CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Jay Alan Paterson**
Citation:	**[2019] ACTCD 6**
Decision Date:	25 June 2019
Before:	**Chief Coroner Walker**
Decision:	See [4], [69]
Catchwords:	**CORONIAL LAW** – cause and manner of death – use of medication – medical treatment
Legislation Cited:	*Coroners Act 1997* (ACT)
Cases Cited:	*Inquest into the death of Suellen Edith Davis* [2018] ACTCD 10 *Inquest into the death of Lauren Maree Johnstone* [2019] ACTCD 5 *Inquest into the deaths of DB, RG, AH, JD, DC & AB* (State Coroner's Court of New South Wales, Deputy State Coroner Grahame, 1 March 2019)
File Number:	CD 199 of 2017

CHIEF CORONER WALKER:

1. The death of Jay Alan Paterson, a 43 year old man at the date of his death, was reported to me on 4 September 2017 on two bases:

   (a) in accordance with section 13(1)(a) of the *Coroners Act 1997*, as he was thought to have died unnaturally in unknown circumstances; and

   (b) in accordance with section 13(1)(c) of the *Coroners Act 1997*, as his death may have been attributable to a medical procedure.

2. Melissa, Mr Paterson's wife, expressed the following concerns to me in an email sent to the Court shortly after Mr Paterson's death:

   (a) From a public safety perspective, she believes strong pain medication is too readily available via prescription from medical professionals; and

   (b) On 30 August 2017, she called a general practitioner, Dr Peter Renshaw, from the Rutledge Medical Centre in Queanbeyan, New South Wales, to discuss numerous issues regarding Mr Paterson before Mr Paterson's appointment with Dr Renshaw. She believed that Dr Renshaw failed to take her concerns into account by prescribing Mr Paterson more medication during the subsequent appointment. In addition, Dr Renshaw did not conduct any physical examination before prescribing this medication. Family members could hear an audible rattle in Mr Paterson's chest that day and, on admission to Calvary Hospital the next morning, Mr Paterson was reported to have pneumonia.

3. I requested a full brief of evidence be prepared in the matter. Although the majority of the brief was completed in a timely way and delivered to the Court in March 2018, the final material in this case was not received until 19 May 2019.

4. Having considered the brief of evidence, I now make the following formal findings:

   (c) Jay Alan Paterson died on 4 September 2017 at Calvary Public Hospital, Mary Potter Circuit, Bruce in the Australian Capital Territory;

   (d) The manner and cause of death of Mr Paterson are sufficiently disclosed and a hearing is unnecessary;

   (e) The cause of Mr Paterson's death is hypoxic-ischaemic encephalopathy following a polypharmacy overdose and iatrogenic upper airway injury, but I make an open finding as to the manner of his death; and

   (f) Pursuant to section 52(4)(a)(i) of the *Coroners Act 1997*, a matter of public safety is found to arise in connection with this inquest.

Background

5. Mr Paterson was born in the Australian Capital Territory and was the eldest of four siblings. Initially the family lived in Page in the Australian Capital Territory and the deceased attended Saint Matthew's Primary School in Page. When Mr Paterson was in Year 4 at school, the family moved to Queensland. A few years later, the family returned to the Australian Capital Territory.

6. Mr Paterson left school after Year 10 and undertook part of a mechanic apprenticeship.

7. In his early twenties Mr Paterson married his first wife, Kate, and they had two children, Samantha and Connor, who were 20 and 16 years old respectively at the time of Mr Paterson's death.

8. In 1991, Mr Paterson commenced working for Corrective Services NSW.

9. In late 2003, Mr Paterson separated from his first wife.

10. Mr Paterson joined the Australian Federal Police ('AFP') in June 2006 and met his future wife, Melissa, at the AFP Police College. From January 2007, Mr Paterson worked as a General Duties Police Officer within ACT Policing.

11. Mr Paterson injured his right knee in late 2007. In November 2007, he had a knee operation on his right knee and was prescribed Endone after the operation. Mr Paterson later developed osteomyelitis in this knee which resulted in further surgery. Due to the pain in his knee, Mr Paterson was prescribed opioid analgesics (Endone in 2007 and OxyContin in 2008) for the first time as well as medication to assist with sleep (Quilonum and Stilnox in 2008).

12. Mr Paterson also suffered a back injury while undertaking a police training course in 2009. The pain resulting from that injury caused Mr Paterson to have a significant amount of time off work.

13. In 2013, the deceased married Melissa and, in December 2016, they had a son, Ruben.

14. Mr Paterson resigned from the AFP in 2013. After resigning from the AFP, Mr Paterson commenced working again at Goulburn Correctional Centre for a short time before working as a Security Manager for Canberra nightclubs.

15. In January 2017, Mr Paterson was formally diagnosed with Post-Traumatic Stress Disorder ('PTSD') resulting from incidents while in the AFP. Mr Paterson was prescribed Propranolol for this condition.

16. At the time of Mr Paterson's death, he had an active Comcare claim in relation to injuries sustained in the course of his employment with the AFP.

Use of opioid medications

17. The evidence demonstrates that Mr Paterson developed a physical dependence on, and a tolerance to, prescription opioid pain-killing medication due to taking medications on and off from 2007 until his death. Mr Paterson had physical conditions which caused him pain and necessitated the use of strong painkillers. At times, Mr Paterson was successful in reducing, and briefly ceasing, his usage of opioids, however, he was not able to manage his pain in alternate ways in the long term.

18. In 2008, Mr Paterson's then GP recorded that he commenced discussions with Mr Paterson regarding pain management, the potential for dependency on opioid analgesics like OxyContin and the need to see a pain management specialist. After his back injury, Mr Paterson was referred to a number of pain management specialists and completed rehabilitation exercises, physiotherapy and pilates all with minimal effect on his pain levels.

19. By 2012, Mr Paterson's then treating pain specialist noted that Mr Paterson:

> "has been on opiates for years now and has developed a tolerance and dependence to these… and is eager to try something such as a ketamine infusion as to get him off the narcotics."

20. Mr Paterson came to the attention of the ACT Chief Pharmacist in March 2014 for doctor shopping and engaging in drug seeking behaviour. Mr Paterson was said to have:

> "had a major problem with opiate abuse and drug seeking behaviour in the recent past. His drug seeking behaviour and doctor shopping apparently became out of hand so it would be preferable if he was not prescribed opiates at all and was subject to detoxification and permanent withdrawal from these medications."

21. Mr Paterson trialled ketamine infusions in March and June 2015 at a Canberra hospital. While the infusions were apparently well tolerated by Mr Paterson, they did not result in any meaningful pain reduction for him.

22. On 31 July 2015, Mr Paterson was the driver and single occupant of his vehicle when it veered across the road into an embankment in Hawker in the Australian Capital Territory. Mr Paterson later described this accident as the result of a micro-nap which resulted in the loss of control of his vehicle, resulting in a roll-over. Mr Paterson fortunately suffered no major injuries apart from a scalp haematoma. He was counselled by his pain specialist shortly afterwards about the risks of future accidents from micro-naps as a result of poor sleep and sedation from opioid painkillers. Mr Paterson was instructed to stop driving if he was cognitively impaired.

23. In April 2017, despite residing in the Australian Capital Territory, Mr Paterson commenced seeing a GP based in Queanbeyan, New South Wales. This was done on the advice of a Sydney pain management specialist that Mr Paterson had been seeing so as to be able to access the NSW public health system for pain management treatment (which that specialist considered to be superior to the ACT public health system). Mr Paterson had a ketamine infusion in a Sydney hospital in June 2017, but this procedure was not well tolerated and Mr Paterson requested that the procedure be ceased prematurely and he be discharged.

24. The evidence demonstrates that by mid to late-2017 Mr Paterson's doctor shopping had ceased and he was seeing one GP's practice regularly in Queanbeyan. With the benefit of hindsight, it is apparent that he was also misleading that GP as to the amounts of opioid medication in his possession, falsely reporting that medication had been stolen by a friend on one occasion and, on another, saying that his wife had confiscated his medications.

Events in lead up to death

25. By mid-2017, the relationship between Mr and Mrs Paterson had become strained in part due to Mr Paterson's medical conditions and his medication use. Mr Paterson had booked himself in to attend St John of God Hospital in Richmond, New South Wales, to undergo a treatment program for his PTSD. It was due to commence on 6 September 2017.

26. Around 27 or 28 August 2017, Mrs Paterson and Ruben moved out of the family home after a disagreement with Mr Paterson.

27. On the morning of 28 August 2017, Mr Paterson had an appointment with his usual GP, Dr McGuire, in Queanbeyan. After this appointment, Mr Paterson filled a prescription for 28 tablets of OxyContin.

28. From about 4:21pm the same day, ACT Policing received three calls about the dangerous and erratic method of driving of Mr Paterson's vehicle. At about 4:40pm, Mr Paterson's vehicle had collided with another vehicle in Hughes in the Australian Capital Territory, but the vehicle had left the scene without exchanging details with the other driver. The vehicle was later picked up by Police in Isabella Plains in the Australian Capital Territory with Mr Paterson found to be driving the vehicle. He was given an infringement notice but was allowed to drive away after a roadside screening test for alcohol was negative.

29. From about 6:45pm the same day, NSW Police received numerous calls regarding the dangerous and erratic method of driving of Mr Paterson's vehicle on the Monaro Highway heading south towards Michelago, New South Wales. The vehicle ultimately crashed into a speed sign in Bredbo, New South Wales, at about 7:00pm. NSW Police attended and arrested Mr Paterson on suspicion that he had been driving under the influence of illicit substances as a breath screening test detected no alcohol. Mr Paterson volunteered to NSW Police that he had consumed OxyNorm and Valium that morning. He also called Mrs Paterson who explained to NSW Police that they had recently ended their relationship. Mr Paterson was transported to Cooma Hospital where a blood sample was taken for later analysis. I note that sample later was found to contain oxycodone and clonazepam at toxic levels as well as traces of diazepam and benzoylecgonine (cocaine). Police considered that a mental health assessment of Mr Paterson was appropriate and he agreed to remain

at the hospital for that purpose. When, during that assessment, Mr Paterson emphatically denied any thoughts of deliberate harm to himself, Mr Paterson was discharged into the care of a friend.

30. On the afternoon of Wednesday, 30 August 2007, Mrs Paterson heard Mr Paterson on his phone stating: "I'm going to hospital tomorrow and I need to get my medication because I'm going away for two to three weeks." Hearing this conversation gave Mrs Paterson immediate and serious concerns because she believed Mr Paterson was talking to his GP and she knew Mr Paterson had obtained his prescription medication two days earlier. About 4:41pm that afternoon, Mrs Paterson called the Rutledge Medical Centre in Queanbeyan, New South Wales, and spoke to Dr Renshaw. I will discuss in more detail below these events involving Dr Renshaw in relation to potential matters of public safety.

31. About 5:00pm the same date, Mr Paterson's daughter Samantha drove him to his doctor's appointment in Queanbeyan. During the car trip Mr Paterson said to Samantha: "I'd rather be dead than go to rehab." Samantha waited while Mr Paterson saw Dr Renshaw and then took him to fill a prescription at a pharmacist in Queanbeyan before taking him home. Samantha later returned to Mr Paterson's home about 7:30pm because she realised he had left his mobile phone in her car. He greeted her at the door wearing just a t-shirt and she told Police later that he seemed groggy, out of it and in a lot of pain.

32. Mr Paterson was found unconscious in his residence on 31 August 2017 at about 8:20am by his separated wife after he did not respond to phone calls. First responders attended and Mr Paterson was transported to Calvary Hospital, where he was diagnosed with poly-pharmacy overdose (likely oxycodone, paracetamol and propranolol) with liver and kidney damage. Intubation was technically difficult and Mr Paterson went into cardiac arrest during the process and had to be resuscitated. The tube was placed incorrectly leading to air flowing into his chest and neck rather than his lungs. He underwent emergency surgery to correct his punctured trachea. Mr Paterson never regained consciousness and four days later Mr Paterson's brain had ceased to function; a decision was ultimately made to withdraw life support. His death was appropriately reported to the ACT Coroner.

Medical cause of death

33. I ordered that a post-mortem examination of Mr Paterson take place, including toxicological testing of blood and urine samples. Professor Johan Duflou conducted the examination and opined that Mr Paterson died from hypoxic-ischaemic encephalopathy following a polypharmacy overdose and iatrogenic upper airway injury. The latter was due to problems intubating Mr Paterson on arrival in the intensive care unit at Calvary Public Hospital. It was not possible to tell whether the hypoxic-ischaemic brain injury was due to the overdose or the problematic intubation or both. Testing of a blood sample from around the time of hospital admission showed overdose levels of oxycodone and clonazepam, and evidence of recent diazepam ingestion.

34. I am required by section 52(1) of the *Coroners Act 1997* to make findings as to the identity of the deceased person, when and where they died, and the manner and cause of their death.

35. The cause of Mr Paterson's death is hypoxic-ischaemic encephalopathy following a polypharmacy overdose and iatrogenic upper airway injury.

Manner of death

36. Determination of the manner of Mr Paterson's death is difficult. Mrs Paterson does not believe that her husband committed suicide, rather that he was self-medicating with painkillers and he took an overdose but without a specific intention to end his own life.

37. A number of the substances found in Mr Paterson's system were located at levels which have been reported as being toxic in other persons and point away from mistaken consumption. However, given the intoxicating nature of opioids, I cannot exclude the possibility that Mr Paterson was intoxicated to a level where he did not keep track of the amount of pills he had taken. This evidence is equivocal.

38. As against that, there is the statement that Mr Paterson made about "rather being dead than go to rehab." Additionally, although Mrs Paterson denied to coronial investigators that the couple had separated in the days before Mr Paterson's death, there is evidence that this was what Mr Paterson believed (and that she had told NSW Police this when Mr Paterson was arrested two days prior to his overdosing).

39. I am unable to draw any definitive conclusions as to the manner of Mr Paterson's death. My finding on this point remains open.

Family concerns

40. I am also required by section 52(4)(a) of the *Coroners Act 1997* to state whether a matter of public safety is found to arise in connection with the inquest, and if I find such a matter, to comment upon it. As discussed above, the two issues specifically raised by Mrs Paterson for my consideration are:

    (a) the general issue of easy access to opioid medications; and

    (b) the actions of Dr Renshaw on 30 August 2017, both in prescribing Mr Paterson more opioids and failing to diagnose pneumonia.

41. I will also consider issues of Mr Paterson's treatment at Calvary Hospital on 31 August 2017.

Matter of public safety: Easy access to opioid painkillers

42. The evidence demonstrates that by mid to late-2017 Mr Paterson's doctor shopping had ceased and he was seeing one GP practice regularly in Queanbeyan. However, as per the table prepared by the coronial investigator, the medical records also show in the month of August 2017, Mr Paterson was prescribed 296 tablets of oxycodone (240 OxyNorm capsules and 56 OxyContin tablets):

Date	Item	Amount	Pharmacy
02/08/17	OxyNorm 20mg	20	Prince of Wales Hospital Pharmacy
04/08/17	OxyNorm 20mg	20	Prince of Wales Hospital Pharmacy
05/08/17	OxyNorm 20mg	20	Ralph's Pharmacy Campbelltown, NSW
07/08/17	OxyNorm 20mg	60	Blooms Queanbeyan, NSW
16/08/17	OxyNorm 20mg	40	Blooms Queanbeyan, NSW
17/08/17	Diazepam	50	Spence Pharmacy, ACT
21/08/17	OxyNorm 20mg	60	Blooms Queanbeyan, NSW
28/08/17	OxyContin 40mg	28	Blooms Queanbeyan, NSW

30/08/17	OxyContin 40mg	28	Blooms Queanbeyan, NSW
30/08/17	OxyNorm 20mg	20	Blooms Queanbeyan, NSW
TOTAL	**OxyNorm**	**240**	**-**
TOTAL	**OxyContin**	**56**	**-**

43. How was Mr Paterson able to get so much opioid medication? Apparently by being dishonest with his medical practitioners. It appears that Mr Paterson would present well to doctors and not give cause for concern that he was drug dependent.

44. Of note, Dr McGuire, Mr Paterson's primary treating GP in Queanbeyan, rang the Commonwealth 'doctor shopping line' about Mr Paterson and was told that Mr Paterson was not a patient of concern. Dr McGuire had no cause to look behind Mr Paterson's account that he had had medications stolen from his house and thus required a new script notwithstanding the short amount of time since the previous script.

45. In respect of the consultation with Dr Renshaw on 30 August 2017 (discussed in more detail below), Mr Paterson falsely stated that his wife had confiscated his medications.

46. On that basis I do not think any referral to AHPRA is warranted in respect of individual doctors who treated Mr Paterson in the last months of his life. I find that no matter of public safety arises in respect of the treatment of Mr Paterson by individual doctors.

47. However, the general issue raised by Mrs Paterson about access to opioid painkillers is a matter of public safety. Easy access to opioid painkillers by drug dependent persons has been recognised as a matter of public safety by a number of coroners around Australia and, specifically, recently in the ACT in the *Inquest into the death of Suellen Edith Davis* [2018] ACTCD 10 and the *Inquest into the death of Lauren Maree Johnstone* [2019] ACTCD 5.

48. The family concerns have partially been addressed during the passage of time since Mr Paterson's death. In the *Inquest into the death of Lauren Maree Johnstone* [2019] ACTCD 5 I discussed in some detail the Drugs and Poisons Information System Online Remote Access system ('DORA') and how it presently operates in the ACT to provide real-time information to prescribing doctors and pharmacists in relation to patient access to Schedule 8 medications (which includes certain opioid medications). The ACT DORA system includes information from ACT doctors and pharmacists as well as the dispensing of ACT prescriptions in NSW. Had that system been available to ACT prescribers and pharmacists in Mr Paterson's case, it may have led to them taking a different therapeutic course in respect of the treatment he received in the Australian Capital Territory.

49. However, there is no real-time prescription monitoring system available in New South Wales at the present time, despite the recommendations of many coroners over the years. Most recently, NSW Deputy State Coroner Grahame reiterated that recommendation (among others) on 1 March 2019 in the *Inquest into the deaths of DB, RG, AH, JD, DC & AB*, which examined a series of opioid deaths which occurred in New South Wales in June 2016.

50. Although Mr Paterson's apparent reason for seeing a NSW GP is plausible, the evidence also suggests that Mr Paterson leveraged off the information disparity and differences in regulation between the two jurisdictions to obtain opioid medication more readily in New South Wales than he was able to access in the Australian Capital

Territory. In the ACT, all long term opioid prescriptions require the approval of the Chief Health Officer, but, in New South Wales, this only applies to injectable opioids or where the doctor is prescribing because the patient is considered 'drug dependent'. In Mr Paterson's case, the NSW doctors who treated Mr Paterson and provided statements said that because Mr Paterson had pain needs that warranted the prescribing of opioid painkillers, they did not consider they were prescribing for a drug dependent person in the way that this term was interpreted by NSW Health. Dr Renshaw in particular carefully considered whether Mr Paterson fit the NSW definition of drug dependent. However, the delegates of the ACT Chief Pharmacist interviewed by coronial investigators when shown Mr Paterson's prescription record for 2017 said they considered Mr Paterson was engaging in drug seeking behaviour in 2017 and they had no visibility over what was occurring in NSW.

51. I share the view of NSW Deputy State Coroner Grahame, and other Australian coroners, that there is a pressing need for a real-time prescription monitoring system in New South Wales, ideally as part of a national system. A national real-time prescription monitoring system might have enabled Mr Paterson's Queanbeyan doctors to have seen the amounts of medication prescribed to him in the Australian Capital Territory, and to ensure that Mr Paterson could not leverage off the differences in regulation to obtain opioid medication in New South Wales that he was, or would have been, denied in the Australian Capital Territory.

Potential matter of public safety: Actions of GP

52. As discussed above, on the afternoon of Wednesday 30 August 2007, Mrs Paterson overheard Mr Paterson on his phone stating: "I'm going to hospital tomorrow and I need to get my medication because I'm going away for two to three weeks." Hearing this conversation gave Mrs Paterson immediate and serious concerns because she believed Mr Paterson was talking to his GP and she knew Mr Paterson had obtained his prescription medication two days earlier. About 4:41pm that afternoon Mrs Paterson called the Rutledge Medical Centre in Queanbeyan, New South Wales, and spoke to Dr Renshaw.

53. Both Mrs Paterson and Dr Renshaw have provided accounts of the telephone conversation that differ in a key respect.

54. Mrs Paterson told Police that she advised Dr Renshaw that Mr Paterson was just about to attend an appointment with him. She told Dr Renshaw that Mr Paterson was going to tell him that: he was going into hospital the following day for treatment for his PTSD, however, he was not actually going until the following Wednesday; Mr Paterson had only got his prescription filled two days ago; and he had already taken all of his medication.

55. Dr Renshaw did not make a note at the time of the conversation that he had with Mrs Paterson. He has, however, provided a detailed statement which has formed part of the coronial brief of evidence and the practice medical records for Mr Paterson also form part of the brief. The notes for this visit only state: "17:14:05 Going to Sydney 1 week to receive treatment Prince Of Wales for PTSD ?+ pain management." There are no further records in relation to this consultation and the phone call from Mrs Paterson was not noted in Mr Paterson's record. However, Dr Renshaw states that he has a good recollection of these events due to the advice of Mr Paterson's death 'setting' his memory.

56. In his statement Dr Renshaw said that he did not consider Mr Paterson to be drug dependent; he considered Mr Paterson had a genuine physical condition producing significant pain for which pain relief in the form of opioid medications was reasonable. He stated both Mr and Mrs Paterson had told him Mrs Paterson had confiscated all of his medications and this was part of the reason he prescribed more medication to Mr Paterson. Mr Paterson said that he was concerned that, without his usual medications, he would suffer very significant pain before his upcoming admission to the Prince of Wales Hospital. Dr Renshaw said that he considered that, as Mr Paterson's account was consistent with what Mrs Paterson had stated, it was likely to be true. He agreed that, without medications, Mr Paterson was very likely to suffer undue pain. Dr Renshaw prescribed Mr Paterson one box of OxyContin 40mg containing 28 tablets and one box of OxyNorm 20mg containing 20 capsules. Mr Paterson was also provided with a forward dating script for oxycodone for 4 September 2017.

57. Mrs Paterson strongly denies that she told Dr Renshaw that she had confiscated all of Mr Paterson's medications. In the circumstances, it is not necessary to resolve this point of contested evidence.

58. During this consultation, Dr Renshaw had access to records from his practice which showed that Dr McGuire (from the same practice) had prescribed Mr Paterson 60 OxyNorm on 21 August 2017 and 28 OxyContin on 28 August 2017.

59. However, Mr Paterson appears to have given coherent and reasonable reasons as to why he needed painkillers. Dr Renshaw was not to know that Mr Paterson's account of his wife having confiscated his medications was not true – indeed, this would have fitted with the account provided by Mrs Paterson to Dr Renshaw prior to the consultation of her concerns for her husband irrespective of whether Mrs Paterson stated that she had confiscated Mr Paterson's medications.

60. The other concern held by the family is that Dr Renshaw did not conduct any physical examination of Mr Paterson. Family members said later that they could hear an audible rattle in Mr Paterson's chest that day and, on admission to Calvary Hospital the next morning, Mr Paterson was reported to have pneumonia.

61. Dr Renshaw said in his statement for the coronial brief that Mr Paterson made no complaint of respiratory symptoms at the time. The notes of this consultation as discussed above also make no mention of respiratory symptoms. The respiratory symptoms identified on admission to hospital could well be the result of drug toxicity in Mr Paterson's system.

62. Accordingly, I am not satisfied that the conduct of Dr Renshaw on 30 August 2016 amounts to a matter of public safety.

Potential matter of public safety: Iatrogenic injury

63. As described above in paragraph 33, the post-mortem examination of Mr Paterson identified that Mr Paterson died from hypoxic-ischaemic encephalopathy following a polypharmacy overdose and iatrogenic upper airway injury. As the iatrogenic injury cannot be excluded as being causative or contributory to the death, it is within the scope of this inquest and falls to be considered in light of whether it could amount to a matter of public safety.

64. Statements were obtained from the doctors involved with Mr Paterson's treatment at Calvary Public Hospital and specifically the intubation process. That material demonstrates the following course of events:

    (a) On arrival at Calvary Public Hospital, Mr Paterson was in a parlous state and was transferred to ICU. While on initial admission Mr Paterson had an acceptable oxygen saturation level, he developed respiratory distress and part of the reason for his transfer to ICU was to trial non-invasive ventilation.

    (b) Non-invasive ventilation was found to be insufficient for Mr Paterson and a decision was made to intubate him. Mr Paterson was expressly assessed for a difficult airway and was considered to potentially be a difficult intubation due to a short neck, small mandible and beard.

    (c) The initial attempt at intubation was undertaken by the ICU Registrar under the supervision of the ICU Consultant. The procedure to be used was an acceptable method and the Registrar articulated the plan as well as the plan in the event of an intubation failure to the medical team.

    (d) When the Registrar commenced induction and attempted the intubation, he was unable to ventilate Mr Paterson indicating that the tube was not placed in the correct position. The tube was then removed.

    (e) Less than one minute after induction, Mr Paterson had a bradyasystolic arrest and the ICU Consultant took over conduct of the procedure and oversaw resuscitation.

    (f) The consultant was experienced in performing intubations and had completed "hundreds" prior to Mr Paterson. The consultant intubated Mr Paterson with the assistance of a video laryngoscope and ventilated Mr Paterson by hand.

    (g) An anaesthetist was called in to assist with the procedure. She examined Mr Paterson while taking over hand ventilating. She considered that the tube was ventilating despite a low oxygen trace, but then unequal breath sounds indicated that the tube was not correctly placed. The tube was retracted and the anaesthetist reintubated Mr Paterson with the assistance of a video laryngoscope.

    (h) Mr Paterson's cardiac function returned and his oxygen saturation began to improve, however, he began to display symptoms of massive subcutaneous emphysema indicating that air was passing under his skin. Doctors suspected a tracheal perforation and this was confirmed with imaging.

    (i) Mr Paterson was given an urgent tracheostomy to secure an airway. He was not suitable for transfer to The Canberra Hospital. Mr Paterson's condition ultimately did not improve and he displayed signs of brain death. He was palliated and then died.

65. The evidence suggests that, during the intubation attempts, a false track was created through the cricothyroid membrane which resulted in an extraluminal air leak into the neck tissue which caused extensive surgical emphysema. This track was able to be confirmed and identified at autopsy. However, Professor Duflou also noted at autopsy that Mr Paterson's laryngeal cartilages were significantly stiffer, more calcified and more ossified than usual for a man of Mr Paterson's age.

66. Tracheal perforation is a known risk of intubation. Mr Paterson clearly required intubation after he displayed respiratory distress and non-invasive ventilation had failed. In the light of the autopsy findings, I consider that no matter of public safety arises in respect of the conduct of the intubation and no adverse comment or finding is warranted in respect of the physicians involved. It appears that, once the issue was identified, it was promptly remedied with corrective surgery and all appropriate care was taken in undertaking the intubation.

Considerations

67. In all the circumstances, in my view there is no benefit in holding a public hearing in relation to Mr Paterson's death. The investigation undertaken by Detective Senior Constable Chere Hammond on my behalf was thorough and comprehensive. I believe I have all the evidence which exists, or is likely to exist, and which could possibly bear on the decisions I must make. I am able to make recommendations without a hearing.

68. I note also the wish of Mr Paterson's family that the matter not go to hearing if their questions and concerns are able to be resolved in another way.

69. In accordance with my finding of a matter of public safety in relation to the easy access to opioid medications by drug dependent persons, I make the following recommendations:

    (a) There should be instituted a real-time prescription monitoring system in New South Wales, ideally as part of a national system.

    (b) Given the geographical location of the Australian Capital Territory as an island within New South Wales, NSW Health and ACT Health should develop processes and procedures in relation to dealing with drug dependent persons who seek treatment across the two jurisdictions concurrently. Such processes and procedures should address issues of information disparity and differences in regulation, which mean that opioid medication is more readily available in New South Wales than it would be to a similar patient in the Australian Capital Territory.

70. I direct that these findings be published in due course on the Coroner's Court website. I also direct that any response to my recommendations that I receive will also be published on the Court website.

71. I extend my condolences to Mr Paterson's family and friends.

I certify that the preceding 71 numbered paragraphs are a true copy of the findings of Chief Coroner Walker.

Associate: R. Boughton

Date: 25 June 2019