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Department of Health

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CORONERS COURT OF VICTORIA

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Ms Leyla Stefano
Coroners Registrar
Coroners Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Ms Stefano

Re: Court Reference: 4308/2006 – James Bloomfield

Thank you for providing a copy of the inquest findings including recommendations following the death of Mr James Bloomfield at Bairnsdale in November 2006. I note that you have directed recommendations to the Minister for Mental Health, the Minister for Police and Emergency Services, the Department of Health, the Chief Psychiatrist, Victoria Police and Ambulance Victoria, and Latrobe Health Service.

Please find attached a response to those recommendations relevant to the Department of Health.

Yours sincerely

Lance Wallace
Acting Secretary

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State Government Victoria

Attachment 1

Department of Health responses to the recommendations from the inquest into death of James Kellock Bloomfield

Recommendation 1
That the Minister for Mental Health extend the policy of providing triage and integrated services to patients with dual diagnoses to small regional hospitals like Bairnsdale Hospital.

Response
The recommendation is accepted and has been implemented.
It is government policy that all mental health triage clinicians are able to assess and respond to persons with dual diagnosis. While there are separate mental health and alcohol and other drug services, it is expected that both services will be able to carry out a sufficient assessment to determine whether the person needs referral to the other service type. This policy applies to metropolitan and regional hospitals where there is a mental health presence.

Recommendation 2
That the Department of Health and Victoria Police review their protocols relating to mental health telephone triage in Gippsland to improve flexibility of communication between mental health service providers including local service agencies, Ambulance Victoria, Victoria Police, Accident & Emergency Department at Bairnsdale Regional Health Service, Bairnsdale Community Mental Health Service, and the Mental Health Triage Service at Traralgon.

Response
The recommendation is accepted and has been implemented.
There have been progressive enhancements to mental health triage through the introduction of additional resources, standardised scale and education and training. The protocols have been reviewed to reflect these improvements and expectations. In addition every area mental health service convenes an Emergency Services Liaison Committee to consider local issues regarding access to care and emergency services response.

Recommendation 3
That the Latrobe Health Service ensure that Accident & Emergency Department staff report to police all patients who present in police custody and discharge themselves without assessment by a mental health practitioner.

Response
This recommendation is not directed to the Department of Health.

Recommendation 4
That the Chief Psychiatrist ensure that the changes recommended by the Mental Health Triage Scale Advisory Committee are consistent with other triage scales used concurrently in Accident & Emergency Departments of regional health services.

Response
The recommendation is accepted and has been implemented. The Department of Health has issued a Statewide mental health triage scale with associated guidelines for use. There are differences in the triage scales used in Emergency departments and by mental health triage. These reflect the different areas of concern and expected responses. However the triage scales are consistent and have a similar type of scale. Triage data is regularly collected and monitored to support consistency in response.

Recommendation 11
That Victoria Police authorise an independent specialist review of the solvent and propellant systems for oleoresin capsicum to identify an appropriate non-flammable solvent that requires a less flammable propellant with characteristics that are consistent with operational requirements.

Response
This recommendation is not directed to the Department of Health.