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20 September 2019

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Marde Bevan
Coroner's Registrar
Coroner's Court of Victoria
65 Kavanagh Street
Southbank Vic 3006

Dear Ms Bevan

Investigation into the death of Trajce Laboski
COR 2015-005722

On behalf of Northern Health and North Western Mental Health, please find **enclosed** joint response to the recommendations made by Acting State Coroner Caitlin English.

Yours faithfully

Jan Moffatt
DTCH Lawyers

Encl

ID:384092

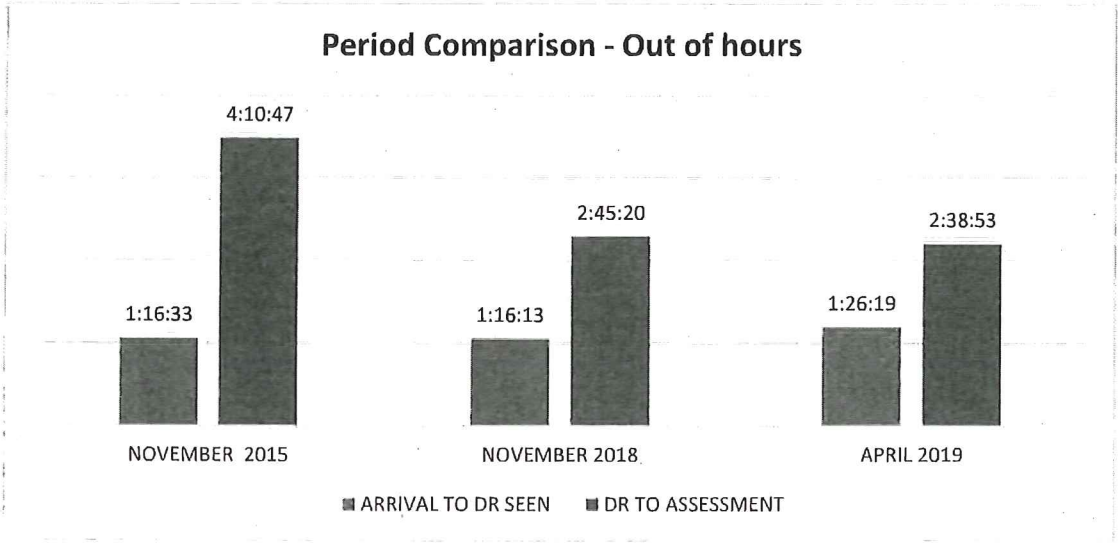
Northern Health & North Western Mental Health

This is a joint response by Northern Health (NH) and North Western Mental Health (NWMH) and in particular Northern Area Mental Health Service (NAMHS) to the Coroner (COR 2015 005722) regarding the following recommendations:

Recommendation 1. The Coroner's recommendation has been implemented.

Recommendation 1: *Melbourne Health North Western Mental Health and Northern Hospital undertake a review of the actual wait times of people awaiting an assessment by the Emergency Department Mental Health clinicians, especially out of business hours to,* ***(1)*** *establish if the two hours noted as a reasonable wait time is the average for patients in the emergency department out-of-hours, and* ***2)*** *address any sustained variance that suggests wait times for patients out-of-hours is on average greater than the two hours considered as reasonable.*

North Western Mental Health (NWMH) and Northern Health (NH) have undertaken a review of the available data to be informed of wait times for an assessment by the Emergency Mental Health (EMH) team clinicians in the NH Emergency Department (ED), especially out-of-hours. The report of the review is attached to this letter (see attached report) (see Graph 1).

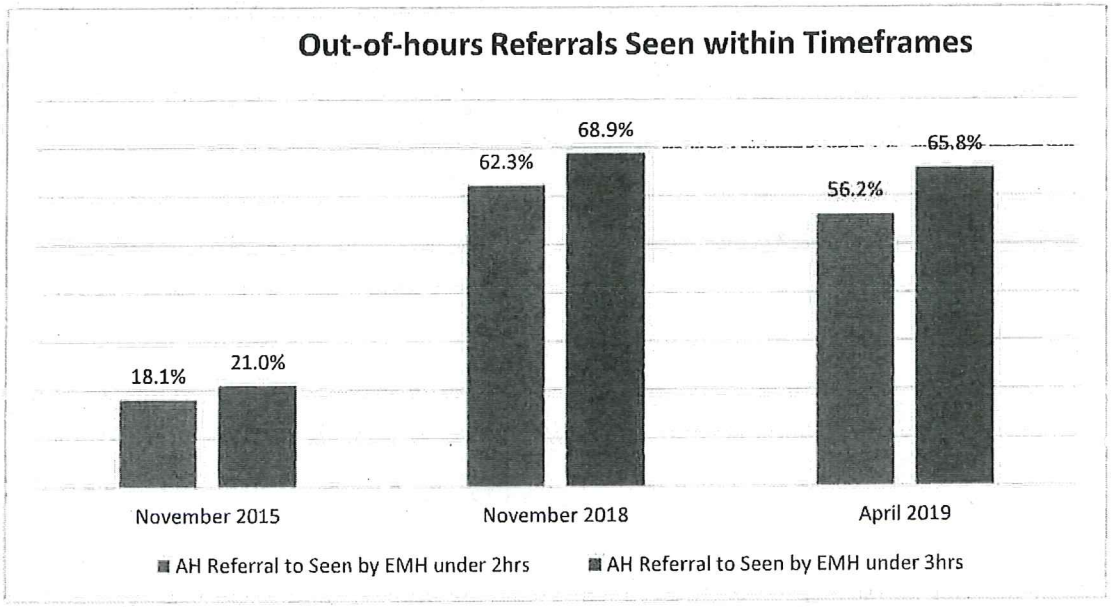


Graph 1

1. The results indicated that an average time to wait to assessment in 2015 was over 4 hours out-of-hours, whereas this has been reduced to just over 2 ½ hours in April 2019. There are many reasons for extended wait times, including patients being too intoxicated or too sedated to be reviewed. For this reason, even under optimal circumstances, wait times will occur.

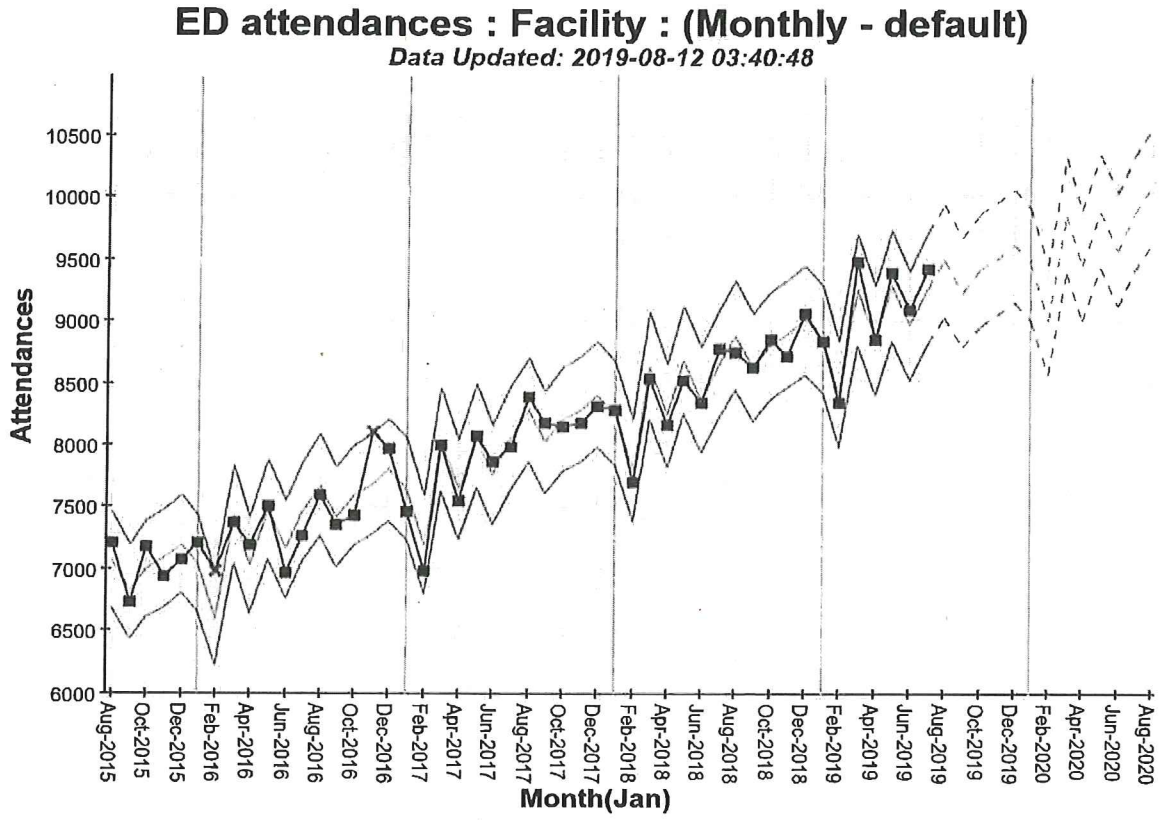
The reduction in wait times out-of-hours between 2015 and 2019 for an assessment by an EMH clinician reflects the improvements made over the past 4 years by the EMH Team in collaboration with NH ED Team, in assessing patients in a timely fashion. This also highlights that Mr Laboski was seen within 1 ½ hours of arrival at NH ED and as such this was a reasonable wait time, given the average wait time in 2015 was over 4 hours for out-of-hours assessments.

2. Out-of-hours wait times have steadily decreased since 2015, from over 4 hours reduced to just over 2 ½ hours in 2019. The proportion of patients seen within 2hrs of referral has tripled between 2015 and 2019 data (see graph 2.)



Graph 2

This has occurred despite the steady increase and demand of patients presenting to The Northern Health ED also highlighted in the following graph 3:



Graph 3

The Blue line is the actual number of attendances to ED. Green line is predicted from trends created by retrospective data. The red lines are three standard deviations above and below the mean.

2.(cont) The fact that the wait time decreased despite the steady increase of attendance to ED has been addressed in recommendation 2, detailing all improvements by the service provided to mental health patients in ED by Northern Health and North Western Mental Health. This improvement does not fully meet the wait time expectation as noted to be reasonable at the Coroner's inquest. We continue to identify, develop and implement strategies to achieve reduced wait times.

In summary: The average wait time out-of-hours in 2015 was over 4 hours. Mr Laboski did not wait longer than average to be seen by an EMH clinician at the time he presented to the NH ED in November 2015. Since this event, more than 60% of mental health patients who present out-of-hours are now seen within two hours of referral by EMH.

Northern Health & North Western Mental Health

Recommendation 2: *Melbourne Health North Western Mental Health and Northern Hospital review the current service model of care provided to patients in the Emergency Department who have a mental illness or who require assessment for a possible mental illness, for opportunities to integrate patient care processes to* ***(1)*** *identify patient needs,* ***(2)*** *increase the communication of critical information,* ***(3)*** *develop shared and comprehensive care planning and* ***(4)*** *the prevention of harm.*

Recommendation 2: The Coroners recommendation has been and will be implemented.

There have been substantial changes made to the way NH and NWMH work together in the Northern Health Emergency Department. This has led to better integration of care and processes, as the coroner stipulated was necessary. There has been a gradual change over the years, and more so in the last year, due to pressures faced by both NH and NWMH in the Emergency Department (ED) regarding the increase of presentations. This improvement in the delivery of care covers the 4 areas identified by the coroner in need of attention:

1. To identify patients' needs
2. Increase communication of critical information
3. Develop shared and comprehensive care planning and
4. The prevention of harm

The improvements in process and delivery of care by NWMH EMH in collaboration with NH ED are bullet pointed below and the 4 identified areas for improvement, according to the coroner's recommendations, are placed in brackets behind the actual improvement in practice:

- EMH clinicians worked in a 2 morning : 2 evening : 1 night roster in November 2015 and this has changed and improved to a 2 morning : 3 evening : 2 night roster since February 2019. This means there are now always **two clinicians on at night (1,2,3,4).**
- Since February 2019, we have added a full time Psychiatry Registrar to the EMH clinician team. This has enabled more timely review and treatment for mental health patients in ED. **(1,2,3,4).**
- NWMH EMH clinicians attend the ED huddle which is a clinical handover including specific discussion of mental health patients and bed demand. This occurs 3 x daily at 0915hrs, 1615hrs and 2330hrs. EMH management also attend NH daily operational safety briefs, which features an organizational level discussion about patient care, including mental health patients in ED. **(1,2,3,4).**
- The bed capacity and demand list is shared between NWMH and NH to support the efficient flow of patient demand and need for patient beds **(2,4).**
- EMH participates in the NWMH bed co-ordination call twice daily, dealing with bed demand across all sites of NWMH. **(2,4)**
- NWMH has provided NH with a dedicated bed access contact number for EMH clinicians **(2,4)**

- NWMH attend both NH NSQHS Standard 5: Suicide and Self Harm (SASH) and NH NSQHS Standard 8 meetings **(2,3,4)**
- Joint participation in executive, clinical and operational meetings including: NH leadership meeting, ED Managers & Directors meeting, Emergency Services Liaison Committee (ESLC) Meeting, Operations Meeting (NH & NWMH), Reducing Restrictive Interventions Meeting, Occupation Violence and Aggression meeting, Frequent Presenters meeting as necessary **(1,2,3,4)**
- NH ED is integrated with NWMH Consultation Liaison & Alcohol & Drugs Services which provide care in ED, Short Stay Units, and throughout the general hospital **(1,2,4)**
- Integration of Emergency Mental Health services within the Short Stay Unit, enabling suitable mental health patients to be transferred to a low stimulus environment while awaiting assessment. **(1,4)**
- Refurbishment of Resus 3, to safely receive and assess high risk emergency mental health patients. **(1,2,4)**
- Referral from triage to ED and EMH has also been reviewed and an improved process is being developed **(2,4).**
- Regular education sessions provided for the ED medical and nursing staff by the EMH clinicians and Psychiatry Team. (3)

Recommendation 3: The Coroners recommendation will be implemented.

Recommendation 3; *Northern Hospital Emergency Department in consultation with North Western Mental Health, review the contemporaneousness and appropriateness of the practice that currently removes medical practitioner responsibilities under the Mental Health Act 2014 and assigns responsibility for its use to North Western Mental Health clinicians. The review should be informed by* ***(1)*** *escalation processes in the Emergency Department,* ***(2)*** *an understanding of the intent of sections 28 — 30 of the Mental Health Act,* ***(3)*** *an understanding of the Mental Health Act safeguards for a patient who is subject to the Act including their rights and responsibilities, and* ***(4)*** *advice regarding the obligations regarding section 30 of the Mental Health Act 2014 from the Chief Psychiatrist in Victoria.*

Northern Hospital Emergency Department is committed to providing quality care for our Mental Health presentations and acknowledges the concerns raised by this Coronial enquiry. We unreservedly support the role of our medical staff in the utilization of the Mental Health Act in our department. Comments made about the "usual practice" at Northern ED reflect a pattern of behavior which has evolved through time and does not reflect a formal directive from Emergency Department management.

Until this review, at risk patients have been initially detained under Duty of Care legislation until further assessment is possible. A significant proportion of our mental health presentations will arrive under the influence of drugs and/or alcohol, making a diagnosis of acute mental illness more challenging and reducing the likelihood of an Assessment Order issue. For these cases, the patient is prevented from

leaving by negotiation, physical or chemical means to keep them safe, under the principles of duty of care.

Although this approach has been largely successful at maintaining the safety of our mental health patients, we accept that we must comply with the obligations of the Mental Health Act. To improve the knowledge of NH Emergency Physicians about the MHA, a specific teaching session took place on 31st July 2019 by the Lead Consultant Psychiatrist from NWMH. This well attended session reviewed our current practice and intent of sections 28-30 of the MHA, as well as patient rights and responsibilities and clinician obligations of the MHA. Northern Health agrees to adhere to their responsibilities regarding sections 28-30 of the Mental Health Act in accordance with the Coronial recommendations.

Specific outcomes for this recommendation include:

- The promotion of key features of the Mental Health Act to medical practitioners of the Emergency Department – including clinician obligations, and legal requirements for involuntary psychiatric admissions. This shall also include appropriate escalations to senior clinicians, legal or mental health specialists, when the application of MHA is unclear.
- This promotion to feature in all levels of Emergency Medical Education, including Registrar, HMO and intern levels.
- Ongoing annual training workshop for all Consultant Emergency Physician staff to ensure that legal responsibilities are refreshed regularly and promoted to junior staff during clinical shifts.

Northern Health
North West Mental Health

Audit of Referral to Assessment Times
COR 2015 005722

In response to the request made by Coroner English in COR 2015 005722, the following audit was commissioned to review the performance of the Northern Emergency Department (ED) / North West Mental health partnership to provide timely care for mental health patients.

Aim

To determine the average waiting time for Emergency Mental Health patients, following referral from the Emergency Department medical team. We also reviewed the amount of time this group of patients waited to be seen by a doctor following arrival to the Emergency Department.

Methods

To be included in this review, patients must fulfil the following criteria.

1. Have been referred to the Emergency Mental Health team by the Northern Hospital Emergency Department between the following dates
    a. 1st November 2015 – 14th November 2015
    b. 1st November 2018 – 14th November 2018
    c. 1st April 2019 – 14th April 2019

    This review will allow measurement of any waiting time changes that may have occurred since the adverse event in 2015.

2. Have been seen by BOTH the Emergency Department and Emergency Mental Health team, enabling the collection of both referral time and mental health assessment time.

The following data points were collected by the Emergency Department

1. Time of presentation to the Emergency Department
2. Time of Doctor Assessment in the Emergency Department

This is electronically collected by the Emergency Department Information System (EDIS) and forms part of the reported VEMD database.

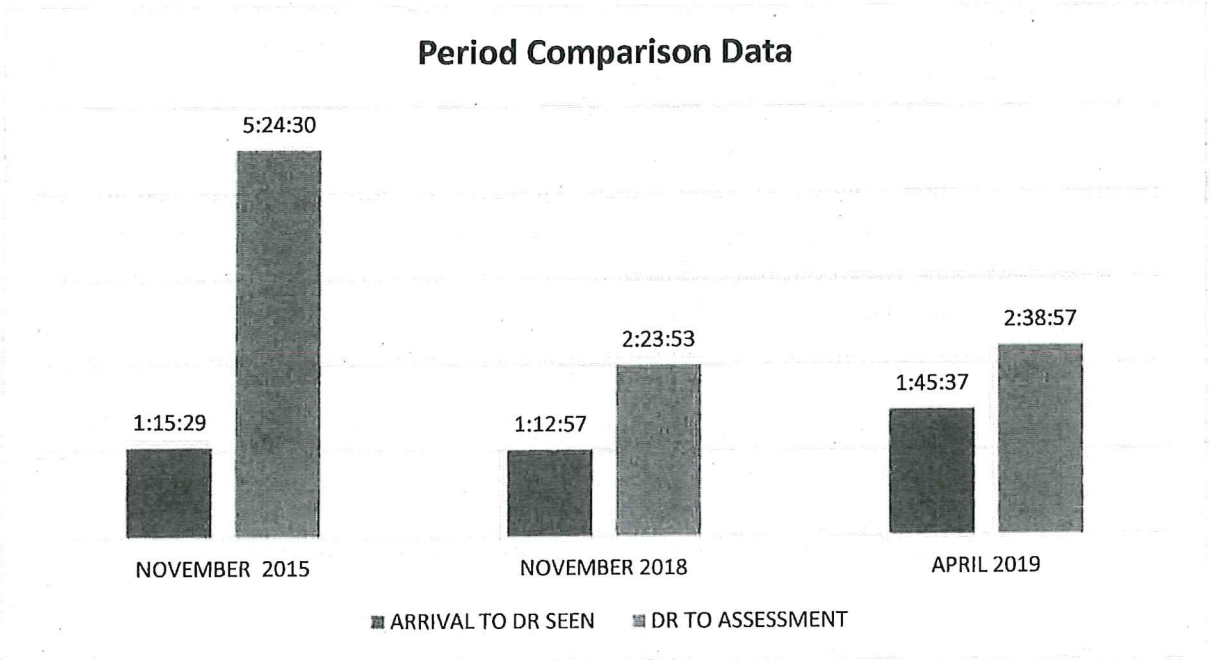
The following data points were collected by the Emergency Mental Health team

1. Time of referral from the Emergency Department for Assessment
2. Time of assessment by Emergency Mental Health

This data is collected manually by the Emergency Mental health team in a daily log of their clinical activity.

Results

- There were 399 patients found from the above query, sourced from the Emergency Mental Health referral records.
- Of the 399 patients, there were 363 complete records – containing ALL time stamps required for the analysis. There were 36 patients for whom one or more time stamps were missing from the query. These records were excluded from analysis.



- In 2015
  - There were 106 valid records who presented between 1st and 14th November
  - On average, these patients waited
    - 1hr 15mins to see a doctor
    - 5hrs 24mins to see mental health after medical assessment
- In 2018
  - There were 134 valid records who presented between 1st and 14th November
  - On average, these patients waited
    - 1hr 13mins to see a doctor
    - 2hrs 24mins to see mental health after medical assessment
- In 2019
  - There were 123 valid records who presented between 1st and 14th April
  - On average, these patients waited
    - 1hr 46mins to see a doctor
    - 2hrs 38mins to see mental health after medical assessment

A subgroup analysis was also performed to determine if these changes had occurred in the "business hours" or "after hours" period of EMH operation. This was defined in agreement with EMH

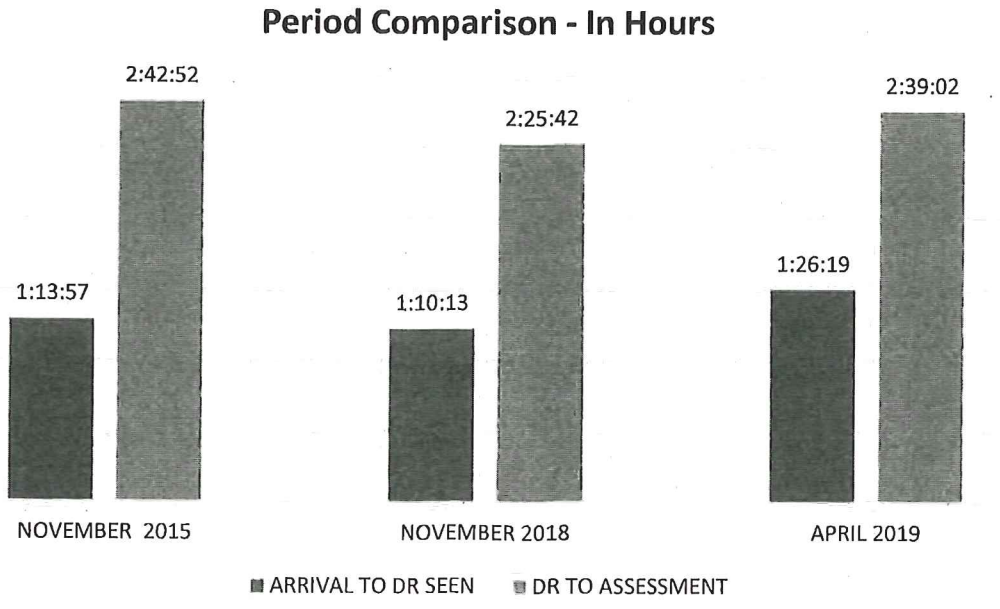
- In hours referrals – 7am – 5pm.
- Out of hours referrals – 5pm – 7am.

Although EMH commence work at 0800hrs, referrals received at 0700 would be seen by the incoming EMH team and would be aligned with an "in-hours" referral.

The groups were then dichotomised for each year cohort, by time of referral and grouped as "In-hours" and "After-hours" referrals.

In Hours

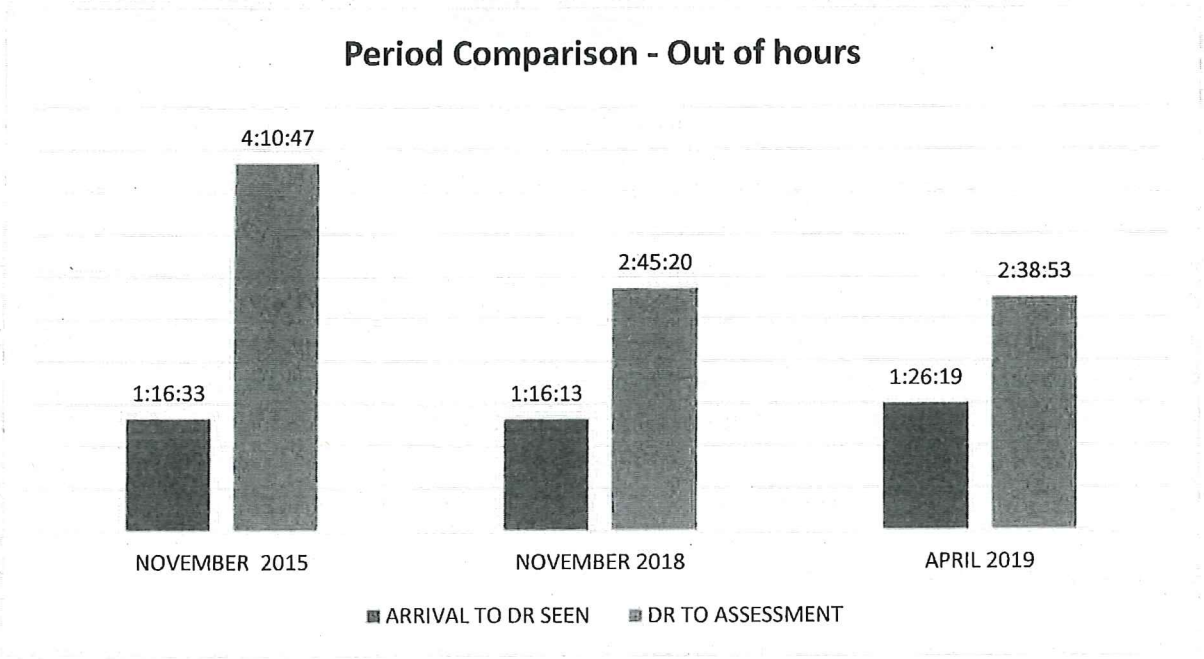
- In 2015
  - There were 43 valid records who presented between 1st and 14th April
  - On average, these patients waited
    - 1hr 13mins to see a doctor
    - 2hrs 42mins to see mental health after medical assessment
- In 2018
  - There were 73 valid records who presented between 1st and 14th November
  - On average, these patients waited
    - 1hr 10mins to see a doctor
    - 2hrs 25mins to see mental health after medical assessment
- In 2019
  - There were 50 valid records who presented between 1st and 14th April
  - On average, these patients waited
    - 1hr 26mins to see a doctor
    - 2hrs 39mins to see mental health after medical assessment

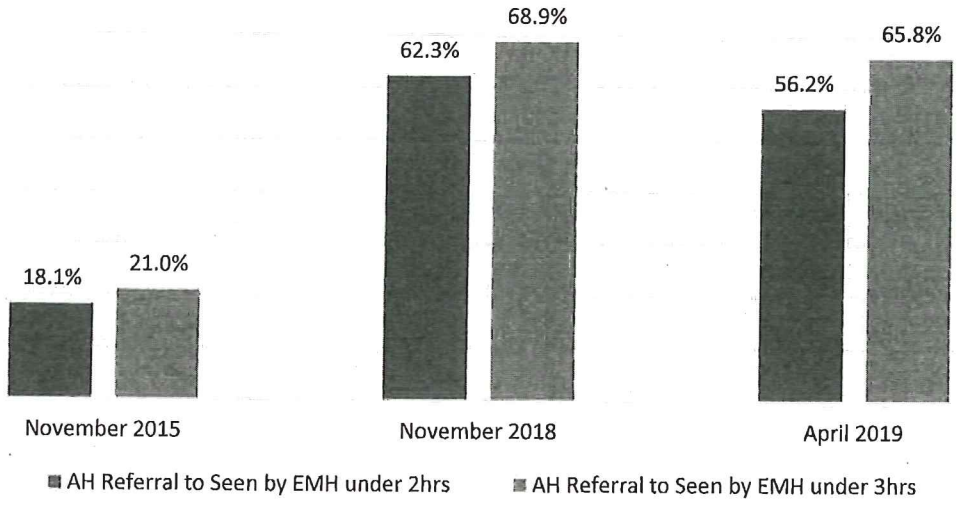


Out of Hours

- In 2015
  - There were 62 valid records who presented between 1st and 14th April
  - On average, these patients waited
    - 1hr 16mins to see a doctor

        - 4hr 10mins to see mental health after medical assessment
- In 2018
    - There were 61 valid records who presented between 1st and 14th November
    - On average, these patients waited
        - 1hr 16mins to see a doctor
        - 2hrs 45mins to see mental health after medical assessment
- In 2019
    - There were 73 valid records who presented between 1st and 14th April
    - On average, these patients waited
        - 1hr 58mins to see a doctor
        - 2hrs 38mins to see mental health after medical assessment





From this data, there appears to be a significant improvement in the time to mental health assessment following referral from the Emergency Department team. **This improvement has been primarily seen during the "After Hours" period.** This is also demonstrated in the proportion of after-hours referrals seen within the specified time frames, showing significant improvement from November 2015. This improvement does not meet the two-hour expectation stated by the Coroner but is progressing the right direction. Recent high activity and decreased overall access performance has worsened ED and overall performance between November 2018 and April 2019.

Dean Pritchard – Deputy Director of ED, Northern Health.