Secretary

Department of Health and Human Services

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Felix Ferris
Coroner's Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Mr Ferris

RE: Coroner's findings into the death of Elizabeth M Gorman (with inquest)

Thank you for your letter of 23 October 2018 accompanying Coroner Mr Peter White's Finding with inquest into the death of Elizabeth M Gorman, who died from pulmonary thromboembolus, pulmonary infarction and deep vein thrombosis.

I refer to the Coroner's recommendation:

'…that the Directors of Emergency Services at the RWH and the RMH together with Ambulance Victoria under the guidance of the Secretary of the Department of Health and Human Services meet to consider the feasibility of a single triage point at the RMH, this to determine whether a female patient should be triaged for admission to the RWH (WEC) or the RMH.'

Following receipt of this recommendation, careful consideration has been given to how best to improve the triage process, including the feasibility of a single triage point.

A meeting was held on 6 December 2018 between the Directors of Emergency Services and Directors of Clinical Operations form the Royal Women's Hospital (RWH) and Royal Melbourne Hospital (RMH), and the Group Manager at Ambulance Victoria (AV). On my behalf, Adjunct Associate Professor Ann Maree Keenan, Deputy Chief Executive Officer, Safer Care Victoria, liaised with RWH to obtain a summary of the meeting outcome.

At the meeting held on 6 December 2018, it was unanimously agreed by the three organisations that it is not feasible to establish a single triage point at the RMH, to determine whether a female patient should be triaged for admission to the RWH Emergency Care (WEC) or the RMH. A detailed rational for this position was outlined. Overall, it was deemed that creating a physical, single triage point for women at the RMH is likely to create delays to appropriate care, inefficiencies and will most importantly, expose patients to greater risk of avoidable harm from increasing the frequency of transfers between the RMH and RWH.

Rather than creating a single triage point for women at the RMH, the three organisations have implemented alternative strategies to improve the triage process for female patients between the RMH and RWH. These alternative strategies include:

- A list of clinical conditions that will direct the transport of pregnant women to the health service that is most appropriate to provide care agreed by the Medical Directors and Executive from the RWH, RMH and AV. The RWH will be the preferred destination for all patients where the primary problem is obstetric in nature and RMH will be the preferred destination in all other circumstances.
- Where paramedics are uncertain of the most appropriate transfer destination, advice can be sought from a senior MICA paramedic or a consultant level medical officer at the RWH or RMH. This position has been communicated to all relevant staff at the RWH, RMH and AV as a matter of priority.
- AV have embedded decision making regarding obstetric care in their education and training programs and have communicated processes for seeing advice when needing to urgently triage a woman between the two sites.

A second meeting was convened on 20 December 2018 where representatives from the three organisations revisited Coroner White's recommendation and reaffirmed their position, that a physical triage point for female patients is not feasible and to endorse alternative strategies to improve the triage process. This position was then endorsed by the Chief Executive Officers (CEOs) of RWH, RMH and AV.

I have asked Safer Care Victoria to monitor the effectiveness of the alternatives strategies to improve the triage process for female patients to be admitted to RWH and RMH. This will be monitored through the quarterly performance meetings between the Department of Health and Human Services, Safer Care Victoria and the respective organisation's representatives, including the health service CEOs.

I thank Coroner White for bringing the matters raised in the Findings with inquest into the death of Elizabeth M Gorman to my attention. I wish to express my sincere condolences to the Gorman family.

If you require further information please contact Ann Maree Keenan, Safer Care Victoria Office of the Chief Clinical Officers, through: chiefclinicalofficers@safercare.vic.gov.au.

Yours sincerely

Kym Peake
Secretary

18 / 1 / 2019

VICTORIA State Government