Paul STRANGE

Paul Strange, aged 30, died on 9 December 2016. The cause of death was determined to be suicide, after he hanged himself less than a fortnight after being discharged from a mental health unit. Paul had chronic major depression with anxiety and episodic interactions with mental health services.

The Coroner reviewed the care provided in hospital, in particular the lack of a documented safety plan, the absence of further risk assessment after an attempt at self-harm whilst on the ward, the absence of documentation around Paul's alleged requests not to involve his family in his care, the inadequacy of discharge planning and failure to arrange follow-up. The Coroner concluded that when viewed globally, that Paul's care at the hospital was suboptimal.

It was noted that the death had initially been notified under the Clinical Incident Management Policy, but the incident was inactivated after case review and no formal investigation had been carried out by the Health Service Provider (HSP).

The Coroner made six recommendations, five were directed to the HSP (East Metropolitan Health Service) and one to the Office of the Chief Psychiatrist. The recommendations focused on the discharge planning procedures and suggested amendments to relevant mental health policies to include requirements to ensure the discharge planning process includes information about follow up appointments, contact details for support services and process for re-entry to health services if needed. The recommendations also included developing strategies to ensure staff were familiar with the relevant policies and examine the feasibility of establishing a post discharge follow-up team.

The CRC reviewed these findings and made enquiries with the relevant stakeholders.

August 2020 Update

The East Metropolitan Health Service (EMHS) has reviewed the findings and recommendations. They have established an EMHS Care Coordination Working Group to revise the current Care Coordination in Mental Health Policy to address a number of the recommendations. EMHS have also undertaken significant work with discharge summary compliance. With respect to ensuring staff are familiar with the key policies, the EMHS Mental Health Quality Improvement Program will establish and review policy awareness processes at orientation as well as an ongoing nature.

February 2021 Update

The EMHS review of the findings and recommendations continued. The Care Coordination Policy has been revised and endorsed with implementation of the changes associated with the policy a priority. Work towards the use of a card showing the date and time of all the appointments for services they have been referred remains in progress. Similarly, the EMHS Discharge Communication Policy has undergone significant revision with policy implementation currently underway. In seeking to align the discharge template with the mental health Care Transfer Summary a proposal has been submitted to the statewide Notifications and Clinical Summaries (NaCS) Business User Group (BUG). In supporting post discharge follow up an Assertive

Recovery Team model is being piloted as an enhancement to existing Assessment and Treatment Teams to provide more assertive community follow up and intensive wrap around support for patients, in partnership with non-government organisations and peer support workforce. During the CRCs discussion the other HSP members agreed to consider the recommendations and subsequent actions outlined by the EMHS for applicability to their own services. Subsequently Progress Report for Health-Related Coronial Recommendations - February 2022 they have provided assurances of the existence of relevant policies and practices that are currently implemented and/or actioned system improvements including amendments to relevant care coordination and discharge policies within their services as required.

August 2021 Update

EMHS presented the proposal on aligning the NaCS Discharge Summary with the mental health Care Transfer Summary requirements to the NaCS BUG in February 2021 at which time the request was approved. Given the current competing priorities of Health Support Services (HSS), whom are responsible for completion of action items identified from the NaCS BUG, this work has yet to be commenced. EMHS remains committed to this recommendation and is working in collaboration with HSS and the NaCS BUG to ensure that the importance of the changes are understood and the work appropriately prioritised, in the interest of patient safety.

February 2022 Update

Advice was sought from HSS who advised the NaCS BUG have agreed on a prioritisation rating of High and 8 items have been added to the Enhancements and Defects Priority list to align the NaCS Discharge Summary with the mental health Care Transfer Summary. Two items have been scoped and deployed to production for March 2022. The remaining 6 items have not been assigned a release date. As the changes required to NaCS are extensive and part of a large scale information and communication technology project, CRC members agreed that recommendation 3 has been considered and deemed closed and acknowledged whilst the changes to NaCS have not been implemented to completion they are considered long term commitments of the WA health system.