Secretary

Department of Health

50 Lonsdale Street
Melbourne Victoria 3000
Telephone: 1300 650 172
GPO Box 4057
Melbourne Victoria 3001
www.health.vic.gov.au
DX 210081

SBR-260500027

Marde Bevan
Coroner's Registrar
Coroners Court of Victoria
Via e-mail: cpuresponses@coronerscourt.vic.gov.au

Dear Ms Bevan

Thank you for providing the findings of Coroner Sarah Gebert dated 20 February 2026 into the death of James Tsindos. I offer my condolences to James' family and loved ones.

Coroner Gebert made the following recommendations directed to the Department of Health (the department):

Recommendation 2

With a view to enhance the safety of emergency department responses in Victorian hospitals to anaphylaxis presentations and, increase awareness of biphasic or recurrent anaphylaxis, I recommend that Safer Care Victoria give consideration to utilising the learnings from James' case to develop a statewide approach to the treatment of anaphylaxis such as the ANZCA pathway/cards or guidelines.

Recommendation 5

With a view to minimising the risk of adverse allergic reaction from inadvertent exposure to allergens, I recommend that, consistent with New South Wales, the Department of Health give consideration to requiring that all Food Safety Supervisors undertake food safety training which includes comprehensive food allergen management training, noting the free training module, food allergen management module, developed in consultation with Allergy & Anaphylaxis Australia.

Recommendation 6

With a view to minimising the risk of adverse allergic reaction from inadvertent exposure to allergens for people ordering food online, I recommend that the Department of Health give consideration to utilising the Best practice guidelines for food allergen management for online ordering being developed by the National Allergy Council and the Allergy & Anaphylaxis Australia.

Recommendation 7

Noting the advice to the Court by Allergy & Anaphylaxis Australia of an increase in the number of people experiencing anaphylaxis from vegan dishes online as well as the learnings from James' case, I recommend that the Department of Health, task the Food Safety Unit to action identified ways to improve safety around this issue, including consideration of consumer education, reform to relevant and applicable food

labelling laws with specific reference to the labelling of plant-based or vegan food substitutes, to ensure consistency with definitions under the Food Standards Code.

The department's response to these recommendations is outlined below.

Recommendation 2

The department acknowledges the Coroner's recommendation that the learnings from James' case be utilised and has considered a statewide approach to the treatment of anaphylaxis, including the development of guidelines.

On 12 May 2026, the department and Safer Care Victoria (SCV) met with key stakeholders to discuss development of a statewide guideline for anaphylaxis treatment. This meeting was attended by Allergy & Anaphylaxis Australia, Asthma Australia, Ambulance Victoria, various children's hospitals, as well as paramedics, emergency physicians and people with lived experience with anaphylaxis. This meeting built on work already underway in this area that has been the subject of significant prior consultation with relevant stakeholders.

Given differing clinical opinions amongst stakeholders, there is no universally agreed interpretation of evidence-based practice that would support the development of a singular guideline.

In light of this, SCV will produce a broad, practice point document intended to be adaptable across multiple clinical settings, including hospital and ambulance environments. This document will be released by the end of June 2026, and is designed to guide health services to use the established clinical practice guidelines. These include the Royal Children's Hospital Clinical Practice Guidelines – Anaphylaxis, the Australasian Society of Clinical Immunology and Allergy (ASCIA) Acute Management of Anaphylaxis Guidelines, and the Australian Commission on Safety and Quality in Health Care – Acute Anaphylaxis Clinical Care Standard.

These guidelines and standards are widely recognised and routinely used across emergency, paediatric and primary care settings. They are the primary clinical reference point for most health services in managing anaphylaxis and related presentations. The practice point document will highlight aspects of clinical practice guidelines and standards on allergy and anaphylaxis to be embedded into the health services' own practices.

The department also increases awareness of biphasic and recurrent anaphylaxis through a combination of clinical guidance documents, contributions to national and jurisdictional guidelines, and education and system-level safety work which emphasise post-treatment observation periods for biphasic and recurrent anaphylaxis and the risk of delayed recurrence.

SCV further supports the current system through guidance materials, clinical safety communications and quality improvement activities to promote consistency in practice across the system. In February 2019, SCV published the Anaphylaxis Clinical Care Standard with the aim of bringing consistency to how adult patients with anaphylaxis are managed, treated, and cared for in Victoria. This standard is intended to be used in conjunction with the established clinical practice guidelines outlined above.

SCV reviews adverse events and coronial findings and disseminates key learnings to health services. In addition, training programs for clinicians and ambulance staff reinforce recognition, monitoring and discharge planning for anaphylaxis, while consumer resources from allergy organisations help educate patients and families about the risk of biphasic reactions after initial treatment.

Cumulatively, these materials, clinical guidance, and the existing clinical guidelines outlined above comprehensively address biphasic or recurrent anaphylaxis.

Recommendations 5, 6 and 7

The department acknowledges the Coroner's recommendations 5, 6 and 7, all of which relate to food regulation and the mitigation of allergy and anaphylaxis risk.

Responsibility for food regulation in Victoria is currently shared across four main regulators:

- Dairy Food Safety Victoria;
- Agriculture Victoria within the Department of Energy, Environment and Climate Action;
- Prime Safe; and
- Food Safety within the department.

Local councils also have responsibility for various aspects of food safety regulation under the *Food Act 1984*.

From 1 July 2026, a new food regulator known as Safe Food Victoria (SFV) will formally commence operation, reporting to the Minister for Agriculture. SFV will consolidate the four regulators into one independent statutory body to streamline food regulatory functions across Victoria. The establishment of a centralised body will lead to a more streamlined regulation of risks such as allergy and anaphylaxis.

The department considers recommendations 5, 6 and 7 are most appropriately addressed by SFV.[1] These recommendations are for future actions, and it will be important for SFV as the new regulator to determine the regulatory approach it intends to take to address the coroner's recommendations. The department has communicated these recommendations to the interim CEO of SFV.

I trust this response is of assistance to the Court.

Yours sincerely

Jenny Atta PSM
Secretary
20/05/2026

[1] The *Safe Food Victoria Bill 2026* passed on 2 April 2026, officially creating the SFV body.