QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of a male child aged 20 months**
TITLE OF COURT:	Coroners Court of Queensland
JURISDICTION:	CAIRNS
FILE NO(s):	2013/3030
DATE	15 July 2019
FINDINGS OF:	Nerida Wilson, Northern Coroner
CATCHWORDS:	CORONERS: Prescription opioids, drugs of dependence, opioid overdose, oxycodone, oxycontin; Schedule 8 medications, drugs of dependence; controlled drugs, doctor shopping, prescribing practices, real-time prescription monitoring, electronic recording and reporting of controlled drugs; Monitored Medicines Unit; oxycodone intoxication 20 month old male child death; drug toxicity fatalities - children.

Contents

Introduction

1. In preparing these findings I have been assisted by the responses of;

   a) The Australian Health Practitioner Regulation Agency (AHPRA)
   b) The Medicines Regulation and Quality Unit (MRQ) now known as the Monitored Medicines Unit (MMU);
   c) Queensland Health; and
   d) Department of Communities, Child Safety and Disability Services

Family Background

2. [Deceased name deidentified for publication purposes] hereinafter referred to as 'the child' was a 20 month old aboriginal male, born on 3 December 2011 to first time parents. By the time of the child's birth his parents had separated. The child's father identifies as Aboriginal.

3. The child lived with his mother; they shared a room in a four bedroom house at an address in Bentley Park, Cairns. The other regular occupants of the home were the child's maternal grandparents, a maternal aunt and a family friend.

4. Although his mother was the primary carer, it was not unusual for the child to be left in the care of his maternal grandparents for several days at a time. There is also evidence of an informal arrangement for shared time between the child, his father and broader paternal family although I have not been furnished with specific details about the frequency or length of these shared times.

5. Sometime between 11:00am and 11:30am on Saturday 24 August 2013 the child was located in his bed by his grandfather. The child was non responsive and cold to touch. He was unable to be revived and was pronounced deceased at the scene.

6. He was aged just 20 months at the time of his death.

Circumstances Surrounding the Child's Death

7. Establishing a definitive timeline of events is somewhat limited by the discrepancies among the witness statements, however it is apparent that the child and his mother had recently returned home after a three week holiday in Western Australia.

8. On the morning of Friday, 23 August 2013, the mother went to visit friends and left the child in the care of the maternal grandparents and aunt. The mother was not present when her son died and returned only after she was notified of his death the following day.

9. On the day before he died, the child was in good spirits despite a cold which caused him to have a runny nose and occasional cough. It appears that the child had developed the cold about three days earlier however none of the occupants of the house observed any symptoms that caused them to worry excessively or consider this was anything beyond a common illness.

10. The child spent the day at the lagoon with his maternal grandparents and later fell asleep for a nap sometime between 4:00pm and 6:30pm, before eating dinner with his grandfather, aunt and the family friend at around 7:00pm. After dinner, the child was reportedly kicking a ball and playing on a pushbike with his maternal aunt and grandfather. He was still awake when his grandmother returned to the family home at around 9:00pm having been to the airport.

11. In her statement to police, the family friend said she observed the child to fall over several times whilst playing however she reports that the child was not upset or injured by the falls, which were *'nothing unusual'.* The grandparents and aunt told police that the child had not fallen on the evening prior however noting the cause of death, and a lack of post-mortem evidence to confirm it, I find that this discrepancy is not significant.

12. It is suggested that the child resisted bed-time that evening before finally settling sometime between the hours of 11:30pm and 2:30am on Saturday morning. Although there is some variation in the report, all occupants of the household agree that it was much later than usual. This accords with the mother's statement to police that her son was not yet readjusted to his '*normal routine'* following their holiday.

13. The child's grandfather says he read a book with the child before putting the child in the bed he usually shared with his mother. There are no reports that the child woke over night or was seen until the following day.

14. It is clear that several of the occupants were in and out of the home on Saturday morning. Based on statements, a general timeline is established as follows:

    a) The family friend went to the airport at around 4:00am and returned with her mother, who was visiting from Western Australia. When the women returned, they had coffee and were talking with the grandparents outside;

    b) The aunt reports that she awoke at around 4:30am and spoke briefly with her parents (the grandparents), the family friend and her mother. She returned to bed shortly after and awoke at around 8:30am but stayed in her room until approximately 9:30am;

    c) The family friend took the grandfather to a doctor's appointment at around 9:00am and they returned sometime after 10:00am;

    d) Shortly after, the family friend and her mother left the home to go out for lunch and the grandmother departed about five minutes later. Before leaving, the family friend says she told the grandfather to wake the child or he would not sleep that night, however he chose not to because of how late the child had gone to bed the night before.

15. There are several inconsistencies as to when and how many times the child was checked on that morning however I accept that the grandfather saw the child sometime around 8:30am on Saturday morning.

16. The grandfather claimed that he gave the child a bottle of chocolate milk and left him lying on the bed and apparently in good health. It was reportedly a common occurrence that the child would have a bottle during the morning then doze off.

17. The grandmother says she observed the child asleep on his belly (that morning at an unspecified time), with his head on the pillow and the blanket over him with one arm resting on top of it. The child was reportedly giggling and dreaming. The grandmother says that at the time she left the home later that morning, the child was asleep in the bed.

18. Resuming the chronology from paragraph 14 above:

    e) The aunt says she checked on the child sometime after she had breakfast. The aunt claims to have seen her father (the grandfather) check on the child at least three or four times that morning however this does not accord with the grandfather's version of events.

    f) The grandfather and aunt were the only people home when the grandfather discovered the child's body sometime between 11:00am and 11:30am. The grandfather says he went to check on the child and found him lying on his left side in the middle of the bed on top of the bedlinen with his head towards the top of the bed. He observed the child to have a wet mouth, which he attributed to the milk, but did not observe any other fluids on the bed. The bottle was said to be by his mouth. The grandfather states the child '*did not look right'*, he was '*dark around the mouth'* and '*cold*'.

    g) Queensland Ambulance Service (QAS) records indicate the call for service was received at around 12:05pm. Officers arrived at the home shortly after and observed the grandfather performing CPR on the child in the lounge room under the guidance of the QAS operator.

    h) Officers placed the child on the floor and resumed CPR however were unable to revive him.

    i) The child was pronounced deceased at the scene at approximately 12:25pm.

Autopsy report

19. An autopsy was performed on the child on 26 August 2013. Toxicology testing was also conducted. The Forensic Pathologist finalised the autopsy report on 13 January 2014 and has further been called upon to clarify his conclusions by the Queensland Police Service (QPS) and the Crime and Corruption Commission (CCC).

20. Post mortem examination showed lung congestion and some healing sores on the left ankle, but no significant injuries were noted. The Forensic Pathologist reported that no obvious injuries indicative of past abuse or neglect were identified during the examination.

21. The cause of death was not clear at the time of autopsy and further investigations were performed including toxicology screening. Microscopic examination showed some lung infection with evidence of inhaled food material, and inflammation of the lining of the voice-box region.

22. Testing for drugs and poisons detected the presence of a painkiller, oxycodone, at 3.6mg/kg in the child's blood; a level which in adults would be within the reportedly lethal range. This drug was not detected in milk submitted for testing.

23. No alcohol was detected in the child's blood or other tested bodily fluids. Bacteria was also detected in the blood stream, the oral cavity and in the lung.

24. The Forensic Pathologist suggested that '*while the presence of congestion and inflammation of the lung would be consistent with a significant lung infection that might be responsible for death, the presence of oxycodone in the blood was both unexpected and may conceivably increase the chance of development of lung infection that may have resulted in death'*. The report also notes that although '*there were no overt features suggesting past abuse or neglect… the circumstances leading to the presence of the painkiller in the bloodstream remain unclear'*.

25. The cause of death was ultimately determined as lung infection on the background of oxycodone intoxication.

Medical Records and Access to Oxycodone by Occupants of the Bentley Park Household

26. I have also been assisted by a comprehensive Queensland Police Service investigation report dated 15 May 2018 prepared by a Detective Senior Constable of Police. That report considered the circumstances under which oxycodone may have come to be present in the child's bloodstream.

27. I accept the conclusions expressed in that report.

28. After considering all the evidence and material available to me I **find** that the child ingested oxycodone located in the Bentley Park household by means unknown whilst in the care of his grandparents.

29. Having regard to the police investigation and the Medicines Regulation and Quality Unit (MRQ) report I accept that both maternal grandparents had a known history of obtaining drugs of dependence, including oxycodone (in tablet form). They were the only people within the household with relevant prescription drug histories.

30. The grandmother had, in the past, been registered as a drug dependent person however she was not registered at the time of the child's death. The grandfather had no history of being registered as a drug dependent person.

31. Both grandparents were known to have a history of 'doctor shopping'.

The Effects of Oxycodone on Infants

32. Information was obtained during the course of the QPS investigation as to the effects of oxycodone on an infant child.

33. Oxycodone is a semi-synthetic narcotic analgesic which produces an effect similar to morphine. It is commonly used for the relief of moderate to severe

pain; and is available only by prescription as tablets, capsules, liquid form or suppository. Oxycodone produces analgesia (pain relief), drowsiness, sedation, changes in mood (euphoria), muscle incoordination, small or pinpoint pupils and mental clouding. Respiratory depression, coma and death occur at high levels.

34. There is very little data surrounding the effects of oxycodone on children, as it is not prescribed to them. There are also difficulties in relying on adult-based findings to understand the potential impact on children, because of differences between factors such as their size and age-related sensitivities.

35. This matter was reviewed by Forensic Medical Officer (FMO), Dr Griffiths, who is attached to the Clinical Forensic Medical Unit (Qld). Upon review Dr Griffiths stated it was not possible to calculate a backward extrapolation from the approximate ante-mortem level of 3.6mg/kg to determine the amount or number of tablets potentially ingested by the child. He did however confirm, that '*the amount ingested to produce the serum level detected at autopsy was likely to have been extraordinarily high*'.

36. Dr Griffith's report included findings of a review by Dr Olaf Drummer, a Forensic Pharmacologist at the Victorian Institute of Forensic Medicine. Dr Drummer notes that the data does not allow an estimation of the likely dose taken except to say that it would have been sufficiently high to cause sudden death.

37. Although there is consensus that the amount ingested would have been high, there is no way to identify the specific amount or number of tablets that would have caused the levels of oxycodone detected in the child's bloodstream.

38. I do however accept the advice that, the serum level detected in child's blood was in the reported lethal range for adults and this would be fatal for children.

Drug Toxicity Fatalities of Young Children in Australia (2000 – 2018)

39. In preparing these findings I have been assisted by a report prepared at my request by the National Coronial Information System (NCIS). I was provided the statistics for children (under the age of 5) across all Australian States and Territories who died as a result of exposure to chemical and other substances. The report identified seventeen such deaths in the period 1 July 2000 to 26 June 2018.

40. Of that cohort seven deaths were as a consequence of 'unintentional' drug toxicity, another seven were identified as an 'assault', that is there had been some level of intent and of the remaining three the element of intent could not be determined.

41. Ten of the seventeen deaths involved Schedule 8 substance listed under the *Poisons Standard*; oxycodone specifically accounted for two of the deaths.

Procuring Drugs of Dependence and the Bentley Park Household

42. I have been assisted by a statement from an Investigation Officer from the then Queensland Department of Health and Medicines Regulation and Quality Unit (MRQ) setting out the relevant terminology and reporting processes.

43. Since receiving that statement the name of that organisation has changed; it is now known as the Monitored Medicines Unit (MMU). That change was brought about in part by a response to the need for real-time monitoring of certain prescription medication; a development that I will discuss more of later in these findings. It is therefore appropriate to continue using the new name.

44. The MMU has responsibility for data collection and analysis in relation to the frequency, appropriateness and lawfulness of the prescription of pharmaceutical drugs that carry a risk of drug dependence.

45. Oxycodone is listed as a Schedule 8 substance pursuant to the *Poisons Standard* that are issued and updated by the Department of Health (Cth) Therapeutic Goods Administration. A substance listed in Schedule 8 is a 'Controlled Drug' meaning it is available for use but requires certain restrictions be placed upon its supply or distribution in order to reduce the "*abuse, misuse and physical or psychological dependence*" of the substance.

46. The *Health (Drugs and Poisons) Regulation 1996* (Qld) adopts the scheduling system contained within the Poisons Standard for the purpose of defining a "*controlled drug*".[1] Therefore oxycodone is a controlled drug for the purpose of Queensland legislation.

47. The listing of oxycodone as a controlled drug imposes obligations on practitioners in the way they prescribe and dispense it.[2] Specifically, if a practitioner prescribes oxycodone or any other controlled drug for **more than two months** (emphasis added) they are required to provide a report to the Chief Executive about the circumstances of the patient's treatment.

48. Obligations are also imposed on people seeking to be prescribed with a controlled substance. Specifically that person must disclose to a practitioner all other prescriptions for controlled substances they have obtained from another practitioner in the previous two months.[3] This seeks to address the issue commonly referred to as 'doctor shopping'.

49. The term 'doctor shopping' is not a defined within legislation however the MMUs own threshold for meeting that definition involves a person "*within any three month period*" consulting with four prescribers or obtaining twelve prescriptions within that period.

50. The obligations on both practitioners and prescription-seekers provide a means by which a practitioner may identify whether a person is drug dependent. Section 5 of the *Health Act 1937* (Qld) relevantly defines a drug dependent person as someone:

> *(a) who, as a result of repeated administration to the person of controlled or restricted drugs or poisons—*
>
> *(i) demonstrates impaired control; or*

[1] Section 5 – *Health (Drugs and Poisons) Regulation 1996*
[2] Section 79 – *Health (Drugs and Poisons) Regulation 1996*
[3] Section 121 – *Health (Drugs and Poisons) Regulation 1996*

(ii) exhibits drug-seeking behaviour that suggests impaired control; over the person's continued use of controlled or restricted drugs or poisons; and

(iii) who, when the administration to the person of controlled or restricted drugs or poisons ceases, suffers or is likely to suffer mental or physical distress or disorder.

51. If a practitioner "*reasonably believes*" a person is drug dependent they must first seek approval from the Chief Executive to dispense, prescribe, administer or supply a controlled drug to that person.[4] In that regard the onus rests solely with the practitioner to bring their clinical judgement and experience into focus when assessing a person who presents themselves, seeking to be prescribed with a controlled drug.

52. Whilst the MMU has the capacity to monitor drug dispensing data there were, at the time of these events and currently, delays between when a controlled drug is dispensed and when that data is uploaded. That delay period is typically four to six weeks. This delay underscores the critical, front-line role practitioners perform to identify people who may be drug dependant.

The Child's Maternal Grandfather

53. Notwithstanding the child's maternal grandfather had no 'known history' of drug dependence for MMU purposes, it was incumbent on any practitioner to still make an assessment of whether he was drug dependent before prescribing any controlled drug to him.

54. No medical practitioner had sought or been granted approval to prescribe any Schedule 8 controlled drug to the grandfather.

55. Between 5 June 2012 and 24 September 2013 (1 year and 20 days) the MMU was contacted on five occasions by four different medical practitioners and the Alcohol Tobacco and Other Drugs Service (ATODS) seeking advice or patient details for the grandfather. Each contact had been triggered by the grandfather seeking to be prescribed with OxyContin.

56. I make the following distinction between OxyContin and oxycodone, the former is a particular pharmaceutical brand of which the latter is an active component.

57. I infer from the grandfather's history, that those medical practitioners with whom he had contact, had formed a reasonable belief that the grandfather was drug dependent. I also note the last contact, on 24 September 2013, was after the death of the child.

58. On 24 September 2013, the medical practitioner that contacted the MMU informed them the grandfather had been referred to their practice by Dr Sanouiller. I will address the nature of the therapeutic relationship of Dr Sanouiller with the grandfather (and grandmother) separately.

[4] Section 122 – *Health (Drugs and Poisons) Regulation 1996*

The Child's Maternal Grandmother

59. As identified in paragraph 30 of these findings the child's maternal grandmother had, at different times, been registered as a drug dependent person. The effect of those registrations being that approval had been sought from and granted by the Chief Executive to prescribe her with controlled drugs.

60. The grandmother's known drugs of dependence were morphine sulphate and oxycodone.

61. The first registration commenced in September 2009 then ended in January 2010. There were four subsequent registration periods between May 2010 and April 2013. In the last of those registration periods the grandmother approached another medical practitioner, other than the one already approved to prescribe her, and sought to be prescribed Oxycodone. The MMU was notified of this event and the grandmother was referred back to the medical practitioner who held approval.

62. The grandmother's last registration period as a drug dependent person concluded on 14 April 2013. Following that the grandmother began being prescribed by Dr Sanouiller; this commenced on 23 April 2013.

Dr Alain Sanouiller

63. Investigations revealed that in the month prior to the child's death, Dr Sanouiller prescribed the grandfather with oxycodone on nine separate occasions. Four of those occasions involved scripts for 40mg doses and the remaining five occasions involved scripts for 80mg doses, with a total of 252 oxycodone tablets. Those prescriptions were dispensed at pharmacies based in Cairns.

64. In that same period Dr Sanouiller prescribed the grandmother with oxycodone on eleven occasions. Six of those occasion involved scripts for 80mg doses and the remaining five occasions involved scripts for 40mg doses, with a total of 308 oxycodone tablets. Those prescriptions were dispensed at pharmacies based in Cairns.

65. **In total 560 oxycodone tablets were prescribed to the grandparents by Dr Sanouiller in the one month period prior to the child's death.**

66. MMU records indicate Dr Sanouiller provided prescriptions to the grandfather for a total of 1209 x 40mg OxyContin tablets and 2158 x 80mg OxyContin tablets in a 480 day period. This would include those prescribed in the one month period described above. The statement from the MMU Investigation Officer confirmed '*MMU records indicate that while under Dr Sanouiller's care, [the grandfather] was averaging 800mg of OxyContin daily*'.

67. MMU records also indicated Dr Sanouiller provided prescriptions to the grandmother for a total of 517 x 40mg OxyContin tablets and 868 x 80mg OxyContin tablets in a 290 day period; again this would include those prescribed in the one month period described above.

68. With respect to the appropriateness or otherwise of this dose, the MMU Investigation Officer stated that:

> '*In general terms, when assessing a patient's daily dosage of OxyContin, MRQ is of the view that any dose exceeding 120 – 200mg daily, where no medical or clinical evidence supports a therapeutic dosage exceeding that threshold, that the dosage may be excessive. This view is supported by clinical and medical research'.*

69. The MMU Investigation Officer in a statement provided to me, deposed that the grandmother had been registered as a drug dependent person, Dr Sanouiller was acting unlawfully by prescribing her OxyContin for the period of 23 April 2013 to 10 November 2013 without their approval. The child's death occurred within this time period.

The Child's Access to Oxycodone

70. As part of their investigation the Queensland Police Service considered three potential scenarios by which the drug may have been ingested by the child:

    a) The child (not known to others) located and ingested oxycodone resulting in an overdose;

    b) An intentional administration of oxycodone by a third person (perhaps in good faith), to sedate the child, and ease his cold like symptoms; or

    c) An intentionally administered dose of oxycodone being administered to the child by a third person.

71. In assessing the likelihood of those scenarios I have had regard to the evidence the grandfather and grandmother gave separately during coercive hearings conducted in 2017. It was apparent from their evidence that some differences existed as to how the substance was handled in their household. I note the grandfather and grandmother had separated at the time they gave their evidence and were no longer living together.

72. I do not seek to reconcile the differences in their evidence and no adverse inference should otherwise be drawn, allowing for the breakdown of their relationship and the length of time that had passed between the child's death and their giving evidence.

73. In those circumstances it would be inappropriate to jointly attribute evidence given by one that was not accepted by the other. However where there is commonality in their evidence I have given it some weight. I have also given weight to any concessions made by either the grandfather or grandmother as to their own conduct.

74. The medication was primarily kept in a safe [5] in one of the bedrooms in the house. They each agreed the medication was accessed on a daily basis. Whilst they agreed the grandfather was generally the primary custodian [6] of the

[5] The Grandmother T1.29/40 and The Grandfather T1.26/2-8
[6] The Grandmother T3.9/36-39 and The Grandfather T1.24/4

medication, the grandmother nonetheless had access to the safe [7] and was not reliant on the grandfather to dispense medication for her.

75. The medication was generally left in its blister pack however some of it was transferred into a 'days of the week' tablet dispenser.[8]

76. The grandfather conceded selling some of the oxycodone to other persons.[9] The grandfather also conceded the possibility of the child finding oxycodone and ingesting it.[10] Given the volume of medication that was entering the house and the frequency and manner with which it was being handled, this was an entirely appropriate concession to make.

77. The nature of both the grandfather's and grandmother's evidence suggested the medication was not strictly dispensed and administered in the same room as the safe where it was stored.

78. The grandfather and grandmother acknowledged that they consumed the medication both orally and intravenously [11] however both claimed to take extreme care that this never occurred in front of the children. This was verified by other occupants of the Bentley Park household in their statements to police.

79. The child was a much loved and there is nothing to suggest he had ever been administered oxycodone in the past to either pacify or medicate. He was generally of good health. There was no evidence of oxycodone in his bottle from that morning.

80. The grandfather and grandmother themselves vehemently deny they would ever have supplied their grandson with the drug for any purpose, and this has been supported by all occupants of the household including their daughter, the child's mother, who reports they loved the child and would never do that.

81. There is no evidence that anyone in the home had ever previously hurt the child or may have sought to cause an overdose by providing him with the drug.

82. In this course of this investigation I considered whether the child either, located and ingested the oxycodone himself, or whether the oxycodone was administered to him by a third person. I am ultimately of the view there is insufficient evidence to understand or resolve the circumstances in which it came to be in his bloodstream. This was also the conclusion of the Queensland Police Service.

83. Whilst there is some ambiguity surrounding who, when and how many times the child was checked on the morning of his death, there is no evidence demonstrating any person gave or administered the drug to the child with an intent to cause him harm.

84. Each of these considerations are complicated by the lack of clear understanding as to how many tablets would have been required to cause the serum levels detected in the child's bloodstream.

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[7] The Grandmother T3.27/13-24 and The Grandfather T4.16/25-27
[8] The Grandmother T3.20-21/37-7 and The Grandfather T4.11/1-15
[9] The Grandfather T1.24
[10] The Grandfather T2.8/41-45, T2.9/22-28
[11] The Grandmother T1.28/44 and The Grandfather T1.17/17

85. None of the specialists have been able to say whether or not it would have been sufficient for the child to ingest a single tablet or whether he would have needed to consume more than one.

Child Safety Concerns

86. Whilst there was no evidence to suggest that the child was subjected to violence or abuse in the home prior to his death, I acknowledge that he was known to child and safety services, as were the grandfather, grandmother and their own children.

87. I have been furnished a report completed by the then Department of Communities, Child Safety and Disability Services as well as the Child Death Review Committee (CDRC). These reviews are required to be undertaken within two years of the death of a child known to the Department.

88. In 2012, a mandatory notification was received citing concerns about the grandmother's substance abuse issues and its potential impact on the child. The notifier reported that the grandmother's use of drugs was increasing in frequency and severity; and that she showed little motivation to stop. It also alerted child safety services to the fact that she had recently been charged with a range of criminal offences which included charges for possession of drugs and a failure to care or take precautions with a syringe.

89. The child safety officer considered that although the grandmother's drug use was *'very concerning'*, there appeared no evidence of any impact on the child. It was nonetheless acknowledged that the grandmother's drug use presented a risk in and of itself. The matter was recorded as a Child Concern Report and no further action was taken. There was no active involvement by the department at the time of the child's death.

90. I am satisfied that the relevant issues pertaining to the child safety response in this case have been identified by the Department and the CDRC.

Child Safety Reforms

91. With regard to the broader coronial function of death prevention, I am cognisant of key reform initiatives that have occurred subsequent to child's death.

92. Chiefly, the child protection system has undergone a suite of reforms since the Queensland Child Protection Commission of Inquiry was finalised in 2013. This includes legislative and policy reform to strengthen processes when a report of suspected or potential harm is made.

93. The reform acknowledges that children are best cared for by their families and that sometimes families need support to safely care for their children at home, without unnecessary statutory intervention by child safety services. There is also a greater focus on early intervention and supporting families by building their capacity and addressing underlying issues which may prohibit their ability to effectively care for children.

94. Significantly, if child safety services were made aware of drug use in the home today, they would have a range of options available to them which were not accessible in 2013, such as Family and Child Connect Services and Intensive Family Support Services.

95. These services work with vulnerable families to identify their needs and link with them with appropriate health providers as part of an early intervention strategy to prevent a child becoming in need of protection or statutory protection. They are local, community-based services that assist families to care for and protect their children at home and facilitate access to intensive support for more complex issues, including drug and alcohol treatment.

96. In cases like this, where there is also evidence that the family may have been reluctant to engage with child safety services, other professionals can also refer families.

97. I am conscious of the breadth of these reforms and therefore do not consider there would be further benefit reviewing the child safety response beyond those already completed.

Institutional Responses

Australian Health Practitioner Regulation Agency (AHPRA)

98. On 7 November 2018 a request was made to AHPRA to provide details of any investigation that may be in process or have concluded in relation to Dr Alain Sanouiller and another. Based on their response the following chronology can be established:

Date	Event
21 March 2014	MRQ notifies AHPRA of its intention to cancel Dr Sanouiller's endorsements for Schedule 8 and Schedule 4 drugs of dependency.
26 March 2014	AHPRA writes to Dr Sanouiller informing him of that notification and seeking his response.
28 April 2014	Dr Sanouiller responds to AHPRA
3 July 2014	MRQ issues Notice of Decision under s.18A of the *Health Act 1937 (Qld)* formerly cancelling Dr Sanouiller's endorsements for Schedule 8 and Schedule 4 drugs of dependency.
4 July 2014	MRQ notifies AHPRA of its final decision. AHPRA subsequently commences its own investigation in relation to the notification.

7 August 2014	Dr Sanouiller provides an additional response to AHPRA acknowledging the decision of the MRQ and informing them he will not be applying to the Queensland Civil and Administrative Tribunal to have their decision reviewed.
3 September 2014	Upon AHPRA concluding its investigation the Queensland Notifications Committee of the Medical Board of Australia resolved that Dr Sanouiller's practice of the profession was 'unsatisfactory' and decided to impose conditions on his registration.
11 September 2014	AHRPA writes to Dr Sanouiller notifying him of the decision to impose conditions on his registration, the reasons for doing so and enclosing a schedule of the conditions imposed.

99. In preparing this chronology I did not have copies of Dr Sanouiller's responses however they were summarised in the AHPRA letter dated 11 September 2014. Based on that summary the following observations might be made regarding Dr Sanouiller:

    a) He had previously worked in a hospital setting between 2008 and 2011 therefore his transition to general practice presented a change in his practice settings;

    b) He considered that he had 'exercised sound clinical judgement' at all times;

    c) He considered staffing levels at the medical practice at the time as having impacted in his ability to meet the needs of patients and comply with the regulations; however

    d) He acknowledged "*several patients*" were 'at risk of being a drug dependent person' and therefore best practice would have been for him to make enquiries with the MMU;

    e) He further acknowledged that he did not seek appropriate approvals before prescribing "*several patients*" with Schedule 4 restricted drugs of dependency or Schedule 8 drugs; and

    f) He had taken steps to refer patients to other health practitioners to ensure continuity of their treatment in light of the restrictions that were proposed on his practice.

100. AHPRA emphatically concluded that Dr Sanouiller's practice was unsatisfactory for a number of reasons, notably it demonstrated "*a substantial lack of judgement in the treatment of patients, most of whom had or were registered on the opioid treatment program at the time of their consultations*". It also noted there were inconsistencies in Dr Sanouiller's response as against the prescribing records provided by MMU.

101. It is apparent from the 11 September 2014 Notice from AHPRA that the MMU had at some time during August 2013 raised concerns about Dr Sanouiller's prescribing drugs to patients on the opioid treatment program. It is unclear whether these concerns were raised before or after the child's death, regardless of that Dr Sanouiller continued to prescribe to patients after those concerns had been raised.

102. I have had the benefit of reviewing the Schedule of Conditions that was imposed on Dr Sanouiller by the Medical Board of Australia on 3 September 2014. Those conditions were comprehensive. They precluded him from obtaining, possessing, administering, dispensing or prescribing either Schedule 8 controlled drugs or Schedule 4 restricted drugs. Dr Sanouiller was further required to undertake additional training regarding the rules and regulations concerning the prescription of such drugs and drug seeking behaviour of patients. Dr Sanouiller was also required to undergo random auditing (at least 4 times over a 12 month period) by a professional colleague to ensure compliance with the conditions.

103. There were other conditions imposed on Dr Sanouiller however I mention these specifically as they touch upon some of the fundamental aspects of his continued ability to practice medicine.

Dr Sanouiller's Compliance with the Conditions

104. On 12 October 2016 the Medical Board of Australia removed four of the conditions that had been imposed in Dr Sanouiller. Those conditions related to training components only; he remained subject to the conditions prohibiting him from prescribing the nominated drugs.

105. On 21 December 2016 the conditions in relation to auditing were also removed.

106. On 15 February 2017 the Medical Board of Australia cautioned Dr Sanouiller for failing to comply with the first condition that remained in effect, namely not to prescribe a Schedule 8 controlled drug. On this occasion it was noted that Dr Sanouiller had prescribed a pharmaceutical item for which a Schedule 8 controlled drug was an active ingredient.

107. On 29 January 2018 Dr Sanouiller was again cautioned, on this occasion for having prescribed a Schedule 4 restricted drug of dependency. It should be noted that at this time Dr Sanouiller was no longer registered to practice medicine on account of having allowed his registration to lapse through non-renewal.

108. I sought information from and had confirmed by AHPRA that this particular prescribing event occurred prior to his lapse in registration, however the disciplinary process was not concluded until after.

109. Whilst I had details of those two disciplinary events it was not apparent on the material when either prescribing event had occurred. It would be a serious matter of concern if those prescribing events had occurred after the lifting of conditions for training and auditing.

Status of Dr Sanouiller's Registration and Endorsements to Prescribe Drugs of Dependence

110. Dr Sanouiller's registration as a medical practitioner ceased on 1 November 2017 when he did not renew his registration and allowed it to lapse.

111. At the time his registration lapsed Dr Sanouiller remained subject to ten of the conditions imposed by the Medical Board of Australia. Chief amongst those were the prohibitions on obtaining, possessing, administering, dispensing or prescribing either Schedule 8 controlled drugs or Schedule 4 restricted drugs.

112. Notwithstanding his lapse in registration, the Cancellation Notice of his endorsements with respect of Schedule 8 controlled drugs or Schedule 4 restricted drugs, as imposed on 4 July 2014, remains in effect.

113. Whilst Dr Sanouiller no longer has endorsements to prescribe the substances and is no longer registered as a medical practitioner he does continue to have a valid prescriber number with Medicare.

Re-Registration of Dr Sanouiller and Endorsements to Prescribe Drugs of Dependence

114. Were Dr Sanouiller to seek re-registration as a medical practitioner in the future the cancellation would remain in effect. It would be a matter for Dr Sanouiller to apply pursuant to s.56A of the *Health (Drugs and Poisons) Regulation 1996* to have that cancellation amended or repealed. Such application could only be made if he were successfully re-registered; that would be a matter for the Medical Board of Australia.

115. Any future application brought by Dr Sanouiller to amend or repeal the cancellation, would require the relevant authorities to consider what training had been undertaken by him. Best practice would no doubt require that training to be contemporaneous with the application i.e. Dr Sanouiller could not, in 2019 or any future time, rely on training completed as part of the conditions imposed on him in 2014.

116. Furthermore, for Dr Sanouiller to be re-endorsed to prescribe Schedule 8 controlled drugs or Schedule 4 restricted drugs he would need to provide evidence in relation to the following issues:

    a) His knowledge and understanding of obligations under the *Health (Drugs and Poisons) Regulation 1996;*

    b) His qualifications and experience; and

    c) His character and standing.

117. I am conscious these findings may be relevant to any assessment of the latter issue.

118. Prior to publishing these findings I sought to provide a copy to Dr Sanouiller to allow him the opportunity to respond to the matters that have been raised. As a result of the enquiries made to contact Dr Sanouiller I received information that he departed Australia on 18 January 2017 and currently does not have a valid visa to return to the country.

Progress Towards a Real-Time Prescription Monitoring System

119. It is a matter of great regret, that the circumstances surrounding the child's death has precedent. On 21 May 2018 at the Coroners Court at Southport, Coroner McDougall delivered findings following the inquest into the deaths of William House, Vanessa White, Jodie Smith and Daniel Milne. Each of those deaths were found to have involved the misuse of opioid prescription medication.

120. Those findings articulated an issue that is confronting all Coronial jurisdictions in Australia and repeated the recommendation that a real-time prescription monitoring system be implemented "*as a matter of urgency*".

121. Noting that recommendation I sought advice from Queensland Health about what steps were being or had been taken towards implementation of the real-time monitoring system. I am grateful for the response received which advises:

    a) Work is in progress to implement a real-time prescription monitoring system with the aim to have that system active by 2020;

    b) Queensland Health is working with the Commonwealth Department of Health (National Data Exchange) which in turn is working with the other States and Territories to facilitate integration of jurisdictional regulatory systems and planning for other requirements such as legislative or police reform to support the real-time prescription monitoring system;

    c) Queensland Health has also established a Steering Committee chaired by its Chief Health Officer, to oversee the implementation of the system. The first meeting of the Steering Committee was held on 7 February 2019. I note that that the Coroners Court of Queensland is, along with a number of other agencies, a member of that Steering Committee;

    d) Queensland Health is also progressing work with regard to legislative reform within the State that will provide a basis for the real-time monitoring system.

122. Separate to the implementation of the real-time prescription monitoring system the Monitored Medicines Unit provides a state-wide telephone enquiry service for medical practitioners to access prescription history information, regulatory advice and support. It is apparent there has been a significant uptake in this service by practitioners.

123. Steps are also being taken to provide education programs for prescribers, dispensers and consumers regarding the monitoring of certain substances. The education will target:

a) Responsibilities under the new legislation;

b) The safe prescription of substances; and

c) Use and understanding of the real-time reporting system

124. I acknowledge these tangible steps taken to date towards the implementation of the real-time monitoring system and emphasise the need for this work to continue as a matter of urgency.

Findings required by s. 45

Identity of deceased	[deidentified for publication purposes]
How he died	I find the child, then 20 months, ingested oxycodone located in the Bentley Park household by means unknown whilst in the care of his grandparents. There is insufficient evidence to understand or resolve the circumstances in which the substance came to be in the child's bloodstream. In the month prior to the child's death, 560 oxycodone tablets were prescribed to the grandparents by a local general practitioner Dr Alain Sanouiller. Dr Sanouiller's registration as a general practitioner has expired and he remains subject to conditions imposed by the Medical Board of Australia including prohibitions on obtaining, possessing, administering, dispensing or prescribing either Schedule 8 controlled drugs or Schedule 4 restricted drugs. Queensland Health and other stakeholders are currently developing a real time prescription monitoring system. Coronial jurisdictions including Queensland have recommended that real time prescription monitoring be implemented as a matter of urgency.
Place of death	Bentley Park QLD
Date of death	24 August 2013
Cause of death	1 (a) Lung infection on a background of oxycodone intoxication

I now close the coronial investigation.

Nerida Wilson
Northern Coroner
15 July 2019