



# MAGISTRATES COURT of TASMANIA

## CORONIAL DIVISION



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### **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995*  
*Coroners Rules 2006*  
*Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Michael Allan Steer

**Find, pursuant to Section 28(1) of the Coroners Act 1995, that:**

- a) The identity of the deceased is Michael Allan Steer;
- b) Mr Steer died in the circumstances set out in this finding;
- c) The cause of Mr Steer's death was mixed drug toxicity; and
- d) Mr Steer died on 7 August 2014 at 3/8 Bishops Drive, Newnham in Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Michael Allan Steer's death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy; toxicological analysis of Mr Steer's blood; relevant police and witness affidavits; medical and pharmaceutical records and reports; forensic evidence; and evidence from the Chief Pharmacist.

Mr Steer was born in Launceston on 27 November 1969 and was aged 44 years. He was a single man with no children. He was a disability pensioner who lived by himself at 3/8 Bishops Drive Newnham. He was one of eight siblings including a twin brother, Bevan Steer ("Bevan"). After his schooling he joined the Navy as a submariner and, after leaving, became a qualified builder. In his affidavit for the investigation, Bevan stated that his brother did not work much as a builder and his mental health deteriorated upon returning from the Navy.

Mr Steer suffered serious mental health conditions and was under the care of his psychiatrist, Dr Surinder Johl, who had been treating him since 1990. In his report for the investigation, Dr Johl provided a summary of Mr Steer's complex psychiatric history and numerous mental health diagnoses. Dr Johl found Mr Steer to be inconsistent in his account of past events, to the point where it was difficult for him to ascertain a truthful history. Dr Johl noted that Mr Steer had three admissions to the Launceston General Hospital prior to 2001, being for drug-induced psychosis, alcohol intoxication with threat of suicide, and a drug overdose respectively.

Dr Johl stated in his report that since 2003, when Mr Steer was declared bankrupt, he had numerous presentations to the hospital emergency department either in an intoxicated state after consuming alcohol or requesting analgesics for pain. It appears from Dr Johl's report that Mr Steer had commenced to engage in drug seeking behaviour in about 2001. It appears that since that time his drug seeking and doctor shopping was continuous,

(especially for diazepam and opiate analgesics) manifesting in inappropriate attempts to access medications in excess of his prescriptions.

Mr Steer's mother, Merlene Steer, provided an affidavit for the coronial investigation. Mrs Steer stated that her son would often fabricate stories, for example by falsely telling her in 2014 that he had breast cancer and was starting chemotherapy. She stated that Mr Steer constantly had dramas in his life and he had expressed suicidal thoughts but he told her he would not end his life. Mrs Steer indicated that her son was very poor at managing his medication and she would give him money on a monthly basis to buy more medication.

At the time of his death Mr Steer's physical health conditions included high blood pressure, diabetes, gout, chronic pain, reflux and obesity. His mental health conditions included depression, anxiety, and borderline personality disorder. He was diagnosed by Dr Johl as having factitious disorder (feigning illness to assume a sick role and/or obtain treatment) and somatic disorder (complaining about pain that has no clinical diagnosis), making his ongoing treatment and accurate diagnoses of his other conditions difficult. He was heavily medicated for his various conditions.

The evidence in the investigation shows that Mr Steer's treating medical practitioners were dedicated in their efforts regarding his care but the evidence indicates that he was a most complex and challenging patient. He was inconsistent in attending appointments and did not act upon treatment advice. As previously discussed, he consistently attempted to, and did, obtain medication in excess of that prescribed.

Medications prescribed to Mr Steer in the months prior to his death included diazepam, Panadeine Forte®, quetiapine and fluoxetine (Prozac®). In the several years before his death he was treated by general practitioners, Dr Clare Cerchez and then Dr Andrew Nolan at the Parkview Medical Practice in Launceston.

Dr Cerchez treated Mr Steer from February 2011 until her last appointment with him on 12 February 2013. Mr Steer elected to see Dr Nolan after this time. Dr Cerchez stated in her report for the investigation that Mr Steer was a challenging patient to manage with his factitious and somatic disorders. During the period she treated Mr Steer, his medication misuse and abuse was a constant issue. He frequently reported loss of prescriptions and medications, and theft of medication. Dr Cerchez stated that Mr Steer made continual requests to alter or increase his doses of certain medications and he would consult other doctors to attempt to obtain more medication.

Dr Cerchez took steps to reduce the amount of medication taken by Mr Steer and to ensure centralisation of Mr Steer's treatment and prescriptions to Parkview Medical Practice in consultation with his psychiatrists, hospital emergency departments and the after-hours medical service.

Dr Cerchez also implemented, in conjunction with pharmacist, Luciana Torrents of City Capital Chemist in Launceston, a system whereby Mr Steer's medications were dispensed in blister packs with weekly pick-ups by him. It was further arranged that his medications were never to be collected early or re-issued and that medication changes would be sent directly to the pharmacist by Dr Cerchez.

From March 2013 until his death Mr Steer was treated by Dr Nolan. His last appointment with Dr Nolan was 30 July 2014, eight days before his death.

By March 2014, Mr Steer no longer wanted to have his medication packed on a weekly basis as he wished to have more control over his life. Dr Nolan stated in his report for the investigation that, in his opinion, the packing and pickup of medications did not work well for reasons discussed further in this finding. Given Mr Steer's request and his own dissatisfaction with the weekly pickup system, Dr Nolan agreed to trial Mr Steer in handling his own medications.

It is unclear on the evidence as to exactly when, after March 2014, Mr Steer regained autonomous access to his prescriptions. Ms Torrents stated that on 23 July 2014 Mr Steer collected his last medication pack from the pharmacy. She said on that date, his scripts and all other medications retained by the pharmacy were returned to him in accordance with the new arrangement.

I note, however, that on 11 July 2014 Dr Nolan received a telephone call from Pharmaceutical Services Branch ("PSB") who had received information that Mr Steer had been presenting to different pharmacies seeking medication. It therefore appears that Mr Steer may have had access to his prescriptions on a date earlier than 23 July 2014. I do not need to resolve this issue.

PSB, part of DHHS, is responsible for administering the *Poisons Act* 1971 and the *Poisons Regulations* 2008. The records of the supply to patients of certain substances, principally Schedule 8 narcotic substances such as morphine, must be sent to PSB by Tasmanian pharmacies and are kept on the PSB database. This database is the Drugs and Poisons Information System (DAPIS). The system records who received the substances, who prescribed them, and where and when they were dispensed. The records of all authorities for prescribing issued to prescribers under s59E of the *Poisons Act* 1971 are also kept on the database. DORA, a real-time prescription monitoring system providing online remote access to relevant DAPIS-housed information is available to doctors, pharmacists and regulators as a clinical decision support tool to help identify and respond earlier to patients with emerging or established drug related problems. Since 1 February 2018 there is now also an obligation upon pharmacists to report the supply of Schedule 4 opioid analgesics, such as tramadol and codeine, to PSB.

However, doctors prescribing non-Schedule 8 drugs of dependence such as benzodiazepines (such as diazepam) or quetiapine are not required under the *Poisons Act* to obtain an authority to prescribe, as would be required with the Schedule 8 substances. Further, pharmacists are not required to report through DORA the dispensing of such substances so as to enable real time monitoring of dispensing.

Thus, PSB has only a limited oversight role in respect of non-Schedule 8 drugs of dependence, categorised as "Declared Restricted Substances" (S4Ds) under the *Poisons Regulations*. Its oversight is limited to those patients who are prescribed these drugs of dependence in addition to Schedule 8 substances. In this case, PSB may modify or place conditions upon the authorities given to doctors relating to these drugs by reason of their interaction with the prescribed Schedule 8 substance(s).

PSB is also the central body for receiving notifications from doctors or others where a patient may be inappropriately seeking or obtaining any drugs of a high misuse potential. In such cases PSB will often issue notifications to medical practitioners and pharmacies alerting them to the drug seeking behaviour, including “doctor shopping”, of any particular individual and requesting that they cease or limit supply. Such notifications do not have statutory force under the *Poisons Act* but are sent by PSB at the behest of the treating prescriber with the desire of reducing the harm caused by excessive prescribing and consequent misuse of such substances.

PSB records contain numerous notifications advising that Mr Steer was seeking prescription medication from more than one prescriber, the last notification being in September 2011 in relation to reportedly collecting diazepam from multiple prescribers. The records from PSB disclose that Mr Steer was prescribed morphine, a Schedule 8 medication, with appropriate authorities issued to various doctors from April 2010 until January 2011 after which the PSB authority was cancelled at the request of his then authorised medical practitioner. This authority had included a condition that he present at his nominated community pharmacy on a daily basis and have doses of morphine consumed under pharmacist supervision.

PSB issued two circulars, in January 2011 and July 2014, to all pharmacies in Northern Tasmania requesting the restriction of supply of Mr Steer’s medication. The July 2014 circular was designed to assist in limiting the supply of Mr Steer’s medication to only that prescribed by Dr Nolan. Dr Nolan appropriately supported the strategy that he should be the sole prescriber to Mr Steer so as to coordinate care and control his access to medication subject to misuse.

### **Circumstances surrounding death**

On Wednesday 6 August 2014 Mr Steer was at his home with his neighbours, Rebecca Bennett and Jye Quinn. Mr Steer was consuming cider. At around 5.00pm Mr Steer took a quantity of his medication including, according to Ms Bennett, three of his “depression pills”. Ms Bennett believed this was excessive and challenged Mr Steer regarding the amount taken but he stated that he “knew what he was doing”. Shortly after this, Mr Steer began slurring his words and became drowsy. Mr Quinn and Ms Bennett returned to their residence leaving Mr Steer in his chair. They believed he would go to sleep as he had done on previous occasions.

At around 7.00pm Ms Bennett returned to Mr Steer’s unit to check on him. She located him asleep in his chair. She tried to wake him by shaking him but was unsuccessful. She was concerned for his welfare and advised Mr Quinn of the situation, querying with him if they should contact an ambulance. Mr Quinn stated he would check on Mr Steer himself and an ambulance was not called.

Ms Bennett stated in her affidavit that Mr Quinn checked on Mr Steer at 9.00pm and found him not breathing but would not call an ambulance. However, Mr Quinn stated in his affidavit that he was in fact breathing at this time. I am not able to resolve this factual dispute but I do not accept Mr Quinn’s statement at face value.

Mr Quinn stated in his affidavit that he contacted Launceston General Hospital for advice and was advised to call an ambulance if he thought Mr Steer required assistance. Mr Quinn

elected again not to phone an ambulance and stated he believed Mr Steer would wake when the medication wore off as he usually did. Mr Quinn returned to his unit.

Several hours later, at 1.10am on Thursday 7 August 2014, Mr Tex Spain, a friend of Mr Steer, visited Mr Steer. Mr Spain was in the course of his work shift as a taxi driver. He would frequently visit Mr Steer whilst working. Mr Spain located Mr Steer sitting in his chair, cold and discoloured. He contacted emergency services.

Ambulance paramedics and police officers attended the scene. Paramedics determined that Mr Steer had been deceased for some time.

The attending police officers formed the view after an examination of the scene that there were no suspicious circumstances and no evidence of suicide.

The evidence indicates that Mr Quinn suffers from a mild intellectual disability and Ms Bennett suffers from multiple mental health disorders. It would appear that their failure to help Mr Steer by calling emergency services arose from their lack of capacity or insight in conjunction with their familiarity with Mr Steer's regular abuse of medication. Nevertheless, their lack of a proper attempt to seek medical help for Mr Steer deprived him of a chance of survival.

A sample of Mr Steer's post-mortem blood was taken for toxicological analysis. The sample revealed the presence of quetiapine in the reported toxic range, as well as codeine, diazepam, fluoxetine and paracetamol. At autopsy, Dr Ruchira Fernando, pathologist, determined that Mr Steer died as a result of mixed drug toxicity.

I also requested that experienced forensic pathologist, Dr Don Ritchey, review the cause of death. He was in agreement with Dr Fernando. In his report to me, Dr Ritchey stated:

*"Dr Fernando identified significant natural disease at autopsy. In particular the heart was markedly enlarged (cardiomegaly, 670 grams) and there was concentric left ventricular hypertrophy both indicative of long standing heart disease. This amount of heart disease is sufficient to cause death by a mechanism of cardiac arrhythmia.*

*There also was cirrhosis, scarring of the liver that may have many causes, and may interfere with the body's capacity to metabolise drugs adequately.*

*The combination of drugs (rather than the individual concentrations) is indeed concerning for the possibility of mixed prescription drug toxicity. Quetiapine, codeine, diazepam (and active metabolites of diazepam) and fluoxetine all are sedating and cause central nervous system depression and respiratory depression by different pharmacological mechanisms that together may enhance their collective toxicity."*

I accept the opinions as to cause of death expressed by Dr Ritchey and Dr Fernando and find that Mr Steer died as a result of ingestion of excess medication. I am satisfied that, in taking an excess of his medication, Mr Steer did not intend to cause his own death. There is no evidence of suicidal ideation around the time in question and no indications in the surrounding circumstances.

## Comments

The main issue raised by this investigation is whether Mr Steer's death could have or should have been prevented by better restricting or attempting to restrict his access to his prescription medication, namely codeine, diazepam and quetiapine. Relevantly, Dr Nolan had ceased the strictly controlled distribution of Mr Steer's medications, and Mr Steer collected his prescriptions and prescribed medications from the pharmacy in July 2014. On 6 August 2014, only a short time later, he consumed a fatal combination of prescription medications known to be subject to misuse (diazepam, codeine and quetiapine), and subsequently died.

This is a very difficult issue, particularly in light of Mr Steer's complex physical and mental conditions.

On the evidence, Mr Steer was incapable of responsibly managing his own medication intake. It would appear that the optimal management of a patient with the complex requirements of Mr Steer was a strict prescribing and dispensing regime of the type imposed by Dr Cerchez and continued by Dr Nolan until shortly before Mr Steer's death. The cessation of that regime by Dr Nolan enabled Mr Steer a greater opportunity to have in his possession quantities of medication for consumption in doses otherwise than prescribed. However, I cannot rule out on the evidence in the investigation that Mr Steer may have sourced the medications ingested prior to his death from one or more general practitioners apart from Dr Nolan, a pharmacy other than City Capital Chemist or even illicitly. I also observe that hoarding or deliberate overconsumption of medication may still occur even if provided by weekly staged supply, although the chances of death from toxicity may be lessened.

The evidence shows that the prescribing and packing of Mr Steer's medication was a difficult issue for Dr Nolan and the pharmacist, Ms Torrents. Since 2011, Ms Torrents, an experienced pharmacist, had worked with Mr Steer's doctors to dispense his medication. In particular, she supported and encouraged the regime of Mr Steer collecting weekly medication packs so long as he maintained regular visits to his general practitioner.

Ms Torrents provided evidence that Mr Steer, despite receiving weekly medication packs, would often come into the pharmacy and claim that his medications had been stolen or that he had locked them in a box with no access. In her statement for the coronial investigation, Ms Torrents stated *"whilst we tried to stay ahead with prescriptions, doctors are also not permitted to write prescriptions in advance so balancing having a current script and being able to pack medications without an outstanding prescription so as to avoid interruption of medication supply is close to impossible"*. Ms Torrents stated that pharmacy regulations do not allow for "owing" prescriptions but only an emergency supply of three days for prescription medications (although Schedule 4Ds and 8 substance cannot be supplied in this manner).

It was therefore necessary for Mr Steer to regularly attend Dr Nolan in order to obtain a current prescription so that the weekly medication packing system could operate.

Both Dr Nolan and Ms Torrents were of the view that, with Mr Steer's documented history of drug seeking and potential diversion of medication, a weekly staged supply could assist in his medication management and compliance.

Dr Nolan ultimately formed the view that the packing system for Mr Steer needed to cease due to consistent requests for prescriptions from the chemist after the medication had been supplied and Mr Steer using the system to avoid having face-to-face consultations. Dr Nolan, stated that Mr Steer resented being counselled on his obesity, diabetic control and other critical health issues when he attended consultations.

Ms Torrents said that, despite her directing Mr Steer to his general practitioner, he would make comment, for example, that he had attended 2 to 3 weeks earlier and he did not intend going again. She said that he would give reasons for not attending such as lack of money, other commitments and unavailability of appointments. Ms Torrents, like Dr Nolan, also stated that the weekly packing regime was becoming untenable due to Mr Steer's outstanding scripts and refusal or inability to attend Dr Nolan regularly.

During the investigation, I requested an opinion from the Chief Pharmacist, Mr Peter Boyles, regarding any prescribing issues that may have contributed to Mr Steer's death. The primary role of the Chief Pharmacist is the administration of PSB. Mr Boyles, after reviewing the evidence of Dr Nolan's treatment of Mr Steer, stated in his report:

*Based on what I now know about the deceased's clinical history, if asked I would have advised Dr Nolan to have the patient reviewed by the Alcohol and Drug Services (despite the fact the deceased was no longer being prescribed narcotics) and that he should carefully consider whether the risk vs benefit of each of the psychoactive agents being prescribed justified their ongoing use (e.g. diazepam is not indicated for chronic management of anxiety). I would also have advised Dr Nolan that if he felt these psychoactive agents were effectively treating the patient that he should consider some safety measures including daily pick up from the pharmacy (or even supervised dosing of these medications in the pharmacy), and supervised urine drug screens to ensure there was not any unsanctioned drug use occurring – either licit or illicit.*

*As noted in my previous correspondence the deceased had a documented history of drug seeking and potential diversion of medication. Through their role as delegate for Section 59E of the Poisons Act 1971 a colleague issued an authority (dated 10 September 2010) to Dr Downer to prescribe morphine on the condition that 'The medication is dispensed to the patient on a daily basis with all of the doses taken under pharmacist supervision' and a recommendation that the patient be referred to the Alcohol and Drug Services for review. Subsequent authorities issued continued to require daily supervision. The authority conditions are consistent with the delegate having the highest level of concern that the deceased may be suffering from a substance use disorder (addiction) – noting the authority conditions were issued consistent with advice from a consultant medical officer qualified as an Addiction Medicine Specialist and Psychiatrist. Addiction is a chronic remitting and relapsing condition and therefore the concern relating to the safe supply of psychoactive substances would remain until and unless an Addiction Specialist medical practitioner review indicated the deceased was not at an increased risk of harm.*

Whilst Mr Boyles makes comments relating to methods of better management of Mr Steer by Dr Nolan, it is clear from a later part of his opinion that Dr Nolan's management of Mr Steer's

medication was within the realm of a reasonable general practitioner, and that the issue of controlling supply of such medication is a major problem for doctors generally in Tasmania.

On all of the evidence, I cannot criticise the decision of Dr Nolan to cease the weekly supply to Mr Steer. It is most understandable that Dr Nolan felt no wish to be complicit in Mr Steer receiving his packed medication from the pharmacy without a current prescription. He has also co-operated in the notification by PSB to be the sole prescriber of Mr Steer's medication.

Under the *Poisons Act* Dr Nolan did not require an authority from PSB to prescribe diazepam, quetiapine or codeine as they are not Schedule 8 substances. Thus, although the intention of Dr Nolan (with the assistance of PSB) was that he would be the only prescriber, this could not be monitored effectively and it relied upon the pharmacies reading and retaining the PSB circulars and complying with the request not to fill prescriptions other than those written by Dr Nolan.

The Coronial Division has recently implemented a Register of Overdose Deaths in Tasmania with a data summary prepared for the years 2007 to 2016. The data was prepared and analysed by Coronial Division manager and policy advisor, Mr Victor Stojcevski, in collaboration with Dr Jeremy Dwyer of the Coroners Prevention Unit of the Coroners Court of Victoria.

Mr Stojcevski and Dr Dwyer examined 410 overdose deaths reported to, and investigated by, Tasmanian coroners during this 10 year period. The information regarding drug contribution to any reported death was analysed in a series of tables showing the annual frequency of Tasmanian overdose deaths by contributing drug groups, drug types and individual drugs. Dr Dwyer and Mr Stojcevski are to be commended for their thorough analysis which will prove extremely useful to coroners in performing their functions, particularly in respect of informing sound recommendations for death prevention in this important area.

From the data summary, it can be seen that of the 60 deaths by drug overdose in Tasmania in 2016, 40 deaths were attributable to pharmaceutical drugs only.

Importantly, the data over the whole 10 year period of the study indicates that diazepam and codeine were, respectively, the first and third most frequent contributing drugs in deaths resulting from multiple drug toxicity, with quetiapine being present in 97.5% of this category of death.

This data also indicated that pharmaceutical drugs contributed to approximately 90% of Tasmanian overdose deaths each year.

In the finding of [Barnes, Deearne Joan](#) Coroner Stephen Carey examined the problem of excessive use of both opioids and prescription drugs of dependence in Tasmania.<sup>1</sup>

Coroner Carey also examined the issue of an expanded role for PSB in monitoring the prescribing of quetiapine and benzodiazepines, stating at p20:

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<sup>1</sup> 2016 TASCDC 179.

*“Noting the resourcing issue that this creates it is further recommended that in the interim Quetiapine and benzodiazepines, “z drugs” and “gaba drugs” such as gabapentin be made reportable drugs that require authority under section 59E for prescribing in circumstances where the patient has been reported or diagnosed as drug dependant or drug seeking/coping.”*

Further, a report commissioned by the Victorian Government and published by Austin Health in March 2017 explored the evidence for mandatory reporting of Schedule 4 prescription medications on a real-time prescription monitoring system.<sup>2</sup> The [report](#) found that there was evidence to support their inclusion.

The Chief Pharmacist, Mr Boyles, provided a report for the investigation relating to general medical practitioner management of patients at high risk of harm through prescription drug use. In his report, he described many cases of deaths by overdose as “likely and avoidable deaths”, a term he suggests should more appropriately be adopted than “accidental deaths” due to the foreseeable nature of the death. The use of such terminology, he stated, highlights the preventable nature of many death by prescription drug toxicity where the deceased are prone to abuse or misuse of the drugs.

In such cases, Mr Boyles states that there are often common factors in those potentially preventable deaths. I set out below his analysis of these factors:

- a) Failure by doctors to recognise the risks associated with the prescription of psychoactive substances including opioids, benzodiazepines, quetiapine, tricyclic antidepressants and gaba analogues;
- b) Over-confidence in the therapeutic usefulness of psychoactive agents through a failure to apply evidence-based best practice guidelines and recommendations to these low value, high risk medications;
- c) Failure to protect high risk patients through routinely implementing:
  - therapeutic drug monitoring (unannounced, supervised urine drug screens);
  - checks for past and current injection site stigmata;
  - restriction of quantities supplied by pharmacy of these medications; and
  - supervision by pharmacists of doses of these medications;
- d) Failure to recognise the complexity of patient presentations, and the medical practitioners’ limitations in their own scope of practice and expertise, and hence not referring to appropriately skilled and qualified specialist medical practitioners and tertiary services such as Alcohol and Drug Services;
- e) Failure to develop the skills required to provide best practice care in scenarios where patients are seeking or requesting from prescribers particular treatments that are unlikely to provide therapeutic benefit and certain to increase the risk of harm to the

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<sup>2</sup> David Liew et al, Department of Clinical Pharmacology and Therapeutics and Pharmacy Department, Austin Health, ‘Evidence to inform the inclusion of Schedule 4 prescription medications on a real-time prescription monitoring system’, March 2017.

patient or public;

- f) Failure to frequently reassess the appropriateness of specific regimens and subsequent failure to taper and cease ineffective, high risk medications in accordance with a “*universal precautions*” approach to prescribing drugs subject to misuse;
- g) Failure to access the DORA database and/or contact the Pharmaceutical Services Branch for advice concerning identifiably at-risk patients, thereby lacking relevant patient history concerning drugs at high risk of misuse and diversion; and
- h) Use of medications such as diazepam and quetiapine in an ‘off-label’ manner - that is, for indications not approved by the Australian medicines regulator, the Therapeutic Goods Administration.

On the evidence, there is a very good case for implementing greater regulation in prescribing drugs regularly contributing to toxicity and death. Clearly, such initiatives would require adequate resourcing of PSB to be able to implement and monitor. There have already been efforts made by PSB, including the implementation of real-time reporting, to improve standards of care in the clinical management of patients with chronic non-cancer pain and opioid dependence.<sup>3</sup> However, Mr Boyles advises that further resourcing is needed for PSB to undertake strategies to improve prescribing and dispensing practices. He expressed the view that clinical educators providing outreach education and guidance to doctors and pharmacists would provide demonstrable benefits with respect to quality use of these medicines.

Mr Boyles advised that, currently, approximately 60% of medical practices and pharmacies have access to DORA since its initial release in 2011. Evidence from the United States would suggest that ensuring DORA is used regularly by all prescribers and suppliers of these high-risk substances as a clinical decision support tool would result in a reduction in high-risk medication over-utilisation.

I also note during the course of this investigation the Tasmanian *Poisons Act* is nearing 50 years since its commencement in 1971. There is a good argument for the development of new, more contemporary Act which aligns with many changes that have occurred in regulating the relevant industries since its inception.

## Recommendations

1. I recommend that the Minister administering the *Poisons Regulations 2008* considers amending Regulation 70 to require any person prescribing drugs of a high abuse potential (such as benzodiazepines, z-drugs, pregabalin and quetiapine) to be specifically authorised by the Secretary (as defined in the *Poisons Act* and *Poisons Regulations*) to do so where the patient has been reported or diagnosed as drug dependent or drug seeking.

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<sup>3</sup> Clinical care and regulation of opioid use – the Tasmanian model; *Medicine Today* 2017; 18 (3 Suppl): 17-21.

2. I recommend that the real-time monitoring system currently used in Tasmania be reviewed with a view to including a requirement for dispensing pharmacists to record the dispensing of Schedule 4 drugs of a high abuse potential on the system at the time of dispensing;
3. I recommend the creation within PSB of a position of Outreach Clinical Educator or similar to provide outreach clinical support to prescribers and dispensers, the functions of that position to include education of prescribing doctors, pharmacists and others regarding appropriate practice for prescribing of Schedule 8 and Schedule 4 drugs of a high abuse potential; and to encourage greater uptake and use of DORA by doctors;
4. I recommend PSB develop and implement a revised s59E application form which requires more comprehensive information to be provided by applicants seeking authority to prescribe under section 59E of the *Poisons Act 1971*. Specific emphasis should be on applicants providing evidence-based risk/benefit assessment of the requested Schedule 8 regimens.
5. I recommend that the Minister responsible for administration of the *Poisons Act 1971* review the current Act with a view to creating a new more contemporary Act in line with modern-day practices for the regulation, control, and prohibition of the importation, making, refining, preparation, sale, supply, use, possession, and prescription of certain substances and plants.

I extend my appreciation to investigating officer, Constable Christopher Langshaw, for his investigation and detailed report.

In concluding, I convey my sincere condolences to the family and loved ones of Mr Steer.

**Dated:** 20 September 2018 at Hobart Coroners Court in the State of Tasmania.

**Olivia McTaggart**  
Coroner

**Notation: This finding has been amended pursuant to an order under section 58(1) of the *Coroners Act 1995*.**