Department of Health and Human Services

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Mikaela Meggetto
Coroner's Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Ms Meggetto

Re: Inquest into the death of Paul Taouk – COR 2015 6477

Thank you for your letter of 1 July 2019 concerning Coroner Jamieson's recommendation to the Chief Psychiatrist in relation to the death of Paul Taouk.

The Coroner has recommended that the Chief Psychiatrist assist clinicians to understand more clearly the processes to be followed when asking Victoria Police to apprehend a patient who has absconded from an inpatient unit, mental health clinic or other setting.

In particular, the Coroner recommends that the Chief Psychiatrist develop a guidance tool to assist clinicians with the interpretation of the requirements of 3.1.1/3.2 (Urgent Request for Police Attendance which required a Triple Zero call) and 3.4.1 (Request for Police to Apprehend) of the *Department of Health Services – Victoria Police Protocol for Mental Health* including clarification of the following:

(a) in what circumstances would both 3.1.1/3.2 and 3.4.1 be applicable;

(b) the limitation of a triple zero call with respect to a police investigation in relation to a patient who has absconded; and

(c) that the outcome of a triple zero call is not automatically communicated to a health service unless a specific request is made for the advice to be given.

The Chief Psychiatrist accepts the recommendation of the Coroner and will include a section on this matter in the next *Chief Psychiatrist's Quality and Safety Bulletin* which will be distributed to all Victorian mental health services later this year. These bulletins are placed on the department's website and can be accessed by service providers at any time.

Yours sincerely

Daniel O'Connor
Deputy Chief Psychiatrist
17/ 9/ 2019