



## Department of Health

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Our ref: RD 2020/00846  
Your ref: COR 2020 002716

Coroner Gebert  
Coroners Court of Victoria  
65 Kavanagh Street  
SOUTHBANK VIC 3006

Dear Coroner Gebert,

### **Investigation into the death of Allison Leah Randall**

We refer to your Finding into the death of Ms. Randall, dated 26 April 2024.

Please see below the responses addressing the recommendations made to the Office of the Chief Psychiatrist (OCP). We note our response to the Coronial recommendations is outstanding and apologise for the delay.

#### Recommendation 1

*"The Chief Psychiatrist consider the following with a view to promote consistency and sharing across Victorian mental health services, namely, the development of research ligature audit tools appropriate for Victorian public mental health services and to identify or develop a standard ligature audit tool for consistent use across all Victorian public mental health services."*

Response:

Following several roundtable events in 2023, which the coroner attended, the Chief Mental Health Nurse, Anna Love, has led the formation of an expert working group via Safer Care Victoria. This group includes mental health leaders and colleagues with lived experience, and it currently meets on a weekly basis. Its purpose is to produce a comprehensive guidance document for the public Area Mental Health and Wellbeing Services in Victoria. The document will focus on establishing training principles that ensure consistent content delivery for training consumers, the workforce, and enhancing organisational and clinical governance. The Coroners Court of Victoria will be engaged as a key stakeholder during the drafting phase.

Status: Accepted in Full

## Recommendation 2

*“Further, that state-wide implementation of such a tool should be accompanied by appropriate guidelines and training for staff in the effective use of the audit tool.”*

Response: In alignment with the implementation of statewide training principles outlined above, phase two of this initiative will focus on the implementation of a standardised ligature assessment tool across Victoria. This phase will be executed in close collaboration between Safer Care Victoria, the Office of the Chief Psychiatrist, with sign-off from the coroner’s office, WorkSafe, and our Industrial Relations colleagues to ensure comprehensive compliance and effectiveness.

Status: Accepted in Full

## Recommendation 3

*“Assess whether the Chief Psychiatrist’s guideline - Criteria for searches to maintain safety in an inpatient unit - should be revised to include reference to a long-handled bag as an example of a dangerous item, or its implications should otherwise be the subject of communication with the sector.”*

Response:

We support in full the proposal to revise the Chief Psychiatrist’s guideline for conducting searches in an inpatient unit to include a reference to long-handled bags as an example of dangerous items. I can confirm that this update will be addressed imminently.

Status: Accepted in Full

## Recommendation 4

*“The development of best practice information around what is considered appropriate ensuite door design in patient’s rooms, noting in this case that a WorkSafe Improvement notice was issued despite the facility’s best endeavours to minimise a known risk.”*

Response:

The Office of the Chief Psychiatrist remains committed to our partnership with the Victorian Health Infrastructure Building Authority (VHIBA) to ensure that best practice standards for patient ensuite door design are developed and maintained. VHIBA guarantees that all new and refurbished units meet the current best practice standards for ensuite doors and related fixtures. We recognise that, due to current capital works budget limitations, immediate replacement or modification of all existing ensuite doors across public mental health facilities may not be feasible. In the interim, we will update the sector about these risks via the OCP’s Quality and Safety Bulletin.

Status: Accepted in Full

We trust that the responses detailed above address the listed recommendations regarding the tragic death of Allison Leah Randall.

Should you need further clarification or additional information, please do not hesitate to contact my office.

Yours sincerely



**Associate Professor Dr Sophie Adams**

Chief Psychiatrist of Victoria

Mental Health and Wellbeing Division

29/05/ 2025