



Secretary

Department of Health and Human Services

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COR 2018 000747

BAC-4316



Coroner John Olle
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Coroner Olle

Thank you for your letter of 11 October 2019 regarding the fatal overdose on 14 February 2018 of Ms Liana Pickup (Coroners reference: COR 2018 000747). I am responding to your recommendations addressed to the Secretary of the Department of Health and Human Services in line with my obligations under the *Coroners Act 2008*.

I can only imagine the distress and pain experienced by the loved ones of those who have died in circumstances such as that of Ms Pickup. I would like to offer my deepest sympathy to her family and friends.

I note that you found her death was the unintentional result of the deliberate ingestion of drugs, including methadone which she commenced the day before her death. I also note your conclusion that a number of factors relating to drug use, both illicit and prescribed, have confounded what contribution methadone had in Ms Pickup's death.

I note and accept your recommendation to develop and implement a program to educate the partners and family members of people prescribed strong opioids, particularly those receiving opioid replacement therapy, about overdose awareness and the administration of naloxone.

A broader range of initiatives and enhancements in drug and mental health services that address the recommendation and issues identified in your report are detailed in *Appendix 1 - Summary of Work relevant to the Coroner's recommendation in the case of Ms Liana Pickup*.

The department works to continually improve existing programs and consider the future design and delivery of drug and alcohol services. We will maintain focus on the issues you have identified that contributed to Ms Pickup's death. In particular, we will work strategically across the health system to minimise harm from polydrug use and provide the loved ones of people who use drugs with the knowledge and tools needed to keep them safe.

The need for continued vigilance and improvement of the Victorian mental health, alcohol and other drug treatment system and the broader health system is brought into stark contrast by tragic circumstances such as Ms Pickup's death. We can always do more, and we can do things differently. My department remains committed to addressing the concerning trend of increased misuse of prescription opioids in combination with other medications, and the related deaths in Victoria.

Yours sincerely



Terry Symonds
Acting Secretary

30/12/2019

Att.

Appendix 1, (BAC – 4316)

Summary of work relevant to the Coroner's recommendation in the case of Ms Liana Pickup:

- In August 2018, the Victorian Government committed to simplifying access to naloxone as part of its response to the Parliamentary Inquiry into Drug Law Reform. The department is advising government on how to implement this commitment, including options to allow health workers in registered needle and syringe programs to directly supply naloxone to clients who are at risk of, or who may witness, an opioid overdose
- Messaging about polydrug use has been integrated into Victoria's Needle and Syringe Programs and broader harm reduction strategies.
- The Royal Australian College of General Practitioners (RACGP) and the Penington Institute are collaborating to develop an overdose awareness campaign for general practitioners. This will likely involve:
 - A standalone awareness and education program to ensure the messages are not lost in other generalised education programs;
 - A "kit" that includes educational materials developed by the Penington Institute; and
 - Samples of Nyxoid (a nasal naloxone delivery system) to allow general practitioners to demonstrate the use of the product to patients and their loved ones.
- The department is helping to craft the education messages and will explore ways to support the uptake of the resources. The department is highlighting opioid stewardship as a primary consideration in this clinical work.
- SafeScript, Victoria's real-time prescription monitoring system, was launched in April 2019 and its use will be mandatory for prescribers and pharmacists from April 2020. This initiative includes a public awareness campaign and a clinician education program to highlight the harms associated with certain high-risk prescription medicines, including opioids.
- The department will meet with the RACGP in early 2020 to further explore the role of general practitioners in educating patients and their loved ones on the risk of opioid overdose.
- The Commonwealth government has committed \$10 million nationally for increased access to Nyxoid and education for general practitioners on the risk of overdose, signs and symptoms and appropriate responses, including the use of naloxone.
- The Drug and Alcohol Clinical Advisory Service has advocated the need for sound clinical governance and quality assurance for clinicians involved in the prescribing of strong opioids. These processes would support the dissemination of best practice principles for opioid prescribing, including discussing harm reduction strategies with patients. The department is exploring with its sector colleagues how to best facilitate the implementation of these processes.