died was AB

Date of death

She died on 13 May 2016.

Place of death

She died at Lane Cove in the State of NSW

Cause of death

She died of multi-drug toxicity.

Manner of death

AB died following the injection of drugs, including Fentanyl. The Fentanyl had been extracted from a patch which had been legally prescribed by a doctor. Her death is the result of an accidental drug overdose.

Recommendations pursuant to section 82 *Coroners Act 2009*

164. For reasons stated above, I make the following recommendations:

To the NSW Department of Premier and Cabinet

1. That the Department facilitate and host a NSW Drug Summit, bringing together experts in the field of health, drug addiction and drug law reform, with members of State Parliament, law enforcement, sociologists, researchers, parents, current and former drug users, family support groups and community leaders, to develop drug policy, that is evidence and human rights based, and focused on minimising harm to users, their families, and the community.

2. The ambit of the Drug Summit should be wide and should give full and genuine consideration to:

   a) Ways of reducing deaths by drug overdose in NSW
   b) The best evidence from countries outside Australia as to what works to minimise the risk of deaths by drug overdose
   c) Decriminalising personal use of drugs, as a mechanism to reduce the harm caused by drug use
   d) Ways of improving and expanding treatment for drug users
   e) Reducing the stigma and shame currently associated with drug use
   f) The availability of alternative non-pharmaceutical pain management options, including, for example, physiotherapy, hydrotherapy, and counselling.
   g) The availability of support mechanisms for family and friends of drug users

3. That, following from the Drug Summit, a new 'Plan of Action' be developed with a comprehensive 'whole of government' and 'whole of community' approach to the management of illicit drug use and the care of users and their families.

To NSW Health

4. Noting that on 2 October 2018, the Therapeutic Goods Association registered naloxone 1.8mg nasal spray as an antidote to opioid overdose, and that stock is anticipated to be available from early 2019, NSW Health should support the immediate distribution of the nasal spray to:

   a. NSW Ambulance officers and paramedics for use in the treatment of those suffering an overdose
   b. NSW Police force members for use in the treatment of those suffering an overdose

c. General practitioners working in areas where there is a high prevalence of overdose, for the free supply to those at risk.
d. Emergency Departments, for the distribution to drug users suspected of having an overdose, and to their families and friends.

5. That NSW Ambulance officers be trained to leave naloxone at the scene of a suspected overdose.

6. That Triple 0 operators receive training on how and when to advise callers about the administration of naloxone to callers themselves or to an individual they are with who is suspected of having an overdose.

7. That further support be given to the expansion of the ORTHN (Overdose Response and Take Home Naloxone) project, providing for the distribution of naloxone, and training, to members of the community most likely to come into contact with those at risk of an opiate overdose, in particular that efforts be made to expand the trial to rural areas.

8. That consideration be given to increasing funding to organisations like NUAA (NSW Drug Users Association), for harm reduction outreach in rural areas, and within specific communities of interest (e.g exiting prison populations, brothels) to distribute naloxone free to users.

9. That attention is given to the introduction of Real Time Prescribing (RTP) in NSW, which includes private scripts as well as drugs provided pursuant to the Pharmaceutical Benefits Scheme (PBS). In this respect, a critical review of operation of the RTP scheme currently in operation in Tasmania may be instructive.

10. That urgent attention is given to improving the affordability of drugs substitution programs (methadone and Buprenorphine) for all drug addicted persons wanting to access them. This should include covering the dispensing fee and other associated costs.

11. That consideration be given to the availability of alternative drug substitution programs for a small group of persons who have not been suited to traditional programs, including low dose mobile methadone, long acting Buprenorphine and pharmaceutical heroin substitution for a minority who are severely dependent and treatment resistant.

12. That consideration be given to additional venues for the medically supervised injection of opiates, including the smaller consumption room model and/or additional medically

supervised injection rooms (MSIR), in areas where there are many drug overdoses and where the community supports the establishment of MSIR.

13. That support be given for a program of opiate monitoring to be available at venues, including the Medically Supervised Injection Centre (MSIC) and the NUAA. This will provide data for planning, implementation and evaluation of public health practise.

14. That funding be allocated to Family Drug Support Australia and/or any similar support groups, to increase the number and availability of support services for the family and friends of drug users in NSW.

15. That, following a study of unmet need for drug treatment facilities in NSW, resources be committed to increasing the number and type of facilities available to assist drug users to address health and related concerns.

16. That support be provided to increase the availability and accessibility of non pharmaceutical pain management strategies, including hydrotherapy, counselling, physiotherapy and mindfulness training. Further research should also be undertaken into the use of medicinal cannabis in chronic non-cancer pain as an overdose prevention strategy.

17. That consideration be given to developing and piloting a system of plain speaking discharge summaries for all persons admitted for a condition related to problematic drug consumption, which contains reference to support hotlines, their next appointment and harm reduction measures.

To the NSW Police Force

18. That consideration be given to providing NSW Police officers with naloxone nasal spray for use in the treatment of those suffering an overdose.

19. That consideration be given to providing NSW Police with training on the use of naloxone, particularly nasal spray naloxone as it becomes available in 2019.

20. That consideration be given to training NSW Police to leave naloxone at the scene of a suspected overdose.

21. That consideration be given to how best to collect and consider data on the involvement of opiates, particularly Fentanyl, in the overdose deaths of NSW citizens.

To the NSW Department of Justice – Office of the Attorney General

22. That the legislation governing the supply of prescription drugs be amended so that:

    a) Family and friends of drug users can obtain a supply of naloxone from their General Practitioner on prescription.

    b) persons cannot be penalised for providing naloxone to a person suspected of having an overdose (the so called 'good Samaritan laws').

23. That the Act and Regulations governing authority to prescribe drugs of addiction be reviewed for the purpose of:

    a) simplifying the wording of the legislation to make it more easily understood by doctors and pharmacists

    b) considering whether Fentanyl should be reclassified, for the purpose of the *Poisons and Therapeutic Goods Act and the Therapeutic Goods Regulation*, so that it is subject to stricter regulation before it can be supplied.

To the Royal Australian College of General Practitioners and NSW/ACT State Faculty of Royal Australian College of General Practitioners

24. That consideration be given to the design and delivery of a combination of training methods for General Practitioners about:

    a) how to care for vulnerable drugs users
    b) The risk assessment to be done before prescribing pain killers
    c) The use of alternatives to prescription pain killers
    d) The interpretation and implementation of opioid and benzodiazepine Prescribing Guidelines developed by the College - including summary documents to guide busy practitioners

25. That consideration be given to mandating training in the RACGP in this area so that General Practitioners are required to complete the training as part of the Continuing Professional Development (CPD) triennium cycle.

To the NSW Pharmacy Guild

26. That The Pharmacy Guild of Australia consider what educational activities could be developed for pharmacists on naloxone, its safe use, importance of stocking in community pharmacies, and the availability of nasal spray naloxone from early 2019.

Conclusion

165. Finally, I once again express my sincere and heartfelt condolences to all those who have been directly affected by these tragic deaths. I remain deeply troubled by the evidence arising from this inquest. In my view it clearly establishes that many opiate and opioid related deaths are genuinely preventable if we, as a community, are prepared to rethink our approach to drug policy.

166. I thank the family and friends who participated in this inquest. Your courage in attending and speaking at these proceedings is greatly appreciated by all those who worked on this inquest. Your participation will help generate change. I also thank the many experts who gave up their valuable time to share their expertise with the court.

167. I thank my Counsel Assisting Dr Peggy Dwyer and her solicitor Janet De Castro Lopo for work well above and beyond what could properly be expected of them in the preparation of this matter. I acknowledge the significant work of Rob McIlwaine before his untimely death last year.

168. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
1 March 2019
NSW State Coroner’s Court, Lidcombe