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5 January 2026

Response by Echuca Regional Health to Recommendations from Finding Into Death Without Inquest of Gary William Bruce, COR 2023 002978

Recommendation 1:

ERH should undertake improved education, training and awareness of the Hospital's deteriorating patient response with its medical and nursing staff and gather evidence to demonstrate improvement amongst its staff.

The clinical escalation system for the deteriorating patient at Echuca Regional Health (ERH) is part of the ward/unit orientation of new nursing staff, including those working in the High Dependency Unit (HDU). The orientation is undertaken by a dedicated Clinical Nurse Educator and covers: activation of a Code Blue response, Medical Emergency Team (MET) calls and clinical reviews; the Clinical Escalation System policy.

The orientation of new doctors in training (junior doctors) by the Director of Clinical Training (DCT) and other senior staff includes clinical escalation, with a particular focus on: the Clinical Escalation System, including who they can expect to attend a MET call or Code Blue; the role of senior medical staff, including their availability around the clock; graded assertiveness to escalate concerns; the role of the After Hours Manager and Executive On call, especially when there is a patient safety concern.

Since December 2024 ERH has conducted regular, ongoing point of care auditing of a range of parameters for recognizing and responding to acute deterioration. Typically, 10 patient records are reviewed bi-monthly in each clinical area.

The results for the HDU for the question "Were the vital signs within clinical review/MET call escalated?" (where clinical escalation should have been activated in accordance with policy) were: 100% compliance for December 2024, February 2025, April 2025, June 2025, August 2025, and October 2025 (Attachment 1).

Recommendation 2:

ERH should consider implementing a mechanism by which anaesthetic or other critical care trained specialist such as ICU or ED staff are available to provide advice to a junior doctor who attends MET calls overnight.

ERH's mechanism for accessing critical care trained specialist advice is outlined in its Clinical Escalation System policy, which refers to "Unresolved Clinical Concerns". Communication between relevant staff (including medical staff) may be facilitated by a member of the Executive (including after-hours) if a safety concern remains unresolved (Attachment 2).

There is 24 hour, seven days, senior medical staff rostering in the disciplines of: emergency medicine (emergency physician or senior medical officer in emergency medicine); adult medicine (general physician or rural generalist); paediatrics (specialist paediatrician or rural generalist); obstetrics (specialist obstetrician or rural generalist); general surgery (general surgeon); anaesthetics (specialist or rural generalist).

External specialist intensivist advice is available from Bendigo Health (via a Service Level Agreement: Intensive Care Specialist Support Services) (Attachment 3), especially for patients already known to the Bendigo Health Intensive Care Unit (ICU) via the daily (seven days) virtual ward round with the ERH HDU.

Inter-hospital transfer of a critically ill patient is coordinated through Adult Retrieval Victoria (ARV), when required.

Response to Comments pertaining to the removal of the arterial line

Further enquiries have been unable to shed additional light on this matter. The Anaesthetic/Recovery Record (MR/138; Version 3, April 2025) has been revised, including a repositioning of the Monitoring section (with a check-box for arterial line) to the top of the page for enhanced visibility (Attachment 4).

Echuca Regional Health expresses our sincere condolences to the family of Mr Bruce following his death.

We respect the findings of the coroner's report and remain committed to supporting transparency, accountability and continuous improvement in the care we provide to our community.

Dr Annemarie Newth
Executive Director Medical Services
Chief Medical Officer

	2024				2025																			
	Q4				Q1				Q2								Q3				Q4			
	December				February				April				June				August				October			
Were the vital signs within Clinical Review / MET Call escalated?: Yes Total	Record Count	N	D	Result Bar	Record Count	N	D	Result Bar	Record Count	N	D	Result Bar	Record Count	N	D	Result Bar	Record Count	N	D	Result Bar	Record Count	N	D	Result Bar
High Dependency Unit	10	5	5	100%	9	4	4	100%	10	5	5	100%					10	5	5	100%	10	3	3	100%
Inpatient Rehabilitation	10	1	1	100%	11	0	0										11	2	2	100%	10	0	0	
Maternity Ward	8	3	3	100%	11	2	2	100%									8	2	2	100%				
Medical Ward	11	0	1	0%	10	0	0		14	0	1	0%	10	2	2	100%	8	2	2	100%				
Surgical Ward	10	2	8	25%	11	2	2	100%	9	0	0						10	1	1	100%				

Narrative: *For the auditing period in February, June, August and October 2025, all departments recorded 100% compliance with escalating vital signs when breaching Clinical Review/MET call parameters. In December 2024 and April 2025, the Medical Ward recorded 1 patient in each auditing period that did not comply with escalation protocol despite being in escalation criteria. In December 2024 there were 2 patients in the Surgical Ward that did not comply with escalation protocol despite being in escalation criteria. Further auditing has seen an improvement with both the Medical and Surgical Wards achieving 100% compliance.*

Clinical Escalation System

Policy Statement:
The clinical escalation system at ERH ensures that staff or teams of staff with the appropriate knowledge and skills will be available to respond on a timely basis to patients who require i urgent medical assessment and treatment
The clinical escalation system at ERH is based on a safety culture that supports all members of the clinical team, patients and carers to raise concerns regarding patient medical status issues that may require an urgent response.

Guiding principles underpinning the clinical escalation system are:

- Patients that require active intervention will be identified and responded to within appropriate timelines.
- Communication will be effective and timely and include support for any member of the multidisciplinary team to speak up and raise a concern.
- Executive supports and provides clear processes for individuals who have unresolved concerns to seek further advice
- Activation of team responses is coordinated and effective
- Suitably trained and competent staff able are available to respond effectively to varying clinical scenarios
- Teams work together and understand their roles enabling a coordinated and timely response
- Patient, family and carers know how to access timely assistance if they have concerns.
- Ongoing review of the effectiveness of the clinical escalation system facilitates ongoing improvement and development of the system.

The clinical escalation system is supported by a range of policy and procedures relating to patient assessment, identification of clinical deterioration, clinical handover and clearly defined courses of action for particular clinical scenarios. See linked documents below. A range of track and trigger observation response charts also support staff to identify patients requiring intervention.

Any concern of a time critical nature or a concern meeting the criteria for activation of a team response will be called as soon as identified.

Team responses include:

- **Code Blue**
- **MET Call**
- **MET Call: Emergency Department**
- **Time Critical Caesar Call**
- **Massive Blood Transfusion Call**
- **Trauma Call**

Definitions:

ISBAR: a standardized framework for effective handover. ISBAR means: Identification, Situation, Background, Assessment, and Request.

Request: requested actions, confirmation of agreed actions and any transfer of accountability. More information is provided in the Clinical Handover Policy.

ORC: Track and trigger patient observation charts with features that are effective in identifying patients who are deteriorating and the appropriate prompt action to take in response to the identified deterioration

Unresolved Clinical Concerns

In the event that an individual clinician has a concern about the clinical status of a patient that remains unresolved even after discussion with the treating team members, and an attempt to clearly articulate the concern utilizing the ISBAR format has been made, it is appropriate for the concerned staff member to progressively escalate their concerns in a systematic and structured manner.
Refer to Appendix 1: Escalation process for a deteriorating patient flow chart.

Escalation beyond the treating senior doctor may include seeking advice from another senior doctor in the same specialty, VMO on-call, another VMO on- call, Clinical Director (e.g. Director of Surgery), ERH specialist (e.g. paediatrician) or external specialist (e.g. ARV, PIPER, Bendigo Health cardiologist). The Executive Director will facilitate communication between the concerned staff member/s and appropriate clinicians to ensure patient safety and outcomes are optimized. Governance of the clinical escalation system is the responsibility of the Clinical Deterioration Committee and Executive Quality Committee.

Personnel to which this policy applies:

All staff, VMOs and patients/carers

Linked documents

Code Blue
MET Call
MET Call: Emergency Department
Critical Caesar Call
Blood Transfusion
Trauma Call
PACE: Patient and Carer Escalation
Vital Signs
Nursing Admission, Screening and Assessment
Clinical Handover
Mental Health admission and risk assessment (in development)

Alternate Key Search Words:

Deteriorating patient

Appendix:

Appendix 1 - Escalation process for a deteriorating patient flowchart
Community Nursing Deteriorating Patient Escalation Flowchart
Community Nursing Deteriorating Patient Escalation – SOP
ISBAR Communication Tool for Escalation of Care
HITH Deteriorating Patient Escalation Flowchart
HITH Deteriorating Patient Escalation - SOP

Accreditation Framework

NSQHS Standard 8- Recognising and responding to acute deterioration

Revision History:

Date Issued:	Feb 2017
Date of Last Review:	August 2021
Original authors:	EDMS/CMO
Stakeholders:	DMS, EDON, Nurse Unit Manager Committee, DDON, Std 8 Committee
Date of Next Review:	August 2025
Approved By:	Clinical Practice Guidelines Committee

MR/138

Echuca Regional Health

Anaesthetic / Recovery Record

SURNAME: _____ UR NO: _____

GIVEN NAME: _____

DOB: _____ SEX: _____ WARD: _____

DOCTOR: _____

USE LABEL IF AVAILABLE

ALLERGIES

ANAESTHETIC HISTORY / ALERTS

ASA: _____

MEDICAL HISTORY

☐ Aspiration Risk ☐ Smoking ☐ Alcohol: _____

INVESTIGATIONS

AIRWAY EXAMINATION

TEETH: ☐ Own ☐ Dentures ☐ Upper ☐ Lower

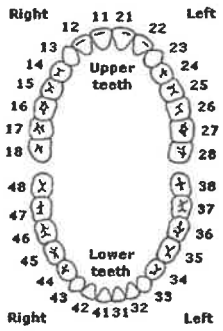
MP:

TM:

NECK:

CVS:

RS:



ANAESTHETIC PLAN

GA Sedation
- ☐ Aspiration
- ☐ Awareness
- ☐ Allergic Reaction
- ☐ Oro-dental injury
- ☐ PONV
- ☐ Sore throat
- ☐ Other: _____

Regional
- ☐ Failure
- ☐ Hypotension
- ☐ Nerve injury
- ☐ Headache
- ☐ Toxicity
- ☐ Shivering / pruritis
- ☐ Other: _____

CURRENT MEDICATION

ANAESTHETIC CONSENT

I consent to the administration of the anaesthetic and have had the benefits/ risks explained to me and all my questions and concerns addressed to my satisfaction.

Patient Signature: _____

Anaesthetist Signature: _____

Print name: _____ Date: _____

DATE	PRE-MEDICATION	DOSE	ROUTE	TIME	SIGNATURE	TIME GIVEN	RN SIGNATURE

Anaesthetic / Recovery Record

MR/138

VER 3
APR
2025

PRE-OP VITAL SIGNS

HR:..... BSL:.....
BP:..... Ketones:.....
RR:..... BMI:.....
SpO2:..... Weight:.....
Temp:..... Height:.....
Fasting:.....

VASCULAR ACCESS

	SIZE	SITE
IV		
IV		
Art		
CVC		

MONITORING

- ☐ SaO_2
- ☐ NIBP
- ☐ ECG
- ☐ $ETCO_2$
- ☐ Entropy
- ☐ Other:.....
- ☐ Volatile
- ☐ BIS
- ☐ Arterial Line
- ☐ Temperature
- ☐ Urinary Catheter

EQUIPMENT

- ☐ Warming Blanket
- ☐ Fluid Warmer
- ☐ Other:.....

Anaesthetist: ..... **Date:** ... / ... / ...

Surgeon: ..... **Time:** .....

Procedure: .....

AIRWAY

☐ Hudson Mask ☐ Nasal Prongs ☐ Optiflow
☐ Guedel ☐ Oral/Nasal Airway ☐ ETT ☐ LMA
Size:..... Depth:..... ☐ Cuffed ☐ Uncuffed
☐ Bougie ☐ Cricoid Pressure Atraumatic: Yes / No Cuff Press:.....
Direct Laryngoscopy grade:..... Blade:.....
Video Laryngoscope view: 0% 25% 50% 75% 100% ☐ FOI

ANAESTHETIC

☐ **Sedation** ☐ **General:** ☐ Inhalational ☐ TIVA
☐ Spont. ☐ Controlled
Mode:..... TV:..... RR:..... PEEP:..... PAP:.....
☐ **Neurexial:** ☐ Spinal ☐ Epidural ☐ Caudal
Awake/Sedation Position:.....
Asepsis:.....
Level:..... No. of Attempts:..... Block Level:.....
Paraesthesia: ☐ Yes ☐ No Blood Tap: ☐ Yes ☐ No
LA:.....
☐ **Regional:** Type:.....
Awake/Sedation Block Time Out: ☐ Yes ☐ No
Asepsis:.....
No. of Attempts:..... Paraesthesia: ☐ Yes ☐ No
LA:.....

NOTES / REMARKS

OT to PACU Handover Time:.....
Anaesthetist Sign:.....
Nurse Sign:.....

Event	
Temperature	
N.M.B.	
Volatile	
SaO_2	
$ETCO_2$	
Entropy	
Ventillator Settings	

OBSERVATIONS

BP ▼ ▲ Pulse ● Resp ○

200 / 150 / 100 / 50

DRUGS \ TIME			
N_2O / O_2 / Air:			
Fluid			
Urine Output:			
Blood Loss:			

T	PATIENT CARE AND POSITIONING	OTHER	
nket	☐ Supine ☐ Prone ☐ Lithotomy ☐ Lateral = ☐ Left OR ☐ Right ☐ Eyes Taped ☐ Pressure Care ☐ TEDS ☐ Calf Compressions ☐ VTE Prophylaxis _____	☐ Throat Pack ☐ In ☐ Out ☐ Torniquet: Time: _____ Position: _____	SURNAME: _____ UR NO: _____ GIVEN NAME: _____ DOB: _____ SEX: _____ WARD: _____ DOCTOR: _____ USE LABEL IF AVAILABLE

Echuca Regional Health

ADULT >18 YEARS
PACU STAGE 1

SURNAME: .... UR NO: ....

GIVEN NAME: ....

DOB: .... SEX: .... WARD: ....

DOCTOR: ....

USE LABEL IF AVAILABLE

ALL

MEDICATION ORDERS

DRUG	DOSE	ROUTE	FREQ.	DOCTOR'S SIGNATURE	DOSE GIVEN - TIME, IN					

Medical Emergency Team Call (MET)

Response Criteria
- **Any observation in a purple area**
- You are worried about the patient but they do not fit the above criteria

Actions Required
- Call MET dial #7
- MET Team to attend patient immediately
- The VMO must be notified
- Document patient management plan
- Document any tolerance for abnormal observation

Clinical Review

Response Criteria
- **Any observation in an orange area**
- You are worried about the patient but they do not fit the above criteria

Actions Required
- HMO review within 30 minutes
- Increase frequency of observations until review
- Document patient management plan
- Document any tolerance for abnormal observations

VARIANCE/MODIFICATION

TIME FRAME	MANAGEMENT PLAN

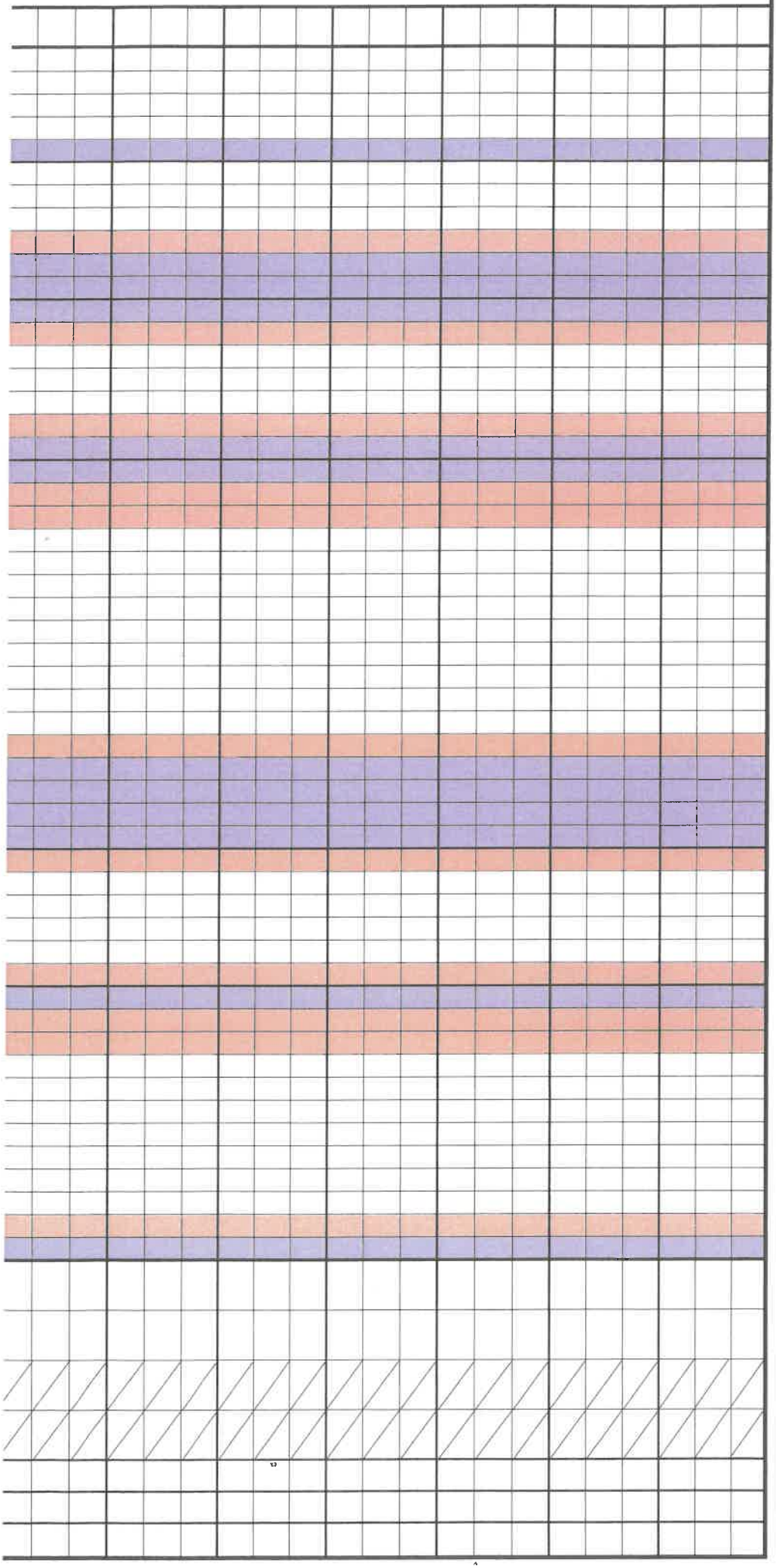
TIME	COMMENTS	INIT	TIME	COMMENTS

MR/138

ERGIES	STAGE 1		Date: / /20	WHEN GRAPHING OBSERVATIO IF OBSERVATION
		Time		
	Level of Consciousness ●	Alert		
		Drowsy		
		Responds to Voice		
		Stable / Unresponsive		
		Unstable / Unresponsive		
		O2 lts/min		
		LMA (LM) Hudson (H) Nasal Prong (NP) Room Air (RA)		
ITIAL, DOSE	O2 Saturation %	Write ≥ 95		
		90-94		
		85-89		
		Write ≤ 84		
	Respiratory Rate p/m ● Dyspnoea (D)	Write ≥ 30		
		25-29		
		20-24		
		15-19		
		10-14		
		5-9		
		Write ≤ 4		
	Blood Pressure (mm/Hg) (Score Systolic BP) ▼ ^	Write ≥ 200		
		190s		
		180s		
		170s		
		160s		
		150s		
		140s		
		130s		
		120s		
		110s		
		100s		
		90s		
		80s		
		70s		
		60s		
		50s		
		Write ≤ 40s		
INIT	Temperature (C°) ● Day Case Temp x1 per stage O/N Temp x2 minimum	Write ≥ 38		
		37.5-37.9		
		37.0-37.4		
		36-36.9		
		35.6-35.9		
		Write ≤ 35.4		
	Heart Rate Beats / min ● (If irregular, document)	Write ≥ 140s		
		130s		
		120s		
		110s		
		100s		
		90s		
		80s		
		70s		
		60s		
		50s		
		40s		
		Write ≤ 30s		
	PAIN	/10		
	NAUSEA	Y/N		
	BROMAGE	R / L		
	DERMATOMES	R / L		
	SEDATION SCORE			
	NURSE INTIALS			

VER 3
APR
2025

; PLACE DOT IN CENTRE OF THE BOX & JOIN WITH A STRAIGHT LINE
Stage 1: **Observations 10 minutely**
ARE IN ORANGE OR PURPLE REFER TO COLOURED BOX



DISCHARGE

Consciousness
2 Awake
1 Verbal
0 To Pain or No Response

BP
2 Within 20mmHg of pre-op level
1 Within 20-50mmHg of pre-op level
0 Not within 50mmHg of pre-op level

Respirations
2 Freely
1 Shallow / Limited
0 Apnoea

Colour
2 Normal / Skin
1 Pale / Dusky
0 Cyanotic

Activity
2 Moves ≥ 3 extremities
1 Moves 2 extremities
0 No movement

Nausea
2 Nil 1 Mild 0 Severe

PAIN = < 4 FOR DISCHARGE
2 Minimal 0 - 4 / 10
1 Moderate 4 - 7 / 10
0 Extreme 7 - 10 / 10

TOTAL SCORE:

A mandatory score of **12 / 14**
is required for recovery to be established and the patient deemed suitable for discharge to the ward.

ISBAR

Identify: Pt name, DOB & UR (pt/carer)
Situation: Operation
Anaesthetic: Drugs Regional Blocks LA
DVT: Interventions
Background: Co-morbidities / Allergies

DISCHARGE CHECKLIST

☐ IV ☐ FBC ☐ Dressings
☐ Artline ☐ IDC ☐ Sling
☐ CVC ☐ CBI ☐ Pack
☐ Epidural ☐ Drain
☐ PCA ☐ Other .....
☐ SCD ☐ TEDS ☐ Bair Hugger

Dentures: ☐ In ☐ Out ☐ */c Pt
Hearing Aids: ☐ In ☐ Out ☐ */c Pt
Glasses: ☐
Assessment: Current status

Documentation:
☐ Op Notes ☐ Tick Sheet ☐ Script
☐ Med Chart ☐ Med Cert
☐ Ward Obs Chart
☐ Neurovascular Obs ☐ Upper ☐ Lower
Altered MET required:
☐ Yes ☐ No ☐ Documented

Discharge: ☐ Ward ☐ DSU

Transfer Time: .....

PACU Nurse: .....

Receiving Nurse: .....