Department of Health
Secretary

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18 JUL 2014

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Ms Claire Coate
Registrar
Coroner's Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Ms Coate

RE: Court reference COR 2012 004565

I am writing in response to your letter addressed to the Secretary, Department of Health (the Department), dated 16 April 2014 regarding recommendations made by the Coroner Spanos in the above case.

Thank you for raising the serious issue of the potential for diversion and misuse of anaesthetic agents from the hospital operating theatre setting. The Department's response to the coroner's recommendations is as follows:

Coroner's recommendations:

1. *That the Victorian Department of Health consult with the RMH Department of Anaesthesia and Pain Management regarding their response to the death of this individual, in particular the changes in place that reduce/regulate access to general anaesthetics and neuromuscular blocking agents.*
2. *That the Victorian Department of Health consult with Victorian hospitals regarding Victorian overdose deaths from misuse of neuromuscular blocking agents and/or general anaesthetic agents, and seek their advice on whether any further measures could be put in place to reduce misuse of these agents.*

Department's response:

1. The Department has consulted with the relevant health service's Department of Anaesthesia and Pain Management regarding this case. The health service has put appropriate measures in place to restrict access to general anaesthetics, including propofol and volatile agents such as sevoflurane. There has been no opposition from staff to the introduction of these changes and no further incidents have occurred.

2. The responsibility for managing and mitigating risk sits with health services, who do this through their clinical risk management committees and associated governance structures. However, the Department has communicated with both the Australian and New Zealand College of Anaesthetists' Welfare of Anaesthetists Special Interest Group (SIG) and the Victorian Therapeutic Advisory Group (VicTAG) regarding this case. The Department will continue to communicate with the Welfare of Anaesthetists SIG who aim to promote personal and psychological wellbeing of anaesthetists and pain medicine specialists and heighten awareness of health issues in anaesthetists. VicTAG will be raising the circumstances and learnings from this case at its next meeting and use these to inform and support guidelines and recommendations around management of drugs in the operating suite in Victorian hospitals.

Furthermore, a summarised version of the case event with Coroner Spanos's recommendations will be published in the next edition of the Department's RiskWatch newsletter accessed at http://www.health.vic.gov.au/clinrisk/publications/riskwatch.htm.

RiskWatch is another medium of communication 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.

If you require further information please contact Ms Theresa Williamson, Manager Quality and Safety Programs on telephone 9096 7258.

Yours sincerely

Dr Pradeep Philip
Secretary