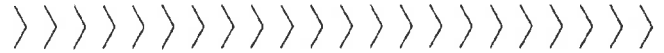




**The Royal  
Melbourne  
Hospital**

**Professor Christine Kilpatrick, AO**  
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22 June 2021

Her Honour, Caitlyn English  
Deputy State Coroner  
Coroner's Court of Victoria  
65 Kavanagh Street  
Southbank, Melbourne, Victoria 3003

Dear Deputy State Coroner English

**Mr BB. Court Reference: 2018 / 6380**

I am writing in response to a recommendation made by you in the matter of Mr BB, in which you delivered a Finding on 30<sup>th</sup> March 2021.

The recommendation is as follows: Pursuant to section 72(2) of the Act, I make the following recommendation connected with Mr BB's death:

1. To improve the safety of patients who are discharged from an emergency department following an assessment of suicide risk, I recommend that NorthWestern Mental Health update relevant guidelines to include a requirement for contact with a family member or carer (where possible) prior to the patient being discharged in situations where a risk has been identified that the patient may be minimising their suicide risk and / or where conflicting information has been provided regarding their suicidality.

**NorthWestern Health Mental Response:**

Please see attached the final draft of *MH02.02.28 Suicide and Self Harm Risk Assessment and Management Procedure* which has been updated to incorporate the above referenced recommendation.

This procedure will be presented to the Royal Melbourne Hospital Comprehensive Care Committee for approval at its July 2021 meeting. Once approved, the procedure will be posted on the Royal Melbourne Hospital iPolicy platform and NorthWestern Mental Health will promote the revised policy to relevant teams within the service.

Yours sincerely

**Christine Kilpatrick AO**  
**Chief Executive**

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<b>RESPONSIBLE EXECUTIVE</b>	Executive Director of Nursing Services
<b>PRIMARY AUTHOR</b>	Behaviours of Concern Working Group
<b>IMPLEMENTATION STRATEGY</b>	The procedure will be disseminated and promulgated via Policy of the week, MH email, Interdisciplinary meetings
<b>EVALUATION STRATEGY</b>	The new procedure will be evaluated by documentation audits at NVMH / bedside audits at RMH campuses, feedback via RISKMAN information
<b>STANDARD/S (National, Aged Care, Disability Services)</b>	Standard 5 Comprehensive Care, Standard 6 Communicating for Safety
<b>VERSION SUMMARY</b>	New Procedure to provide guidance to clinicians to screen and manage patients/consumers identified at risk of suicide or self-harm

#### EXECUTIVE SUMMARY

1. To provide management guidelines for patients identified at risk of suicide and/or self-harm.
2. Screening guidelines for patients/consumers for suicidal ideation or self-harm risk provides guidance for staff and safer care for patients/consumers
3. Medical staff are informed of patients/consumers who are assessed at risk and referred to relevant mental health service for further mental health assessment and management.
4. The environment is made safe for patient/consumer.

#### 1. ASSOCIATED MELBOURNE HEALTH POLICY

MH02 Comprehensive Care – Assessment, Care Planning, Referral & Discharge Planning Policy

#### 2. PURPOSE AND SCOPE

Melbourne Health works with patients, carers and families to prevent and manage patients at risk of self-harm and/or suicide. This procedure outlines the process for the identification, engagement, assessment and management of patients in suicidal distress or who are having thoughts and impulses to self-harm.

Assessment of suicide and self-harm requires an appreciation of the complexity of multiple contributing factors.

The prevalence of suicidal distress is higher in certain specific populations including individuals from culturally and linguistically diverse backgrounds (CALD) particularly refugees and asylum seekers, people living with a mental health condition, Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) people, men living in rural and remote areas, ex-service men, and emergency service workers.

At the individual level long term factors (e.g. chronic illness and disability, family history of childhood abuse, previous suicide attempts) and more dynamic factors (e.g. distress caused by stressors or precipitating events, depression or other mental disorder, harmful use of alcohol and other drugs, job loss, poverty, trauma gendered domestic and family violence, grief, and a sense of hopelessness) are significant warning signs.

At the relationship/family level the presence or absence of resources and protective relationships will influence the risk state of the individual.

The process includes the screening, assessment of 'risk to self' and response.

- Screening for thoughts of self-harm or suicide for people who present with self-harm, mental illness or acute emotional distress
- Responding to the risk
- Ensuring the environment is safe
- Implementing a plan to support recovery

#### 3. DEFINITIONS

Self-Harm	Deliberate harm, such as self-injury or self-poisoning, with the intention to harm as opposed to accidental harm as the consequence of lifestyle or behaviour
Suicidal ideation or	Thoughts of deliberately ending one's own life

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thoughts	
Clinical risk	Suicidal ideation or behaviours, self-harm thoughts or behaviours, risk to others

#### 4. RESPONSIBILITIES

4.1. All employees as outlined in the procedure/guideline

#### 5. PROCEDURE/GUIDELINE

- 5.1. The risk factors for mental health conditions, suicide and self-harm, are multifactorial, operate at many levels and may overlap, including but not limited to:
- a Individual level (e.g. depression or other mental disorder, harmful use of alcohol and other drugs, job loss, poverty, trauma and grief, sense of hopelessness, chronic illness and disability, family history, history of childhood abuse, previous suicide attempts);
  - b Relationship/family level (e.g. level of social support, relationship conflict, gendered domestic and family violence and abuse);
  - c Individuals from culturally and linguistically diverse backgrounds (CALD) particularly refugees and asylum seekers, people living with a mental health condition, Lesbian Gay Bisexual Transgender Intersex and Queer (LGBTIQ) people, men living in rural and remote areas, ex-service men, and emergency service workers.
- 5.2. Identifying patient/consumer at risk:
- a Staff may identify a patient at risk of suicide or self-harm through the following means:
    - i Self-reporting – patient/consumer reports suicidal or self-harm ideation, plan or intent
    - ii Emotional indicators of risk – extreme hopelessness, helplessness, feeling trapped, rage, anger or other sudden changes in mood
    - iii Behavioural indicators of risk – seeking access to medications, weapons, talking or writing about death and dying, withdrawal from family/friends.
- 5.3. Inpatient Interventions following identification of risk
- a Nursing:
    - i Ensure environment is free of potential objects for harm (refer to search policy)
    - ii Advise Nurse, Unit Manager (NUM), Associate Nurse, Unit Manager (ANUM) and treating medical officer for urgent review
    - iii Review need for continuous observation. The level of observation required will depend on the risk and the physical environment. Wherever possible, a person at risk of suicide or self-harm should be appropriately observed until further plan can be developed. The consumer/patient should be involved in developing this plan where possible.
    - iv Consider moving patient to high visibility area
    - v Commence 15 minute visual observations until reviewed by medical staff.
    - vii Consider need for 1:1 care if risk is eminent MH 02.02.09 Nurse Specialising Procedure.
    - viii Consider asking the patient/consumer to elicit further information:
      - Have things been so bad lately that you have thought you would rather not be here?
      - Have you ever tried to harm yourself?
      - Have you made any current plans?
      - Do you have any items that can cause harm?
    - vii Contact relevant mental health service to assist with nursing management e.g. for Emergency refer to EMH and inpatient wards refer to Consultant Liaison Psychiatry.
    - viii Document findings and handover to oncoming staff.
  - b Medical

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- i Investigate and treat underlying presenting medical condition
- ii Refer to relevant mental health service to assist with further assessment.
- iii Consider use of Mental Health Act if patient is at imminent risk
- c Allied Health
  - i Advise ANUM when possible
  - ii Ensure environment is free of potential objects for harm (refer to search policy)
- 5.4. Ongoing management
  - a Management strategies to be developed in conjunction with treating unit, relevant mental health service and the consumer/patient
  - b Refer to other in-patient services as required – i.e. Allied Health, Addiction Medicine
  - c Consider appropriate discharge plan
    - i Where the decision has been made to discharge a person at risk in the community, discharge from the general hospital should occur if adequate support and follow-up arrangements have been considered.
- 5.5. Emergency Department
  - a Triage to a safe and supportive environment
  - b If agitated or trying to leave review the need for additional resources to supervise the patient and prevent them leaving until assessed as safe for discharge.
  - c Patients considered at increased risk who are refusing to stay for care should be discussed with ED medical and EMH staff. Refer to MH01.08 Discharge Against Clinical Advice.
  - d Patients with altered conscious state can be detained under duty of care until the risk can be determined.
  - e All patients require thorough documentation of the degree of risk, and disposition plans including referrals for ongoing care where appropriate.
  - e - Wherever possible, collateral history should be obtained from a family member, carer, friend and/or other clinicians before a patient who presented with suicidal thoughts/attempts (or increased risk of suicide is discharged from ED. This is particularly important where there is evidence that a patient may be minimising their suicide risk, or where conflicting information has been provided about suicidality. If this history cannot be obtained, good clinical practice is to escalate to more senior staff for discussion.
  - f Patients that require transfer from one clinical area to another, the risk should be reviewed and the plan discussed with the admitting unit.
- 5.6. Non- Mental Health Outpatient settings.
  - a Move patient to safe and supportive environment
  - b If patient deemed to be an imminent risk patient should be transported to an emergency department for further assessment
  - c Advice can be sought from North Western Mental Health triage.
- 5.7. Community
  - a Call ambulance, family/supports, present to an emergency department if patient/consumer is already attempting suicide or plan is imminent
  - b Call police if risk to others or non-compliant
  - c Clinician to inform patient/consumer that clinician will need to take action to help the patient/consumer (as above); and,
  - d Clinician to advise manager, to obtain assistance, support and guidance.
  - e Contact North Western Mental Health Triage: 1300 874 243

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r Clinician to contact manager or use EAP post event if additional support is required

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#### 6. ASSOCIATED POLICIES/PROCEDURES/GUIDELINES

- a MH02.02.02.01 Clinical Handover When Clinician Changes
- b NWMH01.02.01 Assessment and Review
- c NWMH02.01.01 Care Planning and Implementation
- d MH02.02.07 Mechanical Restraint Procedure
- e MH02.02.09 Nurse Specialling
- f MH01.08 Discharge Against Clinical Advice
- g Search of a Patient/Consumer flowchart

#### 7. REFERENCES

#### 8. FURTHER INFORMATION

- 8.1. Crisis support service numbers.
- 8.2. Lifeline: 13 11 14
- 8.3. Suicide Helpline: 1300 651 251
- 8.4. Beyond Blue: 1300 224 636
- 8.5. North Western Mental Health Triage: 1300 874 243

#### 9. DOCUMENTATION

#### 10. REVISION AND APPROVAL HISTORY

Date	Version	Author* and contributors
August 2019	1	Behaviours of Concern Working Group*, Approved and authorised by the Clinical Policy, Procedure and Guidelines Committee.
Draft		