Department of Health
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10 DEC 2013

E3226340

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

Dear Ms Pearson

Court Reference: COR 2010 000233

I am writing in response to your letter dated 24 September 2013 in relation to Coroner Michelle Hodgson's recommendations made following the investigation into the death of Leanne Howell.

In response to the relevant recommendations made by the Coroner:

Recommendation 1: ***To prevent suicides from patients granted leave from Acute Inpatient Units, I recommend:***

a) The Department of Health and Human Services ensure there is clear and consistent process, documentation and communication for Leave Plans. Any changes are to be made only after suitable discussion and consideration and such variation recorded and communicated.

Response
Leave from Victorian mental health services is regulated by the *Mental Health Act* 1986. The Chief Psychiatrist recognises the importance of this issue and has issued clinical practice guidelines, '*Inpatient leave of absence (*CPG090801)'. These guidelines address the issues raised and are supported by the Department of Health's publication, '*Working with the suicidal person – clinical practice guidelines for emergency departments and mental health services.'*

b) In addition to Recommendation 1A, the process and documentation of Leave Plans should incorporate supervision and accountability to ensure compliance by all mental health professionals involved in the granting and implementation of leave plans.

Response
Compliance by mental health staff involved in the granting and implementation of leave plans is ensured in part through the clinical practice guidelines, '*Inpatient leave of absence (*CPG090801)'. Importantly, these guidelines refer to the need for each clinical service to have an established policy and procedure concerning inpatient leave and that clinical staff, are able

to articulate sound knowledge of key principles, legal requirements, guidelines and local policy and procedures relating to inpatient leave.

c) *That there be a process for ensuring the accuracy of information provided to the Chief Psychiatrist.*

The Chief Psychiatrist is in frequent communication with clinical services throughout Victoria and expects and relies upon accurate information to be provided. It would be usual and expected that the Authorised Psychiatrist/Director of Clinical Services for the Area Mental Health Service would oversight and review for accuracy and relevance any reports provided to the Chief Psychiatrist (or other agencies) by medical staff made under the supervision of the Authorised Psychiatrist/Director of Clinical Services. The Chief Psychiatrist will regularly seek further information from clinical services and clarify information from services. In addition to this, and to support the accuracy of information, the Chief Psychiatrist conducts formal reviews of clinical services under the auspices of the Quality Assurance Committee (QAC) or in response to specific incidents or concerns.

Under the provisions of the *Mental Health Act 1986*, mental health services are required to notify the Chief Psychiatrist of the death of any patient that is a reportable death within the meaning of the *Coroner's Act 1985*. The Chief Psychiatrist registers an interest with the Coroner regarding the findings arising from any coronial inquest or inquiry into these deaths. The Chief Psychiatrist is able to review these findings and to identify emerging themes across the service system.

Currently, the Chief Psychiatrist publishes regular summaries of coronial findings – these summaries draw together the key clinical practice and standards issues for a given period and highlight areas for ongoing quality improvement action. Services are encouraged to review their local practices, policies and procedures and implement action plans to address the issues identified.

d) *Implement Recommendation 15 made in the report titled "Chief Psychiatrist's investigation of inpatient deaths 2008-2019" that*

> *"That the Chief Psychiatrist convene a panel every three years to inquire into inpatient death 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 information 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 inpatient suicides. In addition to these reviews, the Department is committed to implementing Recommendation 15, and undertaking triennial reviews into inpatient deaths.

Yours sincerely

Lance Wallace
Acting Secretary