ST JOHN OF GOD
Geelong Hospital

Coroners Court of Victoria
65 Kavanagh Street
Southbank VIC 3006
cpuresponses@coronerscourt.vic.gov.au

Ref: COR 2020 001147

7th September 2023

To whom it may concern

Pursuant to section 72(3) of the Act, St John of God Geelong Hospital (SJGGH) herein provides a response to the recommendation set forth by Coroner Magistrate Audrey Jamieson's finding without inquest into the death of Edis Brenner.

SJGGH has implemented **Recommendation 1** provided by the Coroner and commenced discussion of:

'…all unexpected deaths that occur in relation to surgery with Safer Care Victoria's Patient Safety Review Team to ascertain whether the incident meets the criteria for a sentinel event notification and make any necessary notifications accordingly.'

Pursuant to section 72(4) of the Act SJGGH writes to inform the Coroner that the above recommendation **was implemented** after receipt of the Coroner's finding. This can be supported with the following evidence:

1. Contact made in writing on the 11th August 2023 to the Sentinel Event Program to discuss the Coroner's recommendation

2. Contact made in writing to the Sentinel Event Program on 31st August 2023 seeking advice as to if the death of a comorbid 77 year old male having suffered a bladder perforation post urology surgery for which the coroner was notified and reported to VASM is reportable to Safer Care Victoria.

Please contact Emma Hay, Clinical Risk and Quality Manager [redacted] or Dr. Michael Desmond, Director of Medical Services on [redacted] should you wish to discuss the implementation of Recommendation 1 further.

In kind,

Emma Hay

Clinical Risk and Quality Manager