ALMA STREET CENTRE

The Alma Street Centre coronial inquest included the review of the deaths of five former patients: Ruby Natasha Nicholls-Diver; Carly Jean Elliot; Michael Ronald Thomas; Anthony Ian Edwards; and Stephen Colin Robson. All five deaths were by manner of suicide following mental health care provision at Fremantle Alma Street Centre.

The Department of Health's Coronial Review Committee reviewed these findings and members considered that there were already a number of existing plans in place where the carer is able to review and acknowledge the management plan. Health services were advised of the inquest findings and recommendations and requested that they be considered in local mental health service delivery and further implementation of the carer-centred *Mental Health Act 2014* requirements.

To date, 81 of the 127 recommendations from the Stokes Review have been completed. A suite of 21 outcome focussed performance indicators covering 18 key recommendations for compliance measurement, monitoring and measurement has been identified. Once approved by the State Health Executive Forum, it is anticipated that the performance indicators will be measured and reported on an annual basis in line with annual clinical documentation audits and annual consumer surveys. The Chief Psychiatrist will undertake a review a range of Stokes Review recommendations through a biennial monitoring program encompassing both qualitative and quantitative information. Ad hoc targeted reviews will also be undertaken.

Of the two recommendations made by the coroner, both have been duly considered and are now deemed closed.