Court ref: COR 2019 6921
SCV ref: CC2021-15

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

Dear Mr Doolan

**RE: 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. The Therapeutic Goods Administration (TGA) have since reviewed the case and presented their findings, with no immediate changes made to the TGA's reporting pathways as Electronic Medical Records (EMR) are not classified as medical devices under their legislation.

Safer Care Victoria (SCV) are pleased to have now actioned Coroner English's recommendation, where the Coroner recommended SCV promote the TGA's reporting pathway to both health service departments and clinicians. SCV have published communications in our monthly e-newsletters, detailing the TGA's reporting pathway for adverse events that are a caused by medicines, vaccines and medical devices. The e-newsletter is made available to subscribers and circulated to health services throughout Victoria.

Although not a recommendation of Coroner English, SCV can confirm the Digital Health Officer (Department of Health) continue to work closely with Western Health and other Victorian health services that use the Cerner system to operate their EMR. The recommendations made in Western Health's Root Cause Analysis (RCA) were presented at the next Victorian Cerner Collaboration Group (VCCG) meeting, held on 15 September 2021. This included representatives from nine Victorian health services and the aim of the VCCG will be to extend the findings from Western Health's RCA to better improve the use of the Cerner EMR system across Victoria.

Should you have any queries, please contact Curtis Hopkins, Senior Project Officer, Patient Safety, Experience and Response Team on patientsafetyresponse@safercare.vic.gov.au.

Yours sincerely,

Professor Michael Roberts
Chief Executive Officer
**Safer Care Victoria**
Date: 16/09/2021