Secretary

Department of Health and Human Services

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Coroner Audrey Jamieson
Coroners Court of Victoria
65 Kavanagh Street
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By email only: cpuresponses@coronerscourt.vic.gov.au

Dear Coroner Jamieson

I refer to your Finding without inquest into the death of Mr Sydney (Dale) Stanfield (*COR 2017 005763*).

The department accepts the recommendation made in the Finding, and confirms that it is being implemented.

Actions in response to recommendation

In response to your recommendation, the department has prepared specific practice advice to be issued in February 2019 to all staff, aimed at strengthening their understanding of their obligations to report 'in care' deaths to the Coroners Court of Victoria.

In summary, the practice advice states 'in care' deaths includes the death of a resident who has entered palliative care and has not formally vacated departmental services. Previous practice advice did not reference this specific cohort.

Enclosed for your perusal is a copy of the practice advice.

The department is also considering measures to support the training of all new and existing Disability Accommodation Service (DAS) staff, to understand their specific and general obligation to report 'in care' deaths. This includes strengthening the use of the state-wide DAS Practice Newsletter to disseminate updated practice advice to embed practice change in each group home across the state.

For completeness, I confirm the department currently:

- Provides guidance to staff to report the death of a person residing in supported accommodation to the Coroners Court of Victoria in the Residential Services Practice Manual, which includes a checklist for staff to follow 'When a person dies – Critical Client Incident Report – Action Checklist'; and

- Requires that all deaths of residents in Disability Accommodation Services be reported in accordance with the department's critical client incident management instruction.[1] The incident report form requires the manager to indicate when the Coroner was notified and detail the Coroner's reference number.

Yours sincerely

Kym Peake
Secretary

31 / 1 / 2019

Attachment 1: Reporting deaths to the Coroner and ODSC – Practice Advice for staff dated February 2019

[1] Technical update 2014.

Reporting deaths to the Coroner and Disability Services Commissioner

Practice advice for staff, February 2019

Key messages

The Victorian Coroner (CCOV) can investigate any death that must be reported by law. This includes deaths that:

- occur where the person resides in residential or custodial services that are the responsibility of the government (even if the death occurs elsewhere)
- are sudden
- are traumatic or unexplained.

It is mandatory to report the death of a resident of a department managed residential service even if the person dies while absent from the service, for example:

- in hospital
- in palliative care
- on holiday
- on an overnight stay with family or friends.

The Disability Services Commissioner can inquire into and investigate incident reports received by the Department of Health and Human Services (the department), for deaths of persons receiving disability services at the time of their death. These routine investigations occur for both expected and unexpected deaths.

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Reporting client deaths

In accordance with the Critical client incident management instruction, Technical update 2014, all deaths of residents in Disability Accommodation Services (DAS) are required to be reported through an incident report form. The form prompts the notification to the Coroner and requires the manager to detail the date the report has been made to the Coroner and the CCOV Case number.

The Residential Service Practice Manual includes a checklist When a person dies – Critical Client Incident Report – Action Checklist. This checklist also prompts the reporter to report the death of a resident to the CCOV.

What if the resident has been absent from the residential service and/or the vacancy has been declared?

If, at the time of death, the person's principal place of residency was a residential service that is the responsibility of the government and the **tenancy has not been formally terminated in accordance with Section 75 of the *Disability Act 2006***, the death must be reported to the coroner. A critical client incident report must also be completed and submitted.

Note: hospitals and palliative care units are not principal places of residency.

Can the Victorian Coroner and Disability Services Commissioner investigate deaths that did not occur in the group home?

The Victorian Coroner and the Disability Services Commissioner may initiate an investigation into any death that occurs where a person was receiving residential services immediately prior to admission to an alternative facility (e.g. hospital or palliative care).

More information

Further information is available:

- Residential Services Practice Manual (RSPM) sections 6.4 and 6.8.
- Review of residents deaths. Disability Services Commissioner – Information for residential services staff – February 2018.
- *Disability Act 2006*, Part 5 – Residential Services – section 75, Termination of residency.
- Critical client incident management instruction, Technical Update 2014, Section 7.1 – Client death.