Mercy Health
Care first

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9 September 2021

Josh Munro
Coroners Registrar
Coroners Court of Victoria
65 Kavanagh Street
Southbank, VIC
3006

Dear Mr Munro

Re: **Response to the Coroner's recommendations arising from the investigation into the death of Christopher John Peter Dewhurst**
Court reference: COR 2016 005972

Please find attached the written response addressing the recommendations arising from the Coroner's investigation into the death of Mr Christopher Dewhurst.

Yours sincerely

A/Prof Dean Stevenson
Clinical Services Director
Mercy Mental Health

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Response to Coroners recommendations
Inquest into the death of Christopher John Peter Dewhurst
Court reference: COR 2016 005972

Recommendation 2

With the aim of promoting public health and safety and preventing like deaths, I recommend that Mercy Health review its own policies and procedures related to Leave to specifically reference Family Meetings and require that the patient's leave entitlements be suspended until a review of the patient's risk to taking leave – escorted, unescorted, on grounds, off grounds; by the patient's Consultant Psychiatrist can be made.

1. Mercy Mental Health's response to this recommendation is set out below.

   The Coroners recommendation is under consideration.

   Mercy Mental Health notes the Coroners recommendation 1 is addressed to the Chief Psychiatrist. This recommends that the Chief Psychiatrist review the Guidelines related to leave (Leave of absence from a mental health inpatient unit guidelines) to specifically reference Family Meetings and recommends that the patient's leave entitlements be suspended until a review of the patient's risk to taking leave – escorted, unescorted, on grounds, off grounds; by the patient's Consultant Psychiatrist can be made.

   Mercy Mental Health recognises the challenge in managing patient safety in an environment of least restrictive care as required by the Mental Health Act 2014.

   To support its decision making in response to the Coroner's recommendation Mercy Mental Health will take guidance from the Chief Psychiatrist in the form of the revised guideline relating to taking leave on inpatient units.

   Time frames are dependent on the release of a clinical practice directive or of the revised guideline from the Chief Psychiatrist.

   The group responsible for the consideration of the revision to the procedure is the Mercy Mental Health Safety, Quality and Risk Committee. Associate Professor Stevenson is the contact person for that Committee in relation to this recommendation.

Recommendation 3

With the aim of promoting public safety and encouraging best practice in clinical setting, I recommend that Mercy Mental Health take steps to discourage the practice of completing retrospective documentation particularly in respect of risk assessments by providing training, that is repeated periodically, on the principles that contemporaneous documentation in the health care setting should be an effective means of communication, should act as an *aide memoire* to the clinician of the contemporaneous circumstances and of their importance emphasised as they are a legal document.

1. Mercy Mental Health's response to the Coroners recommendations is set out below.

The Coroners recommendation has been implemented in part and will be implemented in full.

The recommendation was reviewed and part implemented following receipt of the Finding into Death with Inquest.

A) A memo has been forward to staff reminding them of their clinical duties to ensure that clinical notes are completed in a contemporaneous fashion.

B) The Learning and Development Team is developing a training package in the form of a slide pack. This will be known as the Clinical Document Standards and is linked to the Mercy Health procedure addressing document standards known as the Health and Clinical Documentation Procedure. The training package will be available for periodic use by staff. The training package will be implemented by December 2021.

2. Documentation to support Mercy Mental Health's response to the Coroner's recommendation.

A) Memo to clinical staff dated 25 August 2021 (Attached)

B) The Clinical Document Standard training package is in development.