Court ref: COR 2018 003723

Ms Rebecca Hudson
Coroner's Registrar
Coroners Support Services

Email to: cpuresponses@coronerscourt.vic.gov.au

Dear Ms Hudson

Investigation into the death of PT

Thank you for your letter dated 30 June 2021 accompanying Coroner Spanos' finding without inquest into the death of PT.

As reported, the tragic death of PT was the result of a missed opportunity to diagnose an aortic dissection whilst in Emergency Department care. Coroner Spanos recommended that Safer Care Victoria (SCV) promote a wider awareness of the risk factors, presentations, and the limitations of clinical signs in ruling out aortic dissection. SCV has implemented the coroner's recommendation as follows:

1. SCV has updated its Chest Pain Clinical guidance to include the important key point that *"Other life threatening causes of chest pain to consider include aortic dissection, pulmonary embolism and tension pneumothorax."*

   Found at: https://www.bettersafercare.vic.gov.au/clinical-guidance/emergency/chest-pain

2. SCV has updated its Chest Pain fact sheet for consumers to include aortic dissection as a cause of chest pain.

   Found at: https://www.bettersafercare.vic.gov.au/clinical-guidance/emergency/chest-pain-patient

3. SCV will communicate these key updates to the Victorian Emergency Care Clinical Network with the aim to promote wider awareness of aortic dissection presentations and missed opportunities to diagnose.

4. SCV will work with the Australian College of Emergency Medicine, Cardiologists, and Emergency Physicians from within the Coroners Prevention Unit (CPU) to improve patient safety and clinician's awareness of aortic dissection.

We are grateful to the Coroner for bring this matter to the attention of SCV.

Should you have any queries, please contact Amelia Johnston, Senior Project Officer on (03) 9500 5193 or emergencycare.clinicalnetwork@safercare.vic.gov.au .

Yours sincerely

Professor Mike Roberts
Chief Executive Officer
Safer Care Victoria
Date: 27/09/2021