Melbourne Health
Executive Office, Level 8 South
PO Box 2155
The Royal Melbourne Hospital Vic 3050
Telephone 61 3 9342 8155 Facsimile 61 3 9342 8813
Website www.mh.org.au
ABN 73 802 706 972

MELBOURNE HEALTH

**Dr Peter Bradford**
**Executive Director Clinical Governance and Medical Services**
Telephone: 61 3 9342 8868
Facsimile: 61 3 9342 8813

18 September 2013

Coroner K M W Parkinson
Coroners Court of Victoria
Level 11
222 Exhibition Street
Melbourne Vic 3000

**Re: Inquest into the death of Mr Stuart Alan Ronning: Court Reference: 2010 / 003795**

Dear Coroner Parkinson

Pursuant to section 72 (2) of the Coroners Act 2008, a single recommendation was made on 11 July 2013 as part of the Finding into the death with Inquest of Mr Stuart Alan Ronning, aged 41 who died on, or about, 1 October 2010 after earlier absconding from the Royal Melbourne Hospital Emergency Department (RMH ED).

**Recommendation**. ..."That arrangements be made for the introduction in accordance with the Royal Melbourne Hospital internal review "HOLS" recommendation, of more securely located Emergency Department beds which will accommodate the monitoring and security needs of mental health patients who require short term monitoring and assessment for both medical and mental health issues".

Melbourne Health deeply regrets the death of Mr Ronning. Melbourne Health has cooperated fully with the Coronial Inquest as a means to reviewing the care and treatment provided to Mr Ronning whilst he was a patient at the RMH ED and to understand whether improvements to systems and processes could reduce the risk of such an event occurring in the future.

An alternative to the Coroner's Recommendation has been implemented.

Melbourne Health has engaged the relevant stakeholders and has developed a protocol as a direct consequence of this tragic event. The protocol: Management of Mental Health Patient's Who Wish to Leave the Emergency Department has been approved and is available to all staff in the Emergency Department. I attach a draft copy for your reference. Essentially, this protocol considers the specific clinical and safety needs of a discrete cohort of patient's who present to the RMH ED. The protocol also considers the circumstances that may determine whether a patient referred to the Enhanced Crisis Assessment and Treatment

Team (ECATT) may leave the ED after the following has been taken into account:

- The patient's ability / capacity to consent to treatment
- The patient's level of impairment
- The patient's level of insight
- The presenting circumstances, and in particular, the level of risk to self or others
- The patient's legal status under the Mental Health Act.

This cohort of patient's typically present as follows:

- Acutely intoxicated with alcohol and / or other drugs and are at risk of acute withdrawal from same
- Dependent on nicotine
- Threatening self-harm, or at an elevated risk of deliberate self-harm
- Presenting in crisis (maturational, social, relationship, financial etc)
- Ambivalent about assessment and/or treatment
- Initially co-operative however often become increasingly un-cooperative as his/her sensorium clears
- Does not meet the criteria for Involuntary Treatment under sec (8) (1) of the Victorian Mental Health Act
- A demonstrated low frustration tolerance combined with poor impulse control
- Often present with a co-morbid physical problem that requires active medical treatment in an ED setting.

Melbourne Health developed a potential model of care which was brought to the Court's attention during the Inquest for this cohort of patients. This model involved the establishment of two High Observation Low Stimulus (HOLS) beds in the Short Stay Unit (SSU) of the RMH ED. These beds would be occupied by patients who require prolonged medical care due to their level of intoxication and who are awaiting a formal risk assessment and discharge planning by the ECATT clinician because of a perceived elevated risk level. In other words, this cohort often cannot be interviewed or comprehensively assessed until the effect of alcohol and or illicit drugs have diminished, or relevant medical investigations have been completed.

The HOLS beds were envisaged as an extension of the on-going program of improvement for patients with significant mental health issues, conducted in partnership between the Departments of Emergency Medicine and Psychiatry at the Royal Melbourne Hospital. This cohort of patients are too medically unwell for a mental health admission but, for the reasons outlined above, have an un-quantified risk to self or others requiring temporary containment. These are the patients who would benefit from a new model of care that is currently unavailable in existing ED Short Stay Units (SSU). Hence, a model of care was developed for this cohort, a business case was developed and a funding submission was presented to the Department of Health in 2011 for consideration. Unfortunately this submission did not attract funding however a modified HOLS proposal is being prepared currently and I anticipate that this will be ready to be presented back to the Department of Health for consideration of funding in the near future.

In the meantime; the strong collaboration has led to the development, successful piloting and subsequent commissioning of the Psychiatric Assessment and Planning Unit (PAPU) and more recently to the implementation of the MOCA-Redi (Management of Clinical Aggression) program. As you noted in your finding; Melbourne Health is not in a position to hold patients in the Emergency Department who have not been made an involuntary patient; however we

feel that the development of the draft protocol, the PAPU, and stronger collaboration between our two services exemplified by the development of a joint protocol; will mitigate the risk of future episodes similar to that which led to the death of Mr Ronning.

Yours sincerely

Dr Peter Bradford
Executive Director Clinical Governance and Medical Services

cc. Ms Diane Gill; Executive Director Royal Melbourne Hospital
Dr Steven Pincus; Acting Director Emergency Department
Associate Professor Ruth Vine; Executive Director NorthWestern Mental Health
Mr Peter Kelly; Director Operations, NorthWestern Mental Health

Attachment. Management of Mental Health Patients who wish to Leave the Emergency Department

**PROTOCOL**

# MANAGEMENT OF MENTAL HEALTH PATIENTs WHO WISH TO LEAVE THE EMERGENCY DEPARTMENT -

**SCOPE (Area): RMH Emergency Department**
**SCOPE (Staff): RMH staff**

## PURPOSE and SCOPE

There will often be occasions where patients referred to ECATT may want to leave the Emergency Department(ED). This may be for a number of reasons. There is no surety that any patient leaving the ED will return despite any assurances the patient may give. These guidelines are to provide a framework for the clinical assessment and management of ECATT patients who may want to leave the ED

## ISSUES TO CONSIDER

- Smoking- this principle reason for patients requesting to leave. Patients should be offered Nicotine replacement therapies. No RMH staff member is expected to escort patients outside to smoke
- Intoxicated patients
- Voluntary patients- it is preferable to manage MH patients in the least restrictive manner possible, however it should be recognised that ECATT patients who are remain voluntary still have a significant risk of an adverse outcome after leaving the ED.
- Patient restraint/containment- the requirement for this should be part of every ECATT assessment and the considerations discussed with the ED treating team

## ACTIONS

- Certified patients - patients certified under the Mental health act 1986 cannot leave the ED
- Patients not yet seen by ECATT- patients may leave the ED at the discretion of the ED staff
- Patients screened by ECATT but not assessed- ECATT clinician must convey their management strategy to the ED treating staff
- Patients assessed by ECATT-these patients must have a management plan conveyed to the ED staff and documented in the notes, in relation to patient wishing to leave
- MH patients awaiting transfer to an MH or other inpatient bed should not leave the ED irrespective of legal status
- In general only patients assessed by ECATT and planned for discharge back to the community should be allowed to leave the ED. This right to leave should be conveyed to treating staff and recorded in the notes

## RELATED DOCUMENTS

**Internal**
**Melbourne Health Policy** 2. Care Planning and Implementation Policy

**External** Victorian Mental Health Act 1986

| **Reg. Authority:** Director & NUM Emergency Medicine<br>**Review Responsibility:** Emergency Department | **Date Effective:** 28.8.2013<br>**Date Revised:**<br>**Date for Review:** 28.8.2016 |
|---|---|
| **Original Author:** *Dr S Pincus* (2013)<br>**Updated by:** | |