CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Joanne Lea LOVELOCK**
Citation:	**[2020] ACTCD 1**
Decision Date:	24 February 2020
Before:	**Chief Coroner Theakston**
Decision:	See [7], [21], [24], [26]
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) *Inquest into the death of Jay Alan Paterson* [2019] ACTCD 6
File Number:	CD 261 of 2015

CHIEF CORONER THEAKSTON:

1. The death of Joanne Lea Lovelock, a 53 year old woman at the date of her death, was reported to the ACT Coroner on 25 December 2015 in accordance with section 13(1)(a) of the *Coroners Act 1997*, as she was thought to have died unnaturally in unknown circumstances.

2. Ms Lovelock was last seen alive the evening before by her son, in an apparently 'tipsy' state having consumed a number of glasses of wine that day. She was described as being happy and in good spirits. Ms Lovelock was found deceased in her residence at 27/3 McCarten Place, Gordon by her children early on Christmas morning, 2015.

3. Ms Lovelock had a complicated medical history. She had suffered a leg injury about 12 years prior to her death, and suffered from chronic pain in her leg, back and hips as a result. Ms Lovelock also suffered from atrial fibrillation and a hernia. She was described by her family as being a heavy smoker and social drinker, with no apparent suicidal thoughts. Ms Lovelock had previously used heroin for a short period 20 years prior, but was able to stop by way of engagement with the Methadone program.

4. Ms Lovelock's children advised Police that her usual treating doctors were Dr Helmy and Dr Thomson in Conder and Dr Verghese in Greenway. A significant amount of prescription medication was found in Ms Lovelock's residence, including multiple tablets and prescriptions for Panamax (Paracetamol), Panadeine (Paracetamol and Codeine), Physeptone (Methadone), Spiriva (Tiotropium bromide), Remeron and Avanza (Mirtazapine), Vesicare (Solifenacin), Aspirin, Ramapril, Atorvastatin, Endep (Amitriptyline), Sotalol, Prochlorperazine, Omeprazole, Predinsolone, and a number of asthma inhalers.

5. Then Chief Coroner Walker initially had carriage of this matter. Her Honour directed that a post-mortem examination of Ms Lovelock take place. Associate Professor Jain undertook that examination, and opined that Ms Lovelock died from the combined effects of alcohol, Amitryptyline

and Methadone. There was no evidence of injury located, but toxicological testing of Ms Lovelock's blood identified the following:

a. Alcohol was present at 0.289 g/100 ml of blood (by way of reference, the driving limit is 0.05 g/100 ml), and this level of alcohol has been reported to produce both toxic and lethal effects;

b. Amitryptyline at 0.30 mg/L of blood, and this level has been reported to produce both toxic and lethal effects; and

c. Methadone at 0.24 mg/L of blood, and this level has also been reported to produce both toxic and lethal effects.

Other substances located in Ms Lovelock's blood at lower or trace levels were Diazepam (Valium) and its metabolite Nordiazepam), Oxycodone, Promethazine, Codeine, and Morphine (but this is also a metabolite of Methadone).

6. Former Chief Coroner Walker directed that Ms Lovelock's records of treatment from Dr Helmy, Dr Thomson and Dr Verghese be obtained, and that these doctors be asked to provide a statement as to their treatment of Ms Lovelock. Her Honour then became unavailable and I assumed carriage of this matter. I also directed that Medicare and PBS records be obtained to ascertain if Ms Lovelock was seeing and obtaining prescriptions from other doctors in the period immediately prior to her death, and for statements also to be taken from those doctors.

7. 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. On the basis of the information above I find as follows:

Joanne Lea Lovelock died on 25 December 2015 at 27/3 McCarten Place, Gordon in the Australian Capital Territory. The cause of her death was the combined effects of alcohol, Amitryptyline and Methadone.

8. In terms of the manner of Ms Lovelock's death, I note that there was no indication of prior thoughts of suicide, and that Ms Lovelock was reported by her family to have been happy and jolly the day before her death. I note that some of the medication prescribed to Ms Lovelock includes antidepressants, and the medical records suggest that Ms Lovelock suffered from a degree of situational depression following the loss of her parents. A number of the substances found in Ms Lovelock's system were located at levels which have been reported as being lethal and toxic in other persons, and might point away from mistaken consumption. However, given the intoxicating nature of the medication found in Ms Lovelock's system, and the degree of alcohol intoxication evident, I cannot exclude the possibility that Ms Lovelock was intoxicated to a level where she did not keep track of the amount of pills she had taken. On balance I think the evidence probably best supports a finding that Ms Lovelock's death was the result of accident or misadventure.

9. 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.

10. The matter of public safety evident in this case is the prescription medications that Ms Lovelock was able to access, and which ultimately contributed to her death. This is both an issue of general public importance, but I also examine the issue from the perspective of whether the individual doctors who prescribed medications to Ms Lovelock acted appropriately in all the circumstances.

11. The evidence from Medicare is that Ms Lovelock saw the following general practitioners and obtained prescriptions in 2015:

    a. Dr Shamim Khan (on one occasion) and Dr Philip Verghese (on thirty occasions), in Tuggeranong;

    b. Dr Thomas Johnston (on eleven occasions) and Dr Gamal Helmy (on eighteen occasions), in Conder;

c. Dr Philip Sutherland (on seven occasions) and Dr Leon Van Der Walt (on one occasion), at practices in Gosford;

d. Dr Roshan Awmee and Dr Olufemi Olutayo (each on one occasion), as part of the National Home Doctor Service in Canberra; and

e. Dr Michael Futter (on one occasion) and Dr Ma Therese Colina (on two occasions), in West Gosford.

I understand that Ms Lovelock's parents resided in Gosford, and when she visited her parents, she would visit doctors in Gosford. Specifically, during 2015 both Ms Lovelock's parents suffered from chronic diseases that ultimately caused their deaths, and Ms Lovelock spent much of that year in Gosford with her parents.

12. Dr Verghese stated that Ms Lovelock had legitimate physical conditions which caused her pain and necessitated the use of painkillers. He did not prescribe Ms Lovelock anything stronger than Panadeine Forte and indicated his belief that he had weaned Ms Lovelock off stronger opioids. Dr Verghese said that Ms Lovelock never appeared to him in consultations to be sedated or intoxicated by alcohol but believed that she had dramatically reduced her alcohol consumption. He believed that Ms Lovelock had addictive behaviours, but he took steps to manage those by insisting on regular consultations and only issuing sufficient medication to last the period between visits. (I note that the pattern of consultations evident from the Medicare records supports this claim.) Dr Verghese was unaware that Ms Lovelock was presenting to medical practices other than the Tuggeranong clinic.

13. Dr Helmy also stated that Ms Lovelock had legitimate physical conditions which caused her pain and necessitated the use of painkillers. He prescribed Endone and Targin (Oxycodone) for those purposes but did so under the guidance and direction of a pain management specialist. Dr Helmy said that he did not recall having any specific concerns about alcohol or medication misuse in relation to Ms Lovelock, nor any

consultations in which Ms Lovelock presented as sedated or intoxicated, nor did he consider that Ms Lovelock displayed any addictive behaviours. Dr Helmy was unaware that Ms Lovelock was presenting to medical practices other than the Conder clinic.

14. Dr Sutherland also stated that Ms Lovelock had a chronic pain condition which was being managed by a pain clinic in Canberra, and necessitated the prescription to her of Endone, Targin and Valium. He stated that he also prescribed Ms Lovelock Avanza after her parents' deaths, to assist her in coping with the grief associated with her loss. Ms Lovelock had been attending on Dr Sutherland irregularly since 2005. Dr Sutherland said that he knew that Ms Lovelock had a regular doctor in Canberra, and he had contacted that clinic and received faxes from that practice. The records supplied by Dr Sutherland are letters and faxes from Dr Helmy and the Conder practice; Dr Sutherland appears to have been unaware of Dr Verghese and the Tuggeranong practice. Dr Sutherland stated that he had no knowledge of Ms Lovelock's prior illicit drug use or of a high level of alcohol use and considered that she did not display addictive behaviours. He considered that Ms Lovelock was compliant with the doses of medications advised by the pain clinic, she did not request any increase in dose, and he only prescribed the standard PBS quantities of painkillers. Dr Sutherland also stated that the practice contacted the Doctor Shopping Phoneline and was told that Ms Lovelock was not identified as a 'doctor shopper'.

15. Dr Colina stated that she only saw Ms Lovelock twice, on 27 March and 31 March 2015. She prescribed Targin and Endone for chronic pain, but at lower doses than she thought Ms Lovelock had been prescribed by other doctors. Dr Colina was unaware of any alcohol use by Ms Lovelock, and considered that Ms Lovelock did not display any addictive behaviours during the consultations. Dr Colina noted that Ms Lovelock attended from Dr Sutherland's practice in Gosford and stated that she reviewed a letter from Ms Lovelock's pain specialist and medical records from Canberra.

16. Dr Futter stated that he only saw Ms Lovelock once, on 18 April 2015, where he prescribed Endone for chronic pain. The notes of the consultation include the comments that Ms Lovelock presented claiming that she had run out of Endone and showing a packed of Endone that had been prescribed by Dr Helmy dated 16 April 2015. Dr Futter recorded in the patient progress notes "*this well (sic) be the last time I prescribe in view (of) complex medical history*".

17. Dr Awmee stated that he only saw Ms Lovelock on one occasion on 18 May 2015 as part of the National Home Doctor Service. She claimed to be suffering from pain and a headache but did not want to go to hospital. Dr Awmee diagnosed Ms Lovelock as suffering from opioid withdrawal symptoms and declined to prescribe her any opioids, saying that she would have to follow up with her GP.

18. No responses were received on behalf of Dr Van Der Walt, Dr Khan or Dr Olutayo. However, given Ms Lovelock only saw each of these doctors once, and given the evidence already obtained in this investigation, I think little would turn on the information they could provide.

19. Dr Johnston now practices in Western Australia and advised that without access to the relevant consultation notes he would be unable to provide a response. However, given Ms Lovelock only saw Dr Johnston when Dr Helmy was unavailable, and given the evidence already obtained in this investigation, I think little would turn on the information he could provide.

20. The evidence demonstrates that Ms Lovelock developed a physical dependence on and a tolerance to prescription opioid painkilling medication due to her long-term usage of these medications for chronic pain until her death.

21. I find that there was good reason for Ms Lovelock to attend upon doctors in Gosford, and this fact in and of itself does not constitute 'doctor shopping'. However, it is clear that Ms Lovelock effectively had two regular GPs in Canberra, Drs Helmy and Verghese, neither of whom knew about each other, and Ms Lovelock failed to advise treating

professionals of the entirety of her treatment regime in 2015. This I find constituted 'doctor shopping' in the way in which that term is commonly understood. It appears that Ms Lovelock would present well to doctors and not give cause for concern that she was drug dependent. Ms Lovelock's family also advised Police investigating her death that Ms Lovelock would see Dr Helmy because Dr Verghese would not prescribe her the painkillers she desired.

22. It is of some concern that when Dr Sutherland caused the Doctor Shopping Phoneline to be contacted and was advised that Ms Lovelock was not identified as a doctor shopper. This Phoneline is now known as the Prescription Shopping Information Service (PSIS), which is part of the Prescription Shopping Programme (PSP) run by the Federal Department of Human Services. It is not clear to me exactly how this system or its equivalent operated in the past, but I presume it was along similar lines to how it is presently run, by which I understand:

    a. It has access to Pharmaceutical Benefits System (PBS) data via pharmacies;

    b. The data is updated every 24 hours;

    c. Patients meet the PSP criteria if in any three month period, they received:

        i. PBS items from six or more prescribers; or

        ii. 25 or more PBS target items (there is a list available at https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/prescription-shopping-programme but for current purposes it is sufficient to note that the list includes Methadone, Codeine, Amitriptyline, Oxycodone and many other prescription drugs of dependence); or

        iii. 50 or more PBS items irrespective of whether they are targeted items; and

d. It is not a proactive identification system but relies upon doctors holding sufficient concerns to call the PSIS to obtain information, whereby they are given point-in-time advice as to whether the patient meets the PSP criteria in respect of the last three months.

23. Certainly by the year immediately before her death, Ms Lovelock met the PSP criteria on multiple bases in order to have been identified as a doctor shopper. However, given its point-in-time nature, and the lengthy period over which Dr Sutherland treated Ms Lovelock, it is entirely conceivable that when the practice contacted the Doctor Shopping Phoneline the advice that Ms Lovelock did not meet the doctor shopping criteria was correct at that point in time. If the PSIS had been contacted by a doctor in 2015, I consider it possible that the advice provided would have been that Ms Lovelock was a doctor shopper. However, it is clear from the statements received from her treating doctors that at no time did her conduct or presentation raise any concerns for them about addictive or drug seeking behaviours, and certainly not to a level at which I could find they should have contacted the PSIS in 2015.

24. On that basis I do not think any referral to AHPRA is warranted in respect of individual doctors who treated Ms Lovelock in the last year of her life. I find that no matter of public safety arises in respect of the treatment of Ms Lovelock by individual doctors.

25. Easy access to opioid painkillers and other medications 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, the *Inquest into the death of Lauren Maree Johnstone* [2019] ACTCD 5, and the *Inquest into the death of Jay Alan Paterson* [2019] ACTCD 6. In these cases, ACT Coroners have made recommendations in support of expanding the ambit of the Drugs and Poisons Information System Online Remote Access system ('DORA') in operation in the ACT, as well as the

need for a real time prescription monitoring system in NSW, ideally as part of a national system.

26. I find, pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, that a matter of public safety – being the easy access to prescription medications by drug dependent persons – is found to arise in connection with this inquest.

27. This case demonstrates why a proactive system of identifying drug dependent persons is required, rather than point-in-time information provided under the PSIS. Had a system existed in the PSP to audit PBS data on such a basis, Ms Lovelock could have been identified as a doctor shopper early on, her doctors informed, and prescriptions then issued by her doctors with a much better understanding of the medications she was already receiving.

28. In all the circumstances, in my view there is no need to hold a public hearing in relation to Ms Lovelock's death. I believe I have all the evidence which exists or is likely to exist which could possibly bear on the decisions I must make. There is no issue about which I would be empowered to hold a public hearing and which in and of itself warrants that course being taken. I note specifically in this regard the ACT Coroners Court has in the last few years held hearings in a number of doctor shopping and/or prescription drug misuse deaths, including the cases I have listed above. Furthermore, my ability to make recommendations is not predicated on the holding of a hearing.

29. I add my voice to that of other ACT Coroners, and NSW Deputy State Coroner Grahame in the matter of *Inquest into the deaths of DB, RG, AH, JD, DC & AB* (delivered on 1 March 2019), in that I also recommend a national, real time prescription monitoring system be instituted, with such system to include a proactive auditing and identification function to identify drug dependent persons. I note that while the ACT DORA system does potentially include proactive auditing functionality, it does not do so for as wide a target list as does the PSP.

30. 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 also be published on the Court website.

31. I extend my condolences to Ms Lovelock's family and friends. I hope my recommendations act as a significant legacy from her untimely death.

I certify that the preceding thirty-one [31] numbered paragraphs are a true copy of the reasons for the judgment of his Honour Chief Coroner Theakston.

Associate: Lauren Dreyar

Date: 24 February 2020