



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 28th day of September 2020 and the 6th day of December 2023, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Jason Mark Cullen.

The said Court finds that Jason Mark Cullen aged 37 years, late of 6/7 Glenburnie Street, Seaton, South Australia died at Seaton, South Australia on or about the 22nd day of June 2017 as a result of mixed drug toxicity. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

- 1.1. Jason Mark Cullen was born on 8 May 1980 and died on or about 22 June 2017. He was found on a couch at his residence on 23 June 2017, after the alarm was raised when he failed to turn up for work. The television was on, and he was wearing in-ear headphones. There was a fentanyl patch on each arm. In a nearby notebook he had written, '*Do Not Revive, Jason Cullen*'.
 - 1.2. An autopsy was conducted by Forensic Science SA Senior Specialist Forensic Pathologist Dr Stephen Wills on 27 June 2017.¹ Testing was undertaken for the presence of common drugs and poisons. Dr Wills concluded, taking all the findings into consideration, that Mr Cullen's death may be attributed to mixed drug toxicity, with the potent synthetic opioid drug fentanyl being the principal agent. Fentanyl, and all but one of the other drugs identified in Mr Cullen's blood, were drugs prescribed to him.

¹ Post mortem report, Exhibit C2

2. Reason for inquest

2.1. This is a mandatory inquest pursuant to section 21(1)(a) of the Coroners Act 2003 as at the time of his death Mr Cullen was subject to court-imposed home detention bail with GPS monitoring. He was facing sentence for three armed robberies of pharmacies to which he had entered guilty pleas. At the time of his arrest on 7 October 2016 for the third of these alleged offences, he was already on bail for the two earlier alleged offences. On 26 October 2016, following consideration of a Bail Enquiry Report, a Magistrate released Mr Cullen on home detention bail conditions, including GPS monitoring. Mr Cullen remained on home detention bail until his death.

3. Affidavit only inquest, leading to further investigation

3.1. This inquest was heard without oral evidence, as an affidavit only inquest. After carefully considering the evidence which was tendered, I determined that further investigation was required, focussing on two particular issues:

- whether Mr Cullen's death was to be correctly characterised as an accidental overdose of prescription medication, as postulated by the SAPOL investigating officer;²
- whether, during an admission to The Queen Elizabeth Hospital (QEH) on 1 May 2017 following an apparent suicide attempt, it was identified that Mr Cullen had been previously admitted to the QEH on 30 September 2016 following an apparent suicide attempt by prescription drug overdose.

3.2. Also, the Court commissioned an independent expert overview report by consultant specialist psychiatrist Dr Maria Naso.

3.3. Following these further investigations, the following expert reports, statements of witnesses and items of physical evidence were tendered administratively:

- expert report of Emeritus Professor Jason White dated 17 June 2021;³
- supplementary report of Professor White dated 3 September 2021;⁴

² Investigation report of Detective Brevet Sergeant Childs, Exhibit C11

³ Exhibit C27

⁴ Exhibit C27a

- addendum statement of David Childs dated 21 May 2021;⁵
- physical evidence seized from Mr Cullen's home:
 - empty blister pack;⁶
 - empty box fentanyl Sandoz;⁷
 - notepad;⁸
- disc of video walk-through of Mr Cullen's home;⁹
- Report of Dr Maria Naso, consultant specialist psychiatrist, dated 22 April 2022;¹⁰
- letter to Coroners Court from Ms Graham, National Practice Manager, 13SICK National Home Doctor dated 11 July 2022;¹¹
- affidavit of Dr Han Kyung Oh dated 26 July 2022;¹² and
- supplementary affidavit of Dr Oh dated 18 October 2022.¹³

4. Background

- 4.1. Mr Cullen was born at the Lyell McEwin Hospital on 8 May 1980 to parents Leisa Wegener and Steven Paul Cullen. He had an older brother and younger half-sister. He attended Trinity College until the age of 14, then Elizabeth High School where he completed Year 11.
- 4.2. As a young man Mr Cullen showed a passion and talent for woodwork and he worked in a furnishing business, where he learned further woodworking skills. During his early 20s he bought an old house which subsequently burnt down, destroying all his possessions. Shortly after the house fire he was in a serious motor vehicle accident where he sustained vertebral injuries. His partner took her own life soon after. His injuries affected his ability to work in the roofing industry in which he was by then employed. Mr Cullen undertook further study and moved into the information

⁵ Exhibit C11e

⁶ Exhibit C11f

⁷ Exhibit C11g

⁸ Exhibit C11h

⁹ Exhibit C11i

¹⁰ Exhibit C29

¹¹ Exhibit C30

¹² Exhibit C31

¹³ Exhibit C31a

technology industry. At the time of his death he was an IT manager for Modere Australia.

4.3. Mr Cullen was single and had no children.

5. Idiopathic intracranial hypertension - long-term treatment and complications

5.1. Mr Cullen's complicated medical history began when he was a young boy. For a time he had to wear a leg calliper at night to deal with a growth abnormality.

5.2. In 1984, at the age of four, Mr Cullen had a shunt inserted into the left-hand side of his head to manage the presence of a large left arachnoid cyst and hydrocephalus. In February 1993, after complaining of persistent headaches, he underwent eye examinations which identified a build-up of pressure in his brain. This pressure was reduced through multiple lumbar puncture procedures. He was prescribed prednisolone, which led to excessive weight gain. In April of 1993, the existing shunt was removed and a lumbar-peritoneal shunt was inserted.

5.3. In August of 2013 Mr Cullen was referred to neurosurgeon Dr Nikitas Vrodos.¹⁴ Mr Cullen had lost weight through regular exercise and had begun to experience pain under his right rib cage. The existing shunt had been in place for some 20 years with a possibility that an associated catheter had stopped working.

5.4. In September 2013 Dr Vrodos operated to remove the lumbar-peritoneal shunt. There were post-surgical complications and Mr Cullen was readmitted to hospital where the wound was opened and excess fluid drained to enhance healing. In the intensive care unit (ICU) he was commenced on intravenous prescribed antibiotics, as well as oxycodone and diazepam to assist with management of his pain and headaches. When the headaches continued and a CT scan showed minimal change, Dr Vrodos concluded that Mr Cullen needed the assistance of a shunt to regulate excess cerebrospinal fluid. The wounds were healing well and Dr Connolly, ICU specialist, prescribed fentanyl, administered through patient control (a button press) for more effective immediate relief from pain of headaches.

5.5. On 24 September 2013, after release from the ICU, Mr Cullen complained to a physiotherapist of a severe headache, and he was transferred back to the ICU for

¹⁴ Affidavit of Dr Vrodos, Exhibit C9

monitoring. By 25 September 2013 he was still complaining of bi-frontal headaches and was being administered oxycodone, morphine and paracetamol. On the same day, it was noted that he had developed a facial weakness and each eye was unable to turn outwards, a false localising sign caused by the stretching of a nerve within the brain, causing palsy. He was referred to an eye specialist on 26 September 2013, and the results of this examination showed raised pressure. That night, Dr Vrodos inserted a Medtronic ventricular-peritoneal shunt with a programmable strata valve, to allow variance of pressure to provide more flexibility in the management of the pressure in Mr Cullen's brain.

- 5.6. Mr Cullen responded well to this intervention and was discharged from hospital on 2 October 2013 with oxycodone, tramadol and diazepam, which were being reduced over the last two to three days of his admission.
- 5.7. Upon review by Dr Vrodos on 13 November 2013, Mr Cullen's facial movements had returned to normal, and he was experiencing a small amount of double vision when turning to his left, which Dr Vrodos considered to be good, given the circumstances. He reported that his headaches had almost completely resolved, he was walking 10 to 15 kilometres per day and that he had returned to work a week after the operation. Dr Vrodos referred Mr Cullen to Dr Schultz, neurologist, to ensure there was not a missed neurological condition contributing to headaches. Dr Schultz felt that Mr Cullen's condition did not warrant the ongoing use of medication, but left that to Dr Vrodos and Mr Cullen's general practitioner to manage.
- 5.8. On 30 June 2014, Mr Cullen returned to theatre for review of the shunt, after presenting at the Royal Adelaide Hospital with severe headaches. Dr Vrodos found that the ventricular-peritoneal shunt was blocked at the brain end, a not uncommon malfunction, which was corrected by replacement of the catheter. Mr Cullen was discharged with oxycodone and paracetamol for pain management. Upon review in August 2014 he appeared to have dramatically improved. He was back at work and back at the gym.
- 5.9. On 13 August 2015, Mr Cullen returned to Dr Vrodos stating that he was still getting headaches and pain. A decision was made to return to a lumbar-peritoneal shunt. On 7 September 2015 Dr Vrodos removed the ventricular-peritoneal shunt and inserted a lumbar-peritoneal Medtronic programmable strata valve shunt. Mr Cullen was

discharged on oxycodone, diazepam and paracetamol for pain management post-surgery.

- 5.10. On 28 October 2015, 27 November 2015 and 16 February 2016 Mr Cullen consulted Dr Vrodos regarding ongoing pain and headaches. Dr Vrodos modified the programmable strata valve pressures to investigate whether this would provide relief. At the first of these appointments, Dr Vrodos prescribed tramadol and diazepam, advising Mr Cullen's GP that he expected a lot of Mr Cullen's pain to settle over time and he thought these medications would be needed for at least a couple of weeks. He emphasised that Mr Cullen would need to wean off these medications and was aware of their addictive nature.¹⁵ After his review on 27 November 2015 in which Mr Cullen complained of ongoing headaches, Dr Vrodos prescribed oxycodone and diazepam for pain management. In his report to Mr Cullen's referring GP, he reported that Mr Cullen requested these but Dr Vrodos emphasised the need for care as they are both quite addictive.¹⁶ In deciding to re-prescribe these medications, Dr Vrodos took into account Mr Cullen's previous '*crash*' leading to facial palsy and felt there was still a legitimate need to factor in Mr Cullen's descriptions of his symptoms in deciding whether to re-prescribe. In his words, Dr Vrodos gave Mr Cullen '*the benefit of the doubt*'.¹⁷

6. Doctor shopping

- 6.1. Neither Dr Vrodos nor Mr Cullen's referring GP (at either Norwood Village Medical and Dental Centre or Seaton Medical Centre) would have been aware that, as identified by Dr Naso from prescribing records, during 2015 Mr Cullen had on 16 occasions seen GPs at a southern suburbs GP clinic, obtaining prescriptions variously for tramadol, tramadol and diazepam, or Endone (oxycodone) and diazepam.¹⁸
- 6.2. As set out in Dr Naso's report,¹⁹ from April 2016 until March 2017, Mr Cullen attended a Woodville GP practice as his primary general practitioners, on 28 occasions, seeing various doctors. He continued to obtain prescriptions, variously for tramadol, diazepam and Endone. Dr Eismin noted a suspicion that Mr Cullen was doctor shopping on 13 April 2016. In July 2016, explaining using 50 diazepam tablets in three weeks, Mr Cullen told Dr Raitnake that his script had been stolen. On 23 August 2016

¹⁵ Exhibit C13, GP notes, letter dated 28 October 2015

¹⁶ Exhibit C13, GP notes, letter dated 9 February 2016

¹⁷ Exhibit C9

¹⁸ Dr Naso's report, Exhibit C29, page 7

¹⁹ Exhibit C29, page 8; See Exhibit C12, Adelaide Medical Solutions notes

Dr Hissey refused to prescribe Endone after Mr Cullen told him that tramadol was ineffective. On 30 August 2016 Mr Cullen told Dr Hissey that his diazepam had been stolen.

- 6.3. On 28 September 2016, as referred to by Dr Naso²⁰ in her expert overview, a GP Dr Lower referred Mr Cullen to the QEH Emergency Department (ED) after he presented with back pain and was requesting a prescription for diazepam. Dr Lower noted concerns from Dr Le that Mr Cullen was doctor shopping. Dr Lower did not prescribe diazepam or pain medications and referred Mr Cullen to the ED, where he was prescribed simple analgesia, ice packs and physiotherapy.
- 6.4. The ED doctor obtained a patient summary which noted that from 1 July 2016 to 28 September 2016, the Prescription Shopping Information Service identified nine different prescribers and that Mr Cullen had received 60 prescriptions for 13 different medications. These included large quantities of diazepam, tramadol and amitriptyline.

7. 28 September 2016 - pharmacy robbery

- 7.1. On that same day, 28 September 2016, after his discharge from the QEH, Mr Cullen was arrested and charged after committing an offence of aggravated robbery at Compounding Pharmacy at Pooraka. It was alleged he produced a Stanley knife, threatened a staff member and fled with two bottles of Valium.²¹ He was released on police bail to appear in court on a later date.

8. 30 September 2016 - QEH admission following overdose

- 8.1. On 30 September 2016, Mr Cullen was admitted to the QEH ICU after being found collapsed at home following an overdose of amitriptyline, paracetamol/codeine and diazepam. His typed suicide note included an apology for theft at a chemist, a description of suffering through three to four years of pain without improvement and of attending multiple doctors seeking medications.²² During the admission he stated he felt his life revolved around his pain and he had not found psychology helpful in alleviating it. He said diazepam and Endone were the only medications which provided

²⁰ Exhibit C29, page 15

²¹ Diazepam

²² Exhibit C23, page 196

some relief, but he noted doctors began to notice his reliance on medications and were either not prescribing them or prescribing lower amounts.²³

- 8.2. A Level 1 Inpatient Treatment Order (ITO) was imposed and confirmed the next day. Dr Kenny, the psychiatrist who confirmed the order on 1 October 2016, felt Mr Cullen was at high risk due to lack of supports and the fact he left a suicide note and suggested that prescribing of amitriptyline be ceased and substituted with duloxetine, due to the risks associated with overdose.
- 8.3. Dr Naso noted in her report that Mr Cullen's ECG was typical of a tricyclic antidepressant (amitriptyline) overdose.
- 8.4. Mr Cullen was discharged from hospital on 3 October 2016, stating he was future focussed and denying suicidal ideation or intent. He was also denying abuse of benzodiazepines and other prescription medications.
- 8.5. Dr Naso expressed the opinion that Mr Cullen would have been unlikely to admit his abuse or addiction even if further pressed and that without a willingness on his part to seek further advice and management, the options for the psychiatric team were limited. I accept Dr Naso's opinion that there was no basis for criticism of the care provided to Mr Cullen during this admission and the follow-up management put in place.

9. 3 October 2016 - the second pharmacy robbery

- 9.1. On the day of his discharge, 3 October 2016, Mr Cullen committed an aggravated robbery at Chemmart Chemist, Henley Beach Rd, Fulham. A box cutter was produced and diazepam and Endone²⁴ were demanded. The offender fled with four boxes of Endone and four boxes of diazepam. The identity of the offender was not immediately ascertained. Three months would pass before Mr Cullen was charged with this offence.

10. 7 October 2016 - the third pharmacy robbery – home detention bail

- 10.1. On 7 October 2016 Mr Cullen was arrested for allegedly committing an aggravated robbery on that day at Kidman Park Pharmacy, Grange Rd, Kidman Park. Staff were threatened with a knife and the offender escaped with three boxes of Endone and four bottles of diazepam. Mr Cullen was refused police bail and remanded in custody at

²³ Exhibit C29, page 16

²⁴ Oxycodone

Yatala Labour Prison. On 26 October 2016 he was released on home detention bail with GPS monitoring and comprehensive conditions including drug and alcohol testing.

- 10.2. On 5 January 2017, following an investigation of the pharmacy robbery on 3 October 2016, Mr Cullen was arrested for this offence. He was initially refused police bail and was then released on court bail on 6 January 2017. He was, of course, already on bail with home detention conditions.

11. Medical care during period of home detention

- 11.1. In February 2017, after about six months of seeing Dr Hissey at Adelaide Medical Solutions as his primary GP, Mr Cullen began to see Dr Eismin, who held concerns that Mr Cullen was using prescription medication at a faster rate than prescribed. Dr Eismin obtained collated information from the Department of Human Services regarding Mr Cullen's prescriptions and confirmed that he was using more prescription medication than prescribed. On 22 February 2016, upon being questioned by Dr Eismin about his medication use, Mr Cullen became argumentative and abusive, and Dr Eismin declined to prescribe any further medication. Dr Eismin recorded speaking to Dr Hissey, who had found that Mr Cullen had been lying to him for six months and was a doctor shopper. Mr Cullen ceased attending the Adelaide Medical Solutions general practice.
- 11.2. In the meantime, on 14 February 2017 Mr Cullen was referred by Dr Vrodos to Dr Philip Cornish, a pain management specialist.²⁵ During three consultations on 2, 16 and 23 March 2017 Dr Cornish administered bilateral greater occipital nerve blocks, which Mr Cullen advised gave relief of ongoing pain and headaches for approximately 48 hours.
- 11.3. Dr Cornish referred Mr Cullen to Dr Tim Manners, a general practitioner, to whom Mr Cullen described his chronic headaches. He explained his ongoing pain management regime as tramadol twice a day and diazepam twice a day. Dr Manners recommended that Mr Cullen see a psychologist, to seek assistance in managing pain without ongoing prescription medications. For the time being, Dr Manners prescribed oxycodone for pain management.

²⁵ Dr Cornish's notes, Exhibit C18

- 11.4. On 29 March 2017 Mr Cullen presented again to Dr Manners for review. He detailed how he had recently trialled nerve blockers to the back of his head, administered by Dr Cornish, with limited success. Dr Manners counselled Mr Cullen about his long-term use of diazepam and discussed the aim to reduce his intake. Dr Manners prescribed tramadol, diazepam and oxycodone, a decision made having regard to information provided by Dr Cornish about his treatment of Mr Cullen.
- 11.5. On 3 April 2017 Mr Cullen presented to Dr Manners for another review of his headaches. He said that since the last appointment on 29 March 2017 he had seen a locum doctor who prescribed tramadol and oxycodone to assist with his pain management.
- 11.6. On 11 April 2017 Mr Cullen contacted Dr Cornish and told him his current model of shunt had been recalled. Dr Cornish suggested the trialling of fentanyl 25µg/hour patch instead of the medications he was using. On 13 April 2017, Mr Cullen consulted Dr Manners, who prescribed fentanyl 25µg/hour patches, once every three days, warning Mr Cullen about the possibility his motor skills could be affected and further warning him of the potential for excessive sedation if he combined fentanyl with diazepam. Dr Manners ceased prescribing oxycodone.
- 11.7. Guilty pleas
- 11.8. On 6 April 2017 Mr Cullen entered pleas of guilty in the Adelaide Magistrates Court to three charges of committing theft with the use of force, aggravated by the use of an offensive weapon. He was committed for sentence to the District Court of South Australia, to appear for arraignment on 26 May 2017.²⁶ I note that although Mr Cullen might well have hoped that the prison term to which he would inevitably be sentenced would be suspended, it was on the cards that he would be sentenced to imprisonment to be served.

12. 1 May 2017 – admission to QEH following overdose

- 12.1. On 1 May 2017, Mr Cullen was taken by ambulance to the ED of the QEH following a police welfare check instigated by a friend to whom Mr Cullen had sent an email referring to thoughts of suicide. He reported having taken a whole box of oxycodone

²⁶ Exhibit C28 (*admitted administratively*) Bundle of Certificates of Record of the of the Magistrates Court of South Australia and the District Court of South Australia

two days earlier, as well as a near-full bottle of diazepam and then, the following morning when he awoke, cutting his wrists intending to take his life but not cutting sufficiently deeply. He was admitted with a diagnosis of a major depressive episode in the context of chronic persistent pain and psychosocial stressors. To protect him from self-harm and enable treatment, he was detained upon a Level 1 ITO. I find that Mr Cullen was lawfully and appropriately placed upon this order.

- 12.2. The QEH notes of the 1 May 2017 admission are notable for the absence of any record that Mr Cullen had been previously admitted (on 30 September 2016) to the QEH following a suicide attempt.²⁷ As I shall discuss further, the previous admission was missed by QEH staff on this occasion.
- 12.3. Upon review of the ITO the next day, Mr Cullen was remorseful and denied ongoing intent to end his life. He said he needed to return to work. The ITO was confirmed, providing time to ensure he had community supports upon discharge. During the rest of his stay in hospital he re-engaged with his mother from whom he had disconnected, his pain had improved slightly and he was expressing plans for the future.
- 12.4. As observed by Dr Naso,²⁸ on 5 May 2017 information was placed in the case notes by way of an updated pharmacy record showing that from Pharmacist Advice Seaton and Haddad's Pharmacy, Mr Cullen had been dispensed in 2017:
- Mersyndol OTC²⁹ (20 tablets) on 10 February;
 - Tramadol SR³⁰ (20 tablets) 150mg BD³¹ on 16 February;
 - Tramadol SR (20 tablets) 150mg BD on 22 February;
 - Tramadol SR (20 tablets) 150mg BD and diazepam 5mg BD on 2 March;
 - Tramadol 50mg TDS³² PRN,³³ Tramadol SR 150mg BD, diazepam 5mg BD (50 tablets) and Endone 5mg PRN (20 tablets) all on 9 March;
 - Tramadol 50mg and Tramadol SR 150mg tablets on 16 March;
 - Tramadol SR 150mg BD (60 tablets) on 21 March;

²⁷ This likely explains the overlooking of the 30 September 2016 suicide attempt in the SAPOL Investigation Report

²⁸ Exhibit C29, page 20

²⁹ Over-the-counter

³⁰ Sustained-release

³¹ Twice-daily

³² Three times daily

³³ As required

- Tramadol 50mg TDS (20 tablets), Endone 5mg BD, and diazepam 5mg BD (50 tablets) on 29 March;
- Tramadol 50mg TDS on 31 March '*accidentally left prescription at mum's*';
- Diazepam 5mg BD (50 tablets) and fentanyl patch 25µg every three days on 13 April;
- Mersyndol OTC (40 tablets) on 19 April;
- Diazepam 5mg BD (50 tablets) and fentanyl patches 25µg on 26 April.

12.5. On 6 May 2017, as noted by Dr Naso, it was recorded that Mr Cullen was irritable and would only consider Endone for his pain.

12.6. QEH staff discussed pain medication management with Mr Cullen's pain specialist Dr Cornish, after which the plan developed was for him to commence on fentanyl patches 50µg per hour every three days with diazepam 10mg BD.

12.7. The ITO was revoked on 8 May 2017, by which time Mr Cullen was not considered to be suffering a mental illness and his depression was considered to be reactive in the context of psychosocial stressors, some of which had improved. In particular, his pain had improved somewhat and he had re-engaged with his mother after a long hiatus and was going to stay with her, he was planning to continue to go to work and he told staff that he was designing and building a sensor and shunt.

12.8. Mr Cullen was also prescribed amitriptyline. To ensure that he was not able to use his medications at a rate greater than prescribed, he was to have staged supply every three days and the Seaton North Pharmacy agreed to facilitate this. Review by Dr Cornish was arranged for 11 May 2017. Mr Cullen was encouraged to make an appointment with his GP, was advised of private psychiatry pathways and provided with the Mental Health Triage number, which he agreed he would ring if he needed help again. The Department for Correctional Services was advised of his discharge.

13. Dr Naso's opinion as to the care provided by the QEH Psychiatry Department from 1 May 2017 to 8 May 2017

13.1. Dr Naso notes that upon presentation Mr Cullen did not disclose his suicide attempt in 2016 and even omitted to mention his ICU treatment on that occasion. Despite the fact that Mr Cullen himself did not disclose it, Dr Naso is critical of the failure of QEH staff

to identify Mr Cullen's first overdose in 2016 and hospitalisation at the very same hospital, a record of which was on both the CBIS and EPAS electronic record systems.

13.2. Dr Naso points out that this oversight meant that those involved in treating Mr Cullen missed the following:

- the vital information that the earlier overdose had included amitriptyline, which was prescribed again despite its potential lethality in overdose;
- that the current presentation was a significant escalation of Mr Cullen's suicide risk and behaviours, rather than a first instance; and
- the opportunity for a healthy and open discussion around why Mr Cullen omitted to tell staff about the first suicide attempt, and to discuss his severe dependency.³⁴

13.3. The QEH failure to identify this previous admission compels me to agree with Dr Naso's characterisation of the care provided to Mr Cullen during this admission as superficial.

13.4. Dr Naso also expressed the view that there was clear evidence of addiction and dependence by Mr Cullen on his pain medications. The QEH staff were aware of the list of medications which he had been supplied and were aware that on 6 May 2017 he would only consider Endone for his pain. Dr Naso expressed the view, undoubtedly correctly, that Mr Cullen fulfilled the criteria for Opioid Abuse Disorder and Benzodiazepine Abuse Disorder under the DSM-V criteria. I find, that at the time of this admission and for some years previously, Mr Cullen was addicted to and dependent upon prescription opioid and benzodiazepine medications.

14. Affidavits of Dr Han Kyung Oh

14.1. Following Dr Naso's criticisms, a request was made of the Department for Health and Wellbeing and, through the Crown Solicitor, the affidavit of Dr Han Kyung Oh, dated 26 July 2022 was prepared and provided. It has been administratively tendered as Exhibit C31. A supplementary affidavit dated 18 October 2022 was administratively tendered as exhibit C31a.

³⁴ Exhibit C29, page 21

- 14.2. Dr Oh is a Senior Medical Practitioner, Psychiatry at the Women's and Children's Hospital, where she has been working since 2019. Dr Oh previously worked at the QEH from 2013 to 2019 and in 2017 was employed as a Registrar, Psychiatry.
- 14.3. Dr Oh conducted an assessment of Mr Cullen in the ED after he was referred by the ED medical team for a psychiatric assessment. Dr Oh took a history which included low mood for a few months leading up to this presentation, reported anhedonia,³⁵ intermittent suicidal ideation and impaired self-esteem. Mr Cullen also discussed becoming less functional at work and feeling a sense of hopelessness, which he said was unlike his usual self. He attributed these feelings to the difficulties he had managing his chronic pain as well as losses of relationships over the years. He was cooperative and at times tearful. Although reporting suicidal ideation, he denied any imminent intent or plan to self-harm. Dr Oh noted some symptoms associated with depression, such as insomnia dating back several years and disturbances of his energy levels, memory and concentration. Dr Oh's impression was of a moderate to high acute risk of harm to himself in the context of his symptoms of depression. Also noted were other symptoms including his chronic persistent pain and that he reported an overdose three days prior to his presentation to hospital that day, but he did not seek any help after this self-harm attempt. As Mr Cullen was presenting with depression and ongoing risk of self-harm or suicide attempt, but was not agreeable to remaining in hospital to be treated with antidepressant medication, Dr Oh regarded him as being *'at an acute risk of further self-harm or suicide attempt given his suicide note and the recent overdose without engaging in an appropriate self-help seeking behaviour'*. For this reason, Dr Oh placed him on a Level 1 ITO to facilitate his admission to hospital so that treatment with medication could be commenced, and his acute risk of harm to himself could be better monitored and managed.
- 14.4. Dr Oh stated that Mr Cullen did not volunteer any information about his previous suicide attempt in September 2016 when directly asked about his past medical history and gave the impression that he had not had any previous suicide attempts.
- 14.5. Dr Oh states that the information about Mr Cullen's previous admission would have been available in CBIS and EPAS and her usual practice would be for those platforms to have been checked prior to the assessment, but it is possible she missed that

³⁵ Loss of joy or positive emotions

information. The clear inference to be drawn is that for some reason Dr Oh either did not read the previous clinical notes or did not read them closely enough.

- 14.6. In my opinion, Dr Oh's affidavits suggest that there was no systemic issue leading to the failure to identify the previous hospital admission for a suicide attempt; I am well aware that a psychiatric practitioner in Dr Oh's circumstances would be expected as standard procedure to check those available sources for earlier history. This should have been done on this occasion. In this instance I have no reason to treat an individual medical error as evidence of a systemic issue.

15. Was it appropriate to discharge Mr Cullen?

- 15.1. On the basis of all the relevant information about Mr Cullen's admission, Dr Naso expressed the opinion that, when discharged, Mr Cullen no longer fulfilled the criteria under the Mental Health Act 2009 for an ongoing ITO. Even if Mr Cullen had been offered a longer inpatient stay (on a voluntary basis) he would likely not have accepted this as he was keen to get back to work. A longer admission to address his addiction and dependence could only have been done as a voluntary patient. There was nothing to indicate he was ready to admit his addictions and submit to treatment with the regime for medication reduction.
- 15.2. Upon discharge there was a plan for follow-up by the Community Mental Health Team, which occurred on 15 May 2017. It was also suggested to Mr Cullen that he seek the assistance of Dr Tony Davis, a psychiatrist with experience in chronic pain management.
- 15.3. I find that it was appropriate for Mr Cullen to be discharged on 8 May 2017.

16. Medical treatment following discharge from the QEH

- 16.1. Mr Cullen saw Dr Cornish on 11 May 2017 and discussed referral to another neurosurgeon for a second opinion. His fentanyl prescription was continued for three days at a time only.
- 16.2. On 30 May 2017 Mr Cullen's GP, Dr Manners, referred him to Dr Zacest, a consultant neurosurgeon. Dr Manners continued the prescription of fentanyl and diazepam, and also prescribed amitriptyline, for three days at a time, as per Mr Cullen's hospital discharge.

16.3. There had been a Therapeutic Goods Administration hazard alert in relation to a potential for under-drainage in certain Medtronic devices, including the type implanted in Mr Cullen. There was considered to be a very small chance (.007% over a two-year period) of such devices suffering a reverse polarisation of a magnet associated with the strata valve, leading to a valve malfunction.³⁶ Dr Zacest consulted the shunt manufacturer and arranged to see Mr Cullen on 20 June 2017, in the presence of Mr Zerella, a representative of the manufacturer Medtronic, for the purpose of interrogating the performance settings of the shunt. Dr Zacest and Mr Zerella interrogated the shunt's performance settings and conducted an x-ray to ascertain whether the valve was operating correctly.³⁷ Dr Zacest concluded that the shunt did not appear to be malfunctioning. He reduced the pressure setting and discussed with Mr Cullen the possibility of conducting intracranial pressure monitoring for the purpose of clarifying the relationship between that pressure and Mr Cullen's headache symptoms. A follow-up appointment was made, but Mr Cullen died before that occurred.

17. Appearance in the District Court – 26 May 2017

17.1. On 26 May 2017, Mr Cullen appeared in the District Court of South Australia where his counsel sought an adjournment to obtain a neuropsychological report and a home detention report. Mr Cullen was remanded to appear for guilty arraignment on Friday, 30 June 2017 at 9am.³⁸ Undoubtedly, from Mr Cullen's perspective, the prospect of imprisonment would have been closing in upon him.

18. 23 June 2017 – Mr Cullen found deceased

18.1. On 23 June 2017 Mr Cullen did not turn up for work at Modere Australia and did not answer phone calls from his workmate Andrew Kirss.³⁹ At about 2pm Mr Kirss telephoned the Department for Community Corrections and then attended Mr Cullen's home address in Seaton, where he called police. Police and Community Corrections officers attended, and with the help of a locksmith, they entered Mr Cullen's unit and located him deceased. Mr Cullen was lying on a sofa with the television on, wearing spectacles and in-ear headphones. He was wearing a dressing gown and long tracksuit

³⁶ Exhibits C11b and C11c

³⁷ Exhibit C8

³⁸ Exhibit C28

³⁹ Exhibit C1

pants. There was a fentanyl patch on each arm. Nearby was a notepad⁴⁰ open to a page bearing handwriting apparently about a pressure sensor, evidently related to the ongoing investigations of Mr Cullen's intracranial pressure. One page back, alone on an otherwise empty page was a signed note, '*Do Not Revive. Jason Cullen*'.

- 18.2. Detective Brevet Sergeant David Childs⁴¹ took charge of the coronial investigation and in due course prepared a detailed Investigating Officer's Report for the State Coroner.
- 18.3. A forensic examination was undertaken by a crime scene officer, who took a series of photographs.⁴²
- 18.4. There was no sign of a disturbance and no other side of anyone else having been inside the house.
- 18.5. Various prescription medication-related items were seized.
- 18.6. There were no illicit drugs and no injecting equipment found. There was nothing else found to suggest the presence or administration of greater amounts of fentanyl than that contained in the two patches found on Mr Cullen's arms.

19. Psychological report of Ms Lucinda Moeck

- 19.1. The Court received in evidence a psychological report from Lucinda Moeck,⁴³ prepared two months before his death for the purposes of Mr Cullen's sentencing in the District Court. It provides significant information from Mr Cullen's perspective and much of what Ms Moeck records ties neatly into the history I have thus far outlined.
- 19.2. Ms Moeck first saw Mr Cullen in August 2016, before the robberies. She diagnosed a major depressive disorder of a severe level. In addition to his various symptoms, she noted mild suicidal ideation but no plans to harm himself. Mr Cullen also reported grief from the breakdown three to four months earlier of his relationship with his fiancé. He described chronic pain arising from intracranial hypertension causing headaches, and from the scarring from multiple surgeries.

⁴⁰ Now admitted into evidence and marked Exhibit C11h

⁴¹ Exhibits C11 and C11e

⁴² Exhibit C10

⁴³ Exhibit C11d

- 19.3. On 8 September 2016 Ms Moeck continued treatment, including psychoeducation, cognitive therapy and mindfulness-based meditation.
- 19.4. After the robberies, Ms Moeck saw Mr Cullen on a further seven occasions from November 2016 to March 2017. Mr Cullen told her he robbed the pharmacies because of his inability to obtain pain medication of the type and quantity that he desired and that at times he was unable to bear his pain. Ms Moeck noted Mr Cullen was extremely remorseful. He said he had seen a different GP prior to the offences who had prescribed a significantly lower dose of tramadol to that which he had been used to. I note that in Mr Cullen's Adelaide Medical Solutions GP records⁴⁴ it is recorded that on 13 September 2016 prescription of Tramal (tramadol) was ceased. '*Reason for cessation - Completed without problems*' was recorded by Dr Hissey.
- 19.5. Mr Cullen told Ms Moeck that after the first robbery he had attempted suicide by overdose.⁴⁵
- 19.6. Ms Moeck opined that in January 2017 '*Mr Cullen's depression was ameliorating although still moderate to severe*'. She noted Mr Cullen was seeing a pain specialist to facilitate effective pain management in the longer term, including options other than daily pain medication. She stated that, provided he could achieve some improvement in the quality of his life in that regard (pain management), there would be no reason why his prognosis would not be positive.
- 19.7. For the purposes of the report, Ms Moeck expressed the view that Mr Cullen would not be likely to reoffend if released on a suspended sentence or home detention, referring to his lack of prior history of criminal activity or illicit drug use, lack of pro-criminal attitudes and willingness to seek to improve his situation, his sincere remorse, his lack of history of impulsive or malicious behaviour, his stable employment, highly developed work ethic and strong loyalty to his employer, having purpose, meaning and direction in his life, his resiliency in the face of adversity, his ongoing psychological treatment and the change of circumstances with his pain medication, including his ongoing treatment with a pain specialist.
- 19.8. I record that Dr Naso expressed no criticism of the psychological treatment provided to Mr Cullen by Ms Moeck.

⁴⁴ Exhibit C12

⁴⁵ This referred to the admission to the QEH on 30 September 2016

20. Post-mortem examination and toxicology – clues to the nature of the fentanyl overdose

- 20.1. Dr Wills conducted the post mortem examination on 27 June 2017. None of the various physical findings was considered to have contributed to the cause of death. Analysis of blood taken at post mortem found the presence of concentrations of diazepam, lorazepam, codeine, amitriptyline and paracetamol, each consistent with non-toxic concentrations. Importantly, a quantity of 130µg of fentanyl per litre of blood was found.
- 20.2. Dr Wills referred to fentanyl serum concentrations found in studies after the administration of fentanyl patches. In one study, concentrations 24 hours after the application of a 25µg per hour patch ranged from 0.3-1.2µg/L. Serum concentrations for the 50, 75 and 100µg/hr patches ranged from 0.6-1.8, 1.1-2.6 and 1.9-3.8µg/L respectively. In another study examining the fentanyl blood concentration in ten opioid tolerant subjects after the use of five consecutive applications of 100µg per hour transdermal patches, the mean maximum concentration of fentanyl was 2.6µg/L.
- 20.3. Dr Wills also referred to a retrospective study of fentanyl related deaths in Canada between 2002 and 2004 in which of 112 fentanyl related deaths, 54 involved fentanyl alone. The concentration range of fentanyl in the 54 cases was 3-383µg/L. In the 27 cases where the fentanyl was due to transdermal administration, the concentration range was 4-54 µg/L.
- 20.4. Dr Wills also described studies indicating that fentanyl may exhibit post mortem redistribution, leading to significant increases in concentrations of fentanyl in specimens collected between four and 22 hours post mortem, with fentanyl concentrations rising from an average of 4.6 to 17µg/L.
- 20.5. Thus it may be seen, by reference to Dr Wills' observations and the studies cited, that the quantity of fentanyl of 130µg/L of Mr Cullen's blood appears to be a far greater concentration than would be expected by the application of two transdermal patches.

21. Reports of Professor Jason White

- 21.1. In the light of this I sought advice from Emeritus Professor Jason White, Clinical and Health Sciences, University of South Australia. Professor White is a well-known expert in pharmacology.

- 21.2. Referring to studies, Professor White opined⁴⁶ that two patches releasing fentanyl at a rate of 50µg/hour would result in blood fentanyl concentration of less than 10µg/L and in most instances less than 5µg/L. He would expect that prior to death Mr Cullen's fentanyl concentration would have been less than 10µg/L. This opinion was later revised to add the proviso that such concentration would be expected if the patches were not misused.
- 21.3. As to changes in fentanyl concentration after death, in cases involving dosing from 12 to 150µg/hour, the 24-hour post mortem blood concentrations ranged from 0.4-22µg/L.
- 21.4. As to post mortem concentrations of fentanyl in people who have died wearing fentanyl patches, Professor White referred to four studies involving in excess of 200 people. In not one of those cases did the post mortem concentration of fentanyl come anywhere near Mr Cullen's concentration of 130µg/L of blood.
- 21.5. Professor White's opinion was that Mr Cullen's fentanyl concentration was well in excess of what would be expected from the two patches on his arms prior to death, even having regard to post mortem distribution. He regarded the probability of a concentration as high as 130µg/L from two patches as being zero. In his opinion, the concentration of fentanyl in Mr Cullen's peripheral post mortem blood was not readily explicable by the presence of the two fentanyl patches located on his arms at the time of death.
- 21.6. In his further report dated 3 September 2021, Professor White provides details of various methods of interfering with fentanyl patches to extract fentanyl from them without application to the skin, or to increase the release rate so that a person receives a much higher dose than intended in the period after placing it on the skin, which could conceivably account for Mr Cullen's high level of fentanyl. Furthermore, explained Professor White, such tampering would not necessarily be obvious once the patch is worn. I have chosen in this finding not to provide details of the different types of tampering.

⁴⁶ Admitted as Exhibit C27

22. Further information from Dr Wills

- 22.1. Dr Wills has advised that it was usual practice at Forensic Science SA, in the absence of a specific reason or request to retain medication patches, to remove them and dispose of them in the mortuary. This had occurred in Mr Cullen's case.
- 22.2. However, Dr Wills was able to check from post mortem photographs of the patches in situ on the left and right bicep and reported⁴⁷ that there was some peeling of the adhesive at the upper medial edges, but the patches looked undamaged as far as he could determine.
- 22.3. I accept and find that the patches when removed in the mortuary did not obviously appear to have been tampered with. However, they were not, and are not now available to be, subjected to the sort of extremely close examination which might reveal tampering of the types referred to by Professor White. No assumption can be made about what might have been revealed by close examination. The patches may have been tampered with, explaining Mr Cullen's high level of fentanyl, or they may not have been tampered with, in which case an alternative source of extra fentanyl would appear likely.
- 22.4. Since the issues in this particular case came to light as a result of these further enquiries during the inquest process, Forensic Science SA practices have been reviewed to ensure that close examination of patches, or retention in case that might be required, occurs in cases where it might provide relevant information. I wish to make clear I make no criticism of the decision to dispose of the patches in this case. It was the appropriate decision to make at the time.

23. What was the source of the extra fentanyl and was it self-administered?

- 23.1. The post mortem examination revealed no evidence of any injury to Mr Cullen which might suggest non-consensual involvement of any other person. Neither was evidence of any injection site seen at post mortem.
- 23.2. There was no injecting equipment found in the premises.
- 23.3. There was only one fentanyl patch wrapper found in the premises, and one box labelled as containing one patch. This suggests either the application of one patch outside the

⁴⁷ Exhibit C2b

unit or the disposal of rubbish since the application of one of the two patches. There was no other fentanyl, either in patch form or some other form found in the unit. There were no other containers or wrappers located which might have been used to contain any other quantity of fentanyl.

- 23.4. The SAPOL forensic examination provides no suggestion that anyone other than Mr Cullen had been in the unit. I have reviewed the photographs of Mr Cullen's unit taken by the crime scene examiner, and also the CIB investigator's video walk-through.⁴⁸ I have taken into account Mr Cullen's comfortable position on the couch, his comfortable clothing, the headphones, glasses and television.
- 23.5. Also, as Dr Naso pointed out, of the various substances found in Mr Cullen's blood, all (fentanyl, doxylamine, diazepam, nordiazepam, lorazepam, amitriptyline, nortriptyline and paracetamol) could be explained from prescription medications, except for lorazepam. Even if he only had medications prescribed to him in his system, there would be no reason to think that Mr Cullen could not readily obtain fentanyl off prescription. In this case, the fact that Mr Cullen had lorazepam without prescription, provides evidence that he did not confine himself to the drugs which he was prescribed.
- 23.6. I am satisfied, and I find, that the drugs found in Mr Cullen's system were self-administered. Whatever is the explanation for the quantity of fentanyl in his system beyond what would be expected from the two patches if he had not interfered with them, I am satisfied that another person was not involved in administering it.
- 23.7. As to what accounts for the quantity of fentanyl in the peripheral blood sample I can conclude, and I find, that either:
- (1) Mr Cullen brought into the unit fentanyl from another source; or
 - (2) that he extracted fentanyl from another patch or patches, the remains of which were not in the premises or were not found; or
 - (3) that he interfered with one (or more) of the fentanyl patches applied to his arms, to overcome the slow-release properties and deliver the majority of its active ingredient continuously.

⁴⁸ Exhibit C11

23.8. Even if there is another explanation which has not come to mind, I am satisfied, and I find, that Mr Cullen either consumed fentanyl from a source other than the two patches on his arms or interfered with one or more of those patches to accelerate the release of fentanyl.

24. What was Mr Cullen's intention?

24.1. A finding that a person who died as a result of the consequences of their own intentional act, intended by that act to bring about their own death, should not be lightly made.

24.2. For the following reasons I have concluded that in administering the large quantity of fentanyl which was instrumental in his death, Mr Cullen intended to take his own life.

24.2.1. Mr Cullen had a long history of chronic pain.

24.2.2. Following numerous surgical interventions, he had been prescribed strong and addictive medications and was appropriately referred back to GPs for management.

24.2.3. The evidence in this inquest has revealed that from an early stage Mr Cullen doctor shopped, often going behind his regular GPs, in order to obtain large quantities of opioid and benzodiazepine medications.

24.2.4. There can be no doubt that certainly by 2014 and probably earlier, Mr Cullen was addicted to prescription medications, particularly opioids and benzodiazepines. I note that Mr Cullen's mother expressed a suspicion that Mr Cullen's addiction to prescription medications commenced at age 13 when he was prescribed pethidine.⁴⁹ Dr Naso thought this quite likely to be true.

24.2.5. On 30 September 2016, after being arrested two days earlier robbing a pharmacy of diazepam, Mr Cullen was admitted to hospital after an overdose, primarily involving amitriptyline, paracetamol/codeine and diazepam. He left a suicide note. It is clear, in my opinion, that on this occasion he took prescription drugs intending to take his own life.

24.2.6. Mr Cullen committed further robberies of pharmacies on 3 and 7 October 2016, following which he remained on home detention bail until his death.

⁴⁹ Exhibit C5, page 7

He pleaded guilty to all three pharmacy robberies and at the time of his death was one week away from a sentencing hearing in the District Court. He must have regarded a sentence of imprisonment to be served as a starting point, and a real likelihood, although he would have hoped for a suspended sentence or, if not, a sentence to be served on home detention.

24.2.7. Mr Cullen was hospitalised on 1 May 2017 after taking a large overdose of oxycodone and diazepam and, after waking up, cutting his arms. He sent to his ex-partner a link to a video of him saying goodbye. It is plain that on this occasion also, he took prescription drugs intending to take his own life.

24.2.8. On the occasion of taking medications which led to his death, in addition to wearing twice the prescribed quantity of fentanyl patches, Mr Cullen either took an additional substantial quantity of fentanyl or manipulated one or more of the patches to ensure delivery of a large dose of fentanyl. In my opinion, bearing in mind his long-term experience of abuse of prescription medications, and having been prescribed fentanyl for at least two months, Mr Cullen must have been well aware that he was taking a large and likely fatal dose.

24.2.9. After taking these medications, Mr Cullen made himself comfortable, having written and signed, on a nearby pad, '*Do Not Revive*'.

24.3. Prior to his death, Mr Cullen had taken a number of different medications which, in combination with the fentanyl, caused his death. I cannot find precisely when he took any of these medications or whether some were taken at different times to others. Except as to fentanyl, I cannot make a finding as to Mr Cullen's specific intention at the time of taking each medication. However, as to the large quantity of fentanyl which Mr Cullen took or, in the alternative, administered to himself by manipulating a controlled release fentanyl patch or patches, I am satisfied, and I find, that he did so intending to take his own life.

25. Department for Correctional Services – supervision whilst on bail

25.1. Mr Cullen was on home detention bail from 26 October 2016 until the date of his death, supervised by the Port Adelaide Community Corrections Centre. He was appropriately inducted onto the home detention monitoring program and fitted with an electronic

monitoring device. His assigned Community Corrections officer was Ms Anna Feltrin⁵⁰ who met him on 27 October 2016, discussing his obligations on home detention and informing herself, in detail, as to his personal and medical circumstances. Mr Cullen was approved to attend work, and he did so throughout the term of his home detention. He obtained passouts as required for medical appointments and monitoring confirmed his attendances. He was punctual. The Department for Correctional Services obtained ongoing material documenting his prescribed medications and his supervisor ensured compliance either by sighting prescriptions at face-to-face meetings or obtaining correspondence from doctors. Legitimacy of the prescriptions was randomly checked by ensuring that their issue corresponded with a monitored attendance at a medical appointment. There were five random alcohol tests, which were negative and five random drug tests, which showed the presence only of Mr Cullen's prescribed medications. His supervisor found Mr Cullen to be typically organised and he would contact DCS for any reason he was not attending work or another location as per his scheduled passouts. His Community Corrections officer was concerned for his welfare when, at 2pm on 23 June 2017, the monitoring system indicated that his home detention bracelet remained on charge, despite him having a pass to attend work that day. Ms Feltrin contacted Mr Cullen's employer to obtain a key to the unit but found that the employer also was worried and was already on his way.

- 25.2. I find that pursuant to his court issued bail conditions, Mr Cullen was lawfully under the supervision of the Department for Correctional Services pursuant to home detention bail conditions and that he was correctly and properly supervised.

26. ScriptCheckSA

- 26.1. Since Mr Cullen's death, a monitored drugs database known as ScriptCheckSA has been established to provide real-time monitored medicines prescription information for prescribers and pharmacists. Since 1 April 2022, prescribers of monitored drugs must take all reasonable steps to check relevant information held in the monitored drugs database relating to the person for whom the drug is to be prescribed. Prescribers must also register and connect clinical software so that information about prescriptions is transmitted to ScriptCheckSA so that real-time monitoring is achieved.
- 26.2. Dr Naso in her report expressed the opinion that Mr Cullen was over-prescribed opioids and diazepam on a regular basis by both general practitioners and locum service

⁵⁰ Exhibit C6

doctors, despite their awareness of the risks associated with addiction and dependence and, in some cases despite an awareness that the medications did not alleviate Mr Cullen's pain.

- 26.3. The commencement of ScriptCheckSA and the obligations of prescribers to use it, and provide information to keep it up-to-date, persuades me that it is not necessary in this finding to consider making recommendations that address the ready availability of opioid and benzodiazepine medications to those who become addicted to them and doctor-shop.

27. Could Mr Cullen's death have been prevented?

- 27.1. Dr Naso's expert report addresses this question, in a manner which I accept and agree with, as follows:

'Jason's life was centred around his chronic illness with numerous operations, shunts and revisions. From an early age he was invalidated and bullied. He was made to feel that he would never succeed in life.

The idiopathic intracranial hypertension defined his life and even stopped him from getting married and having children. His chronic pain was impacting on his work and exercise which in essence was all he had left.

Jason became a victim to the systemic over prescription of opioids and benzodiazepines.

I agree with Jason's mother that Jason most likely became addicted to these medications as a teenager.

All the clinicians involved with prescribing Jason with opioids have documented the potential for addiction and the need to reduce doses. The ineffectiveness of these medications in relieving Jason's pain was also documented. Despite this awareness the prescriptions continued.

All the clinicians involved tried hard to help Jason and certainly he did present with a complex set of issues. It is not clear to me given the above why Jason was continued to be supplied with addictive medications without a plan for withdrawal and support. Despite his serious dependency not once could I see him being offered DASSA⁵¹ or medication assisted treatment for opioid dependence (MATOD). This was despite him even being on home detention for stealing from pharmacies to feed his addictions.

My opinion is Jason's addiction and dependency to opioids and diazepam was identified too late. It seems prevention of dependency and addiction was paramount in Jason's case. Once the addiction was identified his medications were decreased without a support plan in place. This was likely perceived as punishing by Jason. This led to him relying on locum services and ultimately out of desperation he turned to crime. This in turn brought him even more shame and despair.

⁵¹ Drug and Alcohol Services South Australia

Jason was ashamed of his addiction and like most patients addicted to substances was not honest about his misuse which also caused a level of frustration in his care providers.

Jason's suicide was not driven by an unidentified psychiatric illness but was rather a suicide driven by his despair. He had chronic pain, was socially isolated, he was struggling to maintain work and his exercise regime. He became addicted and dependent on opioids and diazepam. The prescribers began reducing amounts of these medications available to him and he was on home detention as a result of his severe addictions. Dr Manners had referred Jason to a psychologist, physiotherapist, two neurosurgeons and a pain specialist without any significant relief to his pain levels or his need for pain prescriptions. This ultimately fed into Jason's belief that he had exhausted all avenues, leading to his sense of hopelessness and his belief suicide was his only solution.

....

The only way Jason's death may have been prevented is if when he was first prescribed addictive medications he was strictly observed. The nature of pain is biopsychosocial and requires a multifactorial approach which combines pharmacological and nonpharmacological management. All prescribers must follow guidelines and protocols when prescribing any Schedule 8 or 4 drugs. There must be a vigilance when prescribing and awareness that if there are any signs of misuse then patients will require referral to specialist pain clinics. All prescribers should be educated around the risks associated with prescription opioids and benzodiazepines and especially made aware of how ineffective pharmacological therapy is in the relief of chronic non-cancer pain.

Prescription checking is the first step in trying to reduce the over prescription of addictive medications, but in Jason's case the clinicians were aware he was overusing but continued to prescribe him these medications. Clinicians need to go beyond checking if a patient is doctor shopping by putting in place appropriate referrals and alternate pathways, so the patient is not left feeling abandoned and desperate.'

- 27.2. Dr Naso's conclusion, with which I agree, is that despite the less than thorough treatment Mr Cullen received during his May 2017 admission, a longer admission would not have prevented his death. Dr Naso observes that if Mr Cullen had admitted he was addicted and dependent, his treatment would have been voluntary and required a high level of motivation on his part. There would then be no certainty that if he underwent drug rehabilitation and possibly MATOD that his death would have been prevented.

28. **The opioid health crisis**

- 28.1. Dr Naso⁵² describes Mr Cullen's history and death as an example of the opioid health crisis currently facing us and cites the National Drug and Alcohol Research Centre at

⁵² Exhibit C29, page 27

the University of New South Wales⁵³ noting that 1045 Australians aged between 15 to 64 died from opioid overdoses in 2016. 76% of those deaths were attributed to pharmaceutical opioids. 45% of opioid induced deaths in 2016 also recorded benzodiazepine as contributing to the death.

- 28.2. Dr Naso refers⁵⁴ to the U.S. Food and Drug Administration safety communication⁵⁵ in August 2016 warning about serious risks and death when combining opioids with benzodiazepines.
- 28.3. In South Australia, a Model of Care for Chronic Management of Pain was developed in 2016.⁵⁶ One South Australian example of the promulgation of precautions to address the issue is the Northern Adelaide Local Health Network protocol stating that benzodiazepines should not be prescribed with opioids without a consultant's approval, and requires extra monitoring.
- 28.4. Dr Naso expresses the assumption that the clear protocols relating to the storage and prescription of Schedule 4 and 8 medications which apply in the public health system are mirrored by similar guidance for private hospitals and practitioners.

29. The role of general practitioners

- 29.1. Dr Naso comments that prevention of opioid addiction and dependence can start with general practitioners, who initiate the majority of Australia's opioid medications. There are guidelines published by the Royal Australian College of General Practitioners⁵⁷ which Dr Naso states are evidence-based guidelines which should be the framework all general practitioners use when prescribing opioids and benzodiazepines.

30. Scope of this inquest and recommendations

- 30.1. Without the involvement of interested parties and their legal representatives, the scope of this inquest did not extend to a detailed survey of the governance of prescription of drugs of dependence, particularly opioids and benzodiazepines, since Mr Cullen's death. Neither did the inquest proceed as a review of their adequacy. However, it is

⁵³ [Majority of opioid overdose deaths in Australia are related to pharmaceutical opioids | NDARC - National Drug and Alcohol Research Centre \(unsw.edu.au\)](https://www.ndarc.gov.au/research-centre)

⁵⁴ Exhibit C29, page 28

⁵⁵ [FDA Drug Safety Communication: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning | FDA](https://www.fda.gov/oc/2016/08/08-fda-warns-about-serious-risks-and-death-when-combining-opioid-pain-or-cough-medicines-with-benzodiazepines-requires-its-strongest-warning)

⁵⁶ [Model+of+care+for+Chronic+Pain+Management+in+SA+-+FINAL.pdf \(sahealth.sa.gov.au\)](https://www.sahealth.sa.gov.au/modelfofcareforchronicpainmanagementinSAFINAL.pdf)

⁵⁷ [RACGP - Prescribing drugs of dependence in general practice](https://www.racgp.org.au/clinical-resources/clinical-guidelines/pdf/2015/13/prescribing-drugs-of-dependence-in-general-practice)

clear that much has been done in Australia and overseas to identify the extent of the problem and develop and implement reforms.

30.2. Having regard also to the implementation of ScriptCheckSA and its obligatory use since 1 April 2022, I have no recommendations to make in this matter.

31. Summary of findings

31.1. Jason Mark Cullen, aged 37 years, late of 6/7 Glenburnie Street, Seaton died at Seaton, South Australia on or about 22 June 2017 as a result of mixed drug toxicity with the potent synthetic opioid drug fentanyl being the principal agent.

31.2. The various drugs leading to the fatal toxicity were self-administered by Mr Cullen. All except lorazepam were prescribed medications. It is possible that the majority of the fatal quantity of fentanyl was not prescribed.

31.3. The majority of the large dose of fentanyl, which was the principal agent in causing Mr Cullen's death, was either obtained by him illicitly, extracted by him from fentanyl medications prescribed to him, or caused by him to be released in a large quantity by his interference with one or more of the fentanyl patches applied to his arms, in order to overcome the patch's slow-release properties.

31.4. At the time Mr Cullen self-administered fentanyl, he intended to end his life.

Key Words: Death in Custody; Home Detention; Drug Overdose; Suicide

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 6th day of December, 2023

State Coroner