Safer Care Victoria

Court ref: COR 2017 006132
SCV ref: CC2019-11

Rachel Nicol
Coroner's Registrar
cpuresponses@coronerscourt.vic.gov.au

Dear Ms Nicol

Investigation into the death of Maria Kerr

Thank you for your letter dated 28 June 2019 accompanying Coroner Jacqui Hawkins's finding without inquest into the death of Maria Kerr.

I refer to the Coroner's recommendation:

'...to Safer Care Victoria – Emergency Care Clinical Network – to develop, implement and disseminate an Emergency Department Practice Update to be distributed to all Victorian health service Emergency Departments advising of the new clinical standard Venous Thromboembolism Prevention Clinical Care Standard (October 2018) and their need to ensure their policies and procedures are up-to-date, specifically in relation to VTE risk management of patients who are discharged from an Emergency Department with significantly reduced mobility compared to their normal state.'

The Emergency Care Clinical Network (ECCN) will be implementing the Coroner's recommendation as outlined above.

The new clinical standard Venous Thromboembolism Prevention Clinical Care Standard (October 2018) will be distributed by the ECCN to Victorian health services, clinicians and consumers through the monthly Safer Care Victoria clinical newsletter. The clinical newsletter has a reach of 6,000 subscribers with 1,250 of them identifying that they work in the emergency care sector.

Victorian emergency department directors, nurse unit managers and urgent care centre directors of medicine and directors of nursing will also receive information about the new clinical standard via email from the ECCN. The email will encourage services to review their current policies and procedures to ensure alignment with the new clinical standard by the end of the year.

A standing item on the ECCN Insight sub-committee agenda is to review Coroners cases specific to the emergency care sector to ensure learnings are shared. The ECCN Insight sub-committee's membership comprises of clinicians and consumers from public and private health services across the state. The sub-committee members will assist in increasing awareness of the Coroner's recommendation across Victorian health services. The Insight sub-committee will also endeavour to use the Coroner's recommendation to inform the development of its suite of quality and safety indicators where applicable.

Should you have any queries, please contact Claire Doherty, Project Lead Emergency Care Clinical Network on (03) 9096 7770 or Claire.Doherty@safercare.vic.gov.au.

Yours sincerely

Professor Euan Wallace AM
Chief Executive Officer
Safer Care Victoria
Date: 11/9/2019

VICTORIA State Government