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22 September 2015

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Our Ref: JAM:120419

Pela Demertzis
Coroner's Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Madam

Re: Investigation into the death of [redacted] – COR 2012 001503

We refer to the Finding in this matter and now **enclose** response on behalf of NorthWestern Mental Health, namely letter from Peter Kelly, Director of Operations, NorthWestern Mental Health and Clinical Risk Bulletin referred to therein.

Yours faithfully

per: **Jan Moffatt**
Donaldson Whiting + Grindal

Encl

21 September 2015

NorthWestern Mental Health

Level 1 North
Main Block
The Royal Melbourne Hospital
Grattan Street
Parkville Vic 3050
Tel 61 3 9342 7705
Fax 61 3 9342 8216

Coroner Rosemary Carlin
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Coroner Carlin

Finding into death without inquest - [redacted] Court Reference: 2012 / 1503

I am writing in response to the Finding into a death without Inquest pertaining to [redacted], Court Reference: 2012 / 1503, in which a single recommendation was made pursuant to section 72(2) of the Coroners Act 2008 in *..."I recommend that NorthWestern Mental Health re draft their policy **Removal of Hazardous Items in Inpatient Units**...".*

NorthWestern Mental Health (NWMH) concedes that the above referenced memorandum could be open to interpretation and therefore could be seen to be somewhat ambiguous in its meaning. To an extent this is understandable because adult acute inpatient units admit both voluntary (Informal) patients as well as involuntary patients into 25 or 29 bed units and the memorandum had to cater to both patient groups whose access to various items during their hospitalisation varies dependent on their legal status and presenting risks.

NWMH has given this information more importance and more prominence by producing a **Clinical Risk Management Bulletin # 13**, issued in September 2015, which I attach for your reference. This bulletin replaces the above referenced memorandum.

The bulletin is distributed electronically to approximately 1800 staff via the 'NWMH Everyone' email address. A hard copy is also printed off and inserted into the NWMH Clinical Risk Management Bulletin folders which are located in the staff base at each Inpatient Unit.

Yours sincerely

Peter Kelly
Director Operations
NorthWestern Mental Health

Attachment: NWMH Clinical Risk Management Bulletin # 13 issued September 2015

Clinical Risk Management Bulletin

NorthWestern Mental Health

BULLETIN # 13
Issued
September 2015

This bulletin assists NWMH clinical staff with risk associated to personal Items on Inpatient Units.

Distributed To:

NWMH
Everyone

Action Required By Staff: Searching, removal to include these additional items.

Action
Please ensure that this information clinical staff employed in your inpatient unit via :
-staff meetings
-staff notice boards
- staff information folders

Please inform

All Staff

In 2008 NWMH identified plastic bin liners as a particular hazard in inpatient units. Specifically, plastic bin liners had been implicated as the means to a completed suicide in an inpatient unit in New South Wales and accordingly NWMH ceased the supply of plastic bin liners and mandated the substitution of these with a paper product.

Similarly, neck scarves have been implicated as the means to completed suicides in inpatient units in Victoria and as such these items should be removed from consumers and placed into safe keeping for the duration of the consumer's admission irrespective of the patients (a) legal status, (b) risk assessment or (c) care setting i.e Low Dependency Unit or Intensive Care Area. NWMH recognises that this intervention is necessary for the safety of the patient being admitted to the inpatient unit as well as other patients already admitted to the inpatient unit

Staff should interpret this Clinical Risk Management Bulletin to mean that they should also be vigilant to other items of clothing or equipment that can be potentially fashioned into a noose or ligature to be used in an act of deliberate self-harm. Such items may also include, but are not restricted to pashminas, shawls, wraps or other long pieces of fabric such as dressing gown cords, tracksuit cords, shoelaces, belts and headphone cords. These items must be removed from patients in the Intensive Care Area and may be removed from patients in the Low Dependency Area, subject to the patients legal status and risk assessment.

Staff are reminded to re-acquaint themselves with the *Chief Psychiatrists Guideline - Criteria for Searches to Maintain Safety in an Inpatient Unit for Patients, Visitors and Staff,* - revised to coincide with the release of the new Mental Health Act in July 2014. This guideline aims to describe search processes that are permissible by law and can ensure clinical safety while respecting patients' rights.

Notwithstanding the specific prohibition of plastic bin liners and scarves as per the instruction in this Clinical Risk management Bulletin and the need to be vigilant in regard to other potentially harmful items, the need to undertake a search of the room or belongings of a patient admitted to a mental health inpatient service, or to undertake a physical search, must be based on an assessment of the patient and the level of clinical or environmental risk to the patient, other patients, visitors and staff.

Based on this assessment, there will be times when it may be necessary to search a patient or their room and belongings to ensure their safety or the safety of others. This may occur at various points in an episode of care, for example, on admission to an inpatient unit, following any planned or unplanned leave, or prior to an episode of seclusion. While safety is the primary concern, human rights such as respect, privacy, dignity and confidentiality must be taken into account. Searching a patient or their belongings is an intrusive intervention that must only be used when it is the only reasonable and practicable course of action to avoid or prevent a serious risk of harm to a patient or harm to others. When a search is undertaken, every effort should be made to observe the patient's rights to the greatest extent possible under the circumstances.

SAFETY first AWARDS

Quality, Planning & Innovation
NorthWestern Mental Health
Level 1 North
The Royal Melbourne Hospital

A/Prof Peter Burnett
Director of Clinical Governance