



Department of Health

Secretary



8 MAY 2013

50 Lonsdale Street
Melbourne
Victoria 3000
GPO Box 4541
Melbourne
Victoria 3001
Telephone: 1300 253 942
Facsimile: 1300 253 964
www.health.vic.gov.au
DX 210311

e2915230

Ms Esther Reeves
Registrar
Coroner's Court of Victoria
Level 11, 22 Exhibition Street
MELBOURNE VIV 3000

Dear Ms Reeves

Re: Court reference 2009 005807 FIKRI MEMEDOVSKI

I write in response to your letter dated 12 November 2012 regarding recommendations made by the coroner in the above case; two of the recommendations included reference to the Department of Health (the Department):

- Hospitals and Health services should have appropriate programs, policies and procedures to ensure medical practitioners in their employ are educated and made aware of their legal obligations to report deaths that are reportable to a coroner. The Department of Health consider communicating this to all hospitals and health services in Victoria;
- To minimise the possibility of medical practitioners failing to report a 'reportable' death as defined in the Coroners Act, the Department of Health consider communicating with hospitals and health services to implement a process of peer review of the medical cause of death by a senior medical practitioners prior to submission to the Registrar of BDM.

The Department note the above recommendations relevant to the case and the report on the 'Review of deaths reported to the Coroners Court of Victoria by the Registry of Births, Deaths and Marriages'.

The Department has written to Victorian public health services requesting their ongoing medical education programs include liaison with the Coroners Court of Victoria and the legal obligations of notifying reportable deaths under sections 4(2)(a) and 4(2)(d) of the *Coroners Act 2008*.

A summarised version of the case event with the coroner's recommendations will be published in the next edition (volume 10, issue 2) of RiskWatch newsletter accessed at <http://www.health.vic.gov.au/clinrisk/publications/riskwatch.htm>.

RiskWatch is another medium of communication to alert all medical practitioners about adverse events, prevention of recurrence of events and recommendations for improved processes in the delivery of health care for Victorians.

If you require further information please contact Ms Theresa Williamson, Acting Manager Quality and Safety Programs on telephone 9096 7258.

Yours sincerely



Dr Pradeep Philip
Secretary