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Cheryl Vella Coroners Registrar Coroners Court of Victoria 65 Kavanagh Street SOUTHBANK VIC 3006



Dear Ms Vella

20110727

Investigation into the death of Dean W Wright (Court ref: COR-2011 000277)

I am writing in response to your letter of 19 April 2016 relating to Coroner Paresa Spanos' recommendations to the Department of Health and Human Services in her finding into the death without inquest of Mr Dean Wright.

The department's response to the Coroner's recommendations follows:

Recommendation 1:

In line with the recent recommendations published by State Coroner Ian Gray in the Finding into the death of Anne Brain [COR 2011 4794], I recommend that the Victorian Department of Health progress the implementation of a Victorian-based real-time prescription monitoring system as a matter of urgency to prevent ongoing harm and deaths associated with pharmaceutical drug misuse and inappropriate prescribing and dispensing of pharmaceutical drugs.

The department's response:

The Coroner's recommendation will be implemented.

The Victorian Government has now committed \$29.5 million over four years in the 2016-17 State Budget to implement a real-time prescription monitoring system in Victoria, as well as workforce packages to support doctors and pharmacists with the implementation of this system.

The department has noted with great concern the data provided by the Coroners Prevention Unit revealing the increasing number of pharmaceutical drug-related deaths in Victoria. The department also acknowledges the more than 20 findings since 2012 that have called for the implementation of a real-time prescription monitoring system in Victoria. We recognise that strong action must be taken to curb the growing problem of pharmaceutical drug misuse in Victoria.

While a national system is best, we agree with the Coroner that Victoria can no longer afford to wait for the other states and territories, and we are now moving ahead with implementation of a



Victorian-based system. We will continue to push hard for all other states and territories to follow our lead in implementing this critical initiative.

Recommendation 2:

While the Victorian Department of Health continues with its efforts to implement a real-time prescription monitoring program for Schedule 8 drug dispensing, I recommend that it also identifies the legislative and regulatory barriers that might prevent drugs listed in other schedules (particularly Schedule 4) from being monitored within the scope of the program. And, if any such barriers are identified, I recommend that the department considered what reforms are necessary so that in due course its real-time prescription monitoring program can be expanded beyond Schedule 8 drugs.

The department's response:

The Coroner's recommendation will be considered on advice from experts.

The department has noted with concern that numerous overdose deaths investigated by Victorian Coroners involve combinations of Schedule 8 and certain Schedule 4 medicines, particularly benzodiazepines. Extensive consultation with medical and pharmacy groups will determine how best to bring into a real-time prescription monitoring system these high risk medicines.

Legislative amendments will be necessary to establish a real-time prescription monitoring system and to provide doctors and pharmacists with access to prescription records contained within the system. These amendments must ensure an agile regulatory framework for real-time prescription monitoring that will have scope to capture those medicines which are deemed necessary to monitor. This will require ongoing vigilance and input from clinicians.

If you require further information, please contact Matthew McCrone, Director, Medicinal Cannabis and Real-Time Prescription Monitoring Taskforces on 9096 5066 or via email matthew.mccrone@dhhs.vic.gov.au.

Yours sincerely



