



PERTH CORONERS COURT

13 FEB 2024

RECEIVED

**Hon Amber-Jade Sanderson MLA
Minister for Health; Mental Health**

Our Ref: 76-25054

Dawn Wright
Manager Listings
Office of the State Coroner
Level 10, Central Law Courts
501 Hay Street
PERTH WA 6000

Dear Ms Wright

Thank you for your letter of 27 December 2023 regarding the State Coroner's findings and recommendations relating to the inquest into the death of Ms Ashleigh Rebecca Hunter. I note the eight recommendations made by State Coroner Fogliani. I understand that the Department of Health (DOH) and the East Metropolitan Health Service has conveyed its broad support for the recommendations.

I would like to draw your attention to work being undertaken to address emergency access issues highlighted during this inquest. Significant investment in emergency care reforms has continued into the 2023-24 year and provides for the establishment of the WA Virtual Emergency Department and a State Health Operations Centre (SHOC), dedicated hospital-based teams to address discharge delays, and a reduction in the number of long-stay patients awaiting aged care or National Disability Insurance Scheme (NDIS) support. Enhanced key performance indicators including a new public dashboard are being implemented to improve monitoring capabilities. Ultimately, these reforms aim to reduce bed block and ambulance ramping.

Implementation of an electronic medical record is a key priority of the WA Health Digital Strategy 2020-2030 with funding committed to supporting the delivery of Stage 1. Stage 1 focusses on transitioning all public hospitals and health sites from paper records to a digital medical record.

The DOH's Coronial Review Committee is due to review these findings at the next scheduled meeting. The Committee will determine what further actions should be taken at a system level to address the recommendations. Following this discussion, relevant stakeholders will develop strategies to implement the recommendations; this may include broader consultation. Any actions taken by the Western Australian public health system in response to the recommendations will be included in the DOH's routine six-monthly progress reports to the State Coroner.

I trust that this information, and that provided in the ongoing six-monthly reports, will assist the State Coroner to fulfil the annual reporting requirements to the Attorney General.

Thank you for bringing this matter to my attention.

Kind regards


HON AMBER-JADE SANDERSON MLA
MINISTER FOR HEALTH; MENTAL HEALTH

08 FEB 2024