**IN THE MATTER** of the Coroners Act 2008

*and*

the death of **RACHEL PISKUN – COR 2023 000222**

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**RESPONSE BY WESTERN HEALTH**

## THE RECOMMENDATIONS

1. Pursuant to section 72(3) of the Coroner's Act 2008 (Vic), Western Health hereby responds to the following recommendation made by Coroner Audrey Jamieson on 17 October 2025:

> With the aim of promoting public health and safety and preventing like deaths, I recommend that Western Health explore the use of their existing monitoring and reporting mechanisms such as RiskMan to identify systemic problems in the care delivered to people with disabilities.

## STATEMENT OF ACTION IN RELATION TO RECOMMENDATIONS

2. The Coroner's recommendation will be implemented, and Western Health has commenced exploring the use of, and strengthening existing monitoring and reporting mechanisms to better identify systemic issues in the care delivered to people with disabilities.

3. Health Passports, whether paper-based or electronic, are recognised as important tools to support safe, person-centred and accessible care by enabling consumers and their supports to communicate important personal information, including needs and preference, and key health information with providers. These tools are especially important for people with disabilities as they can be critical to guide and assist with effective handover, support care planning discussions, and identify issues in care delivery, which help to reduce healthcare trauma and anxiety whilst supporting self-determination and dignity. Western Health are currently working in partnership with other metropolitan and regional Disability Liaison Office programs, Peninsula Health, Monash University, and the National Centre for Healthy Ageing to explore the feasibility of implementing an electronic Health Passport across Victorian Public Hospitals.

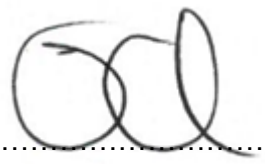
4. The electronic medical record (EMR) Disability Identifier (DI) is anticipated for implementation at Western Health in 2026. The DI consists of three voluntary self-report questions embedded into the EMR and allow patients or their carers to voluntarily disclose information that will help identify whether a person has support needs related to a long-term health condition, impairment or disability. Where disclosed, the DI information will be 'flagged' and visible in the patient's EMR and will automatically initiate a referral to the Disability Liaison Service (DLS). This system enhancement is anticipated to minimise the risk of care-related issues for patients with disability through earlier identification and support.

5. RiskMan will continue to be utilised to capture and facilitate review of individual clinical incidents and near miss events for all patients, including those with a disability. Use of RiskMan will include thematic analysis of incidents involving patients with a disability, particularly Serious Adverse Patient Safety Events (SASPEs) to identify contributory trend and themes.

6. Collectively, Western Health expects these actions will assist to improve identification of patients with a disability, strengthen detection of systemic issues in care delivery, and facilitate:

    a. Earlier specialist involvement of the DLS to enable deeper exploration of issues and consumer needs to reduce the risks of clinical incidents occurring; and

    b. Education and recognition of reasonable adjustments via the DLS to the clinical teams to address the underlying power imbalance, lack of understanding of the disability sector and carer knowledge and skill.



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Executive Director, Nursing & Midwifery
**Western Health**
16 January 2026