ACT Government Health | CANBERRA HOSPITAL AND HEALTH SERVICES

[redacted]

Dear [redacted]

I refer to correspondence regarding the request made by you for information under the *Freedom of Information Act 1989* (the FOI Act) to:

> *All documents relating to investigations into methadone stolen from, or otherwise unaccountable for by, hospital, medical centres and methadone clinics in the Australian Capital Territory from 2002 until 14 March 2012, and*
>
> *Records of the quantities of methadone stolen from, or otherwise unaccountable for by, hospital, medical centres and methadone clinics in the Australian Capital Territory from 2002 until 14 March 2012.*

As Executive Director, Mental Health, Justice Health and Alcohol and Drug Services, ACT Government Health Directorate, I am an officer authorised under Section 22 of the FOI Act to make a decision in relation to this matter.

After conducting a thorough search of all relevant ACT Government Health Directorate records, documents were identified that fall within the ambit of your request.

I have decided to exempt certain documents, or part thereof, under the following provisions of the FOI Act:

- **S21 Deletion of exempt matter;**
- **S38 Documents to which secrecy provisions of enactments apply; and**
- **S41 Documents affecting personal privacy.**

In making my decision I have considered the sections of legislation listed at **Attachment A** to this letter. In addition, I have provided a Statement of Reasons for my decisions, at **Attachment B**.

GPO Box 825 Canberra City ACT 2606 | phone: 02 6205 1313 | www.health.act.gov.au

If you wish to seek a review of this decision you should write to:

The Principal Officer
c/- FOI Coordinator
Executive Coordination
Health Directorate
GPO Box 825
CANBERRA ACT 2601

You have 28 days from the date of this letter to seek a review of the outcome or such other period as the Principal Officer/ Secretary permits.

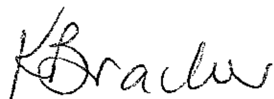
You also have the right to complain to the Ombudsman about the progression of your request. If you wish to lodge a complaint you should write to:

The Ombudsman
GPO Box 442
CANBERRA CITY ACT 2601

In accordance with the recent ACT Government policy on open government I advise that all written material made available to an applicant under an FOI will be published online within 15 days.

Should you have any queries in relation to this matter please contact Fraser Powrie, Freedom of Information Coordinator on telephone 6205 1340 or Fraser.Powrie@act.gov.au.

Yours sincerely



Ms Katrina Bracher
Executive Director
Mental Health, Justice Health, Alcohol and Drug Services

12 April 2012

Attachment A

Sections of relevant legislation that have been considered by the Decision Maker in determining the status of each document:

Freedom of Information Act 1989 (FOI Act)

Section 21 of the FOI Act – Deletion of exempt matter

(1) Where—

(a) a decision is made not to grant a request for access to a document on the ground that it is an exempt document; and

(b) it is possible for the agency or Minister to make a copy of the document with such deletions that the copy would not be an exempt document and would not, because of the deletions, be misleading; and

(c) it is reasonably practicable for the agency or Minister, having regard to the nature and extent of the work involved in deciding on and making those deletions and the resources available for that work, to make such a copy;

the agency or Minister shall, unless it is apparent from the request or as a result of consultation by the agency or Minister with the applicant, that the applicant would not wish to have access to such a copy, make, and grant access to, such a copy.

(2) Where access is granted to a copy of a document in accordance with subsection (1)—

(a) the applicant shall be informed—

(i) that it is such a copy; and

(ii) of the provision of this Act by virtue of which any matter deleted is exempt matter; and

(b) section 25 does not apply to the decision that the applicant is not entitled to access to the whole of the document unless the applicant requests the agency or Minister to give to the applicant a notice in writing in accordance with that section.

Section 38 of the FOI Act – Documents to which secrecy provisions of enactments apply

A document is an exempt document if there is in force an enactment applying specifically to information of a kind contained in the document and prohibiting persons referred to in the enactment from disclosing information of that kind, whether the prohibition is absolute or is subject to exceptions or qualifications.

Section 41 of the FOI Act - Documents affecting personal privacy

(1) A document is an exempt document if its disclosure under this Act would involve the unreasonable disclosure of personal information about any person (including a deceased person).

(2) Subject to subsection (3), subsection (1) does not apply to a request by a person for access to a document only because of the inclusion in the document of matter relating to that person.

(3) Where—

(a) a request is made to an agency or Minister for access to a document of the agency, or an official document of the Minister, that contains information of a medical or psychiatric nature concerning the person making the request; and

(b) it appears to the principal officer of the agency, or to the Minister, as the case may be, that the disclosure of the information to that person might be prejudicial to the physical or mental health or wellbeing of that person;

the principal officer or Minister may direct that access to the document, so far as it contains that information, that would otherwise be given to that person is not to be given to that person but is to be given instead to a doctor to be nominated by that person.

Health Act 1993 (Health Act)

Section 124 of the Health Act – What is *sensitive information*?

In this Act:

sensitive information means information that—

(a) identifies a person who—

(i) has received a health service; or

(ii) is a health service provider; or

(iii) has provided information to a quality assurance committee under section 35 (Quality assurance committees—obtaining information) or otherwise in the course of the committee carrying out the committee's functions under this Act; or

(iv) has provided information to a scope of clinical practice committee under section 64 (Scope of clinical practice committees—obtaining information) or otherwise in the course of the committee carrying out the committee's functions under this Act; or

(b) would allow the identity of the person to be worked out.

Section 125 of the Health Act - Offence—secrecy of protected information

(1) An information holder commits an offence if—

(a) the information holder—

(i) makes a record of protected information about someone else; and

(ii) is reckless about whether the information is protected information about someone else; or

(b) the information holder—

(i) does something that divulges protected information about someone else; and

(ii) is reckless about whether—

(A) the information is protected information about someone else; and

(B) doing the thing would result in the information being divulged to another person.

Maximum penalty: 50 penalty units, imprisonment for 6 months or both.

(2) This section does not apply to the making of a record or the divulging of information if the record is made or the information divulged—

(a) under this Act; or

(b) in the exercise of a function, as an information holder, under this Act.

(3) This section does not apply to the making of a record or the divulging of information if—

(a) the protected information is not sensitive information; and

(b) the record is made or the information divulged—

(i) under another territory law; or

(ii) in the exercise of a function, as an information holder, under another territory law.

(4) This section does not apply to the divulging of protected information about someone with the person's agreement.

(5) An information holder must not divulge protected information to a court, or produce a document containing protected information to a court, unless it is necessary to do so for this Act.

Note A quality assurance committee may give protected information to the Coroner's Court (see s 43).

(6) In this section:

court includes a tribunal, authority or person with power to require the production of documents or the answering of questions.

produce includes allow access to.

Attachment B

Statement of Reasons for decisions made in relation to documents within the scope of the applicant's request

Folios	Explanation
1-7 14-15 18-19 23-30 31-111	In considering the release, non-release or partial release of these documents I have determined the following: • **Section 21 of the FOI Act** has been applied to allow the document to be partially released to you. • **Section 38 of the FOI Act** has been applied as the document contains information relevant to secrecy provisions in the Health Act. There is no public interest test in relation to this section of the Act. • **Section 41 of the FOI Act** has been applied as the document contains information that is personal health information as it forms part of a medical record. There is no public interest test in relation to this provision of the FOI Act. • **Section 124 and of the Health Act** has been applied as the document contains sensitive information that identifies a person who is a health service provider; or has provided information to a quality assurance committee under section 35 of the Health Act. • **Section 125 of the Health Act** has been applied as the disclosure of these documents would be an offense under the Act.

SCHEDULE OF DOCUMENTS

[redacted] - FOI 12/22

FOLIO	ITEM	STATUS	REASON FOR EXEMPTION	Internet publication – YES/NO – if no, why not
1-7	Email from Sharon Swain to Katrina Bracher regarding methadone unable to be accounted for and attached Riskman report – Non individual – Methadone bottle empty.	Full release	Nil	Yes
8-9	Ministerial brief – incident regarding a missing methadone does at the Alexander Maconochie Centre.	Full release	Nil	Yes
10-11	Riskman report – Non individual – drug book error.	Full release	Nil	Yes
12-13	Riskman report – Non individual – methadone bottle empty.	Full release	Nil	Yes
14-15	Riskman report – Non individual – 11B medication room.	Partial release	• **Section 41 of the FOI Act** has been applied as this document contains personal information about a person. • **Section 21 of the FOI Act** has been applied to allow the documents to be partially released to you.	Documents released online in accordance with the "Reason for Exemption" status
16-17	Riskman report – Non individual – methadone stock in S8 safe.	Full release	Nil	Yes

18-19	Riskman report – Non individual – methadone 5mg/ml: hospital register number 06291-06300.	Partial release	• **Section 41 of the FOI Act** has been applied as this document contains personal information about a person. • **Section 21 of the FOI Act** has been applied to allow the documents to be partially released to you.	Documents released online in accordance with the "Reason for Exemption" status
20	Hospital register number 06291-06300.	Full release	Nil	Yes
21-22	Riskman report – Non-individual – methadone delivery	Full release	Nil	Yes
23-30	Incident reports at the AMC.	Partial release	• **Section 41 of the FOI Act** has been applied as this document contains personal information about a person. • **Section 21 of the FOI Act** has been applied to allow the documents to be partially released to you. • Redactions relates to matters out of scope to the FOI request.	Documents released online in accordance with the "Reason for Exemption" status
31-32	File note – Missing methadone tablets – incident at TCH early February 2006.	Partial release	• **Section 41 of the FOI Act** has been applied as this document contains personal information about a person. • **Section 21 of the FOI Act** has been applied to allow the documents to be partially released to you.	Documents released online in accordance with the "Reason for Exemption" status
33	Letter to Dr Guest regarding stolen regulated medicines.	Partial release	• **Section 41 of the FOI Act** has been applied as this document contains personal information about a person. • **Section 21 of the FOI Act** has been applied to allow the documents to be partially released to you. • Redactions relates to matters out of scope to the FOI request.	Documents released online in accordance with the "Reason for Exemption" status
34	Letter from Health Protection Services regarding recorded balance of methadone hydrochloride oral liquid.	Partial release	• **Section 41 of the FOI Act** has been applied as this document contains personal information about a person. • **Section 21 of the FOI Act** has been applied to allow the documents to be partially released to you. • Redactions relates to matters out of scope to the FOI request.	Documents released online in accordance with the "Reason for Exemption" status

35- 111	Action minutes of the Community Health Clinical Review Committee	Exempt	• **Section 38 of the FOI Act** has been applied as the document contains information relevant to secrecy provisions in the *Health Act 1993*. There is no public interest test in relation to this provision of the FOI Act. • **Section 21 of the FOI Act** has been applied to allow the documents to be partially released to you. • **Section 124 (a)(i) and (a)(ii) of the Health Act** has been applied as the document contains sensitive information that identifies a person who has received a health service; or is a health service provider. • **Section 125(1)(b)(i) and (ii) of the Health Act** has been applied as I believe that divulging the protected information about someone else would be reckless and would be an offence under this section of the Health Act.	Documents released online in accordance with the "Reason for Exemption" status

I

From: Swain, Sharon
Sent: Friday, 9 July 2010 2:47 PM
To: Bracher, Katrina
Subject: RE: Day 1 high risk incident - RiskMan ID: 186862 - methadone unable to be accounted for

Great, thanks Tina

Kind regards

Sharon

Sharon Swain
Clinical Risk Coordinator
Patient Safety and Quality Unit
ACT Health

Building 6, Level 2
Canberra Hospital
Email: sharon.swain@act.gov.au
Ph: 6205-3280

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From: Bracher, Katrina
Sent: Friday, 9 July 2010 2:35 PM
To: Swain, Sharon
Subject: RE: Day 1 high risk incident - RiskMan ID: 186862 - methadone unable to be accounted for

I did it

Put a few comments in too

ta

From: Swain, Sharon
Sent: Friday, 9 July 2010 2:07 PM
To: Bracher, Katrina
Subject: Day 1 high risk incident - RiskMan ID: 186862 - methadone unable to be accounted for

Hi Tina,

Please see attached Day 1 high risk incident report for RiskMan ID: 186862 – Methadone unaccounted for.

<< File: Methadone unaccounted 186862.pdf >>
I have had phone tag today with Vera and made attempts to contact Gayle to gain further information today on this incident i.e. whether any prisoners were adversely affected, although conscious this should be submitted today and the day is getting on.

Please let me know if you would like to hold off for this information or if you are happy to submit with the content that is there. If happy with content and to submit I'm happy to submit on your behalf if you'd like – just let me know .

Kind regards

Sharon

Sharon Swain
Clinical Risk Coordinator
Patient Safety and Quality Unit
ACT Health

Building 6, Level 2
Canberra Hospital
Email: sharon.swain@act.gov.au
Ph: 6205-3280

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Sharon Swain
Clinical Risk Coordinator
Patient Safety and Quality Unit
ACT Health

Building 6, Level 2
Canberra Hospital
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Ph: 6205-3280

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From: Bracher, Katrina
Sent: Friday, 9 July 2010 9:16 AM

To: Swain, Sharon
Subject: RE: RiskMan ID: 186862 - methadone unable to be accounted for

Yes please

From: Swain, Sharon
Sent: Thursday, 8 July 2010 4:10 PM
To: Bracher, Katrina
Subject: RiskMan ID: 186862 - methadone unable to be accounted for
Importance: High

Hi Tina,

Re: RiskMan ID: 186862 – Bottle of methadone unable to be accounted for in medication round

I just read this incident and identified it as a possible high risk incident. After speaking with Vera, I understand a ministerial brief is being written. Would you like this to be reported as a high risk incident through in line with the SIB process also?

Thanks Tina

Kind regards

Sharon

Sharon Swain
Clinical Risk Coordinator
Patient Safety and Quality Unit
ACT Health

Building 6, Level 2
Canberra Hospital
Email: sharon.swain@act.gov.au
Ph: 6205-3280

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Who did the incident happen to?

Incident Involved: Non-Individual
Surname: Bottle of Methadone Missing
Street:
Suburb/City:
Postcode:
Country:

When did the incident occur?

Incident Date: 8 July 2010
Incident Time: 08:00
Notification Date: 8 July 2010
Sterilising Services?: No

What happened in the incident?

Summary: Bottle of methadone was unable to be accounted for during the court medication round

Details: At approximatley 0800 during the court medication round a bottle of methadone for [redacted] was not able to be located. Prior to dispensing any medications the officer incharge was unable to house me in the hutch as it was locked and unable to be opened. During dispensing 4 officers were present and multiple inmates were walking past the medication trolley at various times. When preparing to dose [redacted] it became evident that his pre dispensed methadone was not present. At this time I double checked the court medication container, medication trolley, contacted the sentenced nurse to see if she had the methadone and double checked the cupboards and garbage bins. I also asked one of the officers to check the inmates but was told that wasn't necessary. When I returned to the clinic I asked the nurse on duty the night before who packed the medications and she was certain it had been packed. I then informed the CNC of the above.

SI Details: At ~8:00 on 8 July 2010 during the court medication round, a bottle of methadone for a prisoner, [redacted] was not able to be located.

Medications are usually dispensed from "the hutch", a secure area behind a counter with a roller door. The roller door was locked and the key could not be located by the officer in charge so the nurse dispensed the medication from the trolley beside the counter in the admissions area. Two officers were in attendance while the nurse was dispensing medications, a third officer was raoming the vicinity and a fourth officer in an office located close by. Multiple prisoners walked past the medication trolley at various times. One prisoner touched the medication trolley.

When preparing to dose [redacted] it became evident to the nurse that his pre-dispensed methadone was not present. The court medication container and medication trolley were double checked by the dispensing nurse. The nurse on duty the night before was also contacted and she was certain the methadone had been packed. All clinical areas including rubbish bins were also searched. The methadone bottle was unable to be located. The nurse also asked the custodial officers if the prisoners to be searched. The nurse was told it wasn't necessary. [redacted] was dispensed his correct dose of methadone from standing order stock.

The Corrections Health CNC was notified of the incident at ~10:00. The CNC notified the admissions officer and all holding cells in the admissions area were searched. All nine prisoners were then searched also.

The missing dose is 55mg. Three out of the nine prisoners are on methadone, with a fourth having ceased methadone 3 weeks ago. The prisoner that ceased the methadone 3 weeks ago was the prisoner that touched the trolley.

All nine prisoners are on camera in the CTU and all are observed every 15 minutes. Corrective Services staff were told to notify Corrections Health staff if any prisoner appears sedated.

The superintendent was made aware of the incident and CCTV footage will be reviewed and investigated by Corrective Services.

Refer to controls implemented.

Incident Outline:
Date R.O.I. Received:
Date R.O.I. Prepared:
Outline Prepared By:
Origin of Incident Report:
Reporter's Name: Noble, Samuel
Reporter's Position: Registered Nurse / Midwife
Contact Phone: 0431736373
Reviewed By: Clinical Nurse Consultant (CNC)
Reviewed By Name: Gayle Berthold
Treatment Given:
Steps Taken By:
Steps Taken:

Investigations/Findings: Incident reported to me by nurse on return from medication round approximately 1000hrs. Admissions officer notified, and all holding cells in admissions area searched, CTU senior officer notified immediately and all 9 prisoners were searched, all clinical areas of heath including rubbish bins searched and methadone unable to be located

One prisoner touched the medication trolley and left a piece of sticky tape on the trolley. The nurse asked for the prisoners to be checked and the officer declined. and said it was not necessary.

The nurse usually dispenses the medication behind a counter that has a roller door. The roller door was locked this morning and the key could not be located therefore the nurse dispensed the medication from the trolley beside the counter in the admissions area. There were 2 officers in attendence whilst the medication was being dispensed. One officer roving and one officer in the office located near by.

The missing dose is 55mg. 3 out of the 9 clients are on methadone and one recently ceased 3 weeks ago. The client that ceased methadone is the client that touched the trolley.

All 9 prisoners are on camera in CTU and all prisoners are observed every 15 mins. CTU staff are aware to notify health staff if anyone appears sedated.

The superintendent is aware of the incident and CCTV footage will be reviewd and investigated by Corrective Services.

Investigated By: Gayle Berthold

Controls Implemented: All staff have been sent a reminder email that all medictions are to be dispensed behind the counter in admissions area. If the roller door is locked all staff are to insist it is opened before medication can be administered. Corrective Services will send an email to all their staff to inform them of this also

Deceased: No

Coroner Notified: No

Autopsy performed: No

Date of Death:

Time Of Death:

Next Of Kin Notified: No

Police Notified?: No

Date of Notification to Insurer:

Insurer Notif Mode:

Personnel Involved

Person #1: Noble, Samuel

Person #1 Position: Registered Nurse / Midwife

Person #2: Gayle Berthold

Person #2 Position: Clinical Nurse Consultant (CNC)

VMO: No

Admitting Specialist:

Code Blue/MET?: No

Outcome: Minor

Significant Incident Level: High Risk

Significant Incident Type: Incident with potential to attract immediate significant media attention

Contributing Factors

Classification		
Medication	Medication Involved	Other
Medication	Medication Management	
Medication	Administration Related	

Risk Rating:

Potential Risk Rating:

Significant Incident Details

Significant Incident Category: Reputation

Person Responsible for SI Report: Sharon Swain

Initial SI Report: Yes

Media Interest: No

Complaint by Family/Carer: No

Circumstances Likely to evoke service sensitivities : No

Initial SI Comments: Ministerial brief being prepared. No report of advserse outcome to any individual. Referral made to CRC.

Initial Report Submitted: Yes

Initial Report Submitted By: General Manager, Community Health (Community Health General Manager)

Date Initial Report Submitted: 9 July 2010

Interim SI Report: No

Interim Status Update:

Interim Investigation Type:

Interim Clinical Review/Investigation Status:

Interim ongoing action still required: No

Interim SI Comments:

Interim Report Submitted: No

Date Interim Report Submitted:

Interim Report Submitted By:

Final SI Report: Yes

Final Status Update: CCTV: client seen putting bottle up sleeve, bottle never found. Client was the client who ceased methadone 3 wks prior to the incident. No further incidents. Correct staff process added to SOP.

Final Investigation Type: Internal Investigation

Final Clinical Review/Investigation Status: Investigation concluded

Final ongoing action still required: No

Final SI Comments:

Final Report Submitted: Yes

Final Report Submitted By: Swain, Sharon (Sharon Swain)

Date Final Report Submitted: 27 August 2010

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):

Debriefing Date (Pt/Client):

Debriefing Time (Pt/Client):

Pt/Client Debriefed By:

Open Disclosure Comments (Pt/Client):

Follow-Up Status (NOK):

Debriefing Date (NOK):

Debriefing Time (NOK):

Next Of Kin Debriefed By:

Open Disclosure Comments (NOK):

Follow-Up Status (Carer):

Debriefing Date (Carer):

Debriefing Time (Carer):

Carer Debriefed By:

Open Disclosure Comments (Carer):

Follow-Up Status (Family):

Debriefing Date (Family):

Debriefing Time (Family):

Family Debriefed By:

Open Disclosure Comments (Family):

Open Disclosure Status (Pt/Client):

Open Disclosure Date (Pt/Client):

Open Disclosure Time (Pt/Client):

Disclosure completed by (Pt/Client):

Open Disclosure Status (NOK):

Open Disclosure Date (NOK):

Open Disclosure Time (NOK):

Disclosure completed by (NOK):

Open Disclosure Status (Carer):

Open Disclosure Date (Carer):

Open Disclosure Time (Carer):

Disclosure completed by (Carer):

Open Disclosure Status (Family):

Open Disclosure Date (Family):

Debriefing Time (Family):

Disclosure completed by (Family):

Review Dates

FLAGS

Admission 1

£ ;sion2

Refer to Clinical Review Committee

Date referred to CRC:

Associated Risks

No Associated Risk.

Journal Entries

Date/Time	Journal Entry	Reference	Cost
Journal Type:	General Comments		
Created by: 08 Jul 10 15:38:00	Swain, Sharon In discussion with Ag Director, Corrections Health, prisoner identified as [redacted] recieved correct dose of methadone from standing order stock. Clinical Risk Coordinator. Actioned: No Linked Document Path:	Mail Sent On:	
Journal Type:	General Comments		
Created by: 08 Jul 10 15:41:00	Van de Velde, Vera Hi Gayle. Can you please clarify if the prisoners were searched in the Court transfer holding area, or had they already left AMC for court? Actioned: No Linked Document Path:	Mail Sent On:	
Journal Type:	General Comments		
Created by: 27 Aug 10 10:54:00	Swain, Sharon In discussed with Corrections Health CNC, no further incidents have occurred. Correct staff processes (administration of methadone to occur behind the screen only) added to local SOP and supported by Corrective Services staff. Day 100/final reported submitted on behalf of GM, Community health. Clinical Risk Coordinator. Actioned: No Linked Document Path:	Mail Sent On:	

Documents

No Attached Documents.

MINISTERIAL BRIEF

GPO Box 825 Canberra ACT 2601
Website: www.health.act.gov.au
ABN: 82 049 056 234

To: Katy Gallagher MLA, Minister for Health

Subject: Incident regarding a missing methadone dose at the Alexander Maconochie Centre.

Through: Dr Peggy Brown, ~~Chief Executive~~ 21/7/10

Critical date and reason

N/A

Purpose of Brief

To provide information about an incident regarding a missing dose of methadone that occurred on 8 July 2010 at the Alexander Maconochie Centre (AMC).

Issues/Background

2. Clients at AMC who are attending court for the day are usually administered their methadone early in the morning in a secure area of the admission area of AMC by a nurse from the Corrections Health Program (CHP). Client methadone is pre-dispensed by Devlin's Pharmacy and bottles are clearly labelled with client's name and date for administration.

3. Prior to dispensing any medications during the court medication round on 8 July 2010, the Corrective Services Officer in charge of the admissions area was unable to house the nurse in the secure dosing area as it was locked and a key was not accessible. The nurse then proceeded to dispense the medications from the trolley in the general admissions area. During this medication round a bottle of methadone for one client was not able to be located although it had been counted onto the medication trolley. The bottle contained 55 mg of methadone. There were four Corrective Service Officers present during dispensing and prisoners were walking past the medication trolley at various times. When preparing to dose one of the clients it became evident that his pre-dispensed methadone of 55 mg was not present.

4. A search of the court medication container, the medication trolley, the cupboards and garbage bins did not locate the missing methadone. The client whose dose was missing was then dosed from standing orders stock. The nurse asked the Corrections Services Officer for the prisoners to be checked and the officer declined stating it was not necessary. The CHP Clinical Nurse Consultant (CNC) was notified and a Riskman report completed.

5. The CNC contacted the officer in charge of the admission area and all holding cells were searched. The Court Transport Unit (CTU) officer was notified and all prisoners who had been present in the admissions area were searched. All prisoners who were present at the time were also observed every 15 minutes and CTU staff advised to notify health staff if anyone appeared sedated. There have been no reports that any of these prisoners were suffering adverse effects. The Superintendent of AMC was notified and a request made to check CCTV footage taken in the admissions area during the time the dispensing took place. This footage showed one of the prisoners taking the methadone off the trolley and hiding it in the sleeve of his suit. ACT Corrective Services are managing the disciplinary action for the prisoner concerned.

6. Following a number of recent methadone incidents, all CHP Nursing staff are now required to complete a four week placement at the Alcohol and Drug Program for professional development. The nurse involved in this incident has been counselled and all nursing staff have been directed that all medications are only to be dispensed from the secure area in the admissions area. If the roller door is locked all staff are to insist it is opened before medication can be administered.

7. The CHP Director will discuss this incident and the mitigation options with the Superintendent of AMC, during their weekly scheduled meeting. The Community Health Clinical Review Committee (CRC) has recommended that a centralised dosing area for methadone be investigated. This investigation is currently in progress.

Media

8. There is the potential for adverse media.

Recommendations

9. That you note the above information.

Katrina Bracher
General Manager Community Health

Action Officer: Vera van de Velde
Phone: 62053373

AGREED / NOT AGREED / NOTED / PLEASE DISCUSS

Katy Gallagher 23/7/10
Katy Gallagher MLA

Incident ID: 12906

Who did the incident happen to?

Incident Involved: Non-Individual
Surname: Drug Book error
Street:
Suburb/City:
Postcode:
Country:

When did the incident occur?

Incident Date: 6 March 2007
Incident Time: 19:00
Notification Date: 6 March 2007
Sterilising Services?: No

What happened in the incident?

Summary: Drugs Register discrepancy
Details: 26 mls methodone documented in S8 Drugs Register, only 13 mls actually in S8 cupboard
SI Details:
Incident Outline:
Date R.O.I. Received:
Date R.O.I. Prepared:
Outline Prepared By:
Origin of Incident Report:
Reporter's Name: Buchanan, Gaye
Reporter's Position: Registered Nurse / Midwife
Contact Phone:
Reviewed By Name:
Reviewed By:
Treatment Given:
Steps Taken By:
Steps Taken:
Investigations/Findings: 13mls Methadone checked into S8 cupboard only - however - pharmacist & RN recorded it as 26mls received. Error noted and pharmacist entered in comments column ERROR, however, did not continue to re-enter correct amount in the column. Staff from next shift noted error on checking S8 counts at change of shift. Pharmacist informed of error as well as RN. For comment by Pharmacy director
Investigated By: Leanne Oakman, CNC 9A
Controls Implemented:
Deceased: No
Coroner Notified: No
Autopsy performed: No
Date of Death:
Time Of Death:
Next Of Kin Notified: No
Police Notified?: No
Date of Notification to Insurer:
Insurer Notif Mode:

Pe[illegible]nnel Involved

Person #1:
Person #1 Position:
Person #2:
Person #2 Position:
Admitting Specialist:
VMO: No
Code Blue/MET?: No
Outcome: Insignificant
Significant Incident Level:
Significant Incident Type:

Contributing Factors

Classification

Treatment Support	Documentation	Documentation Error
Old Medication Data	Medication Form / Route	Medication
Old Medication Data	Medication Form / Route	Oral
Old Medication Data	Medication Error	Drug Register Error / Discrepancy

Risk Rating:
Potential Risk Rating:

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):
Open Disclosure Status (Pt/Client):
Debriefing Date (Pt/Client):
Open Disclosure Date (Pt/Client):
Debriefing Time (Pt/Client):
Open Disclosure Time (Pt/Client):
Pt/Client Debriefed By:
Disclosure completed by (Pt/Client):

Open Disclosure Comments (Pt/Client):
Follow-Up Status (NOK):
Debriefing Date (NOK):
Debriefing Time (NOK):
Next Of Kin Debriefed By:
Open Disclosure Comments (NOK):

Open Disclosure Status (NOK):
Open Disclosure Date (NOK):
Open Disclosure Time (NOK):
Disclosure completed by (NOK):

Follow-Up Status (Carer):
Debriefing Date (Carer):
Debriefing Time (Carer):
Carer Debriefed By:
Open Disclosure Comments (Carer):

Open Disclosure Status (Carer):
Open Disclosure Date (Carer):
Open Disclosure Time (Carer):
Disclosure completed by (Carer):

Follow-Up Status (Family):
Debriefing Date (Family):
Debriefing Time (Family):
Family Debriefed By:
Open Disclosure Comments (Family):

Open Disclosure Status (Family):
Open Disclosure Date (Family):
Debriefing Time (Family):
Disclosure completed by (Family):

Review Dates

FLAGS

Admission 1

Admission2

Refer to Clinical Review Committee

Date referred to CRC:

Associated Risks

No Associated Risk.

Journal Entries

Documents

No Attached Documents.

Incident ID: 131669

Who did the incident happen to?

Incident Involved: Non-Individual
Surname: Methadone bottle empty
Street:
Suburb/City:
Postcode:
Country:

When did the incident occur?

Incident Date: 14 August 2009
Incident Time: 09:30
Notification Date: 14 August 2009
Sterilising Services?: No

What happened in the incident?

Summary: Methadone bottle empty
Details: Opened methadone 10mg bottle, seal intact, however bottle completely empty & dry.
SI Details:
Incident Outline:
Date R.O.I. Received:
Date R.O.I. Prepared:
Outline Prepared By:
Origin of Incident Report:
Reporter's Name: Carter, Shane
Reporter's Position: Registered Nurse / Midwife
Contact Phone: 62072933
Reviewed By:
Reviewed By Name:
Treatment Given:
Steps Taken By:
Steps Taken:
Investigations/Findings:
Investigated By:
Controls Implemented:
Deceased: No
Coroner Notified: No
Date of Death:
Autopsy performed: No
Time Of Death:
Next Of Kin Notified: No
Police Notified?: No
Date of Notification to Insurer:
Insurer Notif Mode:

Personnel Involved

Person #1:
Person #1 Position:
Person #2:
Person #2 Position:
Admitting Specialist:
VMO: No
Code Blue/MET?: No
Outcome: Insignificant
Significant Incident Level:
Significant Incident Type:

Contributing Factors

Classification

Medication | Medication Management | S8 Broken / Split Ampoule

Risk Rating:
Potential Risk Rating:

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):
Open Disclosure Status (Pt/Client):
Debriefing Date (Pt/Client):
Open Disclosure Date (Pt/Client):
Debriefing Time (Pt/Client):
Open Disclosure Time (Pt/Client):
Pt/Client Debriefed By:
Disclosure completed by (Pt/Client):
Open Disclosure Comments (Pt/Client):
Follow-Up Status (NOK):
Open Disclosure Status (NOK):
Debriefing Date (NOK):
Open Disclosure Date (NOK):
Debriefing Time (NOK):
Open Disclosure Time (NOK):
Next Of Kin Debriefed By:
Disclosure completed by (NOK):
Open Disclosure Comments (NOK):
Follow-Up Status (Carer):
Open Disclosure Status (Carer):
Debriefing Date (Carer):
Open Disclosure Date (Carer):

Debriefing Time (Carer):
Carer Debriefed By:

Open Disclosure Comments (Carer):
Follow-Up Status (Family):

Debriefing Date (Family):
Debriefing Time (Family):
Family Debriefed By:

Open Disclosure Comments (Family):

Open Disclosure Time (Carer):
Disclosure completed by (Carer):

Open Disclosure Status (Family):
Open Disclosure Date (Family):
Debriefing Time (Family):
Disclosure completed by (Family):

Review Dates

FLAGS

Admission 1

Admission2

Refer to Clinical Review Committee

Date referred to CRC:

Associated Risks

No Associated Risk.

J rnal Entries

Documents

No Attached Documents.

H

Who did the incident happen to?

Incident Involved: Non-Individual
Surname: [redacted]
Street:
Suburb/City:
Postcode:
Country:

When did the incident occur?

Incident Date: 3 June 2010
Incident Time: 15:00
Notification Date: 3 June 2010
Sterilising Services?: No

What happened in the incident?

Summary: 11B Medication room. During a regular shift S8 medication check, it was noticed that a singular Methadone tablet was missing.
Details: 11B Medication room. During a regular shift S8 medication check, it was noticed that a singular Methadone tablet was missing. After re-checking the count, notified Nurse in charge, and notified pharmicist.
SI Details:
Incident Outline:
Date R.O.I. Received:
Date R.O.I. Prepared:
Outline Prepared By:
Origin of Incident Report:
Reporter's Name: Almoros, Walter
Reporter's Position: Registered Nurse / Midwife
Contact Phone:
Reviewed By Name:
Reviewed By:
Treatment Given:
Steps Taken By:
Steps Taken:
Investigations/Findings: Pharmacist notified,Methadone tablets returned to pharmacy.
Investigated By:
Controls Implemented:
Deceased: No
Coroner Notified: No
Autopsy performed: No
Date of Death:
Time Of Death:
Next Of Kin Notified: No
Police Notified?: No
Insurer Notif Mode:
Date of Notification to Insurer:

Personnel Involved

Person #1:
Person #1 Position:
Person #2:
Person #2 Position:
VMO: No
Admitting Specialist:
Code Blue/MET?: No
Outcome: Insignificant
Significant Incident Type:
Significant Incident Level:

Contributing Factors

Classification

Medication | Medication Management | Incorrect Drug Count

Risk Rating:
Potential Risk Rating:

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):
Open Disclosure Status (Pt/Client):
Debriefing Date (Pt/Client):
Open Disclosure Date (Pt/Client):
Debriefing Time (Pt/Client):
Open Disclosure Time (Pt/Client):
Pt/Client Debriefed By:
Disclosure completed by (Pt/Client):
Open Disclosure Comments (Pt/Client):
Follow-Up Status (NOK):
Open Disclosure Status (NOK):
Debriefing Date (NOK):
Open Disclosure Date (NOK):
Debriefing Time (NOK):
Open Disclosure Time (NOK):
Next Of Kin Debriefed By:
Disclosure completed by (NOK):

Open Disclosure Comments (NOK):
Follow-Up Status (Carer):
Debriefing Date (Carer):
Debriefing Time (Carer):
Carer Debriefed By:

Open Disclosure Status (Carer):
Open Disclosure Date (Carer):
Open Disclosure Time (Carer):
Disclosure completed by (Carer):

Open Disclosure Comments (Carer):
Follow-Up Status (Family):

Debriefing Date (Family):
Debriefing Time (Family):
Family Debriefed By:

Open Disclosure Status (Family):
Open Disclosure Date (Family):
Debriefing Time (Family):
Disclosure completed by (Family):

Open Disclosure Comments (Family):

?eview Dates

?LAGS

?dmission 1

?dmission2

Refer to Clinical Review Committee

Date referred to CRC:

A...ociated Risks

No Associated Risk.

Journal Entries

Documents

No Attached Documents.

Who did the incident happen to?

Incident Involved: Non-Individual
Surname: Methadone stock in S8 safe
Street:
Suburb/City:
Postcode:
Country:

When did the incident occur?

Incident Date: 3 June 2010
Incident Time: 15:00
Notification Date: 3 June 2010
Sterilising Services?: No

What happened in the incident?

Summary: Methadone tablet count was out in the safe
Details: The methadone was counted this morning and there were 18 tablets, when it was rechecked at 15:00 there were only 17 tablets.
There were no patients prescribed any methadone on the ward and morning staff nurse said that the counted 18.
SI Details:
Incident Outline:
Date R.O.I. Received:
Date R.O.I. Prepared:
Outline Prepared By:
Origin of Incident Report:
Reporter's Name: Bowerman, Fernanda
Reporter's Position: Health Professional Officer
Contact Phone:
Reviewed By:
Reviewed By Name:
Treatment Given:
Steps Taken By: Myself and CNC
Steps Taken: Put in riskman and made sure CNC was made aware (she already knew). Tablets were not being used, remainder of tablets taken back to pharmacy
Investigations/Findings: S8 cupboard keys only with RNs.Could not trace missing tablet.
Investigated By:
Controls Implemented:
Deceased: No
Coroner Notified: No
Autopsy performed: No
Date of Death:
Time Of Death:
Next Of Kin Notified: No
Police Notified?: No
Date of Notification to Insurer:
Insurer Notif Mode:

Personnel Involved

Person #1:
Person #1 Position:
Person #2:
Person #2 Position:
VMO: No
Admitting Specialist:
Code Blue/MET?: No
Outcome: Insignificant
Significant Incident Level:
Significant Incident Type:

Contributing Factors

Classification

Medication — Medication Management — Incorrect Drug Count
Risk Rating:
Potential Risk Rating:

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):
Open Disclosure Status (Pt/Client):
Debriefing Date (Pt/Client):
Open Disclosure Date (Pt/Client):
Debriefing Time (Pt/Client):
Open Disclosure Time (Pt/Client):
Pt/Client Debriefed By:
Disclosure completed by (Pt/Client):
Open Disclosure Comments (Pt/Client):
Follow-Up Status (NOK):
Open Disclosure Status (NOK):
Debriefing Date (NOK):
Open Disclosure Date (NOK):
Debriefing Time (NOK):
Open Disclosure Time (NOK):
Next Of Kin Debriefed By:
Disclosure completed by (NOK):

Open Disclosure Comments (NOK):
Follow-Up Status (Carer):
Debriefing Date (Carer):
Debriefing Time (Carer):
Carer Debriefed By:

Open Disclosure Comments (Carer):
Follow-Up Status (Family):

Debriefing Date (Family):
Debriefing Time (Family):
Family Debriefed By:

Open Disclosure Comments (Family):

Open Disclosure Status (Carer):
Open Disclosure Date (Carer):
Open Disclosure Time (Carer):
Disclosure completed by (Carer):

Open Disclosure Status (Family):
Open Disclosure Date (Family):
Debriefing Time (Family):
Disclosure completed by (Family):

Review Dates

FLAGS

Admission 1

Admission2

Refer to Clinical Review Committee

Date referred to CRC:

Associated Risks

No Associated Risk.

Journal Entries

Documents

No Attached Documents.

K

Who did the incident happen to?

Incident Involved: Non-Individual
Surname: Methadone 5mg/ml; hospital register number 06291-06300
Street:
Suburb/City:
Country:
Postcode:

When did the incident occur?

Incident Date: 30 July 2010
Incident Time: 21:30
Notification Date: 31 July 2010
Sterilising Services?: No

What happened in the incident?

Summary: Drug count error

Details: During the routine drug count at 2130hrs on 30/7/2010 with RNs on duty, it was discovered that the methadone count on page 06297 for client [redacted] was incorrect. The book showed that 4 x 6ml bottles were received from pharmacy at 1420hrs making a total of 24mls, but there were only 3 x 6ml bottles inside the white paper pharmacy bag. The count was corrected to 18ml. It was also noted that there was only 1 signature receiving this methadone, the space for the second signature states '4 x 6ml'.
This incident occurred in the Psychiatric Service Unit - LDU treatment room. I seem to be unable to change my location from CRCS.

SI Details:
Incident Outline:
Date R.O.I. Received:
Date R.O.I. Prepared:
Outline Prepared By:
Origin of Incident Report:
Reporter's Name: Finlayson, Sarah
Reporter's Position: Registered Nurse / Midwife
Contact Phone: 62443216
Reviewed By Name:
Reviewed By:
Treatment Given:
Steps Taken By:
Steps Taken: Drug count corrected; team leader - RN Bates - informed; RiskMan completed.
Investigations/Findings: Please review
This is an error on delivery from Pharmacy. The correct sign inprocedure was not followed and it appears unclear the amount dispensed from Pharmacy. Please forward to Pharmacy to review.
Investigated By: Sheree Dimitrescu
Controls Implemented:
Coroner Notified: No
Deceased: No
Autopsy performed: No
Date of Death:
Time Of Death:
Next Of Kin Notified: No
Police Notified?: No
Insurer Notif Mode:
Date of Notification to Insurer:

Personnel Involved

Person #1: Sarah Finlayson
Person #1 Position: Registered Nurse / Midwife
Person #2: Caitlyn Izzard
Person #2 Position: Registered Nurse / Midwife
VMO: No
Admitting Specialist:
Code Blue/MET?: No
Outcome: Minor
Significant Incident Type:
Significant Incident Level:

Contributing Factors

Classification

Medication	Medication Involved	Narcotic
Medication	Medication Management	Incorrect Documentation
Medication	Medication Management	Incorrect Drug Count

Risk Rating:
Potential Risk Rating:

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):
Open Disclosure Status (Pt/Client):
Debriefing Date (Pt/Client):
Open Disclosure Date (Pt/Client):
Debriefing Time (Pt/Client):
Open Disclosure Time (Pt/Client):
Pt/Client Debriefed By:
Disclosure completed by (Pt/Client):

A

Open Disclosure Comments (Pt/Client):
Follow-Up Status (NOK):
Debriefing Date (NOK):
Debriefing Time (NOK):
Next Of Kin Debriefed By:
Open Disclosure Comments (NOK):

Open Disclosure Status (NOK):
Open Disclosure Date (NOK):
Open Disclosure Time (NOK):
Disclosure completed by (NOK):

Follow-Up Status (Carer):
Debriefing Date (Carer):
Debriefing Time (Carer):
Carer Debriefed By:
Open Disclosure Comments (Carer):

Open Disclosure Status (Carer):
Open Disclosure Date (Carer):
Open Disclosure Time (Carer):
Disclosure completed by (Carer):

Follow-Up Status (Family):
Debriefing Date (Family):
Debriefing Time (Family):
Family Debriefed By:
Open Disclosure Comments (Family):

Open Disclosure Status (Family):
Open Disclosure Date (Family):
Debriefing Time (Family):
Disclosure completed by (Family):

Review Dates

FLAGS

Admission 1

Admission2

Refer to Clinical Review Committee

Date referred to CRC:

Associated Risks

No Associated Risk.

Journal Entries

Date/Time	Journal Entry	Reference	Cost
Journal Type:	General Comments		
Created by: 12 Aug 10 10:18:00	Team Leader, PSU Please review. I also require that we get rid of the uneeded S$ and S* medication Actioned: No Linked Document Path:	Mail Sent On:	
Journal Type:	General Comments		
Created by: 23 Aug 10 12:52:00	Dimitrescu, Sheree Neil please follow-up amount of Methodone dispensed to PSU for this patient and the person whom delivered it to PSU. Actioned: No Linked Document Path:	Mail Sent On:	

Documents

No Attached Documents.

THE CANBERRA HOSPITAL

Australian Capital Territory Drugs of Dependence Act 1989, Section 101

Drug Methadone. **Strength** 6 ml **Form** [illegible]

Date	Patient's name/ Received from Pharmacy	In	Out	Balance	Dose	Remarks	Signature of administering nurse	Time of admin.	Checked by	Name of prescriber
30/07/10	from pharmacy	18ml ~~24ml~~		18ml ~~24ml~~		count adjust? HB	3 x 6ml	1420		
30/7/10	checked & incorrect			18ml		amnt in safe		2130		

Comprehensive Custom Report

ACT Health

Incident ID: 143941

Who did the incident happen to?

Incident Involved: Non-Individual
Surname: Methadone Delivery
Street:
Suburb/City:
Postcode:
Country:

When did the incident occur?

Incident Date: 23 October 2009
Incident Time: 08:30
Notification Date: 23 October 2009

Physiotherapy Treatment

Contact Date	Contact Time	Contact Duration (mins)	SAIR# Reference	Contact Type	Episode	Activity Type	Body Part Treated

PhysiotherapyTreatment total records: -1

Sterilising Services?: No

What happened in the incident?

Summary: Incorrect Dosage supplied
Details: Bottle was found to be empty during dosing today.
SI Details:
Incident Outline:
Date R.O.I. Received:
Date R.O.I. Prepared:
Outline Prepared By:
Origin of Incident Report:
Reporter's Name: Carter, Shane
Reporter's Position: Registered Nurse / Midwife
Contact Phone: 62072933
Reviewed By:
Reviewed By Name:
Treatment Given: Nil required
Steps Taken By: Jenny Kusek
Steps Taken: Dose filled from Standing orders.
Investigations/Findings: Nil
Investigated By:
Controls Implemented:
Deceased: No
Coroner Notified: No
Date of Death:
Autopsy performed: No
Time Of Death:
Next Of Kin Notified: No
Police Notified?: No
Date of Notification to Insurer:
Insurer Notif Mode:

Personnel Involved

Person #1: Jenny Kuzek
Person #1 Position: Registered Nurse / Midwife
Person #2:
Person #2 Position:
Admitting Specialist:
VMO: No
Code Blue/MET?: No
Outcome: Insignificant
Significant Incident Level:
Significant Incident Type:

Contributing Factors

Classification

Medication	Dispensing Related	Damaged Stock
Medication	Medication Involved	Narcotic
Medication	Medication Continuum	During Stay

Risk Rating:
Potential Risk Rating:

What Follow-Up Occurred?

Follow-Up Status (Pt/Client):
Open Disclosure Status (Pt/Client):
Debriefing Date (Pt/Client):
Open Disclosure Date (Pt/Client):
Debriefing Time (Pt/Client):
Open Disclosure Time (Pt/Client):

Pt/Client Debriefed By:	Disclosure completed by (Pt/Client):
Open Disclosure Comments (Pt/Client):	
Follow-Up Status (NOK):	Open Disclosure Status (NOK):
Debriefing Date (NOK):	Open Disclosure Date (NOK):
Debriefing Time (NOK):	Open Disclosure Time (NOK):
Next Of Kin Debriefed By:	Disclosure completed by (NOK):
Open Disclosure Comments (NOK):	
Follow-Up Status (Carer):	Open Disclosure Status (Carer):
Debriefing Date (Carer):	Open Disclosure Date (Carer):
Debriefing Time (Carer):	Open Disclosure Time (Carer):
Carer Debriefed By:	Disclosure completed by (Carer):
Open Disclosure Comments (Carer):	
Follow-Up Status (Family):	Open Disclosure Status (Family):
Debriefing Date (Family):	Open Disclosure Date (Family):
Debriefing Time (Family):	Debriefing Time (Family):
Family Debriefed By:	Disclosure completed by (Family):
Open Disclosure Comments (Family):	

Review Dates

FLAGS

Admission 1

Admission2

Refer to Clinical Review Committee

Date referred to CRC: 4 November 2009

Associated Risks

No Associated Risk.

Journal Entries

Date/Time	Journal Entry		Reference	Cost
General Comments				
Created by:	Barter, Dee			
29 Oct 09 08:10:00	Dear Kate, Please refer this incident to CH CRC. Thanks			
	Task Outcome:			
	Actioned:	Yes	Mail Sent On:	
	Follow Up Allocated To:	Evans, Kathleen	Follow Up By Date:	
	Linked Document Path:			
Created by:	Clinical Review Team, PSQU CH			
08 Jul 10 12:48:00	CH CRC executive decision; Referred to Med Dir CHP. No adverse client outcome. Close case			
	Task Outcome:			
	Actioned:	No	Mail Sent On:	
	Follow Up Allocated To:		Follow Up By Date:	
	Linked Document Path:			

Documents

No Attached Documents.

Incident II	Incident Da		Details	SI Details	Treatment Given	Steps Taken	Investigations/Findings	Controls Implemented
186862	8 Jul 2010	**Bottle of methadone was unable to be accounted for during the court medication round**	At approximatley 0800 during the court medication round a bottle of methadone for was not able to be located. Prior to dispensing any medications the officer incharge was unable to house me in the hutch as it was locked and unable to be opened. During dispensing 4 officers were present and multiple inmates were walking past the medication trolley at various times. When preparing to dose it became evident that his pre dispensed methadone was not present. At this time I double checked the court medication container, medication trolley, contacted the sentenced nurse to see if she had the methadone and double checked the cupboards and garbage bins. I also asked one of the officers to check the inmates but was told that wasn't necessary. When I returned to the clinic I asked the nurse on duty the night before who packed the medications and she was certain it had been packed. I then informed the CNC of the above.	At ~8:00 on 8 July 2010 during the court medication round, a bottle of methadone for a prisoner, was not able to be located. Medications are usually dispensed from "the hutch", a secure area behind a counter with a roller door. The roller door was locked and the key could not be located by the officer in charge so the nurse dispensed the medication from the trolley beside the counter in the admissions area. Two officers were in attendance while the nurse was dispensing medications, a third officer was raoming the vicinity and a fourth officer in an office located close by. Multiple prisoners walked past the medication trolley at various times. One prisoner touched the medication trolley. When preparing to dose it became evident to the nurse that his pre-dispensed methadone was not present. The court medication container and medication trolley were double checked by the dispensing nurse. The nurse on duty the night before was also contacted and she was certain the methadone had been packed. All clinical areas including rubbish bins were also searched. The methadone bottle was unable to be located. The nurse also asked the custodial officers if the prisoners to be searched. The nurse was told it wasn't necessary. was dispensed his correct dose of methadone from standing order stock. The Corrections Health CNC was notified of the incident at ~10:00. The CNC notified the admissions officer and all holding cells in the admissions area were searched. All nine prisoners were then searched also. The missing dose is 55mg. Three out of the nine prisoners are on methadone, with a fourth having ceased methadone 3 weeks ago. The prisoner that ceased the methadone 3 weeks ago was the prisoner that touched the trolley. All nine prisoners are on camera in the CTU and all are observed every 15 minutes. Corrective Services staff were told to notify Corrections Health staff if any prisoner appears sedated. The superintendent was made aware of the incident and CCTV footage will be reviewed and investigated by Corrective Services. Refer to controls implemented.			Incident reported to me by nurse on return from medication round approximately 1000hrs. Admissions officer notified, and all holding cells in admissions area searched, CTU senior officer notified immediately and all 9 prisoners were searched, all clinical areas of heath including rubbish bins searched and methadone unable to be located One prisoner touched the medication trolley and left a piece of sticky tape on the trolley. The nurse asked for the prisoners to be checked and the officer declined. and said it was not necessary. The nurse usually dispenses the medication behind a counter that has a roller door. The roller door was locked this morning and the key could not be located therefore the nurse dispensed the medication from the trolley beside the counter in the admissions area. There were 2 officers in attendence whilst the medication was being dispensed. One officer roving and one officer in the office located near by. The missing dose is 55mg. 3 out of the 9 clients are on methadone and one recently ceased 3 weeks ago. The client that ceased methadone is the client that touched the trolley. All 9 prisoners are on camera in CTU and all prisoners are observed every 15 mins. CTU staff are aware to notify health staff if anyone appears sedated. The superintendent is aware of the incident and CCTV footage will be reviewd and investigated by Corrective Services.	All staff have been sent a reminder email that all medictions are to be dispensed behind the counter in admissions area. If the roller door is locked all staff are to insist it is opened before medication can be administered. Corrective Services will send an email to all their staff to inform them of this also

Incident ID	Incident Dat		Details	SI Details	Treatment Given	Steps Taken	Investigations/Findings	Controls Implemented
143941	23 Oct 2009	**Incorrect Dosage supplied**	Bottle was found to be empty during dosing today.		Nil required	Dose filled from Standing orders.	Nil	
							Nil	

Pages 25-30

Exempt Under section 41 of the

Freedom of Information Act 1989

Missing methadone tablets-Incident at TCH early February 2006

14 February 2006

Sue Alexander (Director of Pharmacy TCH) advised by telephone that ten boxes of methadone tablets each containing twenty tablets had been reported as being missing.

15 February 2006

Sue Alexander advised by e mail that it was assumed that PSS would contact the AFP and TCH had not done so at this stage.

16 February 2006

PSS called Woden Police Station who referred PSS to the Victorian Police

The discrepancy was noticed on 3 February 2006, reported to Lisa Hayes that day and to Sue Alexander on 6 February 2006.

The stock usually arrives from the supplier in discreet packs of ten packets of twenty tablet packs.

According to Trish Kennedy who oversees the Drugs of Dependence section at TCH, when this order was unpacked on 1 February 2006 it was immediately noticed that the packets of ten tablets were not in discreet packs of ten but in loose disarray. The packets in the box were not counted at this point of time and the box with its contents was placed in the drugs of dependence safe.

PSS contacted the Victorian Police and was subsequently referred to the Major Drug Investigation Unit (MDIU). Initially a member of this Unit, [redacted] took details of the matter.

17 February 2006

Victorian Police MDIU advised by telephone that a [redacted] was to take over the investigation.

PSS contacted Trish Kennedy who noted that this delivery came directly from Melbourne whereas deliveries usually came from Sydney, notwithstanding that the items may have been originally from Melbourne. The invoice concerned is numbered 1415288 and dated 31 January 2006. Other items in the box were two MS Contin 20mg sachets and one MS Contin 10mg sachets, which have been accounted for by Trish Kennedy.

[redacted] called and said that he would be talking to Trish Kennedy.

21 February 2006

Sue Alexander called to request that further discussion on the matter should go via her.

.JUN.2009 10:54 #7814 P.001 /00

11/06/2009

12 JUN 2009

→ HES
[illegible]

Dr Charles Guest
The Chief Health Officer, ACT
GPO Box 825
Canberra City 2601
ph 62050881
fax 62051884

Dear Sir

I wish to report the theft of a number of regulated medicines which occurred in the pharmacy that I work in on Tuesday, 9th May, 2009. We were involved in an armed robbery during which the following were stolen:

1 Bottle of Biodone (Methadone 5mg/ml) liquid containing 950ml of biodone solution
1 Bottle of Biodone (Methadone 5mg/ml) liquid containing 50ml of biodone solution.

Of course this has been reported to the police, I gave my statement to of the AFP he can be contacted on and our report number for this incident is

The police also informed us on Wednesday 10th May that the suspect for the robbery is in police custody and the have recovered some of the stolen medicines, but it is in police custody pending the court case and they were not able to give me exact details of what and how much was recovered.

Yours faithfully,

A copy is also being sent by mail.
[illegible]

Health Protection Servic
Howard Florey Centenary House, 25 Mulley Street, Holder ACT 261
Locked Bag 5005, Weston Creek ACT 261
Phone: (02) 6205 1700 Fax: (02) 6205 870
Website: www.health.act.gov.a
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Thank you for informing Pharmaceutical Services Section of the imbalance between the recorded balance and the actual balance of Methadone hydrochloride oral liquid at

Following a thorough inspection of the controlled medicines register and Methadone administration charts for the patients who were taking medication from 14 February 2011 to 20 March 2011 inclusive, I consider that the error in the balance of Methadone liquid in the register can be attributed to inadequate recording of doses dispensed.

Enclosed are some extracts from the *Medicines Poisons and Therapeutic Goods Act 2008* and Medicines, Poisons and Therapeutics Goods Regulation 2008 that will help to clarify some issues for you.

Medicines, Poisons and Therapeutic Goods Act 2008:

- Division 4.2.2 Registers for regulated substances, Sections 48, 49, 51, 52 and 54.

Medicines, Poisons and Therapeutic Goods Regulation 2008:

- Chapter 8 Discarding Medicines, Section 390. This includes unused take-away doses.
- Chapter 12 Controlled medicines registers, Sections 542, 543 (1) (a) to (f).
  And Section 545 Prescribed witnesses for discarding of controlled medicines.

We recommend you implement a written procedure for pharmacists dispensing methadone and buprenorphine to assist with orderliness. Please ask all pharmacists employed at to abide by that procedure.

An inspection will be carried out in the not too distant future to ensure compliance with the legislation.

Should you need further assistance please do not hesitate to contact the Chief Pharmacist, Vivien Bevan, the Deputy Chief Pharmacist, Michael Conroy, or Pharmacist Inspector, Patricia MacCallum at Pharmaceutical Services Section.

Yours sincerely

Patricia MacCallum
24 March 2011

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Exempt Under section 38 of the

Freedom of Information Act 1989