

2020

**THE LEGISLATIVE ASSEMBLY FOR THE
AUSTRALIAN CAPITAL TERRITORY**

STATEMENT

**ACT GOVERNMENT RESPONSE TO CORONER'S FINDINGS FROM THE INQUEST
INTO THE DEATH OF THEADORA ZAAL**

**Presented by
Rachel Stephen-Smith MLA
Minister for Health
7 May 2020**

In presenting the Government's Response to Coroner Bernadette Boss' recommendations I would like to acknowledge the life of Ms Theadora Zaal and offer my sincere condolences to her family for their tragic loss.

At the time of the death of Ms Zaal, it was a requirement under the *Coroners Act 1997* for all deaths within 24 hours of surgery to be reported to the Coroner.

Coroner Bernadette Boss found Ms Zaal died on 7 August 2015 at Calvary John James Hospital due to cardiac arrest in the context of aortic stenosis, coronary artery disease and left ventricular hypertrophy. Ms Zaal's death took place within 24 hours following elective surgery at Calvary John James Hospital.

Coroner Boss identified two matters of public safety and made four recommendations for Calvary John James Hospital.

At the time of Ms Zaal's death, Calvary John James Hospital was both licensed as a health care facility and accredited to the National Safety and Quality Health Service Standards. Calvary John James Hospital has remained this way up to and including to the present time.

I would like to assure the public that Calvary John James Hospital has addressed the matters of public safety and the recommendations as handed down by Coroner Boss, including by implementing training and recalibrating all defibrillators.

Following the Coroner's recommendations, the Chief Health Officer has also written to Calvary John James Hospital to reiterate the facility's obligations as a health care facility under the *Public Health Act 1997* and the Health Care Facilities Code of Practice 2001.

The ACT Health Directorate is currently conducting a review of health care facility licensing and regulation in the ACT. The review will take into consideration the findings of Coroner Boss and the lessons from the tragic loss of Ms Zaal. These lessons will strengthen the requirements for health care facility reporting, investigation and response to adverse clinical events.

In accordance with the *Coroners Act 1997*, I present the Government's Response to the Assembly.