Our Ref: SVP:JJ:999697

8 March 2023

Aisha Warsame
Administration Officer - Coroners Prevention Unit
Coroners Court of Victoria
65 Kavanagh St
Southbank 3006

Email: cpuresponses@courts.vic.gov.au

Dear Ms Warsame

COR 2019 001574 - Coronial investigation into the death of [redacted]

1. Introduction

1.1 We refer to Coroner Olle's Finding without inquest in relation to the death of [redacted] dated 31 August 2022.

1.2 On behalf of our client, Mildura Base Public Hospital (**MBPH**), we provide the following response to the Coroner's recommendations.

2. Recommendations

2.1 Coroner Olle made three recommendations to MBPH as follows:

Recommendation 1

(a) For clients that are being discharged from inpatient/acute settings, MBPH implement a formal process to ensure communications with general practitioners regarding admission details, medication and follow up arrangements.

Recommendation 2

(b) MBPH implement a formalised process to ensure that discharge summaries are completed and provided to relevant stakeholders within a timely fashion.

Recommendation 3

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(c) MBPH ensure staff are aware of the requirements to document all clinical contacts relating to clients, with documentation to include adequate mental state examinations and descriptions of risk.

3. MBPH Response to Recommendations

3.1 MBPH has implemented all of the Recommendations, as outlined below.

3.2 In relation to Recommendations 1 and 2, discharge summaries are to include admission details, medication and follow-up arrangements, and are to be provided to the patient's general practitioner within 48 hours.

3.3 Further, MBPH instructs that on or about 24 June 2021, a Discharge Summary Working Group was formalised to monitor discharge summary completion timeliness. As at January 2023, the Clinical Safety and Comprehensive Care was established which continues to monitor discharge summary completion timeliness.

3.4 The data collected by the Clinical Safety and Comprehensive Care committee is reported on monthly to a hospital-wide health information committee and any non-compliance with timeliness of completion is escalated to the executive team at MBPH. Any non-compliance is addressed by workshopping solutions to meet any barriers which may be impacting on the completion of discharge summaries within 48 hours.

3.5 Education to medical staff regarding Recommendations 1 and 2 was completed in January 2023.

3.6 Additionally, guidelines have been created for clinicians and medical staff which informs communication with local general practitioners as the primary clinicians for mental health patients presenting to MBPH.

3.7 In relation to Recommendation 3, this has been and remains an expectation of clinical staff at MBPH and continues to be a part of individual and group education and supervision sessions on a regular basis. For junior medical staff, this includes weekly one-hour one-on-one supervision sessions relating to provision of care and completion of medical documentation, as well as 2 hourly weekly group sessions. Senior medical staff also meet on a regular basis to discuss any concerns with provision of care, treatment planning and any issues with medical documentation.

3.8 Finally, MBPH have circulated the Coroner's findings and recommendations at executive level and as part of education sessions with clinicians.

4. Conclusion

4.1 Should the Coroner require any further information in relation to the above, please advise our office.

Yours sincerely

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