BAC-CO-48144

CC2024-20

Coroner Ingrid Giles

Coroners Court of Victoria

65 Kavanagh Street

Via e-mail: team11@courts.vic.gov.au

Dear Coroner Giles

Coroners Findings and Recommendations: Trevor Lindsay Jones (COR 2023 001947)

Thank you for your letter from 30 May 2024. I am responding to your findings into the death without inquest of Trevor Jones. I was saddened to learn of Mr Jones death and would like to convey my condolences to his loved ones.

Response to Recommendation

> *I recommend that Safer Care Victoria consider whether further guidance is required to clarify the types of events (such as misdiagnosis leading to patient harm) that should be reported as adverse patient safety events, and which should be registered with the Victorian Health Incident Management System and formally investigated.*

I am pleased to advise that Safer Care Victoria (SCV) in conjunction with the Department of Health (the department) is taking actions to address Your Honours recommendation. We acknowledge and agree there is a need for greater clarity regarding reporting of Adverse Patient Safety Events (APSE) and their subsequent need for formal investigation. SCV in partnership with eHealth at the department, continue to work in strengthening user understanding through sector engagement and with the 2024 – 2025 review and upgrade of the Victorian Health Incident Management System (VHIMS) standardised Minimum Data Set (MDS). This large piece of work is nearing completion.

One of the changes we have made is to align the definition of a clinical incident in VHIMS to the definition in the APSE policy. The dataset includes two new data elements - the *Clinical Incident flag* and the *Adverse Patient Safety Event flag.* These have been introduced to ensure classification of clinical incidents in the VHMS MDS aligns with departmental and SCV policies and facilitates Statutory Duty of Candour processes through enabling the identification of SAPSE's. The SCV APSE policy indicates the level and type of review that should be undertaken dependent on the incident severity rating and whether a case is considered a Sentinel Event. In the case of a higher severity rating, a formal review methodology must be undertaken.

To complement these changes, we are creating a training module intended to cover general information about incidents and what role incident reporting plays in a just culture. Included in the module are two guidance documents that have applicability in terms of guidance on what to report. This will provide greater clarity for health care services.

These are in the process of final endorsement, before being communicated to the sector. Additionally, SCV will consider using the learnings of this case in future training. We thank Your Honour for highlighting this important issue.

Should you have any queries, please contact Jodyanne See, Senior Project Officer for coronial matters via email [redacted]

Yours sincerely

Ms Louise McKinlay

Interim Chief Executive Officer

Safer Care Victoria

Date: 23/07/2024