Department of Health

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05 SEP 2014

Office of the Secretary

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Ms Mandy Chancellor
Coroner's Registrar
Coroners Court of Victoria
Level 11 222 Exhibition St
MELBOURNE VIC 3000

Dear Ms Chancellor

RE: COR 2007 002518 - Investigation into the death of Stacey J Smith

Thank you for providing me a copy of the inquest findings, including the recommendations, into the death of Ms Stacey J Smith.

In response to the relevant recommendation made by the Coroner:

Recommendation:
I recommend that the Department of Health, review existing protocols concerning psychiatric review in Hospital Emergency Departments and seek to ensure that where such delay threatens to lead to a compromise to patient care, that there are arrangements put in place, which will allow for communication at Consultant level and permit such review to proceed either following intra Hospital (patient) transfer to a Hospital's psychiatric unit, or by an addition RPN being sent to the Emergency Department for that purpose.

Response
An alternative to the coroner's recommendation is being implemented.

The Department of Health has a devolved system of governance in which health services are responsible for the development of clinical policies and procedures. The department supports the establishment of processes to support timely clinical review and patient handover. An example of this is the requirement for all health services as part of their accreditation requirement under the National Quality and Safety Health Service Standards are required to meet *Standard 6: Clinical Handover*. Governance for handover and mental health emergency department care was identified in the *Chief Psychiatrist investigation of inpatient deaths 2008-2010* and the recommendation that:
"That health services develop clearly documented policies with the relevant emergency departments regarding which service component has primary responsibility for providing care to mental health patients, and who has the responsibility for communication including notification and support of families in case of an adverse event."

The Chief Psychiatrist has been monitoring implementation of these recommendations by health services and will be undertaking a further review to inquire into inpatient deaths over 2011-2013 to consider overall practice improvements including progress on addressing the recommendations from the previous review.

State Government Victoria

In addition, the department is finalising an Acute Community Intervention Service guideline which includes mental health service provision in emergency departments.

Yours sincerely

Dr Pradeep Philip
Secretary