Department of Health

50 Lonsdale Street
Melbourne Victoria 3000
Telephone: 1300 650 172
GPO Box 4057
Melbourne Victoria 3001
www.health.vic.gov.au
DX 210081

HHSD/22/399988

Your ref: COR 2018 005744

Josh Munro
Coroner's Registrar
Coroner's Support Services
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

BY EMAIL: cpuresponses@coronerscourt.vic.gov.au

Dear Registrar Munro

Investigation into the death of Carlene Salveson

Thank you for your letter dated 1 October 2021. I apologise for the delay in responding; we have been working hard on elements of the COVID pandemic response, resulting in delays in recruitment to our eHealth safety role.

I note the recommendation made by Coroner Audrey Jamieson on 10 June 2021, to coordinate with clinical and safety leaders in Victoria and nationally, to review how electronic medical records and electronic medication management systems present and manage high risk medicine. I initiated discussion with other jurisdictional leaders who were supportive of collaborative work in the area recommended.

I can confirm that implementation of the Coroner's recommendations has commenced. The Digital Health Branch at the Department of Health Victoria (the department), through its role as systems manager for the health sector, works to ensure health services operate their ICT safely, securely, cost-effectively and in alignment with state and national digital health strategies.

Digital Health has consulted with Safer Care Victoria, and written to pertinent national and jurisdictional agencies to convene a national eHealth High Risk Medicine Safety advisory group to:

- provide expert advice and guidance on presentation, management, issues and risks related to high risk medicines in electronic medical records (EMR) and electronic medication management (EMM) systems; and
- develop national recommendations and mitigation strategies which improve presentation and management of high risk medicines in EMR and EMM systems.

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High risk medicines to be reviewed will include but are not limited to, anticoagulants including warfarin, the heparins and direct oral anticoagulant therapies.

Since the release of the Coroner's finding, the department has received agreement from the National Health Chief Information Officers Roundtable and the Australian Commission into Safety and Quality in Health Care (ACSQHC), to commence. We have also consulted with digital health and clinical safely leads in Victoria to establish a process for routine assessment of high severity adverse events

An advisory group will comprise clinical and safety representatives from Safer Care Victoria, the Therapeutic Goods Administration, ACSQHC, clinical safety leads and our Digital Health Branch. There will be transparency with vendors of electronic medical record (EMR) system vendors in Australia, including Oracle Cerner.

In addition, Digital Health will work with Safer Care Victoria and sector safety leads to identify and review clinical information systems-related patient safety adverse events in the health sector. This will facilitate assessment and review of adverse events to which clinical information systems are a contributing factor. Incident reporting and analysis requirements, lessons and learnings dissemination, and policies will be revised as indicated.

Should you have any further queries, please contact David Nguyen, eHealth Safety Adviser, Digital Health, via email at david.nguyen@health.vic.gov.au.

Yours sincerely

Neville Board
Chief Digital Health Officer

25 July 2022

Cc:
Prof Mike Roberts, CEO, Safer Care Victoria
Professor Andrew Way, AO, CEO, Alfred Health