BALLAN DISTRICT HEALTH AND CARE

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BALLAN COMMUNITY HEALTH AND MEDICAL CENTRE

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> Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria, 3006 15th February 2019

Attention Audrey Jamieson Coroner,

Investigation into the death of Winifred J Morffew

Court Ref: COR 2018 000437

Response to recommendation 2: "With the aim of promoting public health and safety, I recommend that Ballan District Health and Care implement training to educate their clinicians on their obligations to report deaths to the Coroners Court of Victoria."

Dear Ms Jamieson,

It was only in the days following the death of Winifred J Morffew, that Ballan District Health and Care (BDHC) identified that her death should have been reported to the Victorian Coroner.

BDHC regrets that it was not and fully accepts both your recommendation, and its leadership responsibility in supporting its clinicians to comply with death notifications to the Coroner.

Since that time, BDHC has implemented more robust training of its medical and nursing staff too so that they better understand their own individual professional obligations in notifying the Victorian Coroners on reportable and reviewable deaths in the state of Victoria.

The last mentioned took the form of presentation at BDHC General Practitioner meetings in March 2018 by the Director of Medical Services as part of his role in the education of the GP workforce on medico-legal matters. Similar educational meetings with BDHC registered nurses were conducted by the Director of Clinical Services. These presentations have also been followed up by email communication as well as organisation policy updating.

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5368 1811

childcare@bdhc.com.au

Opportunity on Inglis
159 Inglis Street, Ballan
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I am confident that as a result of these interventions BDHC Clinical staff will have the required professional expertise & knowledge to in future, appropriately notify reportable and reviewable deaths to the Victorian Coroner.

Yours Sincerely,

Bronwyn-Walker

Director of Clinical Services