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30 September 2021

Coroner Spanos Coroners' Court of Victoria 65 Kavanagh Street Southbank VIC 3006

By email: cpuresponses@coronerscourt.vic.gov.au

Dear Coroner.

Re Investigation into the death of Court reference: COR 2018 003723

Thank you for highlighting to the Australasian College for Emergency Medicine (ACEM; the College) the issues associated with diagnosing aortic dissection following the death of the report referred to as PT. Our letter outlines the process that ACEM is pursuing following your report in response to this death, the timeframe for a decision and the contact details for the person responsible for consideration of the recommendation.

We note that the Coroner recommended that ACEM "promote a wider awareness of the risk factors, presentations and the limitations of clinical signs in ruling out aortic dissection." On 30 June 2021, the College received the report from the Coroner regarding the investigation into the death of College is in the process of convening a group of emergency medicine Fellows and trainees to prepare a summary of the findings and recommendations of the Coroner's report. This summary will be provided to ACEM's Quality and Patient Safety (QPS) Committee, which is responsible for reviewing findings and recommendations from Coroners across Australia and New Zealand and providing advice on matters concerning quality and safety in emergency medicine. The QPS Committee are meeting on Friday 12 November 2021 and will discuss the evidence, guidelines and potential issues associated with diagnosing aortic dissection.

Following review by ACEM's QPS Committee, ACEM will promulgate the findings through a number of channels to the emergency medicine community to be used for educational purposes. ACEM is acutely aware that aortic dissection continues to feature regularly in coronial matters and will stress this issue in feedback to members.

ACEM would like to extend our condolences to family for their loss. We are committed to raising awareness amongst our Fellows and trainees of the risk factors, presentations and the limitations of clinical signs in ruling out aortic dissection.

Please contact Katie Moore, General Manager, Research and Partnerships, on katie.moore@acem.org.au if you require further information.

Yours sincerely

Dr John BonningPresident

Dr Carmel Crock

Chair, Quality and Patient Safety Committee