ST VINCENT'S HOSPITAL
MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

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RECEIVED AT
- 4 SEP 2019
CORONERS COURT OF VICTORIA

5 September 2019

Mikaela Meggetto
Coroner's Court of Victoria
65 Kavanagh Street
Southbank VIC 3006

Dear Ms Megett

Investigation into the death of Paul S Taouk
I refer to the findings and recommendations made by Coroner Audrey Jamieson, into the death of Mr Paul S Taouk received by St Vincent's Hospital (Melbourne) Limited (St Vincent's) on 1 July 2019.

Recommendation
With the aim of improving public health and safety and preventing deaths, I recommend that St Vincent's Hospital ensures that it has appropriate policies and guidelines applicable to community based settings which clearly sets out the requirements for clinicians to follow in circumstances where a patient absconds from a community setting and is made absent without leave, and there is an urgent requirement for police to attend as well as a requirement for police to apprehend the patient.

Response to Recommendation
The Coroner's recommendation has been implemented.

St Vincent's has amended its *Community Case Management Policy* in addition to its *Clinical Risk Management Policy* to clearly set out the requirements clinicians are to follow in circumstances where a patient absconds from a community setting and is made absent without leave, and there is an urgent requirement for police to attend as well as a requirement for police to apprehend the patient.

The updates will be broadcast to St Vincent's Mental Health clinicians and incorporated into education provided to St Vincent's Mental Health staff.

Yours sincerely

Angela Nolan
Chief Executive Officer
St Vincent's Hospital (Melbourne) Limited