Corruption and Crime Commission

Report on the Supply and Management of Schedule 8 Controlled Drugs at Certain Public Hospitals in Western Australia

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CORRUPTION AND CRIME COMMISSION

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President of the Legislative Council
Parliament House
Harvest Terrace
PERTH WA 6000

Hon. Peter Watson, MLA
Speaker of the Legislative Assembly
Parliament House
Harvest Terrace
PERTH WA 6000

Dear Ms President
Dear Mr Speaker

In accordance with the *Corruption Crime and Misconduct Act 2003* s 84, the Commission presents its *Report on the Supply and Management of Schedule 8 Controlled Drugs at Certain Public Hospitals in Western Australia.*

Yours sincerely

John McKechnie, QC
COMMISSIONER

20 June 2017

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INTRODUCTION

[1] Mr Matthew Foster was an outstanding pharmacy student. He was awarded Pharmacy Student of the Year in 2008 at The University of Western Australia.

[2] Soon after Mr Foster completed his degree, he was employed by WA Health and undertook an internship at Sir Charles Gairdner Hospital (SCGH).

[3] Becoming a qualified pharmacist at SCGH, he gained experience in operational and clinical pharmacy.

[4] During the latter period of his employment at SCGH, Mr Foster's family suffered a tragedy in February 2014.

[5] There was limited intervention by WA Health to see how the tragedy affected him.

[6] Mr Foster successfully applied for a senior clinical pharmacist position at Fiona Stanley Hospital (FSH), beginning work in October 2014.

[7] But he had a dark secret. Mr Foster came to FSH highly addicted to a potent opioid drug that pharmacists liken to heroin - hydromorphone. He stole and used hydromorphone while at FSH.

[8] Hydromorphone is one of several opioid drugs classified as Schedule 8 controlled drugs (Schedule 8 drugs). These drugs are subject to strong legislative controls. The controls regulate their access, handling, use, storage and disposal.

[9] The amount and regularity of Mr Foster's use indicated he required a substantial quantity of opioids to fuel his addiction. Without building a degree of tolerance, the dosage was likely to be fatal.

[10] In hindsight, it is clear Mr Foster became addicted to opioids at SCGH. Systems in place to manage and control Schedule 8 drugs at SCGH were inadequate and easy to circumvent without detection.

[11] Mr Foster continued to circumvent controls at FSH. He did this for almost 14 months without detection, stealing large quantities of Schedule 8 drugs, mainly hydromorphone. The checks and balances at FSH were inadequate to detect his conduct.

[12] What looked like legitimate supplies of Schedule 8 drugs from hospital pharmacies to wards and units, were in fact something more sinister. Mr Foster was gaining unauthorised access to Schedule 8 drugs to feed his addiction.

[13] Mr Foster was charged, convicted and sentenced for stealing and possession of 17.78 grams of hydromorphone and 11.96 grams of oxycodone. Both are Schedule 8 drugs.

[14] The prosecution related to only 46 of 130 of Mr Foster's unauthorised Schedule 8 drug supply transactions from the FSH pharmacy safe.

[15] The prosecution of Mr Foster was not the end of the matter. Questions remained as to why FSH and SCGH did not promptly detect Mr Foster's unauthorised access and stealing.

[16] Stealing Schedule 8 drugs is serious misconduct.[1] A Commission function is to analyse systems used within public authorities to protect against serious misconduct and to report on ways to prevent and combat serious misconduct.

[17] Mr Foster's case raises concerns about the broader serious misconduct and corruption risks at public hospitals.

[18] Some WA Health records required by legislation to be produced on demand, were missing. These missing records inhibited the investigation and prosecution processes.

[19] No statutory declarations had been made about most missing records despite a legal requirement to do so. A statutory declaration in respect of missing register HA14 was made by Ms Gillian Babe, chief pharmacist[2] at SCGH on 24 May 2017, after a draft copy of this report was sent to her for comment.

[20] The chief pharmacist at each hospital, as the poisons permit holder, is responsible for ensuring and monitoring compliance with the strict legislative controls on Schedule 8 drugs.

[21] Mr Barry Jenkins is the chief pharmacist at FSH. There were failures on both Mr Jenkins' and Ms Babe's parts to ensure their Schedule 8 drug controls detected Mr Foster's conduct promptly. According to Mr Jenkins, in his response to a draft copy of this report, his acknowledged failure should be seen in the context of FSH at the time, when the pharmacy was under pressure, staff numbers were limited and systems were undergoing design. There was turmoil. This may help explain, but does not remove responsibility for failures.

[22] Both chief pharmacists recognise the risks of serious misconduct exposed by Mr Foster's conduct, and have taken some steps to improve matters.

[23] The Commission acknowledges the openness and co-operation which Mr Jenkins, Ms Babe and all other WA Health officers gave during the investigation.

[24] Substantial steps are required by WA Health, FSH and SCGH in order to:

(a) promptly detect such conduct when it does occur; and

(b) reduce the likelihood of serious misconduct and corruption occurring.

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

[2] At SCGH, the chief pharmacist equivalent is described as Head of the Pharmacy Department.

CHAPTER ONE
HOW THE INVESTIGATION CAME ABOUT

Suspected theft by pharmacist

[25] On 8 October 2014, Mr Foster commenced work at FSH. He was a clinical pharmacist and a trusted advisor to medical clinicians, pharmaceutical professionals and patients. He was authorised and approved[3] to possess, supply, administer and dispense any medicines or poisons, including Schedule 8 drugs.

[26] On 15 February 2016, WA Health informed the Commission it suspected serious misconduct at FSH concerning systemic theft of hydromorphone, which may have been occurring for 14 months.

An arrest is made

[27] The Commission commenced an investigation.

[28] In less than 48 hours, the investigation revealed that in the preceding week, Mr Foster had entered the FSH pharmacy after normal working hours on three occasions. In this short time, he stole a total of 1.5 grams of hydromorphone from the pharmacy safe.

[29] Commission officers arrested Mr Foster on 19 February 2016. He made admissions to possession and use of hydromorphone. He admitted self-administering the potent narcotic minutes before his arrest. He said that he was using about 50 to 100 milligrams of hydromorphone each day at that time.

[30] The extent of Mr Foster's use was apparent from items seized by the Commission from his home and another workplace. These included empty hydromorphone and oxycontin boxes, syringes, tourniquets, two full vials and 17 partially used vials of hydromorphone.

Prosecution of Mr Matthew Foster

[31] A brief of evidence compiled by the Commission was referred to an independent prosecution authority. Mr Foster was charged with offences of stealing as a servant[4] and unlawful possession of a prohibited drug.[5] Due to the lack of some WA Health records, the prosecution was limited to 46 unauthorised transactions involving 17.78 grams of hydromorphone and 11.96 grams of oxycodone.

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[3] Registered under the *Health Practitioner Regulation National Law (Western Australia)* which is regulated by the Australian Health Practitioner Regulation Agency (AHPRA).

[4] *Criminal Code* s 378.

[5] *Misuse of Drugs Act 1981* s 6(2).

[32] Mr Foster pleaded guilty to all offences and in December 2016, was sentenced to 12 months imprisonment. The sentence was wholly suspended and he was ordered to serve an 18 month community based order. He was ordered to pay restitution to WA Health and legal costs incurred by the prosecuting authority.

[33] As a consequence, Mr Foster now has 92 criminal convictions. His career prospects have been curtailed and he is not permitted to use his knowledge or skills to practice as a pharmacist.[6]

[34] Each criminal offence constitutes serious misconduct and a gross breach of trust. It took a long time for the misconduct to be detected.

Serious misconduct at two Western Australian public hospitals

[35] From March to July 2016, the Commission worked with WA Health to investigate Mr Foster's unauthorised access to hydromorphone, oxycodone, oxycodone/naloxone and fentanyl, all Schedule 8 drugs.

[36] The Commission obtained information from WA Health, FSH and SCGH. Interviews were conducted with relevant staff. Internal reports, audit records, Schedule 8 registers, Schedule 8 requisition forms and archived records were reviewed. The seriousness of Mr Foster's misconduct was soon apparent. WA Health reported to the Commission that there were approximately 66 transactions at FSH where Mr Foster was identified as having stolen (or diverted) Schedule 8 drugs.

[37] After consideration and review of the reports received from WA Health in March and May 2016, the Commission required FSH to provide requisition forms, registers and iPharmacy transaction reports for all Schedule 8 drug transactions involving Mr Foster. After comprehensive examination, the Commission identified a significant number of discrepancies in the requisition forms and registers which did not reconcile with the records of Schedule 8 drugs supplied by Mr Foster.

[38] The Commission has assessed that on at least 130 occasions between December 2014 and February 2016, Mr Foster took Schedule 8 drugs at FSH without authorisation. There were also five occasions between July and September 2014, whilst he was employed at SCGH, that Schedule 8 drugs were taken by Mr Foster without authorisation.[7]

[39] Each transaction represents a separate act of serious misconduct. The full extent of Mr Foster's serious misconduct cannot be ascertained because WA Health records at both hospitals were deficient, incomplete, and at times, missing.

[6] Effective 28 October 2016, Mr Foster must notify AHPRA within 14 days if he seeks to practice as a pharmacist - Register of Practitioners as at 17 March 2017.

[7] Internal report from N J McIntosh to N J Keen, 19 May 2016, p 3.

Broader risks of serious misconduct for WA Health

[40] The evidence of serious misconduct at both FSH and SCGH led the Commission to look more broadly into systemic issues within WA Health regarding supply and management of Schedule 8 drugs in public hospitals.

[41] The Commission continued to work with WA Health, FSH and SCGH, obtaining documents, records and information relevant to its broader investigation.

[42] Site inspections were conducted and Commission staff consulted with WA Health pharmacies at South Metropolitan Health Service (SMHS), North Metropolitan Health Service (NMHS) and East Metropolitan Health Service (EMHS). Private examinations were conducted with:

- Mr Neil John Keen - WA Health, chief pharmacist;
- Mr Barry Gavin Jenkins - FSH, chief pharmacist;
- Ms Gillian Elizabeth Babe - SCGH, chief pharmacist (Head of Pharmacy Department);
- Mr Neil John McIntosh - WA Health, senior investigator; and
- Mr Kenneth Ken-Yan Tam - FSH, senior pharmacist.

[43] A copy of a draft report was provided to a number of witnesses. Where the Commission accepted their responses, the draft was amended accordingly.

[44] The investigation has:

(a) identified significant deficiencies in detecting unauthorised supply or use of Schedule 8 drugs;

(b) exposed an inability to identify, track and audit records of the unauthorised supply or use of Schedule 8 drugs; and

(c) indicated that some efforts to improve detection and reduce risks of serious misconduct at FSH and SCGH have been endorsed by management, but not yet implemented.

CHAPTER TWO

THE LEGAL FRAMEWORK FOR SCHEDULE 8 DRUGS

The Commonwealth Poisons Standard

[45] The Poisons Standard is a federal legal framework instrument made under the *Therapeutic Goods Act 1989* (Cth) s 52D. It incorporates the Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP).

[46] The SUSMP enables the federal health department's secretary to recommend appropriate classifications for medicines and poisons to states and territories. This promotes national uniformity.

[47] The SUSMP also sets recommended levels of control on the availability of medicines and poisons.

Western Australia's legal framework

[48] Western Australia has implemented the SUSMP classifications.[8] Section 4 of the *Medicines and Poisons Act 2014* (WA) (MPA) defines a Schedule 8 poison as a 'Controlled Drug':

> *Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical and psychological dependence.*[9]

[49] Consequently, Schedule 8 drugs are the subject of strong legislative controls[10] and are characterised as drugs of addiction.[11] These controls are balanced against the clinical need to quickly administer drugs to patients who may be in pain.

[50] Mr Jenkins described Schedule 8 drugs as:

> *… drugs that need to be controlled because of the risk to the community and to people… They are used for treating pain, generally speaking, so they have addiction potential. They are dangerous if used in the wrong dose, and people do die on controlled drugs. They could stop breathing, become unconscious… There's a wide range of opioids, which have different potencies that people don't understand, and the body eliminates them at different rates, depending on the drug, and by different organs. So it really requires specialised knowledge and strong procedures around managing the administration of*

[8] MPA s 4 and *Medicines and Poisons Regulations 2016* (MPR) reg 3 (previously the *Poisons Act 1964* (PA) s 20 app A).

[9] MPA s 4(1).

[10] This State's legal framework in respect of scheduled medicines and poisons moved from being under the PA to the MPA on 30 January 2017.

[11] MPA s 77 (previously PA s 5) and the MDA s 3.

these drugs to patients. It also requires sensible policies so that people get access to these drugs in a timely way so they're not in pain for too long.[12]

[51] Widely known illicit drugs such as cocaine, methylamphetamine, and morphine are listed in Schedule 8.[13] Hydromorphone is a Schedule 8 drug. The potency of hydromorphone is gauged by its controversial use as part of a two drug protocol to execute convicted prisoners in two US states in 2014.

[52] Mr Jenkins described hydromorphone:

Hydromorphone… is a very potent drug. I guess you could compare [it] to heroin, so it's a very strong variant of morphine… initially, when it was marketed, it was for palliative care patients or patients with very high rates of pain untreatable by the usual opioids. But it has found increasing use in a number of different settings... It's not necessarily restricted to palliative care cancer patients.[14]

Illegal possession

[53] Several statutes criminalise unauthorised possession of, or dealing with, Schedule 8 drugs. These include the *Misuse of Drugs Act 1981* (MDA),[15] MPA,[16] and the *Criminal Code* (Cth).[17] Offences expose an offender to large financial penalties and significant terms of imprisonment.

[54] An authorised health professional dealing with Schedule 8 drugs otherwise than in the lawful practice of their profession and in accordance with the legislation, does so without authorisation.

[55] When a public officer is engaged in such conduct while acting or purporting to act in his official capacity, the Commission's serious misconduct function is triggered.[18] It also raises concern about the broader serious misconduct and corruption issues relating to the management and control of Schedule 8 drugs in public hospitals.

Poisons permit holder

[56] The responsibility for ensuring and monitoring compliance with the strong legal framework controls in public hospitals falls on the person who is issued a poisons permit.[19] The WA Health CEO,[20] generally through a

[12] B G Jenkins transcript, private examination, 1 March 2017, pp 13-14.

[13] MPA s 4 and MPR reg 6 item 7.

[14] B G Jenkins transcript, private examination, 1 March 2017, p 14.

[15] Sections 6(1)-(2).

[16] Part 2 and s 115.

[17] Chapter 9 pt 9.1 divs 302, 308.

[18] CCM Act ss 3, 4(c).

[19] MPA s 36. Section 141 also continues poison permits issued under the repealed PA ss 25 and 26 and *Poisons Regulations 1965*(PR) reg 10A. Under the repealed PR reg 50(1)(a) the law specifically placed the obligations on the pharmacist in charge of the pharmacy department who was, in practice, the poisons permit holder.

delegate,[21] grants poisons permits to the chief pharmacist of each public hospital facility. Mr Jenkins and Ms Babe were, and remain the poisons permit holders at FSH and SCGH, respectively.

[57] The conditions of the poisons permit and various legal framework provisions impose obligations on the poisons permit holder in relation to the management and control of Schedule 8 drugs.

[58] The CEO retains discretion to cancel, suspend or revoke a poisons permit. The MPA, which came into effect on 30 January 2017, places specific obligations on poisons permit holders. For example, the CEO can take action against a permit holder if satisfied there was a failure to take all reasonable measures to prevent an employee from engaging in a range of misconduct.[22] Such conduct includes, but is not limited to, contraventions of the MDA[23] or conduct that poses a threat to the health, safety or welfare of a person or the public.[24]

[59] A poisons permit holder must be given resources to allow the holder to comply with the law.

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[20] While the MPA s 3 makes reference to the CEO, in practical terms this is a reference to the Director General of WA Health.

[21] The delegates for this purpose during materially relevant times were Neil Keen (WA Health chief pharmacist); Dr Andrew Robertson (WA Health deputy chief health officer); and Jane Carpenter (manager, legislation and licensing, Medicines and Poisons Regulation Branch).

[22] MPA s 60(2)(b).

[23] MPA s 60(1)(a)(ii).

[24] MPA s 60(1)(b)(ii).

CHAPTER THREE
SUPPLY OF SCHEDULE 8 DRUGS IN PUBLIC HOSPITALS

Overview

[60] In 2015, FSH changed from a manual supply and dispensing system to what is now largely, but not entirely, an automated system. The system assists in the management and supply of Schedule 8 drugs and is also designed to enhance compliance with legal obligations.

[61] Between 2014 and 2016, the FSH supply systems were circumvented by Mr Foster. As a consequence of inadequacies in checks, balances, reconciliation processes and basic audit procedures, FSH did not identify obvious warning signs.

[62] Inadequacies were not isolated to FSH. Significant issues were identified at SCGH. SCGH has not been able to ascertain the full extent of historical unauthorised diversions of Schedule 8 drugs.

[63] SCGH did not conduct its own enquiries to ascertain the extent of the diversion of Schedule 8 drugs for unauthorised purposes. Such an enquiry would have been problematic given the chaotic state of SCGH records, particularly the Schedule 8 drug registers.

[64] Mr Foster diverted about 25 grams of hydromorphone over almost 14 months at FSH without authorisation. This serious misconduct was committed under cover of purported genuine supplies of Schedule 8 drugs by the pharmacy to wards and units.

[65] Mr Jenkins acknowledged this was "an extraordinary amount" and observed "…when it was discovered, my life passed before my eyes… I knew what it meant and so did my deputies, and that was a real shock".[25] Mr Jenkins acted immediately once the misconduct was discovered. However, the question is why it took 14 months to discover?

[66] The pharmacy employee who first noticed Mr Foster's conduct was concerned the hydromorphone might be "going to market" given the quantities involved. The employee also had a concern whether one human body could cope with the amount of drugs being diverted.

[67] Possession of 2 grams of hydromorphone or 5 grams of oxycodone gives rise to a legal presumption that the possessor intends to sell or supply the drugs.[26]

[68] In Mr Foster's case, there was no evidence of an intention to sell or supply the drugs in the illicit drug trade. Rather, Mr Foster's actions were addiction

[25] B G Jenkins transcript, private examination, 1 March 2017, p 15.

[26] MDA s 11(a) sch V item 67. Likewise, under federal law there are presumptions of trafficking for the same quantities: *Criminal Code* (Cth) ss 302.1, 302.4, 302.5; and *Criminal Code Regulations 2002* reg 5A sch 3 item 130.

related. Nevertheless, if such large quantities can be taken without detection, the likelihood or risk that the drugs move into the illicit drug trade is real.

[69] It is difficult to prevent theft or unauthorised use of Schedule 8 drugs from public hospitals altogether. The key principle, as acknowledged by WA Health, is that a public hospital must have practices, procedures and systems in place to promptly identify unauthorised access.[27] FSH and SCGH had inadequate practices, procedures and systems, given the length of time it took to detect Mr Foster's conduct.

Fiona Stanley Hospital: The requisition system

[70] Prior to August 2015, FSH wards and units used approved requisition forms from a book of duplicate forms to order Schedule 8 drugs from the pharmacy. Colloquially, the requisition form is known as a 'pink slip' or 'pinkie'. It is used to generate the supply of Schedule 8 drugs by the pharmacy to a ward or unit. Less frequently, it facilitates a transfer of the drugs between wards or units. A transfer is more common outside pharmacy business hours.

[71] The requisition form is part of an archaic paper based process to supply Schedule 8 drugs. This manual process continues to operate in all public hospitals with little variation.

[72] FSH is the only public hospital that has implemented and operates an approved automated Electronic Storage and Supply Unit (ESSU) system.[28] It uses the Care Fusion Pyxis C^{II} SafeTM System (C^{II} Safe), to supply and manage controlled and restricted drugs at the pharmacy, wards and other units.

[73] The C^{II} Safe commenced operation at FSH in August 2015. The roll-out was completed by March 2016.[29] The approved ESSU system relevantly encompasses:

(a) the C^{II} Safe in the pharmacy department at FSH;

(b) the Pyxis MedStation Units at various FSH wards; and

(c) the Pyxis Anaesthesia MedStation.

[74] The automated system has a software platform that fully integrates the C^{II} Safe and the MedStations. This facilitates the simultaneous exchange of information between each ESSU, signalling the movement of Schedule 8 drugs. The system generates an electronic Schedule 8 drug register. Consequently, the need for manual registers is removed.

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[27] N J Keen transcript, private examination, 1 March 2017, p 51.

[28] The Perth Children's Hospital is in the process of implementing a similar automated system with ESSUs to FSH but is using a different vendor.

[29] K K Tam transcript, private examination, 28 February 2017, p 3.

[75] In order to access the C[II] Safe, it is necessary for a staff member, in the company of a colleague[30] to:

(a) enter their unique Health Employee number; and

(b) scan their fingerprint on a BioID scanner; and

(c) nominate the drug, strength and quantity.

[76] Schedule 8 drugs on the imprest[31] list are dispersed through the integrated automation system. Consequently, there is virtually no need to use requisition forms because orders are automatically generated by the system. Mr Keen described the electronic requisition process:

> *The requisition* [forms] *are actually electronic and they actually form an electronic handshake between two different supply devices, which is far more efficient.*[32]

[77] Mr Jenkins acknowledged the ideal situation is for all Schedule 8 drugs to be imprest and processed through the automated system. This would enable Schedule 8 drugs to be supplied by the pharmacy ESSU to ward and unit ESSUs through a secure closed loop system. Despite this acknowledgement, Mr Jenkins, in a subsequent written submission to the Commission dated 19 May 2017, said that it was not desirable to have all controlled drugs on the imprest list for the following reasons:

> *(a) The cost of keeping low use drugs 'in stock' with an inventory level across the hospital would be significant;*
>
> *(b) Keeping low use drugs on imprest would displace high use non-controlled drugs from imprest which would hamper efficient medicine supply systems;*
>
> *(c) Clinically it is not desirable to have all controlled drugs on imprest readily available,* [it is] *better to supply some specialised agents only on demand using non-imprest supply. So even if storage was plentiful, we would not recommend storing the complete range of controlled drugs on the ward.*

[78] Mr Jenkins said that it is not possible to put all Schedule 8 drugs on the imprest list due to space limitations in the MedStations. He stated that "[f]or a single drug being moved from non-imprest to imprest storage in one ward [MedStation] may take an hour".[33] In this case, one employee noticed an increased supply of hydromorphone to FSH's wards and units and frequent ordering of the drug. The employee suggested to her supervisor that hydromorphone be on the imprest list. Despite the suggestion, the drug was not placed on the imprest list.

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[30] The requirement to be accompanied by a colleague only operates during pharmacy business hours and does not extend to authorised after-hours access to the C[II] Safe.

[31] Each hospital ward has a line of drugs that are regularly used. These drugs are maintained at pre-determined levels on wards and are referred to as imprest drugs.

[32] N J Keen transcript, private examination, 1 March 2017, p 42.

[33] B G Jenkins response to the Commission's draft report, 19 May 2017, p 2.

[79] Even though FSH has a state of the art automated system, a requisition form is relied upon to order non-imprest Schedule 8 drugs from the ESSU in the pharmacy (C^{II} Safe). Once the drugs are removed from the C^{II} Safe, the manual requisition process described below is followed.

The manual requisition process

[80] The manual requisition process involves ordering, issuing, delivering and receiving processes.

[81] This requisition process applies across WA Health public hospitals. It continues to apply at FSH for Schedule 8 drugs on the non-imprest list. Non-imprest Schedule 8 drugs, in general, are less frequently used drugs. Non-imprest stock constitutes about 10 to 15 per cent of all Schedule 8 drugs.[34]

Ordering

[82] A requisition form is used by FSH's ward or unit to order Schedule 8 drugs from the pharmacy. The order is generally instigated by a ward nurse or clinical pharmacist at the direction of a medical practitioner. Generally, a requisition form triggers the pharmacy to supply Schedule 8 drugs to a ward or unit as opposed to a specific patient.[35] In many cases, a requisition is triggered by a particular patient's needs, predicted requirements of the ward or unit, or to maintain stock at a particular level. The supplied drugs are ultimately accepted and placed into an approved storage receptacle at the ward or unit before being removed and administered by a nurse or doctor to a patient.

[83] A transaction record is mandated by WA Health Operational Directive OD 0141/08.[36] It is adopted at FSH and across public hospitals in this state with little variation. Once the form is used, it becomes a record which must be retained for several years.[37]

[84] The pink requisition form is brought to or otherwise arrives at the pharmacy for processing. The white duplicate is retained in the requisition book at the relevant ward or unit.

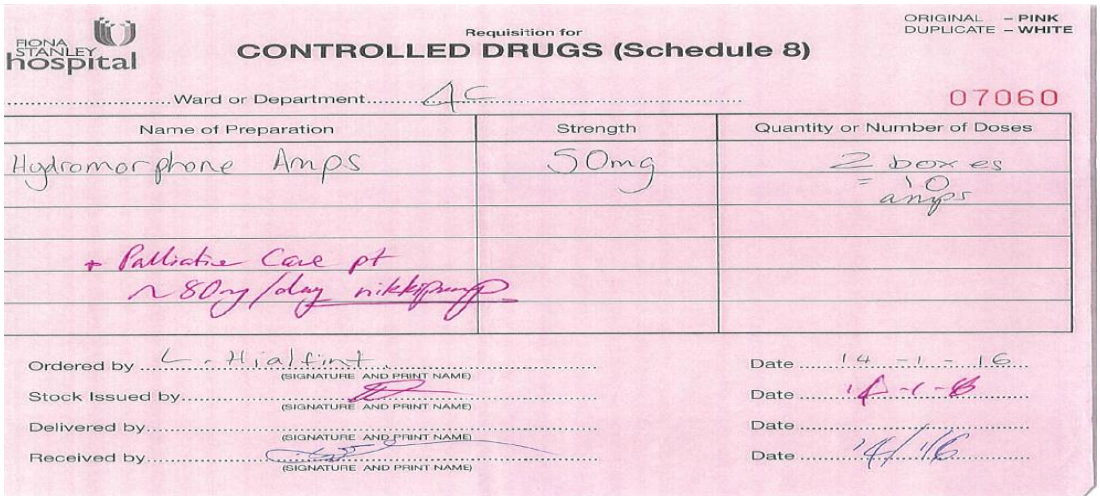
[85] The following requisition form was utilised by Mr Foster to gain unauthorised access to hydromorphone:

[34] B G Jenkins response to the Commission's draft report, 19 May 2017, p 2.

[35] The requisition form may also be utilised to trigger a transfer of Schedule 8 drugs between wards or units.

[36] WA Health, *Code of Practice for the Handling of Schedule 8 Medicines (Drugs of Addiction) in Hospitals and Nursing Posts*, OD 0141/2008, 9 July 2008, p 3[6].

[37] MPR reg 143(2)(c) (5 years) (previously the PR reg 47(2) (7 years)).



FIONA STANLEY hospital

Requisition for
CONTROLLED DRUGS (Schedule 8)

ORIGINAL – PINK
DUPLICATE – WHITE

Ward or Department ED

07060

Name of Preparation	Strength	Quantity or Number of Doses
Hydromorphone Amps	50mg	2 boxes = 10 amps
+ Palliative Care pt ~80mg/day ...		

Ordered by ... (SIGNATURE AND PRINT NAME) Date 14-1-16

Stock Issued by ... (SIGNATURE AND PRINT NAME) Date 14-1-16

Delivered by ... (SIGNATURE AND PRINT NAME) Date

Received by ... (SIGNATURE AND PRINT NAME) Date 14/1/16

Issuing a Schedule 8 drug

[86] A pharmacy technician records a requisition for Schedule 8 drugs in FSH's iPharmacy management computer application (iPharmacy). iPharmacy is a computer application used at FSH and WA Health that assists in managing and purchasing stock. It is also used for a variety of other purposes including recording where medication goes in the hospital.[38] iPharmacy generates a unique picking slip. The picking slip identifies the ward or unit where the specific quantity of Schedule 8 drugs will go. The picking slip is ultimately signed by a pharmacist, in most cases, an operational pharmacist in the dispensary.

[87] The iPharmacy supply record of the Schedule 8 drug must correspond with the requisition form. Both records identify which ward or unit the Schedule 8 drugs will go to.

[88] The Schedule 8 drug is then physically taken from the C^{II} safe in the pharmacy. During business hours, two persons are involved in the issuing process, usually two pharmacists or a pharmacist and a technician. A pharmacist involved in the issuing process signs the requisition form indicating that the stock was issued by him or her.

[89] After-hours, a pharmacist is permitted to issue Schedule 8 drugs alone, which gives rise to corruption risks, exploited by Mr Foster.

[90] In addition to completing the requisition form and the supply entry on iPharmacy, the supply must be recorded in a pharmacy register,[39] a book for recording incoming and outgoing Schedule 8 drugs.

[91] The daily inventory check, the iPharmacy supply record, and the entry into the pharmacy register is FSH pharmacy's 'triple check' process.

[38] K K Tam transcript, private examination, 28 February 2017, p 4.

[39] MPR pt 12 (previously the PR pt 6).

Delivery to a ward

[92] Once the Schedule 8 drug is issued, there is a 'delivery process'. FSH porters transport Schedule 8 drugs to the ward or unit that has placed the order. The drugs are placed in a sealed tamper-proof medication transport bag together with the pink requisition form.

[93] FSH also permits a pharmacist (including a pharmacist who issued the Schedule 8 drugs) to deliver the drugs to the ward or unit.[40] At SCGH, only an authorised pharmacist may deliver the drugs to the ward or unit.

Receipt by a ward

[94] Schedule 8 drugs are received on the ward or unit, generally by two registered nurses. The 'receiving process' entails receipting the drugs in the Schedule 8 register that must, by law, be maintained at every location where these drugs are stored, including wards and units. The drugs are then placed in the approved secure storage receptacle until required for administration to a patient. Less frequently, a Schedule 8 drug may be transferred to another ward or unit's storage receptacle in response to a requisition form.

[95] A pharmacist delivering Schedule 8 drugs to the ward or unit is permitted to be one of the two persons accepting receipt of the drugs. Likewise, a clinical pharmacist on the ward or unit may also be one of two persons receipting the drugs at the ward or unit.

Post-delivery actions

[96] The requisition forms are returned to the pharmacy to satisfy legislative requirements to retain records. Historically, there has been limited scrutiny of the returned forms unless the requisition slip did not have a signature against 'Received By'. This might trigger the pharmacy to follow-up with the nursing staff at the ward.

[97] The lack of scrutiny of returned requisition forms facilitated unauthorised diversion of drugs by Mr Foster.

Sir Charles Gairdner Hospital: The requisition process

[98] The requisition process at SCGH largely mirrors FSH except only authorised pharmacists deliver the Schedule 8 drugs to the nominated ward or unit at SCGH.

[99] Historically, SCGH did not retain the duplicate copy of the requisition form. This practice facilitated serious misconduct at the hospital by Mr Foster.

[40] K K Tam transcript, private examination, 28 February 2017, p 28.

The role of a clinical pharmacist in supplying Schedule 8 drugs

[100] There is little need for a clinical pharmacist to access a pharmacy safe or to be involved in the supply of Schedule 8 drugs.

[101] Mr Jenkins described the role of clinical operations and clinical pharmacists:

> *[t]he clinical operations involve direct patient care and this typically occurs in clinical areas on wards or in theatres, intensive care unit, [and the] emergency department. All those clinical areas have pharmacists attached to them. They work within the medical teams with nursing. They go on the ward rounds to review patients each day. They are involved in admitting and discharging patients, ensuring the drugs are correct and appropriate. They provide advice to doctors on prescribing. They are responsible for quality checks; they pick up errors; they advise on dose changes. So that's the role of clinical pharmacists.*
>
> *They also have some responsibilities to the practical aspects of running a ward, which would also include drug storage; accessing drugs which they don't normally keep; helping them with controlled drugs issues when they arise; investigating discrepancies with the nurse.*[41]

[102] A clinical pharmacist who performs their duties while addicted to opioids is dangerous. Patient care and safety is compromised.

[41] B G Jenkins transcript, private examination, 1 March 2017, p 5.

CHAPTER FOUR
WA HEALTH: STRUCTURE AND INVESTIGATIONS

WA Health corporate structure

[103] The *Health Services Act 2016*[42] made significant changes to the corporate structure for public health services in Western Australia. It imposed a 'devolved model of governance (to) enable decision-making closer to service delivery and patient care'.[43]

[104] Under the new legislative scheme, policy frameworks are issued by the Director General and must be followed by all public hospitals. The policy frameworks align WA Health Services with best practice and seek to provide consistent, transparent and quality health services.

[105] With respect to Schedule 8 drugs, WA Health policy frameworks (previously Operational Directives)[44] provide overarching guidance for each Health Service Provider (HSP). The frameworks are not prescriptive about how hospitals manage local systems and practices. It is the responsibility of each HSP and facility to establish good governance for Schedule 8 drugs.[45]

[106] During its investigation, the Commission reviewed Operational Directives issued by WA Health and local policy, practice and procedure within two HSPs with a focus on identifying the risks of serious misconduct:

(a) FSH pharmacy, governed by SMHS; and

(b) SCGH pharmacy, governed by NMHS.

Compliance with policies and procedures

WA Health policy frameworks

[107] The following Operational Directives, which now form part of WA Health's Public Health Policy Framework, were relevant to the Commission's investigation:

(a) OD 0377/12 - reporting of medicine discrepancies in public hospitals and licensed private facilities which provide services to public patients in Western Australia;[46] and

[42] Came into effect on 1 July 2016.

[43] Department of Health, Government of WA, 'The Role of Health Services and Boards' (Health Reform Fact Sheet, July 2016).

[44] Operational Directives previously issued by WA Health continue to apply until replaced by policy frameworks and supportive documents in the new regime.

[45] MPRB, 'Schedule 8 Medicines Handling Practices in Public Hospitals' (November 2016), p 1.

[46] Issued by WA Health 12 June 2012 and still current. OD 0377/12 refers to two other Operational Directives which are no longer current (OD 0215/09 and OD 0036/07).

(b) OD 0141/08 - code of practice for the handling of Schedule 8 medicines (drugs of addiction) in hospitals and nursing posts.[47]

[108] WA Health Operational Directives OD 0377/12 and OD 0141/08 are binding on all health service hospitals and reinforce the requirements imposed by legislation on all public hospitals:

(a) all transactions (including procurement, use, supply and storage) of Schedule 8 medicines must be recorded in a register;[48]

(b) an inventory of Schedule 8 medicines in stock must be undertaken regularly;[49] and

(c) any discrepancy between the inventory of stock and register balance must be reported by the poisons permit holder to the CEO.[50]

[109] All hospitals are required to 'monitor, document, investigate and prevent or minimise medicine losses' and to 'have an established procedure to identify, investigate and report medicine discrepancies'.[51]

[110] Staff suspected of misconduct in public hospitals are to be reported at the earliest opportunity. A discrepancy is to be reported within 24 hours; an internal review undertaken; and a medicine discrepancy loss report form is required to be submitted by the hospital to Corporate Governance Directorate of WA Health (CGD) as soon as possible.[52] If additional matters come to light, they are also required to be reported to CGD in a timely way.[53]

[111] If the loss or discrepancy is unexplained or identified as suspected misconduct or theft, it is required to be reported to WA Police and to senior staff.[54] Finally, a review and trend analysis may be undertaken for system / practice related losses to identify process improvements.[55]

Policies at Fiona Stanley Hospital and Sir Charles Gairdner Hospital

[112] The SMHS (which governs FSH) issued two practice standards dated 21 October 2014 which 'establish the minimum practice standards for medication management, prescribing, administration, storage and handling throughout the SMHS'.[56]

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[47] Issued by WA Health 29 July 2008 and still current.

[48] PR reg 44, 44B and 44C, now MPR reg 144, 146, 147. OD 0141/08 cl 1.1-1.3, 1.5.

[49] PR reg 44(3a), 45, now MPR reg 148(1). OD 0141/08 cl 1.1, 1.4.

[50] PR reg 46(2), now MPR reg 148(2).

[51] OD 0377/12 cl 3.1.1.

[52] OD 0377/12 cl 1, 4.1-4.5.

[53] OD 0377/12 cl 4.5.

[54] OD 0377/12 cl 4.3.

[55] OD 0377/12 cl 4.4.1.

[56] SMHS, 'CPSM003 Medication Management Clinical Practice Standard & CPSM004 Medication Administration' (Addendum Clinical Practice Standard).

[113] These standards apply to all health practitioners including pharmacy staff employed within SMHS. Relevantly, they endorse WA Health OD 0141/08 for storage and handling requirements concerning controlled medications and WA Health OD 0377/12 for dealing with medicine discrepancies.[57]

[114] These standards prescribe the use of the requisition forms for drugs of addiction (form HA219) and requirements for entry of data on forms. Neither standard details procedures concerning the storage or recording of transactions in registers.

[115] FSH have now issued the following procedures which do address these issues:

(a) Management of S8 and S4Rs Registers and Requisition Books; and

(b) Supply and Reconciliation of process for controlled drugs supplied to clinical areas.

[116] These policies provide practical and technical step-by-step instructions for the issue of registers using FSH's C^{II} Safe[58] and for the reconciliation procedures for both automated (imprest) and manual (non-imprest) records of supply of controlled drugs.

[117] Although these policies have been in force since October and September 2016 respectively, they have yet to be implemented at FSH.[59]

[118] In evidence to the Commission, Mr Jenkins admitted that no sample audits of controlled drug transactions had been completed at FSH, although policy requires they are conducted every three months.[60]

[119] Ms Babe provided the Commission with a considerable number of policy, procedure and supporting documents.

[120] Ms Babe gave evidence that at SCGH there is a "comprehensive" medicines policy[61] which "starts with an overarching statement about how Schedule 8s are to be managed".[62] Contrary to this evidence, whilst there are broad statements in the medicines management policy about requirements for distribution and storage of medicines, the policy does not specify requirements with respect to Schedule 8 drugs or even reference the relevant WA Health Operational Directives OD 0377/12 and OD 0141/08.

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[57] SMHS, 'CPSM003 Medication Management Clinical Practice Standard'.

[58] FSH, 'Management of S8 and S4Rs Registers and Requisition Books' (Policy, October 2016).

[59] A retrospective audit of supplies to the ward has not yet been implemented, an audit was due to commence on 22 May 2017: B G Jenkins response to the Commission's draft report, 19 May 2017, p 2.

[60] Supply and Reconciliation of process for controlled drugs supplied to clinical areas dated September 2016.

[61] SCGH, 'Medicines Management' (Policy 141, 7 September 2016).

[62] G E Babe transcript, private examination, 10 March 2017, p 5.

[121] Other procedures, processes, guidelines and duties statements were provided to the Commission by SCGH, all with varying audiences and purposes. Some of the requirements set out within are duplicated in several documents.

[122] The Commission accepts that there is significant work underway in the review and preparation of new policy, procedures and practical guidance for staff dealing with Schedule 8 drugs at SCGH. Ms Babe's evidence was that SCGH is "in transition" and guidelines or procedures for managing Schedule 8 drugs in the workforce are a "work in progress".[63]

[123] However, the corruption risk of unauthorised access to Schedule 8 drugs remains significant until the 'work in progress' becomes 'work completed'.

WA Health investigations at Fiona Stanley Hospital and Sir Charles Gairdner Hospital

[124] The Commission worked closely with the Medicines and Poisons Regulation Branch (MPRB) (formerly the Pharmaceutical Services Branch) in its investigation. This unit is responsible for administering and regulating compliance by health practitioners with poisons legislation.[64]

[125] MPRB provides advice, develops policy and administers the issue of poisons permits and licences in WA. A team of two investigators and two part-time auditors investigate suspected breaches of the poisons legislation in any private or public health facility in Western Australia. The team is led by the WA Health chief pharmacist, Mr Keen, who reports directly to the Deputy Chief Health Officer, Public Health Division, Department of Health.

Medicines and Poisons Regulation Branch investigation at Fiona Stanley Hospital

[126] After Mr Foster's conduct was identified, MPRB investigated how "a significant amount of medication" over "quite a period of time" could not be accounted for by FSH.[65]

[127] Mr Neil McIntosh, a senior investigator at MPRB, led the investigation. He told the Commission that the initial investigation "wasn't too onerous" and "probably took about a week to complete" and involved mainly talking to the chief pharmacist at FSH, Mr Jenkins, and a few select senior staff at FSH.[66]

[128] On or about 22 February 2016, MPRB investigators attended FSH to inspect their records. The MPRB investigation was intended to identify practices at FSH that were non-compliant with legislation and deficiencies in systems in place for the handling of Schedule 8 drugs. Initial

[63] G E Babe transcript, private examination, 10 March 2017, p 4.

[64] MPRB, 'Schedule 8 Medicines Handling Practices in Public Hospitals' (Report November 2016), p 1.

[65] N J McIntosh transcript, private examination, 28 February 2017, p 42.

[66] N J McIntosh transcript, private examination, 28 February 2017, p 43.

investigations were limited to a reconciliation of pharmacy and ward registers with the iPharmacy reports of Schedule 8 drugs supplied by Mr Foster.

[129] Several transactions indicated hydromorphone had been supplied by Mr Foster, but the corresponding ward register indicated they were not received by that ward. Hydromorphone was missing and likely diverted by Mr Foster.

[130] After the initial review, investigators seized archived FSH Schedule 8 registers and examined them. Their efforts to reconcile the records were hampered because, at that time, 12 Schedule 8 drug ward registers were unable to be located by FSH.[67]

[131] The Commission received evidence that FSH had "a fabulous system (for managing and archiving registers); unfortunately they weren't using it".[68] In his response, Mr Jenkins said that the system worked well to track registers and at any time you could determine where the register was, but some registers were stolen.

[132] The Commission cannot determine which is correct. What is clear, however, is that deficiencies in storage and management of registers by FSH meant that investigators were unable to identify in which archive box a particular ward register may be located. This meant that inspections could be labour and time intensive and when a register is missing, Mr McIntosh stated that "it is impossible to give a conclusive figure of how much medication has been diverted".[69] Similar issues were encountered at SCGH.

Medicines and Poisons Regulation Branch investigation at Sir Charles Gairdner Hospital

[133] After concluding their initial investigation at FSH in March 2016, MPRB investigators were directed by Mr Keen to undertake an audit at SCGH to "check for any diversion there".[70]

[134] Mr Foster's iPharmacy transactions at SCGH were reconciled against records contained in ward registers. However, only a selective audit was conducted of the "most suspicious" hydromorphone transactions or instances where two medications were supplied.[71]

[135] Mr McIntosh told the Commission that he left Ms Babe to conduct her own review of all ward registers against transactions relating to Mr Foster.

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[67] WA Health internal report by N J McIntosh, 14 March 2016, p 3.

[68] N J McIntosh transcript, private examination, 28 February 2017, p 61.

[69] WA Health internal report by N J McIntosh, 14 March 2016, p 6.

[70] Initial WA Health internal report by N J McIntosh, 14 March 2016, p 6.

[71] N J McIntosh transcript, private examination, 28 February 2017, p 49.

[136] Several registers could not initially be located by SCGH upon request by the investigators and one ward register remains missing.[72] Mr McIntosh told the Commission the "ward register archive system at SCGH was undergoing a revamp … with registers everywhere".[73] He described the archiving of registers as "chaotic".[74] When a register is missing, as Mr McIntosh stated, it "makes any conclusion virtually impossible as far as an investigation goes".[75]

[137] Ultimately, MPRB found that there were five transactions at SCGH where Schedule 8 drugs were purportedly supplied by Mr Foster. No record existed of them arriving at the ward, although one ward register remains missing. Of those transactions, three requisition forms were identified by MPRB investigators as possible forgeries and one pink slip could not be located.

Medicines and Poisons Regulation Branch findings about Fiona Stanley Hospital and Sir Charles Gairdner Hospital

[138] Mr McIntosh reached several conclusions concerning FSH and reported these to WA chief pharmacist, Mr Keen, in his initial report:

> *(a) Mr Foster had been diverting medication from the very start of his employment at FSH and used his knowledge of hospital systems to do so;*
>
> *(b) the failure to adhere to procedures and to reconcile Schedule 8 controlled drug requisition forms at FSH allowed Mr Foster to divert the medication for a large period of time;*
>
> *(c) some Schedule 8 drug requisition forms were identified as forgeries;*
>
> *(d) when FSH converted to a fully automated supply process, Mr Foster diverted only non-imprest stock;*
>
> *(e) all transactions occurred after-hours, but out-of-hours access was not checked; and*
>
> *(f) storage of registers was 'unfriendly' and access was not restricted.*[76]

[139] In a covering briefing note to the Director General, Mr Keen summarised the issues identified with respect to Mr Foster's conduct:

> *The report suggests that:*
>
> - *on 63 separate occasions, S8 medicines issued from stock are not accounted for, totalling 355 ampoules and 697 oral doses;*

[72] WA Health internal report by N J McIntosh, 19 May 2016, pp 1-2.

[73] N J McIntosh transcript, private examination, 28 February 2017, p 49.

[74] N J McIntosh transcript, private examination, 28 February 2017, p 60.

[75] N J McIntosh transcript, private examination, 28 February 2017, p 63.

[76] WA Health internal report by N J McIntosh, 14 March 2016, p 5.

- *eleven s8 Registers are missing, and, as these records are no longer available, an additional similar amount of stock issued cannot be verified; and*

- *there is little doubt that these medicines were removed from FSH pharmacy by Mr Foster, were not supplied to FSH wards, and have been diverted elsewhere.*[77]

[140] Mr Keen made recommendations to improve practices at FSH, including routine scrutiny of after-hours access to the pharmacy, adherence to requirements for use of pink slips and changes to practice regarding storage and tracking of registers. He also recommended FSH review non-imprest stock supplies to wards.

[141] Mr Keen reported to WA Health's CGD that 'a number of recommendations to improve the integrity of [Schedule 8] supply and tracking systems were put to FSH pharmacy' and that these 'have been accepted and commitment provided to implement the changes'.[78]

[142] In May 2016, MPRB reported to WA Health that the total quantity of Schedule 8 drugs diverted by Mr Foster at FSH was more than first reported. MPRB also suspected that he made false entries in registers as well as on requisition forms.[79]

[143] MPRB's investigation makes clear that the risks of diversion identified in their report apply to any hospital pharmacy:

> *These risks apply equally to any hospital pharmacy and wherever a similar paper based S8 recording and receipting system is in place. The investigation does not provide any evidence that the overall system is flawed or that the usual protections for recording and receipting practices are not adequate when properly adhered to.*[80]

[144] Mr McIntosh identified a simple solution for detection, noting that although Mr Foster's methods were different at FSH and SCGH, 'in both locations, had a robust checking system been in place to reconcile the pink slips with what left pharmacy and appeared on the ward, the missing items would have been picked up earlier'.[81]

Commission review of findings by WA Health

[145] The Commission was provided with several reports in March and May 2016 detailing findings and recommendations made by MPRB as a result of their investigations. The reports provided a compelling inference that Mr Foster stole a significant quantity of Schedule 8 drugs. However, the extent of missing records and loss of these drugs was not ascertainable.

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[77] Internal memorandum by N J Keen to Barry O'Connor, 16 March 2016, p 2.

[78] WA Health internal report by N J Keen to Barry O'Connor, 20 May 2016, p 4.

[79] WA Health internal report by N J Keen to Barry O'Connor, 20 May 2016, p 3.

[80] Internal memorandum by N J Keen to Barry O'Connor, 16 March 2016, p 15.

[81] WA Health internal report by N J McIntosh, 19 May 2016, p 2.

[146] The Commission considered it prudent to request further investigation by WA Health and asked for all relevant requisition slips and other records, including pharmacy registers be provided to the Commission. From these records, the Commission assessed that a total of 130 transactions concerning Schedule 8 drugs were supplied by Mr Foster without authorisation between December 2014 and February 2016.

[147] The Commission enquired whether WA Health systems could track the supply of Schedule 8 drugs through each stage from a request, supply by pharmacy, delivery to a ward and ultimately administration to a patient.

[148] It proved impossible and impractical for WA Health who informed the Commission that:

> *… although there is a close association between patient usage, ordering and pharmacy supply, there is not a predictable or direct connection between administration of any single dose and ward ordering.*
>
> *Accordingly, it is not possible to conclude that a periodic supply of Schedule 8 medicines from the Pharmacy Department will correlate exactly with any single incidence of administration of an ampoule to a patient in the clinical records provided to the CCC.*[82]

Breaches of requirements to keep and produce registers

[149] Records and registers of the supply of a Schedule 8 drug are required to be stored for several years and produced upon request for inspection to authorised inspectors.

[150] In the event of a register being lost, legislation in force at the time required that a statutory declaration be provided to the CEO and a stock take of all drugs of addiction be undertaken immediately.[83] Although this breach was noted in Mr Keen's report to WA Health dated 19 May 2016, no action has been taken by FSH or WA Health.[84]

[82] Letter from Ms Rebecca Brown, A/Director General, WA Health to Commissioner McKechnie QC, 30 September 2016, p 2.

[83] PR reg 47(3).

[84] G E Babe made a statutory declaration on 24 May 2017 in respect of a missing register.

CHAPTER FIVE
THE GAPS IN MANAGEMENT AND CONTROL OF SCHEDULE 8 DRUGS

Overview

[151] The Commission investigation revealed gaps in the management and control of Schedule 8 drugs at public hospitals. This report focuses on areas where it considers the risk of serious misconduct occurring remains high:

(a) after-hours access to the pharmacy safe;

(b) not reconciling supply by the pharmacy and receipt at a ward or unit;

(c) substandard practices around the use of requisition forms;

(d) inadequate management of registers;

(e) the supply of non-imprest stock.

After-hours access to the pharmacy safe

[152] A clinical pharmacist rarely supplies Schedule 8 drugs from the pharmacy during ordinary business hours.[85] Generally, a clinical pharmacist is working at a ward or unit and seeing patients. Accessing the pharmacy safe and supplying drugs during business hours falls to operational pharmacists and pharmacy technicians.

[153] Mr Keen said:

> *It would be difficult for a clinical pharmacist to access the safe without the observation or involvement of other staff* [in the Pharmacy dispensary] *during normal hours. Additionally, the repeated access by a clinical staff pharmacist for non-imprest stock would be expected to trigger comment by other staff.*[86]

[154] After normal business hours, a clinical pharmacist who is on-call, may require access to the pharmacy safe. FSH's senior pharmacist, Mr Tam, explained the role of the on-call pharmacist:

> *… During the on-call services, the pharmacist is not physically based at the hospital, but is at home. They're available for clinical questions through the hospital switchboard. If there is a supply issue… the on-call pharmacist may direct the staff member within the hospital to a specific location in another ward in the hospital to obtain their stock. If there is no stock available anywhere and there is a critical clinical issue necessitating access to the specific medication and there are no alternatives available, then the on-call pharmacist will come in and supply the medication to the ward.*[87]

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[85] Business hours are between 8:30am to 5:00pm on weekdays and 8:30am to 4:00pm on the weekend: K K Tam transcript, private examination, 28 February 2017, p 18.

[86] Internal memorandum by N J Keen to Barry O'Connor, 16 March 2016, p 13.

[87] K K Tam transcript, private examination, 28 February 2017, p 17.

[155] It is rare for an on-call pharmacist to need access to the pharmacy safe after-hours. Mr Jenkins described the need to access the pharmacy safe after-hours as "virtually nil".[88] Ms Babe explained that the last after-hours supply of Schedule 8 drugs from the SCGH pharmacy she is aware of occurred many years ago. She recalls only one after-hour's supply of Schedule 8 drugs from the pharmacy since she commenced employment at SCGH in 1999. She stated there may have been legitimate after-hours access to Schedule 8 drugs from the SCGH pharmacy that she is not aware of.

[156] The FSH practice is to require two pharmacy staff members to access the pharmacy safe during business hours in order to issue Schedule 8 drugs. After-hours, one pharmacist is permitted to access the pharmacy safe in order to supply Schedule 8 drugs.

[157] FSH records show Mr Foster was involved in 130 unauthorised transactions relating to the purported supply of Schedule 8 drugs. Almost all transactions occurred after-hours. Mr Foster was able to operate alone and without scrutiny. The Commission was informed by one FSH pharmacy employee that "If two persons were dealing with this thing after-hours, it would have never happened".[89]

[158] SCGH restrict after-hours access to the pharmacy safe to a narrow group of senior pharmacists. Mr Foster was not allowed after-hours access at SCGH when employed there.

[159] The failure of FSH to have a system in place to quickly check, detect and identify after-hours access to the pharmacy safe enabled serious misconduct to occur repeatedly.

No reconciliation to verify supply from pharmacy to ward or unit

[160] The FSH pharmacy relied on its 'triple check' reconciliation process to verify supply of Schedule 8 drugs to wards and units:

(a) an inventory check of the pharmacy safe;

(b) an entry of supply into the iPharmacy computer application; and

(c) a manual entry into the Schedule 8 drugs register maintained at the pharmacy.[90]

[161] The triple check process is done during and after the issuing process but before the drugs are delivered to the nominated ward or unit.

[162] After the 'triple check' reconciliation process, the pharmacy was complacent. In most cases, the pharmacy did not check or reconcile other

[88] B G Jenkins transcript, private examination, 1 March 2017, pp 8, 25.

[89] Transcript of interview at Murdoch, 20 September 2016, p 49.

[90] Internal memorandum by N J Keen to Barry O'Connor, 16 March 2016, p 5.

parts of the supply process after issuing the Schedule 8 drugs. The FSH pharmacy did not:

(a) follow-up Schedule 8 drugs requisition forms from wards and units; and

(b) verify that drugs said to be delivered to a nominated ward or unit, actually ever arrived there.

[163] The complacency opened up gaps in the supply of Schedule 8 drugs that were exploited. Mr Foster ensured the triple check process was reconciled and then took advantage of non-compliance with the manual requisition processes thereafter.

[164] There were several instances where requisition forms did not exist at all, despite a requirement that Schedule 8 drugs should not be supplied without one. This meant the iPharmacy entry and pharmacy register did not have a corresponding requisition form. The absent requisition forms inhibited investigation and prosecution processes.

[165] Where a requisition form existed and a signature appeared against 'Received By', the pharmacy staff accepted the signature at face value. In the words of one FSH pharmacy supervisor:

> *… if we have a signed slip* [Schedule 8 controlled drugs requisition form] *then, they're* [the person at the Ward or unit] *saying that they've accepted everything that's on there and they've received that.*[91]

[166] The pharmacy assumed the drugs were delivered to the ward or unit stated on the requisition form. The practice was to archive the form without further enquiries or checks. Mr McIntosh said that the process adopted by FSH pharmacy ' … resulted in a break in the chain from the drug leaving the pharmacy to being registered on the ward'.[92]

[167] The pharmacy had no reconciliation process to check whether drugs had ever been delivered and received by the ward or unit. Furthermore, if a ward or unit did not order the Schedule 8 drugs, they did not have any means to realise that such drugs were purportedly supplied to it. Mr Keen said:

> *… if the stock was not required by patients and the ward had not actually requested supply, then non-imprest stock leaving the Pharmacy and not arriving on the ward would not trigger any alert.*[93]

[168] Mr Tam explained what is required to reconcile the supply of Schedule 8 drugs to wards/units:

> *A. You would have to review the manual register within the pharmacy for this item; you'd have to see where the drug went, was recorded as going. You would then have to go to the relevant ward or clinical area*

[91] Transcript of interview at Murdoch, 3 December 2016, p 29.

[92] WA Health internal report by N J McIntosh, 14 March 2016, p 5.

[93] WA Health internal report by N J McIntosh, 14 March 2016, p 14.

which was, ideally, meant to have received it, and then you'd have to review their register on the ward to see whether the stock was received there.

Q. Fiona Stanley Hospital wasn't doing that at the time --

A. No.

Q. -- checking the register?

A. No.

Q. Has that process changed at the hospital?

A. I don't know.[94]

[169] FSH did not reconcile the requisition form with what was supplied by the pharmacy and what arrived at the ward or unit. About half of major public hospitals in this state also do not conduct such reconciliation.[95]

[170] Mr Foster exploited this gap at SCGH and FSH. The corruption risk is present at all hospitals that do not undertake reconciliation.

Schedule 8 drug requisition forms

[171] FSH wards and units use requisition forms to generate orders for the supply of non-imprest Schedule 8 drugs. Prior to automation, requisition forms were used for the supply of all Schedule 8 drugs at FSH. These requisition forms are used with little variation across public hospitals.

[172] Schedule 8 requisition forms at FSH were not completed properly by staff prior to Mr Foster's conduct being detected. As Mr McIntosh discovered:

> *In January [2016] Mr Foster made 21 entries in iPharmacy showing drugs being sent to wards, a search of the requisition forms found only 6 had been written. None of these had all necessary signatures…*
>
> *Other forms were checked, very few of these contained all the required signatures, most only had the nurse requesting the medication sign the form. These forms turned out to be genuine but not completed properly.*[96]

[173] When requisition forms were completed in full, they were largely accepted at face value without further enquiry. This involved acceptance of forms that were not legible, were forgeries or otherwise had names of persons who were not engaged to do work at FSH. There were signatures on requisition forms that were not capable of being attributed to a FSH staff member. This was largely consistent with the state of requisition forms at SCGH.

[174] FSH did not verify that the names and signatures on the forms were staff. This enabled forged or false requisition forms being accepted and archived without further enquiry.

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[94] K K Tam transcript, private examination, 28 February 2017, p 30.

[95] MPRB, 'Schedule 8 Medicines Handling Practices in Public Hospitals' (Report November 2016).

[96] WA Health internal report by N J McIntosh, 14 March 2016, pp 5-6.

Registers for Schedule 8 drugs

[175] The requirement to maintain Schedule 8 registers is mandated[97] and reinforced by WA Health Operational Directives. Separate registers are required for each location where Schedule 8 drugs are kept. This record is maintained so that the amount of each Schedule 8 drug procured, used, supplied or stored is apparent. Registers must be kept for a period prescribed by statute.

[176] A register must be produced when requested by an investigator. Prior to January 2017, where a register was lost or destroyed, there was a legal requirement to make a statutory declaration and provide it to the WA Health CEO. Despite missing registers at FSH and SCGH, no statutory declaration was made or presented to the CEO.[98]

[177] A missing register has implications for ascertaining the truth about the movement of Schedule 8 drugs and may inhibit investigation or prosecution processes. FSH and SCGH were unable to produce some registers relevant to unauthorised access and supply of Schedule 8 drugs. Neither facility was able to produce numerous registers in a timely manner when requested to do so.

[178] A significant gap that was apparent with registers at both FSH and SCGH, relates to security. Pharmacy staff at both facilities have unfettered access to registers (including archived registers still held at the pharmacy). This meant there was a greater chance that registers could disappear or be stolen to cover up an unauthorised transaction. Mr Keen observed:

> *It* [is] *the experience of my Office that the simplest way of obscuring diversion of S8 medicines is to either not make the legally required record of transaction, or to otherwise destroy any existing record of a transaction. The loss of these S8 Registers means that other than medication charts there are no records for S8 medicine transactions on these wards for this period. An investigation for any other reasons into S8 medicines supplied at FSH over the period will then be largely ineffective.*[99]

[179] FSH has a good system for managing registers. Mr Jenkins explained that the FSH pharmacy manage the registers by establishing:

(a) a password protected excel spreadsheet with limited access;

(b) a mechanism to track the issuing of new registers;

(c) a return transaction for when registers are completed; and

[97] MPR pt 12 (previously the PR pt 6).

[98] G E Babe made a statutory declaration on 24 May 2017. She confirmed she submitted the statutory declaration to the CEO's delegate, Mr Keen: G E Babe response to the Commission's draft report, 26 May 2017, p 1.

[99] Internal memorandum by N J Keen to Barry O'Connor, 16 March 2016, p 15.

(d) a mechanism to know where a current register is and when it has been archived.[100]

[180] Mr McIntosh described the FSH register system as "absolutely superb" and "fabulous", but noted that the system was not being used.[101]

[181] The registers at SCGH were held in a chaotic and disorderly fashion. Accordingly, conducting checks would be resource intensive and not conducive to identifying suspect transactions. Mr McIntosh explained that if you wanted to look at a specific register, that it literally required a search of every register.

[182] This led to significant problems with detecting that registers were missing and reconciling suspect Schedule 8 drug transactions.

Non-imprest stock

[183] The C^{II} Safe removes the need for Schedule 8 requisition forms due to automated re-ordering processes. The system maintains Schedule 8 electronic registers and records each access to the C^{II} Safe, to enable monitoring of access. It is a secure system and is difficult to exploit without detection, particularly if monitored.

[184] Not all Schedule 8 drugs are on the imprest list. For example, hydromorphone, oxycodone, and fentanyl are non-imprest Schedule 8 drugs. The determination of whether a Schedule 8 drug goes on the imprest or non-imprest list is determined on usage and governed by hospital policy.[102]

[185] While there is sufficient space in FSH's Pharmacy C^{II} Safe for all Schedule 8 drugs, the space situation is different at the MedStations. Accordingly, the supply of non-imprest Schedule 8 drugs is done in a hybrid manner, both automated and manual.

[186] A request for the supply of non-imprest drugs requires a requisition form. Once Schedule 8 drugs on the non-imprest list are removed from the C^{II} Safe using the normal access processes, the drugs move into the manual supply process. Ultimately, the non-imprest Schedule 8 drugs are delivered to the ward or unit, receipted in a ward or unit register, and placed in a non-imprest secure storage facility separate from the MedStation.

[187] All Schedule 8 drugs at FSH accessed by Mr Foster without authority were on the non-imprest list.

[188] A weakness in the C^{II} Safe that was identified, but not yet apparently exploited, relates to non-imprest stock. The system allows the pharmacist accessing the safe to treat Schedule 8 drugs as 'non-imprest' even when

[100] B G Jenkins transcript, private examination, 1 March 2017, p 32.

[101] N J McIntosh transcript, private examination, 28 February 2017, pp 60-61.

[102] B G Jenkins transcript, private examination, 1 March 2017, p 23.

on the imprest list. This was made apparent when Mr Tam (and Mr Jenkins)[103] responded to questions on this issue:

Q. If someone accepted [placing hydromorphone] on the imprest stock list because it was being used so much, it would have been very difficult for Mr Foster to continue his conduct, would it not?

A. Difficult, but not impossible.

Q. Okay. Why not impossible because we're very interested in seeing where the risk is?

A. Sure. Because if the medication is on imprest then the system should automatically order and, by default, when you send up the medications to that ward, you send to [Automated Dispensing Machine] check box to say it's going into the meds station; it's automatically ticked. It is still possible to manually untick that check box even though it is on imprest on that ward.

Q. All right. When he goes in to the C[II] Safe, puts his fingerprint in, puts his password in, he can still untick the box?

A. Even though it is on imprest.

Q. Would that not create a red flag on the system?

A. No, because you're telling the safe that you're not sending it to the meds station and, therefore, because you're not sending it to the meds station, the C[II] safe is not waiting for a response from the meds station to say, "I received it".

Q. Could you not put a red flag on the system, yourself, like an alert system if that happened?

A. No, the system is not extensible in that way.[104]

[103] B G Jenkins transcript, private examination, 1 March 2017, p 23.

[104] K K Tam transcript, private examination, 28 February 2017, p 55.

CHAPTER SIX
ACTIONS TAKEN SINCE THE COMMISSION INVESTIGATION

[189] The Commission investigation exposed a number of gaps in the management of Schedule 8 drugs by FSH and SCGH which were exploited by Mr Foster.

[190] Mr Keen, and each of the chief pharmacists at FSH and SCGH, have made progress towards addressing those gaps, although there is still more work to be done.

[191] After reviewing WA Health's initial investigation into the actions of Mr Foster, Mr Keen made recommendations in an internal report[105] to FSH and referred to these recommendations in his evidence to the Commission.[106] He gave high priority to the following recommendations:

(a) scrutiny of after-hours access to drugs by monitoring after-hours card access, verifying on-call records and claims, and flagging after-hours transactions on C^{II} Safe or iPharmacy (in his evidence to the Commission, Mr Keen suggested this occur at an interval of every two to four weeks);

(b) mandating the proper use of requisition pink slips including reconciliation against records contained in registers and at each point in the issue and delivery cycle (of Schedule 8 drugs); and

(c) appropriate security, storage and archiving of registers.[107]

[192] Of moderate or lower priority in his internal report, Mr Keen recommended that FSH make efforts to rationalise Schedule 8 drug stocks and routinely review Schedule 8 drug supply trends.[108]

[193] Mr Keen told the Commission that he had also recommended both FSH and SCGH conduct frequent independent sample audits (monthly or quarterly) of a percentage of Schedule 8 drug transactions to assess proper usage of requisition slips.

[194] Mr Keen made a number of recommendations to each of FSH and SCGH.

[195] The recommendations to FSH were delivered in writing. Some have been acted upon, although not all have been implemented in full.

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[105] Internal memorandum by N J Keen, 16 March 2016, p 7.

[106] N J Keen transcript, private examination, 1 March 2017, p 41.

[107] N J Keen transcript, private examination, 1 March 2017, p 42, see also internal memorandum by N J Keen, 16 March 2016, p 7.

[108] Internal memorandum by N J Keen, 16 March 2016, p 7.

[196] Subsequent to the MPRB investigation, Mr Keen's office conducted a survey of practices of 19 pharmacies.[109] He found that most chief pharmacists "don't conduct the sort of audit activities which would allow them to actually pick up these sorts of aberrant behaviour".[110] This and other findings were communicated to the Director General of WA Health and circulated to each chief pharmacist.[111]

[197] In his response to a draft copy of the report, Mr Keen stated:

> *It is the practice of the Medicines and Poisons Regulation Branch (the Branch) to seek to work with permit holders to obtain compliance with legislative requirements of the Medicines and Poisons Act 2014, and thereafter to further ensure the safe and secure handling of scheduled medicines, to protect public health. In the first instance, the goal is always rapid rectification of any failings, followed by implementation of system related changes that will result in sustainable compliance into the future.*
>
> *Since completing a survey of handling practices in Western Australian public hospital pharmacy departments, the Branch has commenced longer-term program of work in conjunction with the Chief Pharmacists Forum. The intention is to develop tools to support hospital pharmacy departments identify and correct deviations from acceptable practice.*
>
> *This is expected to include the production of guidance documents on the types of audit activities to be conducted, appropriate sampling methods and frequency of audits, as well as when to investigate further and how to respond to findings of concern. Initial workshops with the Chief Pharmacists Forum have already been held.*
>
> *Longer term, I consider that a number of the risks highlighted in the Report could be mitigated by eliminating the reliance on paper based records for Schedule 8 registers and internal transfer requisition documents.*
>
> *Currently the legislation does permit the use of electronic Schedule 8 registers. These can have advantages over paper based registers. Firstly, they can ensure that each and every record field is completed and legible. They can also be designed so that through access codes, any person making an entry is verified and individually identified against every record. In addition, the records contained are immediately and continuously archived.*
>
> *Given the nature and importance of these records, they must be kept secure. This includes being protected from unauthorised access, modification or deletion, and data loss. For this reason, the Medicines and Poisons Regulations 2016 require electronic registers to be approved by the Chief Executive Officer (CEO) of Health. The Branch has a systematic process for assessment and approval of these types of registers.*
>
> *A number of commercial electronic registers programs have been approved by the CEO, predominantly for use in community pharmacies. These are*

[109] MPRB, 'Schedule 8 medicines: handling practices in public hospitals' (Report, November 2016).

[110] N J Keen transcript, private examination, 1 March 2017, p 43.

[111] N J Keen transcript, private examination, 1 March 2017, p 44.

not purposely designed for use in large organisations, such as hospitals. Additional complexities for hospitals include the large number of individual storage locations, the number of staff accessing the registers, and differing needs of wards and the pharmacy.

The integrated supply records used in the ward storage devices employed at Fiona Stanley Hospital are an example of this type of register. However, most Western Australian hospitals do not yet have these devices and at present there is no approved commercial system that would be considered suitable, or practical to use in public hospitals that do not have automated supply technologies. I also note that specialised health information technology used in hospitals normally suffers from a number of complex technical challenges that means implementation is protracted and costly.

It is anticipated that any system suitable for approval and use in a public hospital could also be readily adapted to provide a secure process for requisitions to internally distribute Schedule 8 medicines. The Branch has highlighted this need to existing vendors of electronic registers and will continue to explore these opportunities into the future.[112]

What have Fiona Stanley Hospital and Sir Charles Gairdner Hospital done to change procedures?

Fiona Stanley Hospital

[198] Mr Jenkins appropriately acknowledged the crux of the problem in his evidence to the Commission "you can make sure all your systems and governance are appropriate, but strong, and we had some gaps, and we've filled those now".[113] The Commission accepts that FSH has made progress to address the issues identified by the Commission's investigation.

[199] Mr Jenkins explained that FSH have adopted the following measures:

(a) implementing compliance with the requisition process;

(b) conducting scheduled sample audits of registers set up for the year; and

(c) reviewing C^{II} Safe after-hours login report weekly and cross-checking on-call pharmacist reports and any call-ins.[114]

[200] Mr Jenkins told the Commission that he reminded FSH staff to complete requisition slips adequately and a subsequent quality and compliance audit indicated 100 per cent compliance.[115] Mr Jenkins informed the Commission that FSH had considered moving to e-forms for Schedule 8

[112] N J Keen response to Commission's draft report, 26 May 2017, pp 1-2.

[113] B G Jenkins transcript, private examination, 1 March 2017, p 17.

[114] B G Jenkins transcript, private examination, 1 March 2017, pp 21-22.

[115] B G Jenkins transcript, private examination, 1 March 2017, p 28.

and Schedule 4 drugs, although there "were some work flow issues in making that work".[116]

[201] Additionally, 'imprest optimisation' reviews are being undertaken to assess the need for a range of controlled drugs available in clinical areas.[117] Drugs not in use in ward areas are removed after a review is conducted by a clinical lead pharmacist every three to six months.[118]

[202] FSH currently conducts an annual audit of a sample of 10 per cent of its drug registers. A new policy issued in September 2016[119] requires an audit of registers every three months, however, as at March 2017 no audit had taken place.[120]

[203] FSH has a password protected database which records and tracks the location of registers. They have now locked their storage compactus to restrict access to archived registers.[121]

Sir Charles Gairdner Hospital

[204] Significant risks of serious misconduct remain at SCGH in relation to system deficiencies in the management, recording and control of Schedule 8 drugs. Although some efforts have been made to rectify identified risks, it is apparent to the Commission that there is more work to be done.

[205] Ms Babe indicated to the Commission that the events relating to Mr Foster did trigger a more extensive review of systems at SCGH but that the hospital was in "a bit of transition"[122] so matters such as policy development are "a work in progress".[123]

[206] In her evidence to the Commission, Ms Babe identified a variety of potential solutions to resolve some of the gaps identified by this investigation including:

(a) automated supply of Schedule 8 drugs;

(b) two-man biometric controls over supply of drugs from the pharmacy vault; and

(c) rationalisation and consolidation of drug holdings.[124]

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[116] B G Jenkins transcript, private examination, 1 March 2017, p 28.

[117] B G Jenkins transcript, private examination, 1 March 2017, p 21.

[118] B G Jenkins transcript, private examination, 1 March 2017, p 21.

[119] FSH, 'Supply and Reconciliation process for controlled drugs supplied to clinical areas' (June 2016).

[120] B G Jenkins transcript, private examination, 1 March 2017, pp 24-25.

[121] B G Jenkins transcript, private examination, 1 March 2017, p 33.

[122] G E Babe transcript, private examination, 10 March 2017, p 16.

[123] G E Babe transcript, private examination, 10 March 2017, p 5.

[124] G E Babe transcript, private examination, 10 March 2017, p 27.

[207] As a consequence of site visits to other pharmacies to model new procedures on what had been seen,[125] Ms Babe informed the Commission that SCGH will soon implement new procedures. She described some of the new requirements:

(a) a 'double-sign' to any amendments to white (duplicate) copies of pink slips;

(b) all duplicate copies of requisitions to be retained;

(c) segregation of duties from ordering pharmacist;

(d) archived registers to be given a unique number, sorted by date, location, and secured in a lockable compactus; and

(e) extensive audits.[126]

[208] On Ms Babe's evidence, reconciliation of all returned pink slips at the pharmacy is currently occurring although no compliance audits have been conducted to verify whether this process has been adopted. Similar to FSH, there is currently only an annual compliance audit conducted in relation to drug registers at SCGH.[127]

[209] Ms Babe advised the Commission that efforts to secure more resources for her department have been unsuccessful, including a request for a 'compliance pharmacist' or a person who can draft policy and guidelines, undertake audits and provide education.[128] An action plan, developed by SCGH, which includes development of guidelines, a compliance audit and surveillance system and the implementation of workflows to separate ordering and supply of controlled substances has been impeded by limited resources.[129]

[210] Ms Babe has stated in a statutory declaration dated 24 May 2017 that measures to improve control over registers are being implemented that include the:

(a) provision of unique identifiers to each register;

(b) establishment of a tracking index;

(c) annual assurance review of holdings and outstanding registers; and

(d) processes to record details of individuals and requests made to view archived documents.

[125] G E Babe transcript, private examination, 10 March 2017, p 29.

[126] G E Babe transcript, private examination, 10 March 2017, pp 29-30, pp 37-38, pp 48-49.

[127] G E Babe transcript, private examination, 10 March 2017, pp 26-27, 40.

[128] G E Babe transcript, private examination, 10 March 2017, p 52.

[129] G E Babe, Draft Medication Management Report, undated (post February 2017).

[211] She also declared that access controls are forthcoming with the planned installation of a lockable compactus to increase physical controls over the documentation.[130]

[212] Ms Babe wrote to the Commission on 26 May 2017 and provided an update and progress report on various matters at SCGH. She stated:

> *(a) Reconciliation of pink slips is occurring. A compliance test audit has been undertaken to verify this and results indicate 100% compliance with a 20% sample size audited. This audit has been added to the Pharmacy audit schedule for quarterly completion.*
>
> *(b) Pink forms have been redesigned to require provision of printed name and signature at every stage of authorisation. An audit has been designed and will be implemented once nursing education is finalised. This audit will be added to the Pharmacy audit schedule for quarterly completion.*
>
> *(c) The process for further segregation of duties from the ordering pharmacist has been implemented requiring any ad hoc orders to be assembled and processed by a second authorised individual.*
>
> *(d) The system to issue S8/S4R registers with a unique identifier has been implemented including procedures to track and record registers returned to Pharmacy. An audit of outstanding S8/S4R registers has been added to the audit schedule for annual completion.*
>
> *(e) The system to issue S8/S4R requisition books with a unique identifier has been implemented in Pharmacy including procedures to track and record the books containing the white duplicate copies returned to Pharmacy. An audit of outstanding S8/S4R requisition books has been added to the audit schedule for annual completion.*
>
> *(f) A lockable compactus in which the registers can be stored has been located and is forthcoming pending the decommissioning of the storage unit at another location.*
>
> *(g) A longitudinal audit tool to track randomly selected transactions at each of 31 points of the process from order of item from ward to receipt of item on ward has been developed and remains in test. Once validated and finalised, this audit will be added to the audit schedule for quarterly completion.*
>
> *(h) No additional resources have been provided to support this work. Front line Pharmacy staff have been redirected to perform assurances until such time resourcing is granted.*
>
> *(i) Lastly, a briefing note requesting consideration for an electronically controlled vault for the storage of controlled medicines has been submitted.*[131]

[130] G E Babe, Draft Medication Management Report, undated (post February 2017).

[131] G E Babe response to Commission's draft report, 26 May 2017, pp 4-5.

CHAPTER SEVEN
RECOMMENDATIONS

[213] Mr Foster alone is responsible for his conduct. He has been convicted and an opinion of serious misconduct is pointless.

[214] There is no evidence of serious misconduct by anyone else.

[215] In order to reduce the likelihood of serious misconduct occurring at public hospitals in relation to the supply and management of Schedule 8 drugs, the Commission recommends WA Health and its poisons permit holders consider action with respect to the following:

1. After-hours access to pharmacy and safe

Enhance monitoring of after-hours access to the pharmacy and the pharmacy safe. Give consideration to:

(a) mandatory audits for all after-hours supply or dispensation from the pharmacy safe;

(b) prohibiting after-hours solitary access to the pharmacy safe; and

(c) increasing security and monitoring through technology.

2. Reconcile supply and receipt

Develop and implement a practice to reconcile drugs supplied by a public hospital's pharmacy with receipt by wards and units.

3. Separation of duties

Implement procedures that mandate and reinforce the 'separation of duties' in relation to each act required in the supply process.

4. Regular compliance checks

(a) Conduct regular checks on randomly selected staff, wards and units in order to ascertain the extent of compliance with policies, procedures and practices; and

(b) Conduct independent audits from time to time that measure compliance with policies, procedures and practices.

5. Registers

Develop and implement practices in relation to registers that:

(a) enable registers to be produced, without delay, in response to a request by an investigator or compulsory processes;

(b) provide heightened security to the registers; and

(c) audit the movement of registers.

6. Update and consolidate policies, procedures and practices

Update and consolidate procedures and practices to align with the current statutory regime.

7. Knowledge sharing

Implement a forum for chief pharmacists of public hospitals to share knowledge about drug diversion risks and solutions.

8. Modernise requisition and register system

(a) Consider the introduction of an auditable electronic requisition process; and

(b) Consider the introduction of auditable electronic registers.

9. Enhance automated systems

(a) Take action to maximise Schedule 8 drugs on the imprest list; and

(b) Take action to inhibit automated systems allowing a pharmacist to supply imprest drugs manually.

10. Progressively introduce automation to public hospitals

Progressively introduce automated Electronic Storage and Supply Unit systems to public hospitals to enhance efficiencies and security.