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Barwon Health

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10 July 2017

Coroners Court
Cavanagh St
Southbank VIC 3006

Coronial Ref: COR 2015 004329

RESPONSE TO RECOMMENDATIONS

In March 2017 Coroner Carlin held an inquest into the death of Natasha Calleja, a patient in the mental health facility of Barwon Health. Findings were handed down on 7 April 2017.

Ms Calleja died following an overdose of heroin supplied to her by her long term partner. The Coroner found that Ms Calleja died from combined drug toxicity, mainly heroin.

CORONER'S RECOMMENDATIONS

Recommendation One: *Barwon Health's Searching of a Consumer and their property/belongings procedure be amended in the manner outlined in Comment 1 of this finding so that it contains the words: staff should not touch the contents but the visitor should be requested to remove the contents of their bags* ***and their pockets*** *for inspection.*

The procedure and notice in reception on entry to the mental health unit have been amended accordingly.

Recommendation Two: *The Swanston Centre Visitor Information Sheets be amended in the manner outlined in Comment 2 of this finding so that it contains the warning 'Hospital patients have an increased risk of overdose from illicit substances'.*

The suggested amendment has been undertaken.

Recommendation Three: *Barwon Health take steps to ensure that the Swanston Centre Visitor Information Sheets and warning signs are available in other languages or otherwise capable of being understood by persons with non-English speaking backgrounds or poor English literacy.*

The visitor information sheets are under review as well as signage being translated into the three most common languages of non-English speaking patients in the Swanston Centre.

ADDITIONAL CHANGES

In addition the relocation of administration staff to the reception foyer area provides for an enhanced opportunity to discuss visitors understanding of the materials provided. The requirement of visitors' to wear a visitor badge is a further cue to staff of visitors who have not signed in or read and understood the visitor information.

In the event it becomes apparent the understanding is poor, appropriate steps in the circumstances are undertaken to improve the understanding. This may include the use of

translation services or taking the time to explain the information to a person who reveals poor literacy.

In the case of each of the recommendations, communication to staff is being undertaken at, for example, unit meetings, formal education sessions and orientation.

Lockers for visitor possessions have been purchased and are located in the waiting room of the mental health unit. A clear procedure for the use of these lockers will be developed and visitor information will be provided about the use of these.

In addition, reference has been made to the Chief Psychiatrist Guidelines *Criteria for searches to maintain safety in an inpatient unit – for patients, visitors and staff* https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/criteria-or-searches-maintain-safety-in-inpatient-unit-for-patients-visitors-staff .

Yours faithfully

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