Secretary
Department of Health & Human Services

50 Lonsdale Street
Melbourne Victoria 3000
Telephone: 1300 650 172
GPO Box 4057
Melbourne Victoria 3001
www.dhhs.vic.gov.au
DX 210081

e3813172

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

Dear Mr Munro,

RE: Court reference COR 2013 002058, Mark Brian Wilson

I am writing in response to your letter dated 27 April 2015 regarding recommendations made by the coroner in the above case.

Thank you for again raising the serious issue of the potential for diversion and misuse of anaesthetic agents from the hospital operating theatre setting. The Department of Health & Human Service's (the Department) response to the coroner's recommendation is as follows:

Coroner's recommendation:

"In light of the response received by Coroner Spanos in the investigation into the death of AB, I recommend that the Department of Health and Human Services consult with Victorian hospitals, the Australian and New Zealand College of Anaesthetists' Welfare of Anaesthetists Special Interest Group and the Victorian Therapeutic Advisory Group and obtain an update in relation to hospital practices now in place to manage and mitigate the risks associated with the misuse of neuromuscular blocking agents and/or general anaesthetic agents by medical and allied health staff. They should report whether there have been any changes in the support guidelines and recommendations following the aforementioned meeting."

Department's response:

The Department first contacted the Victorian Therapeutic Advisory Group (VicTAG) chair in July 2014 to make the group aware of the case of AB and to consider means by which the learnings from this might be implemented in Victorian hospitals. VicTAG considered the case and the issues raised around access to drugs in the operating theatre at its next meeting, and in early May 2015, sent a letter addressed to Victorian hospital Directors of Pharmacy, Directors of Medical Services and Directors of Anaesthesia drawing attention to the matters of concern highlighted in the first case and providing guidance on best practice. The letter requested Victorian hospitals to review their practices and to consider any further measures that could be put in place to reduce misuse of these drugs. Good practice points recommended by VicTAG included:

- Use of lockable anaesthetic trolleys in each theatre. The trolley is locked at the end of the theatre session. Keys for each trolley are held in the theatre control room and accessed via the Anaesthetic Nurse Unit Manager

- Restricted access combination locks on anaesthetic cupboards in anaesthetic rooms. The cupboards are locked at the end of each session.
- Restricted swipe card access for imprest rooms, Drug of addiction safes and Section 11 drug storage.
- Regular auditing to monitor transactions of Drugs of addiction and Section 11 drug items.
- Tamper proof seals on resuscitation trolleys to ensure access is available as needed and identifiable.

The Department has also consulted with the Australian and New Zealand College of Anaesthetists (ANZCA). The ANZCA Manager of Safety and Quality advised that the college is reviewing the relevant professional documents to assess if revision is required in light of the recommendations. The Welfare of Anaesthetists Special Interest Group is doing the same for the guidance material it produces.

The Department advised Coroner Spanos in its response to the previous case that it intended to publish a summarised version of the case with the coroner's recommendations in its RiskWatch newsletter accessed at http://health.vic.gov.au/clinrisk/publications/riskwatch.htm. The RiskWatch newsletter aims to alert all medical practitioners and health services about adverse events, prevention of recurrence of events and recommendations for improved processes in the delivery of health care for Victorians. We advise that this article was published in October 2014.

In June 2015, the Department wrote to the Chief Executives of all Victorian health services with an operating theatre suite to remind them of the best practices in regard to access and storage controls of drugs in the operating theatre (as communicated by VicTAG). Health services were requested to provide an update to the Department on their progress with reviewing practices and any other measures being considered to address these concerns. A total of 27 public health services and 22 private health service providers have responded to date, with responses indicating that Victorian hospitals have acted promptly to review their practices and modify accordingly where required. The Department will continue to monitor the remaining health service responses as they are received.

If you require further information please contact Jonathan Prescott, Acting Manager, Safety Programs on 9096 7258.

Yours sincerely

Dr Pradeep Philip
Secretary
23/7/ 2015