MonashHealth

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24 September 2013

Mr Mark Roberts
Coroner's Registrar
Coroner's Court of Victoira
Leel 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Mr Roberts

Investigation into the death of Alyssa Chan: Reference COR2006 001014

I refer to your letter of 19 December 2012 which attached a copy of the Finding of Coroner Hendtlass delivered on 13 December 2012.

In the course of her Finding, the Coroner made eight recommendations, four of which were directed to Southern Health (Recommendations 5, 6, 7 and 8). Pursuant to an Order in Council published in the Victorian Government Gazette on 30 May 2013, Southern Health changed its name to Monash Health.

In accordance with our usual protocols, the Finding was referred for internal consideration within our Quality Unit. I attach details of the Monash Health response to each of the relevant Recommendations, as prepared by our Clinical Review Panel. That response was prepared in February 2013.

I apologise for the long delay in providing our response to the Court. The very detailed Finding of the Coroner was comprehensively reviewed with relevant, treating clinicians involved in the management of Alyssa Chan. That process took a considerable period, as did subsequent consideration as to whether an appeal should be launched by Monash Health, as an interested party, against the Finding of Coroner Hendtlass, pursuant to Section 83 (2) of the Coroner's Act 2008. Ultimately, Monash Health determined not to institute such an appeal.

I note that other entities in respect of which Recommendations were made by the Coroner have also provided their responses to you.

Yours sincerely

John Snowdon
Corporate Counsel

Recommendation(s)	Action taken	Person Responsible
Southern Health to continue to actively promote a ward culture of accessing protocols when patients are booked for rarely performed procedure's including awareness of their Paediatrics Pre and Post Liver Biopsy Protocol.	Pre & Post Liver Biopsy protocol was immediately developed after the death (2006) and revised February 2013. A bedside reference guide will be implemented.	Chief Operating Officer, Monash Clayton Sector Women's & Children's Program
Southern Health retain digital images of all ultrasound radiology of paediatric procedures	Routine practice that all images are retained via the PACS system. This has occurred in the time since the death and is supported by IT system and procedures within Diagnostic Imaging.	Chief Operating Officer, Monash Clayton Sector Women's & Children's Program
Southern Health host a discussion between senior nursing staff in the Endoscopy Suite and ward 42N and paediatric radiologists and gastroenterologists who perform endoscopy procedures to clarify and specify the content and frequency of standard post-operative observations	Neonatal and paediatric patients are managed across a wide variety of Treating Units and services (Diagnostic imaging, Operating theatre, Endoscopy, Day Treatment Unit). The revised procedure will be reinforced across all areas caring for these patients.	Chief Operating Officer, Monash Clayton Sector Women's & Children's Program
Southern Health explore the possibility of introducing permanent recording pulse oximeters in Ward 42N and the Endoscopy Suite.	Pulse oximetry available to ward areas is not able to be modified to allow for permanent recording, but, continuous oximetry is now conducted for the first	Chief Operating Officer, Monash Clayton Sector Women's & Children's Program

	6 hours post operatively, then intermittently and recorded on the observation chart with the vital signs as per procedure schedule	

Other actions put in place by health service

Recommendation	Action taken	Person Responsible
The Women's and Children's Program to repeat the audit conducted during the Coronial inquest, reporting results to the Children's Quality and Safety Committee and acting on the care management problems identified	The previous audit conducted was repeated for all neonatal and paediatric liver biopsies (10^{th} April 2010 – 5^{th} Nov, 2012) The Children's Quality Committee will receive an annual report based on this audit in the future.	Chief Operating Officer, Monash Clayton Sector Women's & Children's Program

Additional actions /comments

The Monash Health (Southern Health) Anatomical Pathologists will review the slides of this case as part of their ongoing quality review and educational / professional development.

Should you require further information, please contact Annie Moulden on 959 **44007** or Justin King on 959 **43732**, or refer to the Clinical Review Panel page on the Quality Unit intranet site.