Northern Health

Coroners Court of Victoria
65 Kavanagh Street
Southbank VIC 3006

Your ref: COR 2024 003534

Dear Registrar

Response to Recommendation – investigation into the death of Helen Danilidis

We refer to his Honour's findings in relation to the above matter dated 21 May 2025 and kindly take this opportunity to outline the actions taken in response by Northern Health.

The purpose of this submission is therefore to outline the steps already taken in response to this recommendation, and outline the additional, further planned measures to address the same subject matter.

By way of background, Northern Health mandates that all inpatient falls are reported and tracked through our incident system, Victorian Health Incident Management System (VHIMS). All inpatient falls which result in serious harm (such as a fracture or intracranial hemorrhage) are considered serious incidents and require at a minimum an investigation and completion of a Falls Serious Clinical Incident Review Template (an internal incident report, SCIRT'). The SCIRT is a dedicated form of specialised fall review.

In relation to the investigations conducted following the fall sustained by Ms Danilidis, we submit that her fall was reported in a way consistent with our policies at the time and that a serious incident review (SCIRT) was indeed undertaken. The SCIRT review found that:

- Interventions in place were not clearly documented in the Electronic Management Record ('EMR'), but appropriate interventions were in place, including by placing the patient near the nurses station and using a falls sensor mat.
- A falls sensor mat was in place on the day of the fall, however this did not sound an alarm as expected. User error may have been the cause, as this sensor alarm was found to be working the following day.
- Rounding was not documented as complete prior to the fall. It is unclear if the patient was asked if she needed to use the toilet.
- The patient had six bed moves during her hospital stay, which may have contributed to her increased confusion and disorientation.

A recommendation was made that specific training be undertaken with staff on the relevant ward that covered:

- Placing sensor mats according to manufacture guidelines.
- Implementing and documenting purposeful rounding on every shift.
- The need for completion of all risk screening assessments, including delirium and cognitive impairment on EMR on every shift.
- That where possible we should limit bed moves for patients over 65 with confusion, as this increases their risk of falls.

On consideration of the recommendation handed down by his Honour, we understand that there are two components to the recommendation made. The first component is that Northern Health review its relevant falls risk mitigation strategies, including relevant policies and procedures. It is appreciated that his Honour's findings note the need for repeat delirium assessment in particular.

Northern Health is able to report that we routinely review our falls mitigation strategies on an ongoing basis, including relevant policies and procedures, through the Falls Prevention Continuous Improvement Committee. This is a multidisciplinary committee that includes a wide variety of clinical and non-clinical staff with specific expertise and investment in preventing falls. This committee meets monthly and reviews internal and external data on falls, serious falls incidents and their investigation, equipment and environmental factors contributing to falls, as well as novel external reports and guidelines on falls prevention. The committee uses all available information to inform continuous improvement in all aspects of our falls prevention governance and practices. This includes an annual review of our Falls Prevention and Management procedure (**Falls Procedure**).

Northern Health's Comprehensive Care - Assessment, Care & Discharge Planning procedure outlines the requirement for nursing staff to reassess delirium risk each shift. Compliance with risk assessment is monitored through our Risk Assessment Monitor report. Overall, Northern Health has had a high level of compliance with delirium risk assessment on admission, including on the ward where the incident occurred (95% compliance for the past financial year).

In December 2024 amendments were made to our Falls Procedure to provide additional instructions on how to correctly document risk assessments, risk mitigation strategies and post falls management using the EMR. These documentation instructions were also distributed to wards for prominent display in staff areas.

The second component of his Honour's recommendation was that we have processes to ensure staff are aware that sensor mat alarms require not only proper placement and positioning but should be routinely tested to ensure operationality.

In alignment with the recommendations of our internal review, initial education was undertaken on the ward where the incident occurred in November of 2024. This comprised three falls prevention simulations in addition to two weeks of physical demonstrations on how to correctly use the sensor mats. The ward

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also has consistent huddles to reinforce education around the proper completion of risk assessments each shift, including delirium risk assessment.

Northern Health has formal sensor mat training planned with representatives from the manufacturer of the device across our medical wards, which will include specific education on how to test their operationality. We endeavour to have formal training from the manufacturer periodically moving forward, to ensure that existing staff remain up to date and that new staff have the same learning opportunity. We have also determined that sensor mat training should be included in our routine internal education sessions, which will necessarily include education around ensuring functionality of sensor mats during set up.

We again thank the court and the patient's family in these difficult circumstances.

Sincerely,

Dr Yana Sunderland
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MBBS FRACP