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LAWYERS

30 April 2015

Contact: Jan Moffatt
Email: jamoffatt@dwglaw.com.au
Phone: 9672 5803
Our Ref: JAM:121274
Your Ref: COR 2012 004587

Cheryl Vella
Coroner's Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Ms Vella

Re: Investigation into the death of CD

We act on behalf of NorthWestern Mental Health Service and now **enclose** Response in relation to the Findings. Kindly acknowledge receipt.

Yours sincerely

Jan Moffatt
Donaldson Whiting + Grindal

Encl

NorthWestern Mental Health

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The Royal Melbourne Hospital
Grattan Street
Parkville Vic 3050
Tel 61 3 9342 7705
Fax 61 3 9342 8216

Provider of mental health services to:
Melbourne Health
The Royal Melbourne Hospital
Western Health
Sunshine Hospital
Western Hospital
Northern Health
The Northern Hospital
Broadmeadows Health Service
Bundoora Extended Care Centre

MELBOURNE HEALTH
North Western Mental Health is part of Melbourne Health Service

www.mh.org.au
ABN 73 802 706 972

29 April 2015

30 APR 2015
BY:

Coroner Paresa Antoniadis Spanos
Coroners Court of Victoria
Level 11
22 Exhibition Street
MELBOURNE VIC 3000

Dear Coroner Spanos

Investigation into the Death of CB - Court Reference: 2012 / 4587

I am writing in response to the handing down of a Finding following the investigation into the death of CB without holding an inquest. CB was admitted to the Broadmeadows Psychiatry Inpatient Unit (BIPU) on the afternoon of 25 October 2012. The admitting Psychiatric Registrar completed the North Western Mental Health (NWMH) Clinical Risk Assessment and Management (CRAAM) form. At the time of the assessment CB was rated a low overall risk of harm to self or others. Based on that assessment, it was determined that CB required a lower level of staff supervision than would apply in an Intensive Care Area (ICA) and accordingly CB would be nursed in the Low Dependency Unit (LDU).

The admitting Registered Nurse described CB as ...*"Pleasant and polite.....cooperative and clothed in warm winter clothing including a purple knitted scarf"*. At the time of admission in accordance with LDU policy, CBs belonging were not searched and none of CBs personal effects – including a mobile phone were confiscated. CB expressed no suicidal ideation, plan or intent when reviewed by the admitting Registered Nurse and stated that she felt safe in hospital.

Pursuant to section 72(2) of the Coroner's Act 2008, you made the following five recommendations connected to the death. I have repeated the recommendations in this letter (in bold type) and have described the actions that have been undertaken by NWWMH immediately below each recommendation.

<u>Recommendation 1</u>. *I recommend that NWMH change its policy that presently allows patients of the LDU to retain items that are capable of being used as a ligature to ensure that it complies with the Chief Psychiatrist Guidelines on Criteria for searches to maintain safety in an inpatient unit – for patients, visitors and staff.*

On 3 September 2014 a memorandum (attachment 1) was issued to all NWMH staff outlining the removal of hazardous items in inpatient units which clearly addresses the need for staff to be vigilant regarding scarves and adhere to the Office of the Chief Psychiatrists – *Criteria for Searches to Maintain Safety in an Inpatient for Patients, Visitors and Staff (September 2014).*

Recommendation 2. ***I recommend that the cupboards in patient rooms of the BIPU be adapted to remove 'hanging points'***

I confirm that cupboards in patient bedrooms of the BIPU have been adapted to remove 'hanging points'. I have attached to this letter (attachment 2) correspondence sent to the Mental Health and Drugs Division, Department of Health, dated 10 April 2013 confirming commencement of $449,740 capital works to remove ligature hazards in ensuite bathrooms in adult acute inpatient units. This capital project has now been completed.

Recommendation 3. I recommend that NWMH reassess the CRAMM guideline or policy regarding the low level engagement required for patients rated 'low risk'. Clear instruction should be developed for staff to produce consistency in:

- ***a. The frequency of formal documented mental state examinations across each shift,***
- ***b. The requirement for a formally documented and notarised rationale explaining determination of a patient's 'low risk' rating; and***
- ***c. The frequency, timing and recording of visual observations of patients***

All NWMH Inpatient Units have introduced a risk assessment and management tool to assist in the rating of a consumers' clinical risk during an admission to an inpatient unit. The tool, "Clinical Risk Assessment & Management" (CRAAM) was introduced to BIPU in October 2010.

CRAMM is a hybrid of two existing frameworks for risk assessment processes. The intention of CRAAM is to increase patient safety by improving the reliability of risk assessment and therefore determining the appropriate frequency of visual observations and the level of engagement required for each client. CRAAM attends to a number of domains when assessing or rating risk including: Risk to self, risk to others, physical vulnerability, risk of absconding, medical co-morbidities and drug and alcohol withdrawal.

NWMH has undertaken a review of the CRAAM documentation and guidelines and changes have occurred and these have been disseminated to all staff within Inpatient Units - All clients admitted to an LDU bed outside of normal business hours and who have not been reviewed by a Consultant Psychiatrist are default rated as 'Medium Risk'. All clients admitted to an ICA bed outside of normal business hours and who have not been reviewed by a Consultant Psychiatrist are default rated as 'High Risk' pending a review by the Consultant Psychiatrist. These CRAAM ratings and associated plans specify the frequency of observation and engagement and make reference to static and dynamic risk factors including collateral history obtained from carers/family.

Recommendation 4. I recommend that NWMH provide focussed and detailed training to nursing and allied staff and medical staff of BIPU concerning the static risk factors (including those specific to particular diagnosed conditions) and dynamic risk factors (including changes in perception and increased anxiety levels) of individuals with mental illness

All Staff at BIPU in 2013/14 undertook further training in risk management including access to the CRAAM e-Learning tool which forms part of the NWMH mandatory training package for clinical staff. Included in this training is a module on static risk factors and dynamic risk factors of the individuals, while incorporating collateral history from carers/family.

<u>Recommendation 5.</u> I recommend that NWMH provide focussed and detailed training to nursing and allied staff and medical staff of the BIPU about procedure for escalation/referral to more senior staff of changes in mental state, dynamic risk factors for suicide (including changes in perception and increased anxiety level) of people with mental illness.

I have attached to this letter (attachment 3) the following NWMH Clinical Risk Management Bulletins:

- Bulletin # 3 April 2009. Evaluation and Management of Suicide Risk: Information from and to Family and Carers
- Bulletin # 4 November 2009. Escalation of Clinical Problems
- Bulletin # 6 September 2010. Top Ten Quality and Safety Initiatives
- Bulletin # 9 April 2013. Management of Suicide Risk for Consumers Presenting to the Emergency Department and who are Relatively Unknown to the Service

Of particular relevance is Bulletin # 9, however the other three bulletins have been included as proactive examples of quality and safety initiatives undertaken by NWMH.

A Summary of other NWMH Safety Improvements

NWMH and the North West Area Mental Health (NWAMHS) have introduced a number of safety and service improvements at BIPU following this tragic event. These improvements are in addition to the aforementioned five recommendations and acknowledge a number of other issues canvassed during in the investigation and include:

1. Changes to the model of care and improvements to the continuity of care provided to clients
2. A specific project within BIPU directly related to *'improving experience of care with the implementation of a primary nurse model'*
3. Memorandum entitled "Removal of all Hazardous Items in Inpatients"
4. Changes to infrastructure
5. Implementation of a new model of risk assessment including mandatory training modules for all staff
6. Implementation of a Ligature Safety program
7. Information and support offered to families

1. Change to the Model of Care and improvements to Continuity of Care

NWMH is introducing a new integrated model of care across all community services that will work in conjunction with inpatient and residential services. This model of care was implemented across NWMH in July 2013. The rationale for the redesign of our service was to address five broad themes of feedback received from consumers, carers/ family and also NWMH staff and its clinical partners. This feedback was derived from an extensive consultation process. The five broad themes relate to (a) Communication (b) Silos and fragmentation of services (c) Service capacity vs demand management (d) Workforce (e) Evidence based practice. NWMH also visited a number of specialist mental health services across Victoria to look at their models of care, service structures, staffing profiles and governance arrangements.

The new model of care is underpinned by the following key principles:

The principles for *Caring in the Community* were developed and are supported by the NWMH Consumer and Carer Advisory Group (CCAG) and the NWMH Executive Committee.

The principles are as follows:

- Care and recovery pathway should be informed by consumers, family / significant others;
- Engagement of family / significant others should occur as soon as is practicable;
- Care should be provided in the least restrictive setting and care should be oriented to supporting the continued integration of the consumer into their community;
- Therapeutic rapport with consumers should be prioritized by treating clinicians;
- Care and recovery should be guided by evidence and research. Evidence should include(a) the personal evidence of the consumer and family / carer; (b) practice based evidence; and (c) evidenced based care;
- Time spent with consumers and family / carers should be maximized and all efforts should be made to minimize duplication of clinical processes.
- *To paraphrase feedback from consumers and staff.... ""I want to receive the care I need, when I need it, <u>once</u>, from someone qualified and experienced to provide it".*

To assist in the transfer or dissemination of clinical information an electronic medical record or Client Patient Folder (CPF) was implemented in 2008. This record is shared with Northern Health and is used across all NWAMHS inpatient, residential and community services. The file content can be viewed on a computer by all NWMH clinical staff at any site and at any service. There is now no need to transport a hard copy of the medical record between sites. Files are either updated daily via the scanning of client information or updated via direct entry into the electronic record on-line. This has helped NWAMHS and its staff to offer better continuity of care for its clients.

2. Improving Experience of Care - Implemented Primary Nursing Model (Aug 2013)

A Primary nursing model has been selected and a shift work schedule was developed. Primary nursing and person-centred care training has been conducted for all nursing staff. Nurses are now allocated to medical teams for continuity of care and to facilitate increased opportunities for direct nursing care to be provided and ongoing engagement with a small group of clients, nursing staff are now attending all medical reviews for their client group and provide a strong advocacy service for clients as required. Primary nurses provide holistic care and support, administer medication, conduct physical observations, assist with activities of daily living, undertake risk management with a greater emphasis on engaging directly with the client throughout the shift. Clients are made aware of who their allocated nurse is and make plans at the commencement of each shift regarding engagement and meeting the client's needs.

3. Changes to the General Ward Infrastructure (2013-2015)

Several changes have been made to the infrastructure at BIPU to improve the level of safety and amenity. Efforts have been made to create a homelike, welcoming and therapeutic environment that is also safe for consumers, visitors and staff. These changes include:

- New beds and mattresses have recently been purchased at a cost of $50,000. These beds are purpose designed for mental health units and they address both comfort and safety concerns.
- A feasibility study has just been completed by consulting architects with a brief to improve the amenity of BIPU. A final design has been selected and this will result in a $1.2m upgrade of BIPU during 2015-2016.
- A $50,000 discretionary funding allocation has been made available to improve the therapeutic environment at BIPU. This funding will be used to purchase items such as art works and activity and entertainment resources for consumers and painting the entire ward.

4. Bathroom Ligature Safety Project

- Modifications to ensuite doors by removing the tops and bottoms of the doors and bevelling the corner of the top of the ensuite door.
- Replacement of ensuite door hinges and replacement with 'piano type' door hinges to prevent the insertion of a ligature into the gap between the door / frame / hinge.
- Replacement of ensuite door furniture including removal of door handles / knobs and replacement with flush mounted grasp handles.
- Installation of 'ball and socket' catches to secure doors in the closed position.
- Replacement of soap dispensers, toilet roll holders, towel rails and shower curtain fittings with approved 'ligature safety' products.
- Replacement of grab rails with bespoke fittings that prevent attachment of ligatures.
- Replacement of shower roses, shower taps and basin taps with approved 'ligature safety' products.
- Shrouding of under basin waste pipes.
- Replacement as necessary of mirrors or light fittings.

5. Implementation of a Ligature Safety Program

The Department of Health & Human Services (DHHS) has provided funding to NWMH to attend to some ligature hazards. NWMH has removed bedroom cupboard doors and has made modifications to air-conditioning vent covers as both items were assessed as potentially hazardous. NWMH has also developed a ligature safety audit program and a revised audit tool was piloted at BIPU in December 2012. This tool has been evaluated and introduced across all bed based programs within NWMH Adult, Aged and Youth Services.

6. Implementation of a Seclusion Reduction Program

BIPU has introduced a seclusion reduction program called the "Peace in Mind" project. This project has been very successful in reducing both the frequency and duration of seclusion interventions and in fact received a Melbourne Health "Best of Health Award" in December 2012. The award recognized the improvements that had been made at BIPU in respect to improving "Patient safety and patient centred care".

7. Information and support provided to carers / families

- NWMH provides all families / carers with a booklet *"Information for "Consumers and Carers - North West Area Mental Health Service"*. This booklet explains what services are provided, the staffing arrangements, the contact details for teams, the contact details for NWMH Triage and also the Emergency Services. The booklet also answers a number of frequently asked questions pertaining to medication and identifies supports available to consumers both within NWAMHS and in the wider community. There are also a number of websites and references provided regarding the availability of additional services that provide support to both the consumer and families.
- BIPU has developed information sheets for consumers, carer/family in regards to admission and in particular it explains why certain items cannot be brought into the unit such as scarves including wraps, shawls etc, plastic bags, charging cords and it recognises that mobile phones and ipads are a link to people's lives and, that on occasions, these items may be removed and the reason for this action will be clearly communicated to the consumer, carer or family especially if there is a direct link to increased anxiety agitation which may result in acts of deliberate self harm / behaviour.
- Building Family Skills Training (BFST) is an intense, family education and support service that is offered to families / carers to assist them to care for a mentally ill family member. NWAMHS Carer Consultant's also extend peer support to families in this regard.

In closing, I hope that this information is helpful in conveying a range of safety and service improvements and ongoing staff education and training that have been undertaken at North West Area Mental Health Service, and in particular BIPU, following the tragic death of CB on October 2012.

Yours sincerely

Peter Kelly
Director Operations
NorthWestern Mental Health

Copy: A/Prof Ruth Vine – Executive Director, NWMH
A/Prof Peter Burnett – Director Clinical Governance, NWMH
Dr Vinay Lakra – Director Clinical Services, North West AMHS
Joy Barrowman – Area Manager, North West AMHS

Attachments:

1. Memo dated September 2014. Removal of Hazardous Items in Inpatient Units
2. Letter to the Department of Health dated April 2013
3. NWMH Quality and Safety Bulletins

NorthWestern Mental Health

Clinical Risk Management Bulletin

BULLETIN 3

APRIL 2009

SUBJECT: Evaluation & Management of Suicide Risk: Information from and to Family and Carers

Assessment and management of patients who have threatened or attempted suicide is one of the most common high risk situations we encounter in mental health services. One of the complexities in this area is the communication between staff and family, friends or carers of the suicidal patient. Often, concerns about confidentiality, or not knowing who to contact, or the pressure of work, result in poor communication so that not all relevant information is known to staff. A patient who has decided to commit suicide, may minimise the risk, denying or rationalising behaviours which would alarm clinicians. Similarly, patients may insist that families, patients or carers not be contacted about an attempt or significant threat, and may return to a vulnerable situation. Several cases over the past year have highlighted the great importance of obtaining collateral information. Undoubtedly different decisions would have been taken if the information had been known. Other cases have demonstrated the danger of sending home suicidal patients without discussion with carer or family. Mental state assessment by itself is not a reliable predictor of suicidal intent, particularly for patients who are not known to the clinician.

Legal Issues:

- The provision of information by family does not compromise an individual's privacy
- If a person who is considered acutely suicidal refuses to allow contact with family, the clinician may override that refusal to keep the person safe (See Mental Health Act S120A(3)ca

Guidelines

Therefore the following guidelines should be used in regard to collateral history and follow up information to families or carers

1. Wherever possible, collateral information should be obtained before deciding on management plan
2. Wherever possible, the management plan should be discussed with family or carer if the patient is not admitted
3. If a patient strongly resists the above, the risk assessment should be amended accordingly

Dr Peter Burnett. Director Clinical Governance NWMH

NorthWestern Mental Health

Clinical Risk Management Bulletin

BULLETIN #4

NOVEMBER 2009

20 November 2009

DISTRIBUTED TO

NWMH—Everyone

ACTION REQUIRED BY

Clinical Staff

ACTION DEADLINE

Nil

PLEASE INFORM

Clinical Staff

Quality, Planning & Innovation Unit

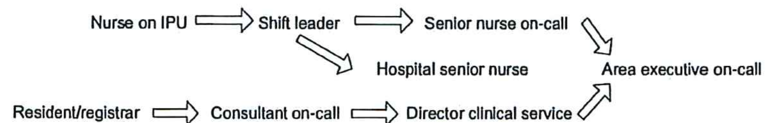
Peter Burnett—Director, Clinical Governance

Ph: 9342 8765
Fax: 9342 8216

SUBJECT: Escalation of Clinical Problems

Several recent reviews of adverse incidents have highlighted the need for clearer understanding and implementation of escalation of clinical or management problems to more senior staff.

Escalation means simply referring the problem to a more senior colleague for advice on appropriate management, or for assistance with problem solving or resolving differences of opinion. This can be a particular issue when managing a complex medical co-morbidity. All services have clear pathways, including both general and discipline-specific escalation.



The difficulties with escalation occur most commonly outside of core business hours and particularly at night or on weekends, and so usually involve inpatient units or CATT/YAT teams.

Examples of escalation are:

Sometime clinicians feel that they should be able to solve a problem, and so are reluctant to ask for advice. Or they may not want to wake someone up in the middle of the night. But there is no point having experienced clinicians on call if they are not consulted. Some useful questions to ask when considering calling are:

- Am I confident that I know what to do in this situation?
- If not, is there someone on duty who can help me find the way to deal with the problem?

Overall, our guiding principle is

"When in doubt, ask for help"

Dr Peter Burnett. Director Clinical Governance NWMH

NorthWestern Mental Health

Clinical Risk Management Bulletin

BULLETIN 6

SEPTEMBER 2010

9 September 2010

DISTRIBUTED TO

NWMH—Everyone

ACTION REQUIRED BY

Staff to provide feedback

ACTION DEADLINE

Nil

PLEASE INFORM

- **All**
- **Update Clinical Risk folder with this Bulletin**

Quality, Planning & Innovation

SUBJECT: Top Ten Safety and Quality Initiatives

Improving the safety and quality of our services is one of our most important goals. To do this we identify possible areas for improvement, investigate, plan and implement changes. This may be at an individual level, or local team or area, or all of NWMH. Some projects are straightforward and can be implemented quickly, others take a lot of planning and negotiation. But all begin because a staff member has noticed an issue, thought about it and recognised the need for improvement. When the improvement plan is developed, it can only be implemented by our staff. So you really are the heart and soul of quality and safety improvement.

Currently we have a number of important safety and quality projects in different stages of development. Most are being trialled in one or two areas / programmes.

1. **Clinical Risk Assessment and Management Project CRAAM).** This combines two earlier projects at NAMHS and IWAMHS focused on new approaches to inpatient observation and risk assessment.
2. **Clinical handover:** this has been developed at MWAMHS, with a plan to trial a structured communication method (SBAR). It could be generalised to many other handover situations.
3. **Peace in Mind:** NWMH has had very promising results with this project which has seen a significant reduction in seclusion without any increase in adverse events. The Department of Health has indicated that seclusion rates will be a priority key performance indicator in the next year.
4. **Medication Safety in the Community.** An improvement project has commenced and is currently collecting data from across NWMH.
5. **Evidence Based Co-design:** has identified a range of improvements in 5 different inpatient and community settings.
6. **Failure Mode Effect Analysis (FMEA)** is a technique which identifies risks in the environment before an adverse event occurs. It has been trialled successfully in Orygen Inpatient Unit.

This list is not complete, and it is great that there are so many projects and ideas being developed. It is important to co-ordinate these, so that staff in one area are not overwhelmed while other areas miss out entirely.

We aim to identify a list of our top 10 projects, which will be developed and implemented over the next two years. If you would like to nominate a new project, please contact your team leader or ESIC (Evaluation and Service Improvement Co-ordinator), or email ideas directly to Nicole Ah Yick (nicole.ahyick@mh.org.au) or Peter Burnett (peter.burnett@mh.org.au).

Dr Peter Burnett, Director Clinical Governance, NWMH

NorthWestern Mental Health

Clinical Risk Management Bulletin

BULLETIN # 9

Issued April 2013

This bulletin assists NWMH clinical staff in Emergency Departments and acute inpatient units to manage consumers who present with suicide risk and who are relatively unknown to the service.

Distributed To:

NWMH Everyone

Action Required By Staff: Risk management for consumers presenting with suicidal risk, especially when they are not known to the mental health service.

Action Deadline

Nil

Please inform

All Staff

Assessment and management of consumers who have threatened or attempted suicide is one of the most common high risk situations encountered in mental health services. This becomes even more complex when the consumer minimises the seriousness of their suicide attempt and is reluctant to engage with the treating team. Clinical Risk Bulletin number 3 issued in April 2009 addressed the issue of information gathering from family and carers to help the decision making in appropriate assessment of risk and provision of care.

This situation is even more challenging in cases where there is lack of previous knowledge about the mental health history of the consumer (who is relatively unknown to the service) and in circumstances, whatever the reason, where collateral information/history is not able to be obtained.

Recent incidents in NWMH and other mental health services in Victoria, suggest a high risk of suicide in consumers who present with suicidal ideas and/or attempt(s), in the context of multiple psychosocial stressors and who are relatively new to the service. Such consumers are usually superficially engaging, minimise their suicide risk and deny or rationalise behaviours which should/could alarm the clinical staff. Their suicide risk can be easily reviewed as low risk, which may not reflect their true risk of suicide. Hanging is the mode of suicide in almost all the completed suicides in inpatient settings.

Guidelines -

1. Consider guidelines in Clinical Risk Bulletin 3, which include:

- Whenever possible, obtain collateral information before deciding on management plan.
- Whenever possible, the management plan should be discussed with family or carer if the consumer is not admitted.
- If the consumer strongly resists the above, the risk assessment should be amended accordingly.

2. For admitted consumers:

- Regularly review their mental state and risk of suicide.
- Identify potential psychosocial factors contributing to their presentation and engage the consumer to support them.
- Review consumers' overall risk status and their Mental Health Act status if needed.
- Review any factors in the environment which the consumer could potentially use to commit suicide and remove them for safe keeping, e.g. items such as belts, cords, scarves, etc. (Please note that scarves constitute a particular risk because they serve as a visual prompt as well as provides a practical means of suicide).
- Discuss and develop a safety management plan with the consumer and review it daily or earlier as appropriate.
- If any behaviours are noted which are contrary to the expectation, e.g. increasing use of PRN medications, isolating self in the room, missing meals etc, review the mental state and communicate information to the treating doctors. Seek help from on call doctors during afterhours. Remember to escalate and seek advice if not sure.

Quality, Planning & Innovation
NorthWestern Mental Health
Level 1 North
The Royal Melbourne Hospital

Dr Vinay Lakra
A/ Director of Clinical Governance

Memorandum

To	Nurse Unit Managers: Youth, Adult and Aged Inpatient Units NWMH
From	Peter Kelly. Director Operations NWMH
CC	Area Managers: Youth, Adult and Aged Programs NWMH Directors of Clinical Services: Youth, Adult and Aged Programs NWMH Dr Peter Burnett: Director Clinical Governance NWMH A/Prof Ruth Vine: Executive Director NWMH Penny Herbert, Manager, Quality NWMH
Date	3rd September 2014
Subject	Removal of Hazardous Items in Inpatient Units

1. In 2008 NWMH identified plastic bin liners as a particular hazard in npatient units. Specifically, plastic bin liners had been implicated as the means to a completed suicide in an inpatient unit in New South Wales and accordingly NWMH ceased the supply of plastic bin liners and mandated the substitution of these with a paper product.

2. Similarly, neck scarves have been implicated as the means to completed suicides in inpatient units in Victoria and as such these items should be removed from consumers and placed into safe keeping for the duration of the consumer's admission irrespective of the patients (a) legal status, (b) risk assessment or (c) care setting i.e Low Dependency Unit or Intensive Care Area. NWMH recognises that this intervention is necessary for the safety of the patient being admitted to the inpatient unit as well as other patients already admitted to the inpatient unit.

3. Staff should interpret this memo to mean that 'scaves' also includes pashminas, shawls, wraps or other long pieces of fabric that can potentially be fashioned into a noose or ligature to be used in an act of deliberate self harm.

4. Staff are reminded to re-acquaint themselves with the *Chief Psychiatrists Guideline – Criteria for Searches to Maintain Safety in an Inpatient Unit for Patients, Visitors and Staff,* - revised to coincide with the release of the new Mental Health Act in July 2014. This guideline aims to describe search processes that are permissible by law and can ensure clinical safety while respecting patients' rights.

5. Notwithstanding the specific prohibition of plastic bin liners and scarves as per the instruction in this memo, the need to undertake a search of the room or belongings of a patient admitted to a mental health inpatient service, or to undertake a physical search, must be based on an assessment of the patient and the level of clinical or environmental risk to the patient, other patients, visitors and staff. Based on this assessment, there will be times when it may be necessary to search a patient or their room and belongings to ensure their safety or the safety of others. This may occur at various points in an episode of care, for example, on admission to an inpatient unit, following any planned

or unplanned leave, or prior to an episode of seclusion. While safety is the primary concern, human rights such as respect, privacy, dignity and confidentiality must be taken into account. Searching a patient or their belongings is an intrusive intervention that must only be used when it is the only reasonable and practicable course of action to avoid or prevent a serious risk of harm to a patient or harm to others. When a search is undertaken, every effort should be made to observe the patient's rights to the greatest extent possible under the circumstances.

6. Please ensure that this information is conveyed to clinical staff employed in your inpatient unit via (a) staff meetings (b) staff notice boards (c) staff information folders

Peter Kelly. Director Operations NWMH

NorthWestern Mental Health

10 April 2013

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Main Block
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MELBOURNE HEALTH

North Western Mental Health is part of Melbourne Health Service

www.mh.org.au
ABN 73 802 706 972

Ms Leanne Beagley
Director Operations
Mental Health, Drugs and Regions Division
Department of Health
50 Lonsdale Street
MELBOURNE VIC 3000

Dear Leanne

Mental Health Inpatient Unit (ensuite bathroom) Ligature Safety Program

As you know, NorthWestern Mental Health (NWMH) has received $449,740 funding from the Department of Health (DoH) to attend to potential ligature attachment points in Mental Health Inpatient Unit ensuite bathrooms. Our Facilities Managers have scoped up the works and we have retro-fitted two prototype ensuite bathrooms at (1) at the John Cade Unit, The Royal Melbourne Hospital and (2) at Sunshine Adult Acute Psychiatry Unit at Sunshine Hospital. Our staff have been evaluating these prototype bathrooms over the past two months as a means to testing the suitability of a number of the anti-ligature products which include:

- Cut down bathroom doors
- Replacement of door hinges with continuous (piano type) hinges.
- Installation of magnetized door catches
- Replacement of grab rails
- Replacement of soap dispensers
- Replacement of taps and faucets
- Replacement of shower heads
- Replacement of toilet roll holders
- Replacement of light fittings
- Removal of towel hooks

We are now at the point where the user group has endorsed the use of specific products and thus we are ready to proceed to the next step of going out to tender for these works.

I think it is important from a process point of view, and because of the aggregate cost of these works, for me to extend an invitation to the Mental Health Drugs and Regions Division to review the work that has been done on ligature safety across NWMH. Please advise whether you would like to nominate a representative from your office to receive a briefing on the NWMH ligature safety program prior to NWMH proceeding to tender.

We would be happy to provide a briefing inclusive of a presentation on the anti-ligature product lines that we have chosen as well as a site visit to view the prototype ensuite bathrooms.

Yours sincerely

Peter Kelly
Director Operations
NorthWestern Mental Health

Copy to: Dr Peter Burnett – Acting Executive Director, NWMH
Glenn Murphy – Business Manager, NWMH
Cosimo Brisci – Facilities Manager, NWMH
Dr Michael Clarke – Facilities Manager, APMHP & OYH