Safer Care Victoria

Court ref: COR 2016 003862
SCV ref: CC2019-10

Sanchia Nigli
Coroner's Registrar
cpuresponses@coronerscourt.vic.gov.au

Dear Sanchia

Investigation into the death of Thi Ha Do

Thank you for your letter dated 11 June 2019 accompanying Coroner Simon McGregors's finding without inquest into the death of Thi Ha Do.

I refer to the Coroner's recommendation:

'that Safer Care Victoria and the Safer Care Victoria Mental Health Clinical Network work to identify inadequate approaches to excluding dangerous items from psychiatric hospital units and to implement improvements, such as the Epworth's, across the Victorian health system'.

Minimising the availability of dangerous items in mental health inpatient units requires balancing the potential risk these items pose whilst preserving the dignity and autonomy of consumers in an environment that facilitates therapeutic recovery. Health services with mental health inpatient units may take different approaches to achieve this balance, causing variation in policies, procedures and practices across services that are warranted in some circumstances. These differences will include similarities and differences to the changes implemented by Epworth. The recommendation provides an opportunity for the Mental Health Clinical Network to engage with public and private health services with mental health inpatient units about this variation.

The Victorian Office of the Chief Psychiatrist (OCP) has provided Safer Care Victoria with references to guidelines, outlining established practices expected in public mental health inpatient units to mitigate against similar incidents. This guidance, available online, is for public mental health services and includes recommendations for minimising the availability of items of risk in inpatient units. We also note recommendations and actions in the OCP's 'audit of inpatient deaths 2011-2014' and quality and safety bulletins, available online, and their relevance to reducing deaths by suicide of consumers in public mental health inpatient units.

In response to the Coroner's recommendation, the Mental Health Clinical Network will host a webinar during 2019, inviting both public and private health services to share the policies, procedures and practices they use in mental health inpatient units to reduce a) the availability of items of risk, and b) built environment features that could be used in a suicide attempt and suicide death. Participating health services will have an opportunity to share and identify areas of procedural and practice variation in comparison to other services. The webinar will be interactive and available to participating health services via registration. A recorded copy of the webinar will be made available to all health services with mental health inpatient units following the live interactive session.

Should you have any queries, please contact Safer Care Victoria at chiefclinicalofficers@safercare.vic.gov.au.

Yours sincerely

Professor Euan Wallace AM
Chief Executive Officer
Safer Care Victoria
Date: 15/8/2019

VICTORIA State Government