

Monash Medical Centre

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Coroner's Prevention Unit - Responses Coroner's Court of Victoria 65 Kavanagh Street South Melbourne Victoria 3006

15 July 2021

Dear Coroner's Prevention Unit.

(4398-18)

Response to Recommendations by Coroner McGregor (15 April 2021)

I am writing in response to your letter dated 15 April 2021, requesting a written response from Monash Health to recommendations made by Coroner McGregor in relation found deceased on 3 September 2018.

I am instructed to provide Monash Health's response to the recommendation as follows:

1. To ensure there is appropriate monitoring of patients with a treatment plan for major depression which is essentially pharmacological, I recommend that Monash Health CATT affirm that medication compliance is a regular part of their clinical reviews. along with assessments of mental state, current situation and clinical risk.

Monash Health does affirm to the Court that medication management is a normal part of clinical practice and clinical reviews. The Monash Health Crisis Assessment and Treatment Team (CATT) provides care to acutely unwell patients in the community and medication management (including review of adherence) continues to be standard practice by staff.

This medication management practice has been reinforced to staff via the development of a local guideline for staff working in the CATT. A copy of this guideline is attached. This guideline is available in printed form at each telephone in the CATT office, is saved on the local team computer drive and is printed in CATT work folders and emailed to all staff. The guideline demonstrates how medication management is a normal part of clinical practice and clinical reviews.

I would also like to extend Monash Health's thanks to the Court to provide its response to the recommendation.

Please do not hesitate to contact me should you require any further information or clarification of our response to Coroner McGregor's recommendations.



Yours sincerely

Peter Ryan

Chief Legal Officer Monash Health