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CCC | Corruption and Crime Commission

Report on serious misconduct risks around ŘI·y∃ŜN2dză drugs in hospitals

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TABLE OF CONTENTS

INTRODUCTION

[1] On 20 June 2017, the Commission's *Report on the Supply and Management of Schedule 8 Controlled Drugs at Certain Public Hospitals in Western Australia* was tabled.

[2] That report described the Commission's investigation of the repeated theft of drugs by a senior pharmacist at Fiona Stanley Hospital (FSH).

[3] The Commission considered the security procedures for handling Schedule 8 controlled drugs at FSH and at Sir Charles Gairdner Hospital (SCGH) where the pharmacist had formerly been employed.

[4] The report revealed shortcomings in those security procedures and made recommendations for improvement.

[5] It is a Commission function to provide information to public authorities and report on ways to prevent and combat serious misconduct.[1] The Commission is concerned this theft of pharmaceutical drugs by an employee of WA Health may not be an isolated incident.

[6] The Commission receives notifications from WA Health about suspected serious misconduct in hospitals and health facilities. Some of these notifications relate to drug discrepancies for Schedule 8 and Schedule 4 Restricted drugs. These drugs are dangerous: they are addictive, and misuse can be fatal. Details of these drugs are provided in Chapter Three.

[7] Drug discrepancies are usually situations in which drugs used for medical purposes in hospitals are found to be either missing or replaced by another substance, for no obvious reason such as accidental spillage.

[8] Drug discrepancies usually involve the loss of a drug in tablet or liquid form. They are generally investigated by the local Health Service Provider. When there is suspected serious misconduct, the Commission is notified and sometimes a report is made to the WA Police Force.

[9] On the basis of the notifications it receives, and other information, the Commission is concerned about the level and nature of unexplained drug discrepancies in hospitals. The Commission is also concerned about the way in which drug discrepancies are investigated by WA Health, and some of the conclusions which WA Health reaches on the reasons for the discrepancies.

[1] *Corruption, Crime and Misconduct Act 2003* (CCM Act) s 18(4)(e).

CHAPTER ONE

Purpose of this report

[10] This report is a supplement to the Commission's June 2017 report. The purpose of this report is to consider more broadly the issue of theft and misuse of dangerous and addictive pharmaceutical drugs by employees of WA Health, and provide advice and recommendations about ways to prevent serious misconduct.[2]

[11] The Boards of WA Health's five Health Service Providers are responsible for the management and security of Schedule 8 and Schedule 4 Restricted drugs held in their hospitals and other facilities, and for mitigating the risks that can arise from the theft and abuse of these drugs.

[12] This report's primary purpose is to assist those Boards in their management of the serious misconduct risk inherent in discrepancies of dangerous drugs.

Information which forms the basis of this report

[13] A note on nomenclature. A response to the draft report was critical of the use of the word 'drug' instead of 'medicine'. Schedule 4 refers to 'prescription medicine'. Schedule 8 refers to 'controlled drugs'. A drug can be a medicine. This report is concerned with the possible use of substances for non-medical purposes, hence the use of the word 'drug'.

[14] This report analyses notifications received from WA Health about discrepancies for Schedule 8 and Schedule 4 Restricted drugs for the period 1 July 2013 to 30 June 2017 from three major metropolitan hospitals, Royal Perth Hospital (RPH), SCGH, and Fremantle Hospital (FH). These hospitals reported the majority of drug discrepancies. The analysis does not include FSH as issues relating to drug security procedures there were considered in the Commission's June 2017 report.

[15] There are common themes or patterns of drug discrepancies arising from the notifications which might guide WA Health in its efforts to deal with this problem.

[16] Relevant documents including legislation, WA Health policies and investigation reports have been considered.

[2] CCM Act s 18(4)(c).

[17] A literature review has been conducted of research nationally and internationally on drug security in hospitals, drug addiction among health professionals and the misuse of pharmaceutical drugs in the community.

[18] In preparing this report, the Commission has referred to several reports on the same, or similar topics. These include the following:

- A report by the Commission titled *Misconduct Handling Procedures in the Western Australian Public Sector: WA Health*, tabled in Parliament on 22 April 2010. This report was based on interviews with a wide range of WA Health employees and a survey.
- A report by the WA Auditor General titled *Pharmaceuticals: Purchase and Management of Pharmaceuticals in Public Hospitals,* Report 7, June 2012.
- Inquests by the WA Coroner in July 2013 into the separate deaths of two WA Health nurses in 2009 and 2010. The inquests revealed that both nurses died from an overdose of drugs, almost certainly accessed from the hospitals at which they worked.
- The Commission's June 2017 report was based on the investigation by the Commission of the theft of drugs from the pharmacy at FSH. The investigation included examinations with senior WA Health officers and site inspections.

[19] The Commission provided a draft of this report to the Department of Health.[3] Representations have been received from the Director General, from the Medicines and Poisons Regulation Branch of the Department, and from the five Health Service Providers. The Commission thanks those agencies for their comments. Where relevant, they have either been incorporated into this report, or are noted.

Conclusions

[20] While the total number of drug discrepancies notified to the Commission by WA Health is small compared to the total number of drug transactions in hospitals, it appears that theft and misuse of dangerous drugs by employees is an ongoing problem.

[21] WA Health's policies guiding employees on the management and recording of dangerous drugs have in practice, often not been complied with or not enforced.

[3] CCM Act s 86.

[22] As a result, there have been gaps in the records and shortfalls in the security of drugs, which means that in many of the cases notified to the Commission, WA Health has been unable to determine whether a drug discrepancy is accidental or the result of theft and, if so, who was responsible.

[23] Drug discrepancies and instances of drug related behaviour have sometimes been investigated by health professionals or human resources officers rather than by professional investigators. This can increase the difficulty in identifying the reason for the discrepancy and, if there has been a theft, in collecting evidence which will enable the person responsible to be identified and dealt with by a criminal or disciplinary process.

[24] WA Health has been inclined to deal with employees with drug offending behaviour from a welfare perspective, which may not sufficiently prevent future risks to patients and colleagues.

CHAPTER TWO

Case studies

Inquests into the deaths of two nurses

[25] In July 2013, the WA Coroner published a *Record of Investigation of Death* on the inquests into the deaths of two WA Health employees in December 2009 and June 2010.

[26] The inquest found that both had died as a result of overdoses of drugs, almost certainly obtained from the hospitals where they were employed.

[27] The employee who died in December 2009 was a registered midwife who worked at a WA Health hospital. She had injected herself at the hospital with a fatal dose of fentanyl, a Schedule 8 drug. Fentanyl is a synthetic opioid analgesic similar to morphine but much more potent.

[28] Approximately two hours before she did this, she had assisted another midwife to obtain, prepare and administer a fentanyl solution to a patient. However, no fentanyl discrepancies were found. The Coroner found it was likely that the midwife had entered the patient's room while the other midwife was not there, and removed the fentanyl from the device administering it to the patient.

[29] The Coroner found that the cause of death was accidental. He found that there was a gap in security at the point of administration of the drug which needed to be addressed. He commented on the possibility of a secure container for the drug reservoir and on staff training, but did not make a recommendation.

[30] The employee who died in June 2010 was discovered at home after failing to report for work. He was found to have died from an overdose of propofol. Other drugs were also found in his system. The Coroner noted that propofol and the other drugs were available to the deceased in his role as a clinical theatre nurse.

[31] A search of the nurse's residence found several types of drugs and medical paraphernalia, all consistent with having been taken from a hospital. One was exclusive to the hospital he worked in. At least six of the drugs were Schedule 4 (but not necessarily restricted) drugs and therefore legally available only on prescription.

[32] The Coroner recommended that WA Health implement a means of restricting the unauthorised use of propofol without placing patients at

risk. Propofol is now on the Schedule 4 Restricted drug list for ward and pharmacy areas.

Case study 1

[33] A nurse was found by two WA Health employees in a hospital staff car park, unconscious in a car with a tourniquet around his arm, a scalp vein needle in his arm, and a syringe in his other hand. Several attempts were made to wake him before he regained consciousness and was assisted out of the vehicle. During this time, the needle and tourniquet were removed. Police and ambulance officers attended, but did not find the needle or evidence of drugs. The nurse was admitted to the emergency department.

[34] On the day of the incident, the nurse had been working night shift and caring for a number of patients. During the course of his shift, he administered both Schedule 8 (morphine) and Schedule 4 Restricted (midazolam) drugs to patients.

[35] The relevant hospital policy required that two nurses be present during the administration of a Schedule 8 drug. The evidence suggested that the nurse had complied with this, although the Deputy Nurse Co-director was recorded in an investigator's notes as saying 'it is common practice across the hospital for nurses to administer the medications without a second nurse present, as those nurses are keen to return to their own patients'. He was also recorded as saying that there was an "honour code" among nurses.

[36] During an internal investigation, the nurse denied injecting or using illicit substances. He gave various explanations of what he was doing and why he passed out, including being fatigued, taking his own blood on advice from PathWest, and dieting for a research trial.

[37] No evidence was found during WA Health's preliminary assessment to explain why the nurse decided to take his own blood in a car, or why there was no blood found in the car, or on his clothing. The medical notes from the emergency department on the day of the incident were vague, but did not record him being intoxicated. There were no previous reports relating to the nurse's performance to suggest a substance abuse problem. The drug registers for that evening had been reconciled with medical records and all drugs he recorded administering, were appropriate to the care of the patients. Thirteen days later, a drug and alcohol test was performed on the nurse and no substances were detected. The nurse returned to work.

[38] In August 2016 the same nurse was admitted to FSH emergency department with sevoflurane toxicity. Sevoflurane is an anaesthetic which is listed as a Schedule 4 (but not restricted) drug. This means it is a prescription only drug but not subject to the same level of control in hospitals.

[39] The nurse was initially suspended from work. In June 2017, WA Health commenced a disciplinary process conducted by Human Resources.

[40] In the course of the disciplinary process, the nurse said he had found the drug in a hospital staff locker room and had taken it. WA Health then advised the Commission that as the nurse had admitted to the facts, an investigation was not warranted.

[41] The nurse was reprimanded and reported to the Australian Health Practitioner Regulation Agency (AHPRA). WA Health advised the Commission that AHPRA had placed restrictions on the nurse's registration. However, a recent search of the AHPRA registry shows no restrictions or adverse findings for the nurse.

Case study 2

[42] In October 2015, the Commission received notifications of two instances where syringes containing fentanyl, a Schedule 8 drug, had another liquid substituted for the drug. In one case, the substitution appears to have taken place in an operating theatre, and the other, in a gastroenterology suite. In the first case, the substituted syringe was administered to a patient during surgery and resulted in a failed response. In the second case, a doctor noticed that the syringe contained less liquid than it should.

[43] In both cases, the syringes were sent to the ChemCentre for analysis and it was confirmed that the fentanyl had been substituted.

[44] Investigations identified a nurse who was suspected by other staff of being involved. This nurse had also been the subject of other allegations relating to drug discrepancies involving fentanyl and drug related behaviour, and fraud in relation to a medical certificate.

[45] WA Health took disciplinary action against the nurse. The Commission followed up with WA Health and was advised that the nurse was issued with reprimands and a final warning. He continued to be employed by WA Health with access to Schedule 8 and Schedule 4 Restricted drugs.

Case study 3

[46] Two ampoules of fentanyl were signed out by a nurse alone and taken to an operating theatre by request of a supervising doctor. The drug register

was signed by both the nurse and doctor at 1.05 pm before the ampoules were left on top of an anaesthetic trolley for the anaesthetist. During this time, there was a handover of patients and a new doctor was assigned to the treatment area. At 1.35 pm, one of the ampoules was drawn up and administered to a patient; the other ampoule remained on the trolley. At 2.10 pm, the doctor was relieved for a tea break and another doctor continued the care of the patient. Upon the doctor returning from break at 2.30 pm, he noticed the ampoule was no longer on top of the trolley. An immediate search was conducted and later the area was thoroughly searched. The ampoule was not found. While an attempt was made to 'look into' the sharps container, sharps handling practices did not permit the container to be opened and searched.

[47] An initial medicine discrepancy review was conducted by a senior nurse and it was then reported to Corporate Governance who conducted a preliminary investigation which involved reviewing the evidence. The investigation found that 'it remains inconclusive' whether the ampoule of fentanyl had been accidentally discarded into the sharps container by a staff member, or had been taken by a staff member.

[48] These findings were endorsed by the nursing director who accepted that an incomplete search of the sharps bin at the time, and an inability to identify a person of interest, warranted no further enquiries.

[49] The WA Health investigation highlighted a number of aspects of the handling of the drug which breached protocols, including:

- When it was determined that the ampoule was not required for a patient, it should have been returned to stock or locked in the theatre's medication cabinet.
- When the first ampoule was administered to another patient, the register was not updated.
- The initial way in which the fentanyl was taken from the drug cupboard to dispense to a doctor was 'outside of the policy but is standard practice in theatre due to the design, activity and flow of theatres'.[4]

Case study 4

[50] Between June and October 2015, WA Health identified eight incidents of dilution of a total of 53.4 ml of methadone and morphine in three areas of a hospital. The discrepancies were picked up because there was excess volume in the drug containers. The containers were sent to the

[4] WA Health, *Investigation Report CMS20150230* (13 November 2015) 10.

ChemCentre for testing and six of them were confirmed to have been diluted with water and in one case, also with sorbitol.

[51] A report was made to the WA Police Force, and WA Health's Corporate Governance Directorate conducted an internal investigation. In November 2015, WA Health advised the Commission that there was insufficient evidence to determine who was responsible for the dilution and theft of the drug, and this was a 'direct result of the operation procedures used and the large number of staff who have access to the drugs'.

[52] Specifically, the WA Health investigation identified the following weaknesses:

- The markings on the bottle were 'poorly marked and unclear'.
- There was no way of knowing when the dilution happened as audits of Schedule 8 drugs had not followed policy.
- The offices that contain the Schedule 8 cupboards were accessible to a large number of staff.
- The keys to the drug cupboards 'are passed on indiscriminately' between nurses and there was no record of who had them at a particular time.
- Only one drug room had CCTV cameras and that faced the back of people standing in front of the Schedule 8 cupboard.
- The policy for dispensing methadone was not being followed.

[53] The investigation report also listed shortcomings identified in other incidents around the same time:

- Poor markings on morphine bottle labels made it difficult to confirm correct liquid volumes.
- When audits were conducted, the amount of remaining liquid which was entered on the register was not consistent with what was actually in the bottle. This was identified from reviewing CCTV footage.
- The register had incorrect records of liquid balances.
- Audits were not conducted by two authorised persons.
- Bottles were not reconciled before new ones were opened.
- The wrong drugs were administered.

[54] The investigator noted 'There is no mandatory continuous training or competency based training for the administration of S8 medication across Health'.

[55] It appeared that methadone and morphine was deliberately and regularly being stolen. It seems inevitable that the person or people responsible for the thefts were WA Health employees.

[56] The hospital acknowledged the necessity for changes to be made to prevent future incidents. The Commission was advised that the following changes were to be implemented:

- Methadone was no longer to be stored in Schedule 8 drug cupboards on wards; it comes directly from the pharmacy to the patient in a sealed bottle in the correct dose.
- The pharmacy was looking to use smaller bottles of hydromorphone and oxycodone to facilitate easier identification of an issue.
- The pharmacy, in consultation with the wards, would assess what liquid drugs they could replace with tablets.
- Nursing directors and ward pharmacists 'are working with staff to ensure all controls are being appropriately followed'.
- Pharmaceutical Services offered to provide 'additional training in relation to medication controls'.

Case study 5

[57] On a Monday morning, a drug discrepancy of up to six ampoules of fentanyl were not able to be accounted for in an Intensive Care Unit (ICU).

[58] At about 7.30 pm on the previous evening, a nurse had signed out three 10 ml ampoules of fentanyl and placed them in an unlocked drawer in a trolley next to a patient's bed. She assumed it would be used soon, but the doctors were delayed. It remained unused until about 3.30 am the next day, at which time another nurse drew up 20 ml from two of the ampoules into a syringe and then noticed that the other ampoule was damaged. The ampoule and the syringe were quarantined and the ampoule moved to the pharmacy. The investigation was unable to determine what happened to the syringe, which was unlabelled and contained 20 ml of fentanyl.

[59] A further 30 ml of fentanyl was signed out as a replacement and placed in a patient controlled analgesia bag, to replace one dated from Saturday, two days previously. The old bag was disposed of. However, at 10.00 pm

on the Monday, another nurse noted that the bag in use was still dated Saturday, and was therefore out of date and had to be replaced. In total, the two incidents meant that 60 ml of fentanyl was not able to be accounted for.

[60] An investigation was conducted by an investigator from Corporate Governance who interviewed all relevant staff members. He did not find evidence to support allegations of theft but identified a number of administrative shortcomings relating to handling of drugs. He found that:

> *It is apparent that for some time prior to these occurrences that, although ICU staff were aware of S8 drug protocols, they chose not to follow them. The lack of adherence to, or enforcement of, these drug protocols appears to have become commonplace. Each staff member interviewed was honest enough to identify this.*
>
> *It should have been the case that more senior nursing staff, team leaders, and coordinators challenged any deviation from drug handling protocols. It is fair to conclude that not only did this not happen, but also that deviation from these protocols was condoned and indeed promoted.*[5]

[61] As a result, the Health Service Provider advised the Commission that the following improvements had been implemented:

1. *A key register has been established for the accountable auditing of both the possession of Schedule 8 keys, and access to the Schedule 8 Drug Cupboard.*
2. *Two staff members are required to sign out the Schedule 8 drugs and take to the bedside.*
3. *A witness is also required for removing the drugs from the package, the drawing up and administration of the drugs, and the disposal of any excess.*
4. *The team leaders are required to perform random checks to ensure the bedside trolley doors remain locked.*[6]

[5] WA Health, *Investigation Report S0150297* (24 March 2016) 16-17.

[6] Letter to Corruption and Crime Commission from Paul Wilding A/Executive Director, Employment and Corporate Governance, 8 April 2016.

CHAPTER THREE

WA Health and dangerous drugs

WA Health

[62] WA Health has approximately 44,000 staff and an annual budget of more than $8 billion. It provides public health services to nearly 2.6 million people across WA.

[63] WA Health consists of five Health Service Providers: North Metropolitan Health Service (NMHS); South Metropolitan Health Service (SMHS); East Metropolitan Health Service (EMHS); Child and Adolescent Health Service; and WA Country Health Service.

[64] These providers were created on 1 July 2016 by the *Health Services Act 2016*. Each Health Service Provider has a Board which is legally responsible for the oversight of the services they provide.

[65] The Act also created the Department of Health (DoH), led by the Director General. DoH is responsible for the overall management, performance and strategic direction of WA Health.

[66] WA Health operates 85 hospitals across the state,[7] and a range of other medical services.

Dangerous drugs

[67] WA Health uses a large number and variety of drugs for medical purposes. Many of these are dangerous if not used under medical supervision. Some are addictive.

[68] WA Health purchases medicines from external providers. Some hospitals also produce their own. For example, the FSH pharmacy manufactures specialised infusions to be used for child patients and patients with cancer.

[69] The Standard for the Uniform Scheduling of Medicines and Poisons (the Poisons Standard) is a national instrument intended to provide jurisdictional consistency with respect to scheduling. It has 10 schedules.

[70] In Western Australia, the *Medicines and Poisons Act 2014* and *Medicines and Poisons Regulations 2016* adopt the schedules of the Poisons Standard.

[7] WA Health, Government of Western Australia, *Hospital Information* <http://ww2.health.wa.gov.au/About-us/Hospital-Information>.

[71] Schedule 8 drugs are controlled drugs which have a medical use and 'which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse, physical and psychological dependence'.[8]

[72] Schedule 8 drugs include, among many others, morphine, methadone, fentanyl, hydromorphone, oxycodone and pethidine.

[73] Schedule 4 drugs are those which are of sufficient toxicity to require medical supervision.

[74] Some Schedule 4 drugs have the potential to cause dependence. These are subject to additional controls. WA Health has designated these drugs as 'Schedule 4 Restricted'. They are defined in WA Health policy 0528/14, *Storage and Recording of Restricted Schedule 4 (S4R) Medicines*. This states:

> *Certain Schedule 4 prescription medicines are liable to abuse and may cause dependence. This includes benzodiazepine and other hypnotic sedatives and opioid or opioid like analgesics such as codeine containing compound analgesics and tramadol.*

[75] There is always a danger that people handling Schedule 8 and Schedule 4 Restricted drugs will steal them, either for their own use, to give to another, or to sell. In some cases, misuse of these drugs can be fatal. In all cases where drugs intended for patients' medical use are stolen, there are risks to patients, to the person who takes them, people close to them, to their fellow workers, to WA Health and to the public.

[76] WA Health has an obligation to develop and enforce policies, processes and security measures to control the use, and prevent the theft and misuse of these drugs.

WA Health policies

[77] The Commission understands that the following Operational Directives (ODs) are currently included in WA Health's Public Health Policy Framework:

- Code of practice for the handling of Schedule 8 medicines (drugs of addiction) in hospitals and nursing posts (OD 0141/08).
- Storage and recording of Restricted Schedule 4 (S4R) medicines (OD 0528/14).

[8] *Medicines and Poisons Act 2014* (WA) s 4.

- Management of Schedule 8 and Restricted Schedule 4 oral liquid medicines (OD 0492/14).

- Reporting of medicine discrepancies in public hospitals and licenced private facilities which provide services to public patients in WA (OD 0377/12).

[78] These ODs are policies which guide staff on the requirements for handling Schedule 8 and Schedule 4 Restricted drugs and on reporting discrepancies. They are supplemented by policies operating in individual hospitals and health services.

[79] The policies set out minimum requirements for record keeping, secure storage, access and administration of dangerous drugs. This can include the number of authorised persons required to sign for receipt of drugs and minimum security arrangements for storage.

[80] The ODs also set out how drug discrepancies should be prevented and dealt with. OD 0492/14 states that 'Suitable controls to prevent theft, unauthorised use or unaccounted loss must be in place to prevent and deter unauthorised access. This includes the need for reporting of all stock discrepancies and losses'.

[81] OD 0377/12 states that each hospital must have a Medical Incident Coordinator (MIC) who is responsible for managing the process for investigating and reporting medicine discrepancies. The MIC nominates an incident reviewer for each incident.

[82] On receipt of an initial medicine discrepancy report from the person who identified the discrepancy, the MIC must report suspected misconduct as soon as possible. The incident reviewer must report losses or theft of poisons to the WA Police Force within 72 hours of the discrepancy being identified.

[83] These ODs are policies which aim to provide guidance on best practice for managing dangerous drugs. The notifications received by the Commission from WA Health suggest that sometimes they have not achieved their purpose.

The role of the Commission

[84] The principal officer of WA Health is required to notify the Commission of any matter which he or she suspects on reasonable grounds concerns or may concern serious misconduct.[9]

[9] CCM Act s 28.

[85] Theft of drugs by an employee of WA Health may be serious misconduct.

[86] The Commission has a role to ensure that an allegation or information about serious misconduct is dealt with in an appropriate way.[10]

[87] Normally, drug discrepancies are investigated by WA Health which notifies the Commission when it suspects serious misconduct, and then reports its findings at the end of the investigation.

[88] Occasionally, the Commission will investigate matters itself, as in the recent case of systemic thefts of hydromorphone (a Schedule 8 drug) from the pharmacy at FSH.

[10] CCM Act s 18.

CHAPTER FOUR

Research into abuse of pharmaceutical drugs

[89] This chapter sets out some recent research relevant to misuse of pharmaceutical drugs generally, and by health professionals specifically. The aim of this chapter is to point out areas of risk, not to suggest that misuse of drugs is rife among staff in WA hospitals.

Misuse of pharmaceutical drugs

[90] The 2015-2016 Australian Criminal Intelligence Commission (ACIC) *Illicit Drug Data Report*,[11] released on 30 June 2017, reported that the two most commonly misused pharmaceutical drugs in Australia are opioid analgesics and benzodiazepines. It said 'The misuse of these pharmaceuticals can lead to dependence and/or overdose'.

[91] The report listed means used to obtain these drugs for non-medical use, including theft from surgeries or pharmacies, forged prescriptions and 'health practitioners self-prescribing or otherwise misappropriating through their work'.

[92] The reasons given for misuse of pharmaceutical drugs 'include self-medication, treatment for an underlying drug dependency problem, improved performance, withdrawal from illicit drugs and to counter or enhance the effects of illicit drugs'.

[93] The report said 'Opioids include drugs derived from the opium poppy and synthetic substances with similar pain relieving properties … The misuse of opioids may result in tolerance and dependence, leading users to seek increasingly larger doses of the drug'. Misuse of opioids causes drowsiness and confusion as well as long term harm.

[94] Common pharmaceutical opioids include morphine, codeine, oxycodone, fentanyl, pethidine and methadone.

[95] Benzodiazepines are commonly prescribed for insomnia, stress and anxiety and are depressant drugs. The effects may include drowsiness, confusion and impaired motor coordination.

[96] Common forms are alprazolam (includes trade name Zanax), diazepam (includes Valium), nitrazepam (includes Mogadon), and oxazepam (includes Serepax).

[11] Australian Criminal Intelligence Commission, *Drug Data Report 2015-2016* pp 129-140.

[97] The report noted that in the US, deaths involving controlled prescription drugs exceed those from heroin, cocaine, methamphetamine, MDA and PCP combined.

[98] Other research suggests a common poly-drug abuse relationship between benzodiazepines and opioids.[12] Poly-drug abuse has been found to be one of the factors associated with overdoses. 'The role of poly-drug use in opioid overdose, for instance with benzodiazepines, essentially reflects a pharmacological interaction in the form of an additive respiratory depressant effect'.[13]

Misuse of pharmaceutical drugs by health professionals

[99] Studies suggest that the security and availability of drugs in the workplace affects the number of health professionals with a substance abuse problem. In a study focusing on drug misuse by nurses, it was found that 'nurses with very easy access were most likely to have misused prescription type drugs' and 'the opportunity to self-medicate as a result of access was an occupational risk factor for substance abuse'. A study found that 'nurses who reported easier perceived availability' and with 'poor to non-existent workplace controls' had almost twice the amount of prescription-type drug use compared to reference groups.[14]

[100] That study concluded with a recommendation for education in 'appropriate responses to personal care issues' and 'changes in drug access to protect the health of nurses while maintaining performance and patient care safety standards'.

[101] Stress in the workplace provides one possible explanation for why some health professionals engage in substance abuse. Studies indicate that medical professionals have very high workloads which contribute to stress.[15]

[102] Another factor which may explain why health professionals are vulnerable to misusing drugs is that they work within a culture where

[12] Jermaine D Jones, Shanthi Mogali and Sandra D Comer, 'Poly-drug abuse: A review of opioid and benzodiazepines combination use' (2012) 125 *Drug and Alcohol Dependence* 1-2.

[13] United Nations Office on Drugs and Crime, *World Drug Report* (2015) 13.

[14] Alison M Trinkoff, Carla L Storr and Mary Patricia Wall, 'Prescription-Type Drug Misuse and Workplace Access among Nurses' (1999) 18(1) *Journal of Addictive Diseases* 12.

[15] Peter Holland, Tse Leng Tham and Fenella Gill, 'What Nurses & Midwives Want: Findings from the National Survey on Workplace Climate and Well-being' (22 September 2016) Monash University <https://www2.monash.edu/impact/articles/australian-nurses-and-midwives-contemplate-leaving-profession-as-workloads-bite-survey/>.

pharmaceuticals are available, and used professionally.[16] As will be explained in the next chapter, a Commission report from 2010 quoted comments made by WA Health staff during interviews that it was accepted practice to take work stock for personal use.[17]

[103] In some cases, stealing a patient's medicine is an easy way for a health professional to obtain drugs. First, they are able to legitimately access the drug. Second, patients are not likely to be aware if they are receiving a lower dosage than prescribed.

[104] Such drug diversion by medical staff poses risks, 'harm can come not only to drug diverters but also to their patients and co-workers and to the reputation of the health care institution that employs them'.[18] This article, relating to the experience of a large US clinic, provides examples of drug theft in the clinic both by health professionals and visitors. Some of these were organised and some opportunistic. Some of the thefts involved substitution of drugs or were at the point of administration to a patient. There were a variety of serious medical outcomes, including contribution to the death of a patient and infection of other patients with hepatitis C.[19]

Misuse of pharmaceutical drugs by health professionals in Australia

[105] There is limited research in Australia examining the prevalence of drug theft in hospitals and links to health professionals. However, a research project considered 404 drug caused deaths reported to an Australian Coroner between 2003 and 2013 involving health care professionals.[20]

[106] All the deceased health professionals considered in the study were employed at the time of their death. Health professionals who were unemployed or retired, or cases that were under investigation by the Coroner, were not included and the study 'does not account for the living HCPs [health care providers] practising in the community who are drug-addicted and impaired'.

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[16] Debra Dunn, 'Substance abuse among nurses - Defining the issue' (2005) 82(4) *Association of Operating Room Nurses Journal* 576.

[17] Corruption and Crime Commission, *Misconduct Handling Procedures in the Western Australian Public Sector: WA Health* (22 April 2010) 66.

[18] Keith H Berge, Kevin R Dillon, Karen M Sikkink, Timothy K Taylor and William L Lanier, 'Diversion of Drugs within healthcare facilities, a multiple-victim crime: patterns of diversion, scope, consequences, detection and prevention' (2012) 87 (4) *Mayo Clinic Proceedings* 674-82.

[19] Ibid.

[20] Jennifer L Pilgrim, Rhyse Dorward and Olaf H Drummer, 'Drug-caused deaths in Australian medical practitioners and health-care professionals' (2017) 112 (3) *Addiction* 486-93.

[107] Females comprised nearly two thirds of the deaths. Nurses comprised 62.9% and medical practitioners 18.1%. Most were found to be intentional self-harm deaths (50%) but 37.6% were unintentional.

[108] The most prevalent drugs used were antidepressants/antipsychotics, benzodiazepines and opioids, detected in more than half the cases. In 17.8% of the cases, the drugs were demonstrated to have been obtained illicitly from the workplace, by theft or self-prescription.

[109] There were a number of specific risk factors identified which suggested that medical professionals are more susceptible to drug abuse than the wider community. These included stress, long hours, self-medication and ready access to drugs.

[110] The study pointed out that drug abuse by health care professionals is often hard to identify in the workplace until it is well advanced. It considered solutions, including the possibility of random or mandatory drug testing, prevention methods and structured rehabilitation programs.

[111] In Western Australia, the WA Auditor General's 2012 report on *Purchase and Management of Pharmaceuticals in Public Hospitals* highlighted the substantial risks which can arise from drug misuse in public hospitals. These include financial loss for the health service, illicit sale of drugs, hospital staff working whilst under the influence of drugs and a threat to public safety when drugs are not readily available for medical purposes.[21]

Warning signs of pharmaceutical drug abuse

[112] Research into the prevalence of drug abuse among health professionals has provided some general warning signs for identifying drug dependence. These include employees who:

- frequently volunteer for duties involving drugs, such as counting, collecting or signing out drugs;
- volunteer to work with patients who receive pain medication;
- request unsupervised evening or night shifts;[22]
- fall asleep at work;

[21] Office of the Auditor General Western Australia, '*Pharmaceuticals: Purchase and Management of Pharmaceuticals in Public Hospitals*', Report No 7 (2012) 5.

[22] Dunn, above n 16, 579.

- display behavioural changes such as impaired attention, slurred speech or anxiety;[23]
- make calculation errors on registers or accidental spillages when handling drugs so that discrepancies can be hidden; and
- have patients who complain of ineffective pain relief which may indicate their dosage has been tampered with.

[23] The Association of Anaesthetists of Great Britain and Ireland, '*Drug and alcohol abuse amongst Anaesthetists guidance on identification and management*' (2011) 9.

CHAPTER FIVE

Analysis of notifications from WA Health

[113] The purpose of this chapter is to analyse notifications received by the Commission from WA Health about drug discrepancies which may indicate theft and misuse of drugs by WA Health employees.

[114] The Commission is aware that the number of drug discrepancies notified is small when compared to the total number of drug administrations within hospitals in Western Australia. DoH estimates there have been 'millions of transactions for Schedule 8 and Schedule 4 Restricted medicines over a 3 year period'.[24]

[115] The Commission is also aware that theft of drugs is only one of the possible explanations for any notified drug discrepancy.

[116] However, the Commission considers that the number of discrepancies notified is unlikely to represent the total of drug thefts and misuse which occurs within WA Health. In its 2017 report on its investigation of the theft of Schedule 8 drugs by a hospital pharmacist, the Commission assessed that before he was detected and the Commission notified, the pharmacist had stolen drugs on at least 130 occasions over a period of 16 months at FSH, and on multiple occasions before that at SCGH. These were not the subject of notification because they were undetected. How many others, is unknown.

[117] Failure to detect a theft is also possible in cases where a liquid drug has been substituted. Some dilutions of this type have only been detected because the container was too full, or because the drug did not have the expected effect on a patient. It is realistic to speculate that there have been substitutions which have not been detected.

[118] A note about terminology used in the CCM Act. Each 'notification' made to the Commission by WA Health or 'report' by a member of the public, may contain more than one 'allegation' because it involves more than one public officer or more than one instance of suspected serious misconduct. Tables 1-6 refer to 'notifications' from WA Health.

[24] Letter from Dr D J Russell-Weisz, Director General, Department of Health to the Corruption and Crime Commission, 23 January 2018.

[119] For the four financial years 2013/14 to 2016/17, WA Health made 390 notifications to the Commission of drug discrepancies at WA Health sites. From these and six additional matters, the Commission identified 440 allegations.

[120] The jurisdiction of the Commission changed on 1 July 2015 and from that date, WA Health was no longer required to notify the Commission of every discrepancy, only those where serious misconduct was suspected. This meant that the number of allegations identified in 2013/14 and 2014/15 (360) was considerably higher than in the two later years.

[121] The Commission acknowledges that some drug discrepancies notified by WA Health, particularly for the 2013/14 and 2014/15 years could be the result of human error, including accidental spillage, miscalculation, poor record keeping, unintentional disposal and manufacturer discrepancy. The Commission is not assuming that all the discrepancies notified are the result of theft.

Notifications

[122] Table 1 identifies the main WA Health sites which have generated notifications to the Commission about drug discrepancies for the financial years 2013/14 to 2016/17.

Table 1: Notifications by WA Health sites

Site	Number	Percentage
Royal Perth Hospital	84	21.5%
Sir Charles Gairdner Hospital	68	17.5%
Fremantle Hospital	31	8%
47 other sites	207	53%
TOTAL	**390**	**100%**

[123] Three metropolitan hospitals, RPH, SCGH and FH have given rise to 183 notifications, 47% of the total.

[124] RPH and SCGH operate the State's largest trauma, emergency and critical care units. RPH currently holds the second biggest trauma workload in

the country,[25] whilst SCGH is WA's principal hospital for cancer treatments and is estimated to treat over 420,000 patients every year.[26]

[125] In February 2015, FH transferred its emergency department and some other major functions to FSH.[27] There were five notifications from FSH about drug discrepancies involving suspected serious misconduct in 2015/16, and 17 in 2016/17. These are included in the '47 other sites' in Table 1. The Commission separately examined security procedures for drugs at FSH in its report to Parliament of 20 June 2017, and does not include them in its analysis in this report.

[126] The five Health Service Providers were established on 1 July 2016 and the figures used in this report cover three years before, and one year after that date. However, using notifications about the WA Health hospitals and other sites which are now in the jurisdiction of those providers, the majority of notifications for the period 1 July 2013 to 30 June 2017 came from the area covered by EMHS, 131, followed by NMHS, 103, and WA Country Health Service, 82.

Concerns about failure to notify

[127] Notifications were made by WA Health for matters occurring at 50 health service sites. Given that there are 85 hospitals and a large number of other WA Health sites, either there are many sites at which there have been either no unexplained drug discrepancies in the four year period, or possible under-reporting. Many WA Health sites are small, with limited staff and with lower stocks of dangerous drugs.

[128] However, evidence of under-reporting at WA Health has been identified by the Commission in the past. During the Commission's 2009 review, some employees described a workplace attitude that, because employees worked long demanding hours in difficult conditions, there was a sense of entitlement about taking items, including drugs.[28]

[25] Government of Western Australia East Metropolitan Health Service, *Royal Perth Hospital About us* <http://www.rph.wa.gov.au/About-us>.

[26] Government of Western Australia North Metropolitan Health Service, *Sir Charles Gairdner Hospital About us* < http://www.scgh.health.wa.gov.au/>.

[27] Government of Western Australia South Metropolitan Health Service, *Fremantle Hospital Emergency Department closes tomorrow* < http://www.fhhs.health.wa.gov.au/About-us/News/>.

[28] Corruption and Crime Commission, *Misconduct Handling Procedures in the Western Australia Public Sector: WA Health* (22 April 2010) 66.

[129] Employees also admitted they had previously withheld information about possible misconduct because of loyalty to co-workers and fear of retribution:

> *… staff know that if you 'blow the whistle' you know they won't make life easy for you … staff would put their head in the sand … there's a fear of retribution when it comes to reporting misconduct …*

[130] Research has attempted to explore the underlying reasons why health professionals are inclined not to report workplace misconduct. A 2004 study examining a case in which four nurses went public with their concerns about hospitals in NSW, found that although nurses were obligated by codes of ethics to take action to protect patient safety, there are risks. It referred to other case studies recorded by the same author (a Professor of Nursing) and said 'Nurses who blow the whistle often end up with their careers and lives in tatters'.[29]

[131] Possible reasons for health professionals not reporting their co-workers can include reluctance to tarnish their employer or the health system, fear of the judgment of others, of implicating a friend, or of losing their job.

[132] A current review of WA Health's investigation reports suggests that WA Health may still be an environment where there is little encouragement or support for employees to either understand the seriousness of drug related misconduct, or to report it.

[133] For example, in one notification, it was explained that a nurse suspected to be linked to a number of drug discrepancies had repeatedly displayed past behaviours which raised a number of his colleagues' concerns:

- He had circumvented drug handling policies, such as drawing up drugs in excess amounts without witnesses.
- He deliberately disobeyed managerial restrictions relating to drug access and entered medical procedure rooms when allocated duties elsewhere.
- He consistently requested to go into procedure rooms and be involved in duties involving drugs.
- He was present shortly before drug substitutions and discrepancies were detected.

[29] Megan-Jane Johnstone, 'Patient safety, ethics and whistleblowing: a nursing response to the events at Campbelltown and Camden Hospitals' (2004) 28 (1) *Australian Health Review* 15.

- He drew up syringes of fentanyl well before they were required for a medical procedure and without another nurse present, which is against policy.
- He had been seen near the sharps container removing syringes, some of which would contain unused amounts of fentanyl and midazolam.
- He was constantly seen staring at drug cabinets.
- He forged a medical certificate to cover his absences.
- On one occasion, while on duty, he appeared drowsy and incoherent and then lost consciousness. He was admitted to the emergency department. When his next of kin was advised, they asked "has he been self-medicating again?". On this day, two crushed ampoules containing fentanyl and midazolam were discovered without any evidence of an accidental spillage.
- He called in sick when a staff meeting about suspected internal drug theft was organised. His close friend, who also worked in the health service, asked questions during the staff meeting such as "what would happen to the person concerned if caught?".

[134] A clinical consultant said she was approached by "many nurses and a few of the doctors" who expressed their suspicions about the nurse. She went to the Acting Director of Nursing who she believes took the matter up but was told that the nurse was to "remain where he was". The Commission understands that the nurse was reprimanded and warned but remained employed and accredited.

[135] The recent investigation by the Commission of a WA Health senior pharmacist for stealing Schedule 8 drugs from FSH also demonstrated the risk of colleagues not having the confidence to treat discrepancies as misconduct:

> *Didn't tell them I was suspecting because I find it's not appropriate to point finger.*
>
> *…*
>
> *It's also a matter of trust. You know we trust them so much … it's a highly trusted job.*
>
> *…*
>
> *I was scared about my - the pharmacists health. I thought that he might kill himself. I thought maybe he's an addict … and we need to help him. The first thinking was oh my god we need to help him, he, you know, could kill himself*

overdosing, because we hear every now and then in news that, okay, this person killed themselves. You know, people working in hospitals.[30]

[136] In a hospital environment, there is a risk that disparities of power between employees may influence internal reporting. Lower level staff may be less inclined to report higher level staff, and certain professionals may be less likely to be questioned. It is important that WA Health recognises this risk when developing and implementing strategies to encourage the reporting of drug related misconduct.

[137] Regardless whether an agency has an effective process for reporting externally to the Commission or to police, unless employees are prepared to report internally, the agency will not be aware of the issues.

[138] While the Commission understands the desire for colleagues and mangers to think first about the welfare of the employee, suspected theft of, and misuse of drugs may be serious misconduct and must be notified to the Commission.

Responses by Health Service Providers

[139] The Commission acknowledges comments made by Health Service Providers as part of their responses to a draft of this report. Several of the providers have given information about measures and initiatives they are undertaking with the aim of reducing discrepancies, improving medication handling practices, and changing the 'culture of under-reporting' described in previous Commission reports.

[140] As an example, the initiatives advised by EMHS include establishment of a Medication Discrepancy Working Group which provides oversight and accountability for the reporting, monitoring and management of Schedule 8 and 4 Restricted medicine discrepancies.

[141] SMHS advised that it has engaged a private company to provide an independent assessment of the control framework for the supply and management of Schedule 8 drugs at four hospitals operated by that service. Governance responsibility for implementation has been assigned to the SMHS Ethical Conduct Review Committee.

[142] The other Health Service Providers have also provided information about initiatives they are implementing to improve the security of dangerous drugs. The Commission welcomes such initiatives.

[30] WA Health employee, record of Interview (20 September 2016).

Drug discrepancies by location

[143] For the 183 notifications received by the Commission relating to drug discrepancies at the three hospitals, the following locations were given for the discrepancies:

Table 2: Drug discrepancies by location within hospitals

Location	Number	Percentage
Wards	95	52%
Emergency	50	27.5%
Pharmacy	20	11%
Psychiatry	4	2%
Theatre	4	2%
Other	10	5.5%

[144] The majority of drug discrepancies occurred on wards.

[145] The Commission has been advised by WA Health that, except for critical care areas, ward areas have more patients and staff in absolute terms, but a lesser intensity of Schedule 8 and Schedule 4 Restricted drug use.

[146] It seems reasonable to assume that generally wards operate in less of a rush and with greater opportunities for responsible drug handling and good record keeping than may be possible in emergency departments. However, WA Health has pointed out that ward areas can also include acute care areas with a high number of Schedule 8 and Schedule 4 Restricted drug transactions. Some wards have similar demands to those of ICU and emergency departments.

[147] It is reasonable to assume that wards are usually the areas caring for the greatest number of patients and with most outside visitors to those patients. They may also have least supervision of staff especially during night shifts and weekend shifts. This is discussed further in relation to Table 5.

[148] A review of WA Health investigation reports include the following incidents relating to drug discrepancies on wards:

- Three ampoules of fentanyl were stored in an unlocked bedside trolley for over seven hours before they were discovered to be missing.
- Two unused tablets of alprazolam were left in a dish by the sink rather than being locked up.
- A nurse left two fentanyl ampoules on top of a patient's bedside trolley for over two hours.
- A clonazepam tablet was observed by a number of ward staff to be left on a bench before it was noted as missing several hours later.

[149] Emergency departments keep Schedule 4 Restricted drugs on emergency trolleys, available for rapid access and transport. WA Health has explained that every ward and clinical area in a hospital has an emergency trolley to hold items which can be rapidly accessed for medical emergencies. The drugs on these trolleys require regular auditing.

[150] Notifications to the Commission suggest that, in the absence of good security procedures and record keeping, trolleys can be an insecure environment for storing drugs. For example:

- Midazolam, held as emergency medicine went missing from a cardiology resuscitation trolley which had not been audited in over 16 days. There were no CCTV cameras.
- Ten ampoules of midazolam and naloxone (a Schedule 4 drug but not restricted) were removed from an unlocked resuscitation trolley in an acute medical unit. It had not been checked for three days. The trolley was located in a corridor near a public entrance which was used by the public and staff from many different areas.

[151] The Commission accepts that staff in emergency areas respond to Medical Emergency Team (MET) calls. This is a system designed to provide rapid response to patients who have life threatening conditions. During these incidents, staff members are encouraged to stop what they are currently doing in order to assist. Sometimes drug stock is taken from trolleys in circumstances where it may not be practicable to measure drugs taken and left, to fill out a register, or to find another authorised person to supervise the transactions.

[152] A MET call can also reduce security in an area where drugs are held, as staff are redirected to urgent duties.

[153] Although the Commission recognises the difficulties which medical emergencies present to staff responsible for the security of drugs, more regular and enforced audits of drugs on emergency trolleys may help to identify whether dangerous drugs have been used legitimately, or stolen.

Drug types

[154] Based on notifications from WA Health to the Commission, the most common drugs with unexplained discrepancies are as follows:

Table 3: Drugs which are most often the subject of discrepancies

Schedule 8	Number of Incidents	Schedule 4 Restricted	Number of Incidents
Methadone	18	Clonazepam	21
Hydromorphone	16	Tramadol	17
Morphine	10	Midazolam	16
Oxynorm	10	Diazepam	10
Fentanyl	9	Temazepam	7
Total	**63**	**Total**	**71**

[155] Interestingly, there is only a small difference between the number of discrepancies for Schedule 8 and Schedule 4 Restricted drugs. The security level for Schedule 8 drugs is higher, and fewer unexplained discrepancies might be expected.

The form of the drug

[156] The forms of drugs notified to the Commission as unexplained drug discrepancies were as follows:

Table 4: Drug discrepancy by form

Drug Form	Schedule 4 Restricted	Schedule 8	Total
Liquid (ml)	32	57	89
Tablet/capsules/lozenges	60	31	91
Patch		3	3

Drug discrepancies involving tablets

[157] These drug discrepancies appear difficult for WA Health to investigate because of the range of possible innocent explanations. For example, tablets are sometimes dropped and not found, especially when they are removed to count.

[158] In one case, CCTV cameras captured an incident where a nurse conducting an audit spilled the contents, attempted to pick up all the tablets, but failed to recount to ensure there were no tablets missing.

[159] In another case a nurse said "it cannot be proven but I believe the tablet has fallen off the bench when several tablets dropped onto the bench as I was pouring them out". The nurse admitted to not recounting and said a tablet could have easily dropped off the bench, been kicked, trodden on or vacuumed.

[160] In other WA Health investigations, discrepancies were frequently categorised as being probably accidental for the following reasons:

- Falling behind furniture or into a bin beside the counting area.
- Staff failing to check whether contents remained in a box before discarding it.
- A cleaner accidentally discarding it.

[161] In addition, it appears staff auditing drugs can make miscalculations due to interruptions, workload, feeling sick, stressed, or lack of time.

[162] Another common WA Health investigation outcome was 'manufacturing loss'. Investigations into drug discrepancies in the pharmacy at SCGH concluded that the extent of loss could not be determined because the original supply was not checked. The seals on bottles were not broken, so if there was a shortfall at the manufacturers end, this was not identified: 'Checking of register identified stock count error - verified on CCTV footage that staff checking did not open the unsealed boxes to check the contents'.[31]

[163] Where initial quantities of drugs received are not verified, in some cases it may be difficult for a reliable inventory to be kept and even if drugs have been stolen, a possible innocent explanation cannot be discounted.

[31] WA Health reference S20150068, *Schedule 8 and restricted Schedule 4 Medicine discrepancy report form* (1 March 2015).

[164] WA Health have advised the Commission that there are practical reasons for not checking individual quantities when initially received. Stock received is verified, but WA Health does not open sealed boxes:

> *Schedule 8 medicines are required to be wholesaled with tamper evident seals showing that the primary container is intact. It is not physically feasible for staff, or economically practical for WA Health, to open every packet and individually count many millions of individual dose units.*[32]

Drug discrepancies involving liquids

[165] WA Health has advised that liquid drugs come in different forms depending on whether they are for oral administration or injectable formulations. Injectable liquid medicines are provided as unit dose forms and not subject to measurement or overage discrepancies.

[166] WA Health also advised that according to manufacturers' advice, bottles are overfilled during manufacture and before sealing to provide more than the stated volume contents. This is because plastic bottles are known to lose volume during storage.

[167] A review of WA Health investigation reports show that discrepancies in liquid drugs are frequently concluded to be possibly the result of spillage, wastage, or routine measurement errors.

[168] As described below, in the section titled *Discrepancies where the shift is 'not identified'*, where there are only intermittent audits of drugs on hand, fairly major discrepancies in liquid drugs can build up. The Commission is aware of examples where these are averaged over a large number of doses and then treated as if they were a large number of individual small discrepancies, each below the threshold for reporting. The Commission realises that depending on the method of application, there can be a small regular discrepancy in liquids, but notes that if there had been thefts, this method of averaging may miss them. The only way to be sure is frequent accurate record keeping.

[169] It also appears from some WA Health investigation reports that if a drug discrepancy met the threshold of possibly being accidental, no further investigation was conducted to assess if it was suspicious or not.

[170] Some investigation reports also stated that staff are not provided with training in drug administration.

[171] For example, a WA Health investigation report into a series of liquid Schedule 8 drug discrepancies at RPH in 2015 stated 'No formal training is conducted in the administration of Schedule 8 drugs. An RN is exposed

[32] WA Health internal memorandum, Public and Aboriginal Health Division, 23 January 2017.

to the requirements during their studies and become proficient at it in practice. There is no mandatory continuous training or competency based training across Health'.

[172] This investigation report also found numerous breaches of policies in relation to drug handling and stated that if the drug administration was being treated according to current polices, the discrepancies would not have occurred.

[173] Undoubtedly, it is possible that liquid drugs can be lost due to leakage and spillage, and recording errors may make it seem there are discrepancies when none exist. However, such errors or accidents should be documented as soon as they are identified so that if a loss needs to be explained, there is documentation to support it.

[174] The Commission is aware from the responses of individual Health Service Providers that improvements are being made in these areas. In the Commission's view, WA Health should be working towards implementing solutions to these discrepancies, particularly in the areas of:

- training for staff in drug administration;
- training for staff in record keeping for recording drugs on hand, and reporting discrepancies as soon as they are identified;
- improving methods for checking and recording the amounts of drugs on hand, on receipt into the hospital system and regularly thereafter; and
- developing clear and consistent policies requiring staff to audit and record drugs on hand and report discrepancies.

[175] The investigation report quoted above stated that for five of the eight discrepancies identified, the drugs were quarantined and tested. In each case, the drug had been diluted and another liquid had been injected into the bottle to cover up the amount stolen.

[176] It is possible that theft, dilution and substitution of drugs in liquid form often goes undetected. When liquid drugs are removed and then diluted with water or another substance, there is often nothing to indicate this has taken place unless a seal has been broken on a new bottle, or the drug does not have the obvious effect on the patient it is supposed to have. In some cases, dilution means there is an excess of liquid, but there are also other possible causes such as incorrect recording, how much was used on previous occasions, or extra being placed in the bottle at the manufacturing stage, which according to WA Health, is a common situation.

[177] For example, an inquest into the overdose death of a nurse (see Chapter Two) revealed she had probably obtained the drug from a patient's intravenous line. This meant that the drug had been used by the nurse even though the records showed it had been properly administered to the patient. Had the nurse not died, this would not have been detected.

[178] In another example in late 2015, an 85 year old patient in an operating theatre was administered a syringe which should have contained fentanyl. The patient did not respond despite the dosage being increased. The doctor became suspicious and requested the syringe be sent to ChemCentre for analysis. It was discovered there was no fentanyl in the syringe. The investigation found that a nurse had substituted the contents of the syringe.

[179] This problem is also common to health facilities in other parts of the world. In one case in the US, a radiology technician who had hepatitis C injected himself from unused fentanyl syringes, then refilled the syringes with saline solution. Five patients were infected with hepatitis as a result.[33] There are other obvious risks to patient welfare associated with dilution or substitution of drugs.

Time of drug discrepancies

[180] The following table sets out the work shifts on which drug discrepancies were believed to have happened. These are based on the estimated times of incidents provided by WA Health in their notifications to the Commission. For the purposes of this report, day shift includes afternoon incidents up to 6.00 pm.

Table 5. Time of drug discrepancies

Shift	Number	Percentage
Day shift	41	22%
Night shift	71	39%
Not identified	71	39%

[33] Keith H Berge, Kevin R Dillon, Karen M Sikkink, Timothy K Taylor and William L Lanier, 'Diversion of Drugs within healthcare facilities, a multiple-victim crime: patterns of diversion, scope, consequences, detection and prevention' (2012) 87 (4) *Mayo Clinic Proceedings* 674-82.

Discrepancies where the shift is 'not identified'

[181] This category includes notifications where it was not possible to identify which shift a discrepancy occurred on because an audit had not occurred for over 24 hours.

[182] The following WA Health ODs apply to record keeping for Schedule 8 and Schedule 4 Restricted drugs:

- The OD for oral liquid Schedule 8 and Schedule 4 Restricted drugs states that clinical areas should perform audits at intervals according to local hospital site policy but 'An inventory is to be performed not less than once daily and an entry recorded in the respective Register'.[34]

- An OD for Schedule 4 Restricted drugs states for pharmacy areas, 'A weekly stock inventory of each S4R medicine is to be performed and signed in the Register by two authorised persons'.[35]

- Another OD for Schedule 8 drugs states that 'An inventory is required to be made at least monthly …', but staff are directed to refer to hospital policy.[36]

[183] An analysis of investigations by WA Health suggest staff have varying understandings of the drug auditing requirements. For example, there were many instances where resuscitation trolleys which held emergency stock were not audited for a number of days despite policy directing staff to regularly check it.

[184] WA Health investigation reports highlight the difficulty in effectively investigating a drug discrepancy when appropriate policies had not been adopted or followed. When there are days, weeks, or even months separating drug audits, there can be a very large number of staff (and often patients, visitors and other non-staff) who could have had access to the area.

[185] Where there are no regular audits, particularly for liquids, fairly major drug discrepancies can be 'averaged' over a number of dispensations and treated as if they were insignificant.

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[34] WA Health, '*Operational Directive Management of Schedule 8 and Restricted Schedule 4 oral liquid medicines'* (2013).

[35] WA Health, '*Operational Directive Storage and recording of Restricted Schedule 4 medicines'* (2013).

[36] WA Health, '*Operational Directive 0141/08 - Code of Practice for the handling of Schedule 8 medicines (drugs of addiction) in hospitals and nursing posts'* (2013).

[186] The WA Health policy on *Management of Schedule 8 and Restricted Schedule 4 oral liquid medicines* (OD 0492/14) states 'If the discrepancy per dose is less than or equal to 0.2 ml/dose and no other irregularity exists, then no discrepancy report is required', although it should be recorded in a register at reconciliation. However, if the loss is over 0.2 ml per dose, then it must be reported.

[187] This can give rise to the following situation, where the quantity of a Schedule 8 drug in a bottle was found to have reduced from a register balance of 25.6 ml to an actual amount of 4 ml. It was reported as a stock loss. The incident reviewer reached the following conclusions:

> *Loss occurred over a 15 month period with 161 doses administered to multiple patients.*
>
> *Loss per dose administration equates to 0.13 mls.*
>
> *As per OD 0492/14 Management of schedule 8 and restricted schedule 4 oral liquid medicines. 161 dose administrations multiplied by 0.2mls = 32.2mls, hence loss is within allowable limits.*[37]

[188] It appears that in this case, no inventory had been carried out of the amount of the drug in the bottle since it was opened some 15 months previously. Interestingly, OD 0492/14 referred to by the incident reviewer, actually requires that 'An inventory is to be performed not less than once daily and an entry recorded in the respective Register'.

[189] Assuming that the number of doses, 161, had been recorded accurately, and accepting that the administration of liquids will result in a small discrepancy dependent on viscosity and the delivery method,[38] the Commission still has difficulty with the simple averaging out of discrepancies as a way of explaining where there has been a failure to keep proper records. It seems possible in this case that a larger loss was incurred at some point in the 15 months when no record was kept. This loss could be the result of theft or of spillage, but because of inadequate record keeping, it is simply not possible to know.

[37] WA Health reference S20140476.

[38] Veronica A Santoro, Samantha C Hilmi, Adam L Hort, Barry G Jenkins, 'Management of Controlled Drug (Schedule 8) Liquid Discrepancies to Achieve Best Practice' (2013) 43(3) *Journal of Pharmacy Practice and Research* 194.

[190] There are other similar notifications to the Commission where liquid drug losses have been deemed as 'acceptable losses' by WA Health chief pharmacists:

> *Considering this bottle was not balanced at the start and there have been 8 doses extracted from it, this discrepancy is acceptable.*[39]

> *As bottle open for 7 months evaporation could be a contributing factor.*[40]

[191] In some of the notifications received by the Commission, losses ranged from 30 ml through to 110 ml.

[192] In these cases, if a total large loss was genuinely made up of incremental smaller losses, these should have been recorded in the relevant register as required by policy. There would then be a timeline explaining the smaller losses, which would prevent suspicion falling on staff.

[193] It seems unlikely that staff stealing a drug would record the reduced amount in a register. Therefore, where there is a significant total discrepancy and the register entries do not record small incremental losses which explain this, in the Commission's view, this should be notified as a matter which may concern serious misconduct.

[194] The Commission accepts there can be accidental and incremental losses, but when the policies for auditing and recording drug quantities have not been followed, it is difficult for WA Health to confidently provide this as an explanation.

Discrepancies on night shift

[195] Based on the notifications received from WA Health hospitals, the rate of discrepancies occurring on night shift is greater than for day shift. This is despite the fact that in most hospital areas, there are normally less staff on duty during the night. This may not apply to ICU and emergency areas.

[196] If there are fewer staff on duty, then there may also be less supervision of those who are on duty. Research literature considered in the course of this report suggests that health professionals who wish to steal drugs may request unsupervised evening or night shifts.[41]

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[39] WA Health, *Investigation Report* S20150570.

[40] WA Health, *Schedule 8 and restricted Schedule 4 Medicine discrepancy report form* S20130800 (18 September 2013).

[41] Dunn, above n 16, 579.

[197] An alternative explanation, and one which has been suggested by WA Health, is that with less staff on duty during the night, there is greater workload and more opportunity for mistakes to be made, especially in the recording of drug dispensation. WA Health have suggested this in a number of their investigation reports into unexplained losses:

> *Although it is generally busy in ICU it was particularly busy that night. Normally [Registered Nurses] only have one patient to look after; however, on this night some of the nurses … had two patients to look after.*
>
> *…*
>
> *At the time of the incident ICU staff members were in the habit of drawing up drugs they needed for later. This was in part due to staffing issues … sometimes there would be no staff available to witness the signing out of drugs. This had led to staff being told by some managers if they wanted drugs for later they had to sign them out now.*[42]

[198] In the reports by the Coroner in 2013 into the deaths of two WA Health nurses, it appears that one nurse remained addicted to drugs while working on night shifts at the hospital. The other nurse was on night shift when she appeared to have deliberately diverted fentanyl from one of her patients and took a lethal dose.

[199] During the Commission's recent investigation into multiple thefts of hydromorphone involving a pharmacist at FSH, on many occasions the drug was stolen outside normal working hours.[43] Inquiries into the procedures at FSH indicated there was a security gap, in that there was no requirement to check what drugs were dispensed overnight and who had accessed the area: 'There is no rule that anyone in the morning would check what happened after hours'.[44]

[200] For notifications of drug discrepancies where a date could be identified, 23% occurred on a weekend shift. It appears from the notifications from WA Health that a significant proportion of drug losses occurred on night and weekend shifts.

[201] From reviews of WA Health investigation reports containing interviews with staff, it appears attitudes to managing dangerous drugs is less strict during night and weekend shifts. It appeared to be accepted that policies were regularly breached during those times.

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[42] WA Health, *Investigation Report S201502977* (24 March 2016) 7, 11-12.

[43] The Corruption and Crime Commission (2016). *Report on the supply and management of Schedule 8 controlled drugs at certain public hospitals in Western Australia,* p 3.

[44] Record of interview (20 September 2016).

Patients' own drugs

[202] Sometimes patients admitted to hospital have their own drugs with them. Sixteen out of the 183 drug discrepancies considered in this report involved the loss of patients' own drugs. Nine were Schedule 8 drugs and seven were Schedule 4 Restricted drugs.

[203] Of these losses, 11 were on wards, four in emergency departments and one in mental health. Five of the losses occurred when patients were being transferred from an emergency department to a ward. The procedure for transporting these drugs appears to differ at each site and could include sealed transport bags; brown paper bags collected by a patient care assistant; or an unsealed cardboard box.

[204] These drug losses could be the result of staff taking advantage of lower security controls in place for the drug as it is transported. For example, in one notification, a paper bag containing drugs was collected by an unknown patient care assistant without it being signed out. In another case, transport bags were identified as being damaged before drugs were placed in the bag and then lost.

[205] WA Health investigation reports record a variety of ways in which patients' own drugs are stored and recorded at different hospitals:

- Stored in a sealed bag in a locked drug cupboard with hospital drug stock.
- Stored without a bag in a locked drug cupboard.
- Stored in a lockable bedside drawer.
- Placed on the drug register and audited like hospital stock.
- Not recorded.
- Patients are discouraged from bringing in other drugs, family members are advised to take them home.

[206] A review of WA Health's investigation reports relating to loss of patients' own drugs showed that the main focus when a patient was admitted to the hospital was, understandably on their treatment rather than their property. Staff often justified not adhering to local site policy on patients' own drugs because they were too busy, especially when patients were admitted through an emergency department:

- In one incident, staff were captured on CCTV cameras conducting an inventory of patients' own drugs without checking the contents of unsealed boxes.

- In another case involving buprenorphine, a Schedule 8 drug, 10 tablets were recorded in the register, but only eight were accounted for:

  > *It is possible that an assumption was made that two of the foil tablet shells contained a tablet each whereas they were in fact empty. The paper cover was only partially removed from the aluminium foil and so on quick inspection, the shell appears intact.*[45]

- In one case, the patient's own drugs were not recorded for the eight day duration of their stay. They were only identified as lost when the patient was discharged. The 10 tablets were not located.

[207] The risk of patients' own drugs being targeted for theft is increased by the fact that most patients, especially in the early stages of admission, are focused on their health rather than on their property. In addition, they may be unaware of the exact amount of drugs they have.

[208] The risks are also increased when patients are vulnerable in some way. In three of the notifications made to the Commission by WA Health about patients' drugs going missing, it appears the patients had been either residents of a psychiatric institute or suffered from an illness such as dementia. The other notifications did not identify the age or illness of the patient and it is unknown whether they were a vulnerable person.

[209] In one notification, a patient's own packet of morphine tablets had not been recorded in the register when it was initially taken off him during admission. The patient had dementia and was not capable of being interviewed and his wife could not recall the amount either. The investigation was closed.

[210] If patients' own drugs are not recorded as initially received, then it is unlikely that a loss will be detected. Of the 16 notifications to the Commission, nine involved shortcomings in relation to receiving, recording, security and checking of the drugs.

[211] Storage for all drugs, especially patients' own drugs, should be secure. To reduce the chances of those drugs being accidentally mixed with hospital stock, they should be clearly labelled or separated. At admission, staff should audit and record the drugs before they are stored and, if possible, the record should be endorsed by the patient.

[45] WA Health, *Investigation Report S20140572*.

Conclusion on analysis

[212] The analysis of notifications received by the Commission from WA Health suggest there are patterns of drug discrepancies occurring at particular locations and times. This gives rise to a suspicion that drugs have been targeted and stolen.

[213] While the numbers of notified suspicious drug discrepancies are small compared to the total number of drug transactions within WA Health, the data suggests that theft of drugs by employees has occurred and is continuing to occur. This often appears to be difficult to investigate successfully because of weaknesses in security and record keeping.

CHAPTER SIX

Investigations by WA Health

Table 6. Outcome of investigation				
Hospital	**Unexplained discrepancy**	**Explained discrepancy**	**Person responsible identified**	**No discrepancy identified**
Royal Perth	64	9	5	6
Sir Charles Gairdner	59	8	0	2
Fremantle	16	14	0	0

[214] The five notifications in the 'Person responsible identified' column refer to two people. One was the subject of two notifications, and the other was the subject of three notifications. Of the 183 WA Health notifications of drug discrepancies, these were the only two people definitively identified as stealing and misusing drugs.

[215] The eight notifications in the 'No discrepancy identified' column refer to notifications of suspected drug related behaviour, but where no drugs were identified as missing.

[216] The 'Explained discrepancy' column refers to discrepancies found to be because of spillage, wrong doses, manufacturer mistake, environmental factors or counting errors.

[217] 'Unexplained discrepancy' refers to notifications where the reason for the discrepancy was not definitively identified after investigation. They are grouped into one category regardless of whether WA Health considered that the discrepancy was likely to have been accidental, non-suspicious or was suspected to be a theft by an identified or unidentified officer.

[218] A majority of the unexplained discrepancy investigations noted a failure to follow policy at some point of the management of the drug. The Commission notes that this makes it difficult for investigators to reach a conclusion about the reasons for a drug discrepancy.

Investigation process

[219] When drug discrepancies are initially identified, a discrepancy form is commenced and the supervisor, security staff and/or pharmacy are notified. Other staff undertake the roles of medication incident coordinator and incident reviewer. If theft or other form of serious misconduct is suspected, the Commission and possibly police should be notified.

[220] The discrepancy reporting form provides a checklist for details of the discrepancy, the people involved, investigative actions and findings. WA Health have advised that the reporting form is available to all staff online.

[221] Although local hospital staff do not specialise in conducting investigations, because they are aware of how drugs should be handled and managed, the Commission accepts they are suitable officers to initially examine discrepancies. This is especially the case in rural and remote areas where WA Health sites will generally not have access to staff specialising in investigations other than by telephone or email.

[222] There are risks associated with internal investigations by local staff. Where local staff are the initial investigators and need to decide whether a discrepancy is suspicious, there is a risk they may be affected by their relationship with colleagues, and possibly a reluctance to believe a colleague is engaging in criminal acts. Local staff may also feel pressure not to attract unwelcome outside attention to their work area.

[223] WA Health assessment and investigation reports received by the Commission have illustrated the following features which make investigation difficult:

- Inadequate or inaccurate drug registers and other record keeping. This makes it difficult for an investigator to establish when a discrepancy occurred and the amount of drugs missing.
- Lack of drug security, for example when staff lack knowledge of policies and protocols for handling Schedule 8 and Schedule 4 Restricted drugs, when many employees had access to drugs storage areas, or when keys were shared.
- Some staff appear to be confused about the process for reporting a discrepancy.

- Delay in incidents being reported and/or investigated. This can make it difficult to obtain evidence: patients may have been discharged; memories fade; CCTV footage may not be retained.
- Security gaps such as lack of CCTV cameras for some secure areas and in others, cameras placed where the actions of staff cannot be seen.
- Initial acceptance of an account given by a person suspected without further investigation and failure to identify or interview other staff.

[224] These features make it difficult for an investigator to establish when and how a discrepancy has occurred. The result is that investigations are frequently not able to obtain evidence to reach a definite conclusion, and most drug discrepancies cannot be explained.

[225] This means investigation findings are often based on speculation and circumstantial evidence such as the following examples:

- Possible administrative errors or leakage.
- Accidentally discarded and bins have been emptied by cleaners.
- Could have evaporated over time.
- Multiple mathematical errors.
- Patient may have accidentally been given the wrong drugs.
- Manufacturer over supply or under supply.

[226] Some WA Health investigation reports demonstrate confusion by staff about who they were supposed to notify when a discrepancy was identified. For example:

> *She telephoned security but was advised they no longer dealt with drug discrepancies.*
>
> *…*
>
> *She called the Nurse Coordinator … who told her to tell the Team Leader.*
>
> *…*
>
> *There had been some delay in reporting this as no one could find the drug discrepancy forms during the night.*[46]

[46] WA Health, *Investigation Report S20150297* (24 March 2016) 5-7.

[227] This investigation report also gave examples of failure to follow policies before the discrepancy was identified:

> *… although ICU staff were aware of S8 drug protocols, they chose not to follow them.*
>
> *In ICU, because of the amount of drugs used, it had been common practice for some staff to go to the cupboard, sign out a large quantity for the whole shift, and leave the drugs unsecured in the top drawer of the bedside trolley.*
>
> *…*
>
> *There was an audit completed on administering S8 drugs earlier this year and the unit failed miserably but no action was taken.*[47]

[228] This investigation demonstrated that the failure to properly manage drugs was not just confined to this discrepancy. It also highlighted the difficulties investigators have in investigating discrepancies when the procedures followed do not match the policies, drug registers cannot be relied on and there is a delay in a matter being reported.

[229] Lax compliance with procedures will benefit anyone who wishes to circumvent them, to steal drugs.

[230] The Commission is also concerned about the quality of investigative training received by staff responsible for making initial inquiries into discrepancies. In its response to the Commission's 2010 report *Misconduct Handling Procedures in the Western Australian Public Sector: WA Health*, WA Health advised that investigative training was one of their intended initiatives to improve their focus on drug-related misconduct.[48] The Commission is not aware of this being implemented. However, in its response to a draft of this report, one of the Health Service Providers advised that 'increased training for those staff conducting the initial medication discrepancy investigations has been identified as an area requiring action to ensure quality investigations and outcomes and action will be taken to progress this in 2018'. The Commission welcomes this initiative and commends it to other areas of WA Health.

Conclusions on investigations by WA Health

[231] The Commission is concerned about the extremely low rate of drug discrepancies which are adequately explained by the investigations undertaken by WA Health. In the Commission's view, this contributes to

[47] WA Health, *Investigation Report S20150297* (24 March 2016) 6, 16.
[48] Corruption and Crime Commission, *Misconduct Handling Procedures in the Western Australia Public Sector: WA Health* (22 April 2010) 53.

a higher likelihood of continuing theft of dangerous drugs, and a higher level of risk for WA Health.

[232] The Commission has two suggestions to make in this regard:

- All drug discrepancies where there is suspected serious misconduct should be investigated by people with investigative skills and independent of the area where the drug discrepancy has occurred.
- WA Health develop strategies to ensure simple and consistent policies are implemented and are used to ensure drug quantities and transactions are recorded at all stages from receipt to final administration, and that discrepancies are identified and reported at an early stage.

CHAPTER SEVEN

How WA Health deals with offenders

[233] The Commission notes that some incidents involving health professionals with drug addictions appear to have been treated by management at WA Health by way of a medical welfare process, rather than as serious misconduct.

[234] While the welfare of employees is important, if it is the exclusive focus, then the risk of drug related serious misconduct is not reduced.

[235] The Commission is aware of situations in which health professionals suspected by WA Health to have a drug addiction, were allowed to continue their employment or to resign:

- A nurse received a spent conviction for holding up a pharmacy. He returned to work under supervision and then stole drugs from his workplace. Colleagues of the nurse had spoken to management about their suspicions, but nothing was done. The nurse then presented at the emergency department from an overdose of non-prescribed Schedule 8 and Schedule 4 drugs before being arrested by police after refusing to comply with a blood and alcohol test.

- A nurse was caught at a sharps container collecting used fentanyl syringes before passing out mid-shift and being admitted to the emergency department. The nurse was suspected by many colleagues to be responsible for a number of earlier unexplained drug losses.

- A nurse stole portions of a patient's intravenous medications and hid the syringes in the sharps bin for personal use.

- A nurse was found unconscious in a car park with a needle in his arm. On a later occasion, the same nurse was admitted to an emergency department for drug related reasons. He said that he had found drugs in a hospital locker room and took them: Case study 1.

- A nurse is suspected to have set fire to a site to destroy drug registers.

- A health professional stole prescription pads from work, wrote fraudulent prescriptions for associates and himself; and when searched by police, had items on him which suggested he may have been committing burglaries.

[236] There is a clear risk involved if WA Health does not take action to prevent staff members who are strongly suspected to have a drug problem from having access to dangerous drugs.

CHAPTER EIGHT

Summary

[237] This report considers notifications received from WA Health relating to discrepancies in Schedule 8 and Schedule 4 Restricted drugs at three WA Health hospitals, RPH, SCGH, and FH for the period 2013 to 2017.

[238] This report supplements the Commission's report dated 20 June 2017 which, among other things, considered procedures for handling Schedule 8 drugs by pharmacies at FSH and SCGH.

[239] Although the Commission has analysed data relating to drug discrepancies at only three hospitals, the problems identified are likely to occur in other hospitals and other WA Health facilities.

[240] Analysis of WA Health notifications (Table 6) suggests that most drug discrepancies remain unexplained after investigation. WA Health is unable to account to the Commission or the community for the majority of drug discrepancies.

[241] In the Commission's view, based on the notifications it has received from WA Health, its own investigations and other sources, the difficulties experienced by WA Health in explaining drug discrepancies is exacerbated by deficiencies in record keeping and compliance with policies relating to security and handling of drugs.

[242] The Commission accepts that WA Health is properly focused on ensuring each patient receives the right treatment, including the right medication. However, the risks that drug theft and misuse by staff pose to the staff members themselves, their colleagues, patients and the health service, requires a high priority be given to drug security.

[243] National and international research indicates that drug abuse by health professionals can pose a significant risk for health agencies. Research suggests that the availability of drugs increases the risk of health professionals misusing them.

[244] Schedule 8 and Schedule 4 Restricted drugs are attractive to people who use drugs illegally. Effective security systems are necessary not only to protect drugs from theft by staff, but also by patients, hospital visitors or other people.

[245] By adopting and following effective policies for managing and securing Schedule 8 and Schedule 4 Restricted drugs, WA Health will reduce the opportunities for their theft and abuse.

[246] Good security procedures not only decrease opportunities for theft, but if theft has taken place, it can enable early identification of the theft and increase the likelihood of establishing what was stolen, when, where, how and by whom; and thereby prevent further thefts.

[247] Where a drug discrepancy has an innocent explanation, good security and good record keeping will help this to be identified and prevent suspicion falling on staff.

[248] The Commission is also concerned that some drug discrepancies are not professionally investigated by WA Health, and are treated more as a human resources or welfare issue than one of potential serious misconduct.

Recommendations

[249] The Boards of the five WA Health Service Providers are responsible for the management and security of dangerous drugs held in their facilities, and for mitigating risks that can arise from theft and abuse of these drugs.

[250] To improve the security and management of Schedule 8 and Schedule 4 Restricted drugs, the Commission makes the following recommendations:

a) WA Health's ODs and hospital policies be reviewed to ensure that policies for drug management, recording and reporting discrepancies are consistent across WA Health.

b) Clear accountability roles be established for the management of drugs.

c) Records of drugs received, drug transactions and audits of drugs on hand be accurate, frequent, enforced and audited.

d) Policies be developed and implemented to improve security for patients' own drugs, including transport and storage of those drugs.

e) Drug discrepancies, whether the cause is known or not, be reported immediately (subject to patient needs) and investigated, and when appropriate, be notified to the Commission as soon as possible.

f) Drug discrepancies which may be the result of theft be investigated by officers with investigative skills as possible serious misconduct.

g) Ongoing education and training be given to relevant staff in drug management, record keeping, reporting discrepancies and investigating discrepancies.

h) Consideration be given to implementing systems which could improve security and better recording of access to drugs. This could include swipe key access, biometric identification or, where feasible, systems where identifications of two people are required to authorise drug transactions.

i) Strategies be developed and implemented for detecting and dealing with drug related misconduct. These could include intelligence analysis of discrepancies and reported behaviour to detect patterns, and risk assessments of WA Health sites which deal with Schedule 8 and Schedule 4 Restricted drugs.

[251] The Commission proposes to further report on the implementation of recommendations which have been accepted by WA Health, together with the initiatives identified in this report in a year's time.