

Opioid Dependence Treatment – Lessons from Inquest

Mental Health Alcohol and Other Drugs Branch – May 2026

Purpose

To raise awareness of the system-level safety risks identified in recent coroner findings highlighting the required clinical best practice associated with methadone prescribing.

Situation

A recent coronial inquest following the death of a 39-year-old woman who was receiving opioid dependence treatment through the Queensland Opioid Treatment Program (QOTP) has recommended sharing learnings with providers. Providers are reminded of the best practice guidance available in the [2023 Queensland Opioid Dependence Treatment \(QODT\) Guidelines](#).

Background

On 20 September 2021, the woman was found unresponsive at her Queensland residence, after having injected methadone from the three take-away oral doses that had been prescribed by her treating General Practitioner under the QOTP. These doses had been collected that morning by a friend acting as an agent. The quantity of methadone taken caused the woman to go into cardiac arrest. Following successful return of spontaneous circulation, she was transferred to hospital, where she tragically passed away later that day due to an unsurvivable hypoxic brain injury.

Assessment

The coroner has made recommendations in response to issues identified in the patient's care that should be considered by all providers of QOTP, with attention to the following:

- Methadone overdose risk and best practice prescribing of naloxone on commencement of treatment.
- Escalating patient risk and requirement to review treatment needs relative to factors including treatment adherence, substance use, mental and physical health impairments, pregnancy and social circumstances.
- Comprehensive and contemporaneous clinical documentation including clear reflection of clinical decision making and rationale.

- Prescribing and review of self-administration (take-away doses) in line with clinical best practice.
- Ensuring that the information about agents collecting medication on behalf of a person is confirmed and documented and that the agent is provided with information about the responsibilities associated with the transfer of self-administered medication to the patient.
- Best practice management for each of these risks is outlined in the 2023 Queensland Opioid Dependence Treatment (QODT) Guidelines. As relevant, updates to the Guidelines will be made as a result of the coroner's findings.

Action(s) required by QOTP Providers:

- 1. All opioid dependence treatment providers under the QOTP should practice in accordance with the [2023 QODT Guidelines](#) and must comply with applicable requirements of the *Medicines and Poisons Act 2019*.**
- 2. QOTP prescribers should undertake overdose prevention education including the co-prescribing of naloxone as standard practice. Training is available via [Insight: Centre for alcohol and other drug training workforce development](#).**
- 3. Patients receiving opioid dependence treatment on QOTP with higher risk profiles and escalating treatment needs should have self-administration doses reviewed within limits as outlined in the [2023 QODT Guidelines](#).**
- 4. Prescriptions for methadone intended for self-administration (i.e. take-away doses) should include instructions for the pharmacist which include dilution to 200mls with purified water unless the prescriber has provided written approval to the contrary.**
- 5. Prescribers authorising agents to collect medication on behalf of patients should include written advice to the pharmacist including the patient details, the name of the agent and the period of authorisation.**
- 6. Pharmacists dispensing opioid treatment medication to agents should provide adequate education to the agent on the medication, including guidance on risks and safe storage.**

Attachments:

[Queensland Opioid Dependence Treatment Guidelines \(version 1.3\)](#)

References:

[Queensland Health, *Queensland Opioid Dependence Treatment Guidelines*, QH-GDL-974, 2023](#)

