Department of Health
Secretary

50 Lonsdale Street
Melbourne
Victoria 3000
GPO Box 4541
Melbourne
Victoria 3001
Telephone: 1300 253 942
Facsimile: 1300 253 964
www.health.vic.gov.au
DX 210311

11 DEC 2013

E3195567

Mr Jeff Dart
Coroner's Registrar
Coroners Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Mr Dart

Re: Court Reference: COR 2011 000291 – HASSEN A YASSIN

Thank you for providing me with a copy of the findings including recommendations into the death of Mr Hassen A Yassin.

In response to the relevant recommendations made by the Coroner:

Recommendation 1:
That the North Western Mental Health Service review the security arrangements relating to exiting the Broadmeadows inpatient facility, in the context of admission of involuntary patients to the low dependency unit at that facility.

Response:
This recommendation is not directed to the Department of Health.

Recommendation 2:
That the North Western Mental Health Service review its procedures relating to notifications to police of absconding patients and documentation on patient file and follow up of same with police by the Mental Health Service staff.

Response:
This recommendation is not directed to the Department of Health.

Recommendation 3:
In view of the review and new procedures adopted by the Werribee Mercy Hospital MHS in relation to the follow up of absconding patients and improvements in the effectiveness of the liaison between inpatient services and the Community Treatment Team, I make no recommendation as to this matter.

State Government Victoria

Response:
This recommendation is not directed to the Department of Health.

Recommendation 4:
The Secretary of the Department of Health and/or the Chief Psychiatrist should ensure that a state-wide co-ordinated procedure for notification of and locating absconding mental health patients is adopted in order to ensure that a co-ordinated approach is adopted and follow up occurs. This procedure may appropriately be advised by way of the existing procedures published by the Department of Health in relation to accessing services.

Response:
The Department recognises the importance of a co-ordinated approach in relation to absconding mental health patients. The Chief Psychiatrist has issued the clinical practice guideline *'Discharge Planning Guidelines'* and it is intended that this guideline will be reviewed and updated to address the issue of patient absconding and the need for a clear and comprehensive response.

Recommendation 5:
In the absence of a state-wide procedure the responsibility for follow up of an absconding patient ought to rest primarily with the facility from which the unauthorised absence occurred. There should be no administrative transfer of care to another facility until the patient has been located. This approach would appear to be supported by existing Departmental directives referred to in the footnote to Recommendation 4 herein.

Response:
The Department agrees that the responsibility for follow up an absconding patient should primarily rest with the facility from which the unauthorised absence occurred. The updated *'Discharge Planning Guideline'* will reflect this.

Recommendation 6:
During the course of the Inquest it became apparent that there were limitations upon access by responsible clinicians to the RAPID database in a context of an absconding involuntary patient. Access arrangements to absconding patient details ought to be reviewed in order that all information on that database is available to any mental health clinician state-wide with responsibility for follow up of an involuntary patient.

Response:
Clinicians can access the database to share specific client related information between Victorian public mental health service providers to support continuity of client care.

Yours sincerely

Lance Wallace
Acting Secretary