Department of
Health & Human Services

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06 MAR 2015

Office of the Secretary

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Ms Anna Summerhayes
Coroners Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Ms Summerhayes

Re: Inquest into the death of June Olive Pegg

Thank you for your letter of 10 December 2014 regarding the findings of the inquest into the death of June Olive Pegg. In her findings Coroner Heffey made one recommendation directed to the Department, this being:

- *To improve the safety of patients of healthcare organisations, the Victorian Department of Health and the Australian Commission on Quality and Safety in Healthcare undertake action to raise the awareness of health care organisations of their responsibility to ensure quality documentation of patient care.*

All Victorian public health services are required to be accredited against the National Safety and Quality Health Service Standards (the Standards) which are held by the Australian Commission for Safety and Quality in Health Care (the Commission). A relevant core action within the standards is *using an integrated patient clinical record that identifies all aspects of the patient's care*. The Commission is responsible for promoting and overseeing the accreditation scheme in which the Standards operate. As the regulator, the Department actively monitors the accreditation status of public health services through its performance framework. Resources to promote the Standards and support health services to meet them are on Department's website http://www.health.vic.gov.au/accreditation/index.htm.

The Department will implement the above recommendation through communication to all health services via the Department's *RiskWatch* newsletter. The Department will refer to Coroner Heffey's findings and the Australian Commission on Safety and Quality in Health Care Accreditation Standards. In particular the Department will reinforce organisations' responsibility to ensure patient care is properly and thoroughly documented in the medical record. A de-identified summary of the case and the Coroner's recommendation will be included in the next edition of *RiskWatch* for 2015.

RiskWatch newsletter aims to improve patient safety by sharing an awareness of factors that contribute to adverse events, innovative system changes, health care alerts and recommendations towards a safe and improved health care system. The newsletter is circulated in electronic version to all Victorian health services and subscribers. It is also made available for view and down-load on the department's website at: http://www.health.vic.gov.au/clinrisk/publications/riskwatch.htm.

If you have any questions in relation to this please contact Mr Jonathan Prescott, Acting Manager Quality and Safety Programs on 9096 7258 or email jonathan.prescott@health.vic.gov.au

Yours sincerely

Dr Pradeep Philip
Secretary