Department of
Health & Human Services

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07 AUG 2015

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Ms Kate Doherty
Coroners Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Ms Doherty

Court Reference: Investigation into the death of Zoran Georgievski (COR 2011 001267)

Thank you for your letter dated 13 April 2015 regarding Coroner Olle's findings and recommendations to the Department of Health & Human Services following the investigation into the death of Zoran Georgievski.

Consistent with section 72 of the *Coroners Act 2008* (Vic), please find attached the department's response.

Yours sincerely

~~Dr Pradeep~~ **Philip**
Secretary

Att

State Government Victoria

Department of Health and Human Services' response to the Victorian Coroner's recommendation regarding the investigation of the death of Dr Zoran Georgievski

The death of Dr Zoran Georgievski has caused sadness and pain for his family and friends. The Department of Health and Human Services (the department) thanks the Coroner for his recommendation regarding opportunities to improve detection of the condition aortic dissection that led to Dr Georgievski's death.

The Coroner's report into the death of Dr Georgievski includes a recommendation for the department.

Recommendation

'I recommend the Department of Health (sic) disseminate to all Victorian Health Services a letter of Northern Health dated November 18, 2014 to the Coroners Court of Victoria entitled Report to Coroner –Northern Health changes to procedures and systems, setting out the initiatives and improvements which have been implemented in the Emergency Department of Northern Health since the death of Dr Zoran Georgievski on the 7 April 2011.'

The Coroner's recommendation has been considered by the department.

It is clear that the death of Dr Georgievski has resulted in Northern Health undertaking an extensive review and improvement of their processes. While the differences between clinical information systems, models of care and staffing across Victorian emergency departments mean that the issues identified and the solutions implemented by Northern Health are, in the most part, particular to the Northern Hospital's emergency department and its systems, themes identified by Northern Health, including clinical information management and handover, are broadly applicable.

To highlighting the key issues raised by the Coroner and ensure that the broader themes identified in Northern Health's review are effectively disseminated to clinical leaders of emergency departments, the department will undertake a targeted approach.

The department will write directly to Directors of Emergency Medicine highlighting the importance of:

- Education regarding aortic dissection and its varied presentations.
- The importance of considering other important but uncommon diagnoses such as aortic dissection and pulmonary embolism in chest pain evaluation pathways.
- Clinical information being readily available to clinicians, especially Ambulance Victoria patient care records.
- Robust clinical handover processes, particularly focussing on investigation results that need to be followed up; this may include appropriate medical officer cover for short stay/observation units overnight.
- Systems that alert clinicians when test results are available and 'log' that they have been looked at.

For further information please contact Jan Pannifex, Manager, Emergency Care Clinical Network on 9096 0578.