ANZCA
FPM

17 February 2022

Mikaela Meggetto
Coroner's Registrar
Coroners Court of Victoria
65 Kavanagh Street
Southbank VIC 3006

By email: cpuresponses@coronerscourt.vic.gov.au

Dear Ms Meggetto

## Investigation into the death of Michael Anderson (Ref COR 2017 001795)

Thank you for your letter dated 29 October 2021 that included a copy of Coroner Audrey Jamieson's Finding with inquest into the death of Michael Anderson. I am replying on behalf of the Australian and New Zealand College of Anaesthetists in my capacity as the Chair of the college's Safety and Quality Committee.

Coroner Jamieson made recommendations that our college:

- Develop guidelines around the use of conscious sedation/anaesthesia, including but not necessarily limited to Propofol, in the dental practice setting on patients within WHO Class II and Class III obesity, with the aim of promoting public health and safety through addressing the increased risks to health by obesity.
- Use the circumstances surrounding the death of Michael Peter Anderson as an educational tool for emphasising the importance of documenting vital signs following the administration of anaesthetic, with the aim of promoting public health and safety through ongoing professional development of our members.

Our college develops and maintains a series of professional documents to promote quality and safety in all domains of anaesthesia practice. They define the college's requirements for training and for hospitals providing such training, they provide guidance on standards of anaesthesia practice, and convey the college's position on particular matters.

We commenced a process in February 2020 to collaboratively review and co-badge our professional document *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures* with 26 other stakeholders involved in the sedation of patients in the course of their clinical work in Australia and New Zealand. Dental stakeholders include the Royal Australian College of Dentists, Australian Dental Association, and the Australian Society of Dental Anaesthetists. At its next meeting scheduled for 4 February 2022 this matter will be added as an agenda item for discussion by all stakeholders.

ANZCA
FPM

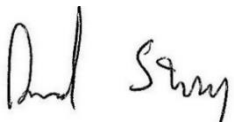
Reference to documenting vital signs following the administration of anaesthetic appears in several college professional documents:

- PG06(A) *Guideline on the anaesthesia record* on page 4, item 6.3.5 https://www.anzca.edu.au/getattachment/7a980821-2346-4659-80ab-b85c209d8254/PG06(A)-Guideline-on-the-anaesthesia-record-(PS06)#page=
- PG18(A) *Guideline on monitoring during anaesthesia* on page 2, item 5.6.1 https://www.anzca.edu.au/getattachment/0c2d9717-fa82-4507-a3d6-3533d8fa844d/PS18-Guideline-on-monitoring-during-anaesthesia#page=
- PG18(A)BP *Guideline on monitoring during anaesthesia Background Paper,* page 2, item 4.4 https://www.anzca.edu.au/getattachment/d2ef10af-bfad-4e1a-8e6d-cdb4d7555cc8/PS18BP-Guideline-on-monitoring-during-anaesthesia-Background-Paper#page=

We regularly highlight clinical issues for the attention of anaesthetists through our quarterly publication, the ANZCA Bulletin, and can include discussion of these matters in an upcoming edition.

On behalf of our college, I thank Coroner Jamieson for making this recommendation to our college. Should you require any further information, please contact our college staff via email to sq@anzca.edu.au.

Yours sincerely



Professor David Story
**Chair, Safety and Quality Committee**