ST VINCENT'S HOSPITAL
MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

St Vincent's Hospital (Melbourne) Limited
ABN 22 052 110 755

1 November 2021

Ms Rachel Nicol
Coroner's Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

By email only: cpuresponses@coronerscourt.vic.gov.au

Dear Ms Nicol

RE: Investigation into the death of Christian Joy
COR 2019 005322

We refer to your correspondence dated 23 July 2021 and Coroner Lorenz's Finding without an inquest into the death of Christian Joy.

Pursuant to section 72(3) of the *Coroners Act 2008* (Vic) (**the Act**), we respond to Coroner Lorenz's recommendations as follows:

(a) St Vincent's Hospital expedites the implementation of the three major recommendations of the RCA.

Recommendation 1 of the RCA: Explore and implement an IT system that supports tracking of radiology requests and reports.

1. The Coroner's recommendation will be implemented.

2. Following a site visit to the Royal Melbourne Hospital by St Vincent's Hospital Melbourne (**SVHM**) staff, as well as consultation with key stakeholders, a business case was developed in October 2020 to build and implement a replacement Picture Archiving and Communications System (**PACS**) to trial in the SVHM Emergency Department.

3. The replacement PACS is anticipated to be fully implemented by early February 2022, and will enable clinicians to track the progress of radiology requests and reports. The replacement PACS has enhanced and dedicated critical results notifications for the delivery of results.

4. The replacement PACS provides increased visibility of examination and report status, including notification functionality for improved clinician communication. Once the replacement PACS is installed, clinician workflows will be modified to take advantage of this functionality.

5. Interim measures have been implemented (please refer to paragraphs 6 to 8 for further detail) to mitigate any ongoing risk following the incident until the replacement PACS is fully implemented.

Recommendation 2 of the RCA: Develop and implement a process and delegate a clinician responsible for the review of printed radiology reports received in the ED from the overnight shift (from 0000 hours to 0800 hours).

6. The Coroner's recommendation was implemented prior to the receipt of the Coroner's finding.

7. Following the completion of the RCA, a process was implemented whereby a specific consultant is responsible for reviewing radiology reports that are printed in the Emergency Department (**ED**) from the overnight shift. This action was implemented by 31 December 2019 and is an interim measure to mitigate the risk of unread radiology reports until the replacement PACS is available.

8. Regular review and reinforcement of this process occurs to ensure that this manual process occurs until the PACS replacement is in place.

Recommendation 3 of the RCA: Medical Imaging department to review the case and learning as a department and to reinforce the policy for telephoning results to the referrer.

9. The Coroner's recommendation was implemented prior to receipt of the Corner's findings.

10. The Medical Imaging Department presented the case at the department Mortality and Morbidity meeting on 18 June 2020, where the case was discussed and policy for telephoning unexpected/critical results to the referrer was reinforced.

(b) *St Vincent's Hospital implements a change in imaging reporting so that the indication or clinical notes on an imaging request are included on the formal report so that the reviewing doctor (who may not be the requesting doctor) can correlate the relevance of the request to the findings in the report.*

11. The Coroner's recommendation was partially implemented prior to the receipt of the Coroner's findings.

12. Most formal reports include a clinical history, where relevant. A clinical history is included for all ultrasounds, CT, MRI, Nuclear Medicine/PET.CT, and interventional procedures. This was the standard practice at the time of this incident in 2019, and remains the current standard practice.

13. Not all plain film examinations, such as routine post-operative films, will include clinical notes. Clinical notes could be included for all plain examinations, however in many cases they would not be contributory to diagnosis (e.g. routine post-operative plain films), and this is not routine practice in clinical radiology.

(c) *St Vincent's Hospital review their triage processes regarding patients with recurrent symptoms or concerns returning to the ED on the advice of ED clinicians following a recent admission, particularly with significant symptoms such as chest pain. Such a recommendation could include that a doctor review the patient's previous notes and results and speak to the patient prior to the patient leaving.*

14. The Coroner's recommendation has not been implemented.

15. The patient was not triaged upon re-presentation to SVHM as they had left the ED prior to the triage process occurring. The patient's re-presentation to ED not being registered by triage was one of the critical events explored by the RCA (critical event 3). It was unknown at the time why the deceased chose not to stay, and because there was no record of this re-presentation, the team were unable to investigate any further.

16. The patient registration/triaging process is guided by the Australasian Triage Scale. The purpose is to undertake a quick assessment of the patient to determine clinical urgency and triage category, and then register the patient. There was no action to alter the order of this.

(d) *St Vincent's Hospital undertakes open disclosure with Mr Joy's family in accordance with the Australian Open Disclosure Framework.*

17. The Coroner's recommendation will be implemented.

18. SVHM's Patient Liaison Office will co-ordinate Open Disclosure by contacting Mr Joy's partner to offer to make a time for the Director of Emergency Medicine and the Patient Liaison Office to meet with them.

Please contact the SVHM Legal team via medicolegalenquiries@svha.org.au or on (03) 9231 3921 if you have any questions.

Kind regards

Caitlin Gill

Director Legal and Commercial Services

St Vincent's Hospital (Melbourne)