



28 August 2018

Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

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

Dear Sir/Madam

**Coronial Inquest into the death of Rohan Grindod
COR 2011 4334
Finding into death with Inquest**



No. 238, RECOMMENDATION:

We refer to the recommendation of her Honour Coroner English in the above matter, namely that:

That TAC, State Trustees and Vista conduct a review, if they have not done so already, to ensure that all clients with lifesaving equipment such as the VitalCall device are recorded appropriately on their electronic systems so the equipment is identified as a risk requiring evaluation in the event of any change to the client's circumstances, such as when moving address.

This recommendation has now been implemented by VISTA.

VISTA's client management system, Carelink, has been updated to incorporate Alerts and Emergency Management details to notify staff and management of important details about the client, including the use of emergency life-saving equipment, the need for particular maintenance requirements of equipment, risks requiring evaluation in the event of any change to the client's circumstances, and important rostering requirements.

I trust the above is sufficient evidence of steps taken by VISTA as outlined in your above recommendation.

Yours faithfully

Scott Sheppard
Chief Customer Officer