Department of Health

Secretary

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Ms Emily Pearson
Coroners Registrar
Coroner's Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Ms Pearson

Re: COR 2009 002156 Mr Matthew Spalding

Thank you for providing me with a copy of the findings including recommendations into the death of Mr Matthew Spalding. Inpatient deaths are extremely distressing for family and friends of the deceased and also for staff of the inpatient unit in which the death took place.

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 1A:
Produce guidelines to assist health services to design inpatient units that maximise adequate patient observations and to mitigate risks 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 1B:
Implement Recommendation 7 made in the report titled "Chief Psychiatrist's investigation of inpatient deaths 2008-2010" that:

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

Response:
The Department is currently implementing this recommendation, with the finalisation of the guideline 'Nursing observation through engagement in psychiatric inpatient care' imminent. Included in this guideline is the need to have clear processes of accountability and processes around nursing observation and how they should be conducted in each service. This document will be widely distributed to the clinical mental health sector and made available on the Department's website: www.health.vic.gov.au/mentalhealth

Recommendation 1C:
In addition to recommendation 1B above, the process of nursing observations should incorporate supervision and accountability to ensure that there is no doubt as to a Nurses 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. The Department has also published *Clinical Supervision Guidelines* that are available of the Department's website.

Recommendation 1D:
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 draft 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.

Recommendation 1E:
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. This is available at: 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