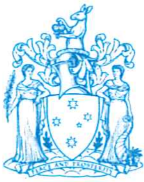

Secretary

Department of Health and Human Services

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7 JUL 2016
CORONERS COURT OF VICTORIA

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Josh Munro
Coroners Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Mr Munro

I am writing in response to your letter dated 6 April 2016 relating to Coroner Audrey Jamieson's recommendations to the Department of Health and Human Services in her finding into the death of Mr Frank Edward Frood.

The Department's response to Coroner Jamieson's recommendations is as follows:

Recommendation:

1. I recommend that the Victorian Department of Health and Human Services review the Policy for maintenance pharmacotherapy for opioid dependence (2013) to ensure it provides adequate and explicit guidance to clinicians on how to manage maintenance pharmacotherapy in patients with asthma or other respiratory conditions.

Department's response:

In her findings, the Coroner also recommends that the Commonwealth Department of Health review the *National guidelines for medication-assisted treatment of opioid dependence* (National Guidelines) to provide such explicit guidance regarding patients with asthma and other respiratory conditions. The National Guidelines is the key reference document that provides clinical guidance on medical treatment involving the use of methadone, buprenorphine or naltrexone for the treatment of opioid dependence.

The Victorian *Policy for maintenance pharmacotherapy for opioid dependence (2013)* is a secondary document that is intended to give guidance to practitioners and pharmacists concerning the Victorian Government's legislative and procedural requirements to support legal and safe maintenance pharmacotherapy. It is not a document with medical status and is not based on independent clinical research. Instead it references the Commonwealth's National Guidelines and other authoritative medical documents and texts concerning all clinical practice issues.

VICTORIA State Government

Accordingly, the Department will make an addendum to its *Policy for maintenance pharmacotherapy for opioid dependence (2013)* and include it on the Drugs and Poisons Regulation website in response to any future Commonwealth changes to the National Guidelines, made in response to the Coroner's recommendations.

Recommendation:

2. I recommend that the Department of Health and Human Services direct Drugs and Poisons Regulation to review the Frankston Healthcare clinicians' diazepam and methadone prescribing to Mr Frood, and determine whether the clinicians require any further training in maintenance pharmacotherapy, prescribing to drug-dependent patients, or the obligations of prescribers under the Drugs, Poisons and Controlled Substances Act 1981 (Vic).

Department's response:

The Coroner's findings regarding the methadone and diazepam prescribing practices of the clinicians at Frankston Healthcare shown in your findings appear concerning. Accordingly Drugs and Poisons Regulation has reviewed the prescribing practices mentioned in the finding but notes that they would result in summary offences only. As they took place over three years ago, they have exceeded the statute of limitations under the *Drugs, Poisons and Controlled Substances Act 1981* (the Act). However, one of the Frankston Healthcare doctors mentioned in your finding was investigated for similar practices within the past year and has been counselled concerning his compliance with the Act. Drugs and Poisons Regulation will also bring this matter to the attention of the local Primary Health Care Network.

I note that the Coroner's findings also address a recommendation to the Australian Health Practitioner Regulation Agency concerning this matter. That agency bears primary responsibility for investigating and addressing unacceptable clinical and professional practices.

Recommendation:

3. Mr Frood's death further reinforces the immediate need for a real-time prescription monitoring system to assist doctors in their clinical decision-making around prescribing, which should not await the involvement of all other states and territories. With this in mind, I recommend that the Victorian Department of Health and Human Services immediately proceed with implementing a real-time prescription monitoring system in Victoria to tackle the ever-increasing toll of pharmaceutical drug related deaths in the state.

Department's response:

The Department notes with serious concern the increasing number of overdose deaths involving pharmaceutical drugs revealed in the Coroners Prevention Unit Data Summary you have provided with your finding, and previously over recent years. The Victorian Government acknowledges that this situation requires a more immediate, responsive and flexible approach to the regulation of pharmaceutical drugs.

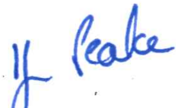
To that effect, the Victorian Government recently announced a commitment of $29.5 million over four years to implement a real-time prescription monitoring system. All key medical and pharmacy stakeholders have been informed of Victoria's initiative and have been very supportive.

Given the relative ease of cross-border prescription shopping and drug diversion, development of a national system would ultimately be the most effective approach to real-time prescription monitoring and the States and Territories are continuing discussions with the Commonwealth Government on this matter.

However, that approach may also take considerable time, so the Victorian Government has agreed to commence by implementing a Victoria-based system. Victoria will continue discussions with the other jurisdictions and provide leadership in development of this very important initiative.

I trust this satisfies the Coroner's recommendations in relation to this matter. If you require further information, please contact Mr Graeme Gillespie, Chief Officer, Drugs and Poisons Regulation on 9096 0422, or email Graeme.Gillespie@dhhs.vic.gov.au.

Yours sincerely



Kym Peake
Secretary
5/7/2016