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Deputy Coroner Iain West
Coroners Court of Victoria
Level 1, 436 Lonsdale Street
Melbourne
VICTORIA 3000

Dear Deputy Coroner West

Coroner's investigation into the death of Louise Litis Court Reference 4970/07

Pursuant to Section 75 of the Coroner's Act 2008, this letter outlines Healthscope's response to the Deputy Coroners' recommendations with regard to the above matter.

Deputy Coroner's recommendation 1

> *Rooms in the Mother Baby Unit at Northpark Hospital that are to be occupied by patients with high or intensive levels of suicidality, be fitted with a nurse call button apparatus that is incapable of being used as a ligature. Potential hanging points within the rooms need to be identified and removed.*

Response

The recommendation was implemented progressively from 2007 to December 2009, which was prior to receipt of the Deputy Coroner's finding.

The intervention comprised three parts:

1. The revision of the Patient Risk Assessment and Observations Policy and Procedure,
2. The identification of potential hanging points and,
3. The removal, where practicable, of potential hanging points and potential ligatures

Revision of Patient Risk Assessment Policy and Procedure

The Healthscope Ltd Patient Risk Assessment and Observations Policy and Procedure was revised, reissued and implemented across all Healthscope mental health facilities.

Revisions included the expansion of the number of points along the patient's continuum of care when risk is assessed and management of the risk is documented. A copy of the policy will be provided to the Deputy Corner should he wish to see it.

In addition to the policy and procedure, a standardised risk assessment form (called the Mental Health Clinical Risk Assessment and Level of Observation) has been produced and implemented. A copy of the form will be provided to the Deputy Coroner should he wish to see it. Comprehension and observance of the Policy and completion of the Risk Assessment is now a component of mandatory training for clinical staff via an e-learning package.

Adherence to policy is assessed through Quality audits at both a local and national level.

Identification of Potential Hanging Points

Healthscope conducts annual environmental risk audits using the Patient Environmental Risk Tool (PERT) During these audits, potential ligatures and ligature points are identified. Reference is made to the Australasian Health Facility Guidelines, and particularly Part B, Health Facility Briefing and Planning documents referring to the Adult Mental Health Acute Inpatient Units and the Child and Adolescent Mental Health Units.

Several items were identified that could present a potential ligature point, including shower apparatus, hand rails, exposed plumbing, curtain rails and tracks.

Removal of Potential Hanging Points and Ligatures

A new nurse call system has been installed in the Mother and Baby Unit at Northpark. All handset cables have been shortened to 40cm.

Shower apparatus has been replaced in the unit with anti-ligature design.

A magnetic suspension system for shower curtains and room curtains has been installed in all rooms in the unit. The Kestrel load-release suspension system has been specifically designed for environments where persons are at the greatest risk of self-harm, such as mental health and detention facilities. According to the Kestrel product brochure (a copy of the brochure will be provided should the Deputy Coroner wish to see it), no part of the system is able to withstand a vertically downward force of more than 400 Newtons, equivalent to a static load of approximately 40kgs. Most readings will be in the region of 15-30kg, depending on configuration and proximity of brackets.

Exposed plumbing under basins has been enclosed in a locked cupboard. The elimination of doors and door hinges is not practical, so staff training is provided to check closed doors and recognise potential ligatures trapped in the doorframe or around the hinges.

Deputy Coroner's Recommendation 2

Protocols be established to ensure that family members, willing to be involved in the psychiatric care of their loved one, are engaged at the outset and be given the opportunity to contribute to ongoing management options.

Response

The recommendation was implemented in December 2009, which was prior to receipt of the Coroner's finding.

The intervention included the revision of Healthscope Ltd's Care Planning and Evaluation Policy and Procedure and the development of the Approved Carer Form that is now included in the admission paperwork. A copy of the policy and form will be provided on request should the Deputy Coroner want to see them.

Healthscope encourages patients and provides opportunities for the patient to involve family and carers in their care planning. The Care Planning and Evaluation Policy states that patients and nominated carers are to be involved in each stage of the care planning process.

Using the Approved Carer Form, the patient nominates a particular person or persons to be included in discussions about their treatment plan and progress, and to contribute to the patient's ongoing management options. This form is completed at admission so that the family and carers are engaged as early as possible in the episode of treatment and care.

Deputy Coroner's Recommendation 3

That protocols be established to ensure detailed and accurate notes are maintained of a psychiatric assessment, diagnosis and management plan.

Response

Policies and procedures were revised to ensure that comprehensive and accurate notes are maintained of psychiatric assessment, diagnosis and management.

The Risk Assessment and Observations-Patient policy and the Care Planning and Evaluation policy were in place and were revised in December 2009, which was prior to receipt of the Coroner's finding. The Healthscope Ltd policy, Admission of a Patient-Mental Health was in place prior to the recommendations and was due for routine review in December 2010 after the coroners recommendations

These policies comprehensively address all aspects of psychiatric assessment, diagnosis and management. A copy of each of these policies will be provided should the Deputy Coroner want to see them.

The Deputy Coroner's recommendations have been tabled and discussed at the Medical Advisory Committee meeting at the hospital.

We trust that each of these interventions addresses the recommendations made by the Deputy Coroner. Please contact the undersigned if further information is required.

Yours sincerely

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