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Judge Jennifer Coate
Coroner, State of Victoria
Coroners Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Judge Coate

Re: Coroners Case 1090/07 Marlene Kenny

On 29 July 2011 Deputy Coroner Iain Treloar West handed down recommendations relating to the death of Marlene Kenny without holding an Inquest.

The Coroner adopted the recommendations of a Root Cause Analysis conducted by Orbost Regional Health.

In adopting these recommendations they became recommendations of the Coroner. It is important to note that Rural Ambulance Victoria (RAV), Air Ambulance Victoria (AAV) and Victorian Adult Retrieval Service (VAERCS) are now all part of Ambulance Victoria.

Insofar as these recommendations relate to Ambulance Victoria, the following actions have been taken:

Recommendation 1

The hospital, RAV and AAV services, work collaboratively to develop and implement a standardized, structured, clinical handover process to standardize communication between all agencies which includes:

Options for providing information on the:

- Maximum number of hours transfer can take for optimum patient management
- Maximum time the patient can be outside the hospital environment for optimum patient management.

Systems to:

- Provide the transferring agency with the expected timeframe for transfer
- Provide transfer agencies with clinical information prompts.

An alternative to the Coroner's recommendation has been implemented. The Rural Ambulance Victoria (RAV) has now merged with the Metropolitan Ambulance Service (MAS) to form Ambulance Victoria. The Rural Operations Centres (OpCens) have been closed and all call taking and dispatch is performed by the Emergency Services Telecommunications Authority (ESTA). The alternative actions for Recommendation 1 have been completed as follows:

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Response 1

Health Services contacting AV for transfer of patients are guided through a structured call taking process by Emergency Services Telecommunications Authority (ESTA) personnel. There are Standard Operating Procedures in place to direct ESTA staff to refer the case to the AV Clinician for specific call types or where an advanced clinical discussion & assessment & transport planning is required.

Health Services requesting transfers are required to provide information regarding the patient's condition, the skillset required during transfer and must nominate a timeframe within which the patient should be collected.

AV Clinicians have standing instructions to discuss with sending institutions the acuity, skillset, timeframe and transport platform for patients moving to a higher level of care. In cases where the planned timeframe is disrupted, the AV Clinician will re contact and re discuss the case with the sending institution.

Recommendation 2

The hospital, RAV (AV) and AAV services to work collaboratively to develop a new classification guideline which includes definitions and descriptors, to expand the options from the current, limited non urgent and time critical options for transfer.

An alternative to the Coroner's recommendation has been implemented as follows:

Response 2

Health Services contacting AV for transfer of patients are guided through a structured call taking process by ESTA personnel.

Health Services requesting transfers are required to provide information regarding the patient's condition, the skillset required during transfer and must nominate a timeframe within which the patient should be collected.

AV has closed the 5 regional Operations Centres (OpCens) during the period Jul 10 to Aug 11. All non-emergency regional call taking & dispatch is also centralised. AV has implemented an AV Clinician commencing 19/4/10 that any clinical queries from internal or external sources can be directed to so that any event can be clinically assessed and categorised by a senior & experienced clinician. This negates the need for a classification guideline.

Recommendation 3

The RAV (AV) review Operations Centre guidelines for contingency planning for transport arrangements.

An alternative to the Coroner's recommendation has been implemented as follows:

Response 3

This recommendation has been dealt with in the introduction of the new ESTA environment with new systems and processes.

Recommendation 4

The RAV (AV) review operations centre policies and procedures regarding the requesting of aircraft for routine and time critical requests.

An alternative to the Coroner's recommendation has been implemented as follows:

Response 4

This recommendation has been dealt with in the introduction of the new ESTA environment with new systems and processes.

Recommendation 5

The RAV (AV) develop and implement a process to audit clinical decision making processes made by staff working in the Operations Centre.

An alternative to the Coroner's recommendation has been implemented as follows:

Response 5

All regional OpCens have been closed – this recommendation is no longer applicable to the regional environment.

Clinician role has been developed and put in place at ESTA as part of the transitions. The Advanced Medical Priority Dispatch System (AMPDS) is also in use for all incoming calls.

Ambulance Victoria is confident that the actions taken have rectified the issues raised by the Root Cause Analysis and as such AV has satisfied the Coroners Recommendations.

Yours sincerely

GREG SASSELLA
Chief Executive Officer

cc: General Manager Specialist Services
General Manager Regional Services
General Manager Quality & Education Services
Manager Professional Standards
Regional Manager Gippsland
Manager Emergency Management & Air Ambulance
Manager Air Ambulance Victoria
Director Adult Retrieval Victoria