

3rd June 2025

Evelyne Dawe
Coordinator Administration and Projects
Coroners Prevention unit (CPU)
65 Kavanagh Street
Southbank
VICTORIA, 3006.

Dear Evelyn,

Re: Finding into death of Eileen Smith

In the first instance, I'd like to apologise on behalf of Mildura Base Public Hospital (MBPH), that you have not received correspondence regarding the implementation of the Coroner's Recommendations regarding the findings into death of Eileen Smith, until now.

I note that this incident occurred in 2020 when the hospital was run as Mildura Base Hospital, operated by Ramsay Healthcare before the hospital returned to government operation in September 2020 and became known as Mildura Base Public Hospital.

Having recently commenced in this role, I offer my deepest condolences to the family and loved ones of Ms Smith. I am also pleased to respond to your office and evidence that despite a lack of communication, MBPH has taken the Coroner's recommendations seriously and implemented immediate and subsequent interventions.

Coroner Recommendation 1

I recommend that Mildura Base Hospital provide further education to its nursing and allied health staff on the importance of adhering to patients falls management plans. Such education should be incorporated into its online and in-person orientation and education programs for nursing students.

Outcome: COMPLETE – entirely adopted and implemented

Comments:

MBPH continues to monitor mandatory training of staff via live dashboards and monthly Team Accountability Meetings (TAMs) led by Executive Directors – compliance is regularly monitored through many of our governance committees. The MBPH Mandatory Training Policy has been updated reflecting the Coroner's recommendations and all mandatory training material has been updated since the time of this incident and indeed the transition from private to public operation. Education for MBPH employees is facilitated via our online learning management system, GOLD, and via face-to-face orientation for new clinical employees and via an externally accessible platform OnLocation for our undergraduate students as well as face-to-face organisation orientation. Records of all undergraduate student orientation are maintained and monitored by the hospital's Clinical Learning and Development team.

Coroner Recommendation 2

I recommend that Mildura Base Hospital develop and implement a system to monitor, review and report on compliance with fall prevention practices within the hospital. Such a system may involve regular observational audits and provision of feedback to nursing and allied health staff to increase awareness and to identify areas for improvement in falls prevention practices.

Outcome: COMPLETE – entirely adopted and implemented

Comments:

The Patient Safety & Improvement (PSI) team at MBPH have a robust audit schedule that is guided by NSQHS standards and responds to needs and trends of the organisation at any given time. The audit schedule is regularly critiqued by the Clinical Governance Committee, and reports of findings and corrective actions are presented right through from ward and operational meetings, Tier 3 working groups and up to Board sub-committee (Quality & Safety) and Board level. The PSI team are regularly evolving their Patient Safety Program to maintain the delivery of fresh, engaging and up to date information for staff to access in an easy yet meaningful way throughout their work day.

I can reassure you that we, MBPH, has met the recommendations as outlined by the Coroner in 2021. Improvements as recommended were implemented in a timely fashion and ongoing quality improvement principles continue in this domain.

Yours sincerely,



Elise Elder

Executive Director Compliance and Patient Experience
Mildura Base Public Hospital