Department of Health and Human Services

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PSD/16/40

Cheryl Vella
Coroners Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Ms Vella

Re: Inquest into the death of [redacted] (Court reference:COR 2009 004252)

Thank you for providing me with a copy of the Coroner's findings in relation to the death of [redacted] who died by hanging in the Orygen inpatient unit on 31 August 2009.

After considering the evidence presented to her, the Coroner recommended that:

"The Chief Psychiatrist considers mandating the removal of the particular hook/housing used in the Orygen inpatient unit, particularly from doors or any other placement where they can be utilized as a hanging or suspension point".

Response

The Chief Psychiatrist has established that the hook used as a ligature point in this case was manufactured in the United States with the intention that it be attached to walls. As a result of [redacted] death, it has become clear that the hook offers much less protection when attached to doors.

In response to the recommendation, the Chief Psychiatrist wrote to the directors and managers of all Victorian mental health services on 12 May 2016, and again on 27 July 2016, to ask if such hooks were attached to doors in patients' rooms in their child, youth, adult, secure extended care, sub-acute or residential units and, if so, what plans they had to remove them.

At the time of writing, all but three services have responded that such hooks, where present, have been removed from all doors. The Services which have not yet responded are being contacted at present for information.

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If you require further information, please do not hesitate to contact me on 9096 7571.

Yours sincerely

Dr Daniel O'Connor
Deputy Chief Psychiatrist
11 / 8 / 2016

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