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15 August 2023

Ms Olivia Collings
Coroner's Registrar
Coroner's Support Services
Coroners Court of Victoria
Level 2, 55 Southbank Boulevard
MELBOURNE VIC 3006

Email: cpuresponses@coronerscourt.vic.gov.au

Dear Ms Collings,

Investigation into the death of Jeffrey Marsden
Court Ref: COR 2019 000142

I refer to your letter dated 6 July 2023 addressed to Mr Cooke, General Counsel, Mercy Health.

As the Chief Medical Officer of Mercy Health, I now provide a response to Coroner Jamieson's Finding into the death without inquest of Jeffrey Marsden dated 4 July 2023, in which two recommendations were made. The following recommendation was directed to Mercy Hospitals Victoria Ltd (**MHV**):

> *'With the aim of preventing like deaths and promoting public health and safety, I recommend that Mercy Hospitals Victoria Ltd develop a system, if they have not already done so, by which they communicate deaths and other serious events to contracted service providers involved in the provision of clinical care to those patients. Such a system would ensure each entity is able to undertake a thorough review of their involvement and implement any necessary restorative and preventative measures in a timely manner.'*

MHV has considered Her Honour's recommendation, and following consultation with its staff, I advise that in July 2021, a system – referred to as RiskMan – was implemented by which clinical incidents such as deaths and other serious events are identified and reported. This system enables clinical incidents to be entered, and when so doing, three mandatory questions must be answered so an incident severity rating (**ISR**) can be calculated, which determines the type of internal investigations which is conducted.

The reporting of a death in RiskMan is not required unless an incident or hazard has contributed to the death. If it is not known whether an adverse event or hazard contributed to the patient's death, the death will undergo review by medical staff using the processes outlined in the Mercy Health Morbidity and Mortality (M&M) Review Framework. If an adverse event is

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identified via this process (or any other process), it is required to be entered into the incident management system.

Contracted service providers such as iMed who are involved in the provision of clinical care to patients who have subsequently died or been involved in a serious event have direct access to RiskMan and can be involved in the investigation conducted. If they do not, direct access will be provided.

MHV has ensured that its contracted service providers are aware and have access to the RiskMan system and that they are active users of this system. It is also currently reviewing its clinical incident framework. Enclosed is a draft of its 'Clinical Incident Management Procedure' which is anticipated to be finalised by October 2023. Section 3.5 provides that the Quality and Safety Unit (Quality Business Partner) will distribute the incident management report to any stakeholders, such as contractors who provide pathology and radiology services, who have not otherwise been notified of the adverse event.

I thank Her Honour for her recommendation and the opportunity to MHV to provide its response. I trust that the information above assures Her Honour and Mr Marsden's family of the gravity with which we have treated the investigation into this death.

On behalf of MHV, I extend my sincere condolences to Mr Marsden's family.

Yours sincerely

Adjunct Professor Jeffrey Kirwan
Chief Medical Officer
Mercy Health

Enclosure: Draft 'Clinical Management Incident Procedure'