Department of Health
Secretary

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Ms Leyla Stefano
Coroners Register
Coroner's Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Ms Stefano

Re: Court COR 2010 004610 Mr Paul A Skinner

Thank you for providing me with a copy of the findings including recommendations into the death of Mr Paul A Skinner. Any inpatient death is a great tragedy not only for the family and friends of the deceased but for the staff of the service who have cared for that person.

I note the recommendations made to both the service and to the Department, and have prepared the following response to the Coroner's recommendations:

Recommendation 1:
That every authorised psychiatric in patient facility endeavour to employ an occupational therapist.

Response:
The Department of Health does not specify the staffing profile, required for in-patient settings in mental health services, although to administer aspects of the Mental Health Act 1986, services are required to employ and use medical doctors and nurses.

The Department of Health encourages services to employ a multi-disciplinary team, to meet the needs of their patients, including their allied health needs, and this may include occupational therapists.

The staffing profile of an inpatient unit is determined by the employing service and they determine how to best use their funding resources.

Recommendation 2:
That consideration be given to the creation of a Medium Dependency Unit (MDU) at authorised psychiatrist inpatient facilities.

State Government Victoria

Response:
The Department of Health currently funds a range of mental health services from acute inpatient services through to community based residential services and a range of outreach and support services. This range of services aims to respond and support the person on their journey of recovery.

Within the hospital (inpatient) settings there are also a number of different types of service responses depending on the needs of the patient. These range from highly intensive responses such as that provided in high dependency units when people are acutely unwell, through to less intensive responses provided in low dependency settings. In which Unit a patient is cared for is a clinical decision, based on the treatment needs and support needs of patients in the unit. Patients are continually assessed and monitored to ensure their treatment and care is the provided in the most appropriate form in the most appropriate setting.

Recommendation 3:
Produce guidelines to assist health services to design inpatient units that maximise adequate patient observations and to mitigate risk associated with ligature points.

***Response*:**
The Victorian Design Guidelines for Hospitals & Day Procedure Centres and the Australasian Health Facility Guidelines provide directions for the design of mental health inpatient facilities, including risks associated with patient observation and ligature points in private areas. The Victorian Government is currently reviewing and updating its design guidelines to ensure its requirements in relation to patient observation and ligature points safety are absolutely clear to users of the guidelines.

The Chief Psychiatrist Investigation of inpatient deaths 2008 – 2010 self assessment tool recommended to health services that "An environmental safety audit including assessment of ligature points on the unit is conducted on a regular basis and a plan developed for eliminating or managing these risks. The inclusion of external staff for audits is recommended as inpatient staff may not always identify certain safety issues in the familiarity of their everyday environment."

The Office of the Chief Psychiatrist also undertakes inspections and ligature point reviews of services as required.

Recommendation 4:
Implement Recommendation 7 made in the report titled Chief Psychiatrist Investigation of inpatient deaths 2008 – 2010 that:

i) The Department of Health and health services ensure there is clear and consistent process and documentation for nursing observations, and that any change in required observational level is made after suitable discussion and consideration. The frequency of observations over the night shift should be congruent with the daytime observations unless otherwise decided and documented.

Response:
The Department is currently implementing this recommendation, and is finalising the Nursing Observation Guideline for the clinical mental health sector. Included in this guideline is the need to have clear processes of accountability and processes around guidelines and how they should be conducted in each service. This document will be distributed to the sector and made available on the Department's website.

Recommendation 5:
The process and documentation of nursing observations should incorporate supervision and accountability to ensure that there is no doubt as to a nurse's responsibility to conduct observations as clinically indicated.

Response:
Included in the (draft) Nursing Observation Guideline, are the following principles:

- nurse observation is multi-faceted;
- observation and assessment are interrelated;
- observation is grounded in therapeutic engagement with the person;
- nurses appreciate how inpatient environments influence behaviour;
- observations are communicated between colleagues; and
- there is a clear process of documentation that is timely and descriptive.

From this guideline it is expected that services will establish rigorous supervision and accountability mechanisms to ensure compliance.

Recommendation 6:
Develop Risk Assessment and Risk Management Guidelines specific to inpatient/bed based Adult Acute Units. The assessment and guidelines should reflect the evidence base and be inclusive of the range of vulnerabilities and risk exposures present in the adult acute unit inpatient setting.

Response:
As part of the Nursing Observation Guideline, the risk assessment and nursing observation literature reviews conducted to support the Guideline will also be made available to the sector.

The Department and the Office of the Chief Psychiatrist develops guidelines to support services deliver high quality and safe services for clients and staff. Included in this are the *High Dependency Units Guideline* and the guideline on *Working with the Suicidal Person*. Both are available on the Department's website: www.health.vic.gov.au/mentalhealth.

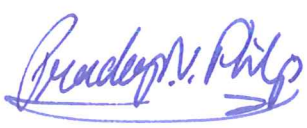
Recommendation 7:
Implement Recommendation 15 made in the report titled Chief Psychiatrist Investigation of inpatient deaths 2008 – 2010 that:

i) That the Chief Psychiatrist convene a panel every three years to inquire into inpatient deaths over that time to consider overall practice improvements and issues relevant to the mental health system.

Response:
The Chief Psychiatrist reviews all deaths in mental health inpatient units (regardless of legal status, cause and where the death actually occurs); and provides advice and direction on quality and practice improvements in light of these reviews. In addition, quality improvement advice is provided to the sector following review of coronial recommendations. http://www.health.vic.gov.au/chiefpsychiatrist/coronial.htm

The Department also undertakes reviews of sentinel events occurring in health services, including in patient suicides. In addition to these reviews, the Department is committed to implementing Recommendation 15, and undertaking triennial reviews into inpatient deaths.

Yours sincerely



Dr Pradeep Philip
Secretary