Court ref: COR 2019 6921
SCV ref: CC2021-05

Will Doolan
Coroner's Registrar
team4@courts.vic.gov.au

Dear Mr Doolan

Investigation into the death of Mr Ian Fraser

Thank you for your letter accompanying Coroner English's finding without inquest into the death of Ian Fraser. I apologise for the delay in responding to you.

Coroner English recommended that Safer Care Victoria (SCV) promote the Therapeutic Goods Association's (TGA) reporting pathway to both health service safety departments and clinicians. The Coroners recommendation will be implemented by SCV in full.

SCV will wait to action the recommendation, pending the development of any new processes to the reporting pathways by the TGA. It is expected SCV will implement the recommendation in full by 31 August 2021 and will write to the Court once this has been completed.

Although not a recommendation of Coroner English, the Digital Health Officer (Department of Health), Western Health and Cerner have commenced work to extend the recommendations Western Health made following their root cause analysis review of Mr Fraser's death. These improvements will be presented to the five other health services who use the Cerner system operated by the Department of Health and shared with two further health services who use the Cerner system (not operated by the Department of Health).

Should you have any queries, please contact Joanne Miller, Manager, Patient Safety, Experience and Response on (03) 9456 3971 or patientsafetyresponse@safercare.vic.gov.au.

Yours sincerely

Robyn Hudson
Acting Chief Executive Officer
Safer Care Victoria
Date: 28/05/2021