HWL EBSWORTH
LAWYERS

Our Ref: SVP:JJ:1150187
Your Ref: COR 2018 4070

20 December 2024

Ann Kho
Coroner's Solicitor
Coroner's Court of Victoria
65 Kavanagh St
Southbank VIC 3006

Email: team10@courts.vic.gov.au

Dear Ms Kho

Coronial inquest into the death of Alan Stewart
COR 2018 4070

1. Introduction

1.1 We act on behalf of the Royal Melbourne Hospital (**the Hospital**).

1.2 We refer to His Honour, Coroner Lawrie's Inquest findings, delivered on 15 August 2024 (**the findings**) which made two recommendations in relation to the Hospital.

1.3 We provide our client's response to the recommendations as follows.

2. Recommendations

Recommendation One

2.1 His Honour recommended that the Hospital's 'Discharge Information Sheet':

(a) remove ambiguity so that it is clear that 'difficulty breathing' is a symptom which ought to prompt emergency treatment/presentation to ED rather than presentation to a GP; and

(b) Include symptoms of internal haemorrhage among the group of symptoms requiring emergency action. We understand the symptoms of internal haemorrhage are defined at paragraph 40 of the findings, as per Dr Vickers' evidence, and includes: dizziness, weakness, fatigue and feeling cold.

Hospital's Response

Level 8, 447 Collins Street, Melbourne VIC 3000 Australia
PO Box 3, Collins Street West VIC 8007 Australia

Telephone +61 3 8644 3500
Facsimile 1300 365 323 (Australia) +61 2 8507 6582 (International)
hwlebsworth.com.au

Adelaide
Brisbane
Canberra
Darwin
Hobart
Melbourne
Norwest
Perth
Sydney

ABN 37 246 549 189

2.2 We refer to our correspondence dated 29 August 2024 which sought to clarify Recommendation One and which flagged proposed changes to the 'Discharge Information Sheet'.

2.3 We have since been instructed that the 'Discharge Information Sheet' referred to in the findings is no longer in use by the Hospital and has been replaced with an 'After Visit Summary'. The After Visit Summary is a document which applies to all day procedures and not just colonoscopies.

2.4 In this regard, any proposed changes to the After Visit Summary will impact and require the input of several Hospital departments (eg. surgical and gastroenterology teams).

2.5 The Hospital proposes to table Recommendation One to the relevant Hospital Committee in 2025 to assess the implications of inclusion of symptoms of internal haemorrhage. The Hospital will provide the Coroner with a further update on the outcome of this meeting by no later than **July 2025**.

Recommendation Two

2.6 The Coroner recommended the Hospital review its patient discharge procedures to ensure a record is kept of the discharge information provided to the patient.

Hospital's Response:

2.7 We refer to our correspondence dated 29 August 2024 which highlighted that the Hospital's 'Day Procedure Record' includes an option (i.e. 'ticking a box') to confirm that written discharge information has been provided to the patient. We acknowledge His Honour's response, by correspondence dated 22 October 2024, that the Hospital's proposed response to Recommendation 2 is *'appropriately responsive*'.

2.8 In this regard, the Hospital does not intend to make any changes to its existing Day Procedure Record.

3. Conclusion

3.1 Should the Coroner require anything further, please contact us.

Kind regards

Sophie Pennington
Partner
HWL Ebsworth Lawyers

Jessica Jones
Special Counsel
HWL Ebsworth Lawyers

[redacted]