Secretary

Department of Health

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COR 2017 004055
BAC-CO-35624

State Coroner Judge John Cain
Coroners Court of Victoria

Via e-mail: team3@courts.vic.gov.au

Dear Coroner Cain

Thank you for your correspondence of 7 March 2023 (Attachment 1) to myself and to the Chief Executive Officer, Safer Care Victoria (SCV) outlining the findings of the inquest into the tragic death of Antoinette O'Brien.

The recommendations (Attachment 2) provided to the Department of Health and SCV have been considered and this response is provided on behalf of both entities.

The *Health Legislation Amendment (Quality and Safety) Act 2022* introduced a number of new reforms, including the establishment of Victoria's Chief Quality and Safety Officer, who can commission quality and safety reviews in health services. Also introduced was the statutory duty of candour and protections for serious adverse patient safety event (SAPSE) reviews, which encourages health services to identify and review SAPSEs, and to apologise and provide open and honest communication to consumers.

These reforms, along with the obligation on providers to report their compliance with the duty of candour, will enhance oversight of emerging quality and safety risks by the department and SCV. Additionally, SCV implemented a state-wide sepsis pathway.

After Antoinette's death, the Department of Health's Private Hospital Unit completed regulatory inspections at St Vincent's Private Hospital in May 2016, May 2018 and again in March 2021. They also undertook regulatory inspections at Holmesglen Private Hospital in May 2018 and 2021. There were no significant regulatory compliance issues identified during these inspections

Recommendations directed to the Department of Health

His Honour has recommended that the Victorian Department of Health amend the *Health Services Establishment Regulations 2013* to mandate that:

- all health facilities, public and private are required to undertake root cause analysis reports of sentinel events and serious adverse patient safety events; and
- private hospitals be required to have an independent member on a root cause analysis panel consistent with the requirements imposed on public hospital.

The Department of Health accepts these recommendations in principle and the reforms will be considered as part of the 2023 review of the *Health Services (Health Service Establishments) Regulations 2013* (the Regulations). That will include consideration of relevant requirements imposed on public and private facilities, and any steps necessary, beyond an amendment to the Regulations, to align those requirements.

Recommendations directed to the Safer Care Victoria

His Honour has recommended that Safer Care Victoria -

(i) review the effectiveness of the inclusion of the SAPSE legislation in the *Health Services Act 1988* within 18 months from commencement with particular focus on the cooperation of health services providing reviews and root cause analyses and reports relating to SAPSE's and sentinel events to Safer Care Victoria.

(ii) give consideration to amending the 'Think Sepsis Act Fast' guideline to include a section on the treatment of maternal sepsis. The amendment should focus on pregnant and post-partem women and include information about recommended antibiotics that should be administered.

(iii) develop and promote a state-wide tool or tools to assist in the proper handover of patient between health professionals and in transfers between health service. An example of such a tool is the ISBAR which captures relevant information in a meaningful and effective way.

Following consideration of the recommendations directed to SCV, I provide the following assurances:

(i) In principle, SCV accepts this recommendation in full, but requests an additional six-month review timeframe, committing to a completion date of November 2024, 24 months post the commencement of the legislation.

- SCV expect receipt of the inaugural data report in January 2024, six months from commencement of mandatory reporting. SCV consider that a review which incorporates data over a twelve-month timeframe will be more indicative of the effectiveness of SAPSE legislation.
- That SCV will accept in full, the recommendation to amend the 'Think Sepsis Act Fast' guideline to include a section on the treatment of maternal sepsis.
  SCV notes that Queensland and New South Wales have a stand-alone maternal sepsis pathway, in our consideration for these guidelines, we are encouraging a tri-state approach toward the sharing and development of future guidance.
- SCV commit to finalise the maternal sepsis guideline within 18 to 24 months.

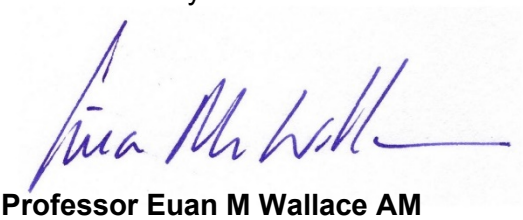
(ii) SCV accepts the recommendation though our commitment is to promote the use of existing tools rather than to develop a new tool altogether. SCV commit to fulfilling this action

- Section 107 of the *Health Services Act 1988* requires private hospitals and other health service establishments to comply with the requirements of an approved accreditation scheme. The current relevant accreditation scheme is the Australian Health Service Safety and Quality Accreditation Scheme.

  As part of this accreditation scheme, Clinical handover Standard 6, Action 6.04 set by the Australian Commission on Safety and Quality in Health Care states that health service organisations must have clinical communication processes to support effective communication when all or part of a patient care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations. The ISBAR model of handover tool forms part of the National Safety Quality Health Service standards for accreditation.

Should you have any questions, please contact Professor Mike Roberts, Chief Executive Officer, SCV by email - [redacted]

Yours sincerely



Professor Euan M Wallace AM
Secretary

16/05/2023

Attachments

Attachment 1	Form 37 - Finding into death following inquest
Attachment 2	Statutory authority- Finding with recommendations provided