Albury Wodonga Health

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2 December 2024 AWH Ref: OUT24-0346

The Hon. Michael Daley, MP
Attorney General
52 Martin Place
SYDNEY, 2000
Australia

By Email: office@daley.minister.nsw.gov.au

Dear Attorney General,

Re: Coronial Inquest into the death of Mr Roger Schnelle

I write to you on behalf of Albury Wodonga Health (**AWH**) in respect of the above matter and the findings and recommendations made on 16 May 2024 by Deputy State Coroner Erin Kennedy.

AWH again offers its sincere condolences to Mr Schnelle's family and friends.

AWH is committed to continuous improvement in public safety and the administration of our policies, and we thank Deputy State Coroner Kennedy for the considered recommendations. I set out below AWH's further response to the recommendations.

The Deputy State Coroner made four recommendations to AWH which are supported.

Recommendations:

1. To the Chief Executive Officer of AWH:

   *That consideration be given to continuing to advocate with NSW Health and the Department of Health, Victoria, for the implementation of an electronic medical record (**EMR**) across AWH mental health services. Such a record should ideally be compatible with systems in both NSW and Victoria, and should include standardised documents for the assessment, formulation and management of risk and patient observations.*

   AWH's response:

   AWH is aware of the urgent need for an EMR system within our regional hospitals and has been working through multiple channels to position itself for the most sensible and cost-effective solution. The findings and recommendations of this coronial inquest confirm the concerns and urgency in this regard.

AWH has recently written to the Deputy Secretaries of Victoria and NSW seeking support for the funding and implementation of a dedicated and fit for purpose EMR at AWH.

The planning for and implementation of an EMR at AWH's regional hospitals will obviously be a considerable task. AWH is dedicated to advocating for the funding and implementation of same in order to improve patient safety.

The Coroner's recommendation is an ongoing advocacy project that AWH continues to progress and support.

2. To the Chief Executive Officer of AWH:

That consideration be given to a review being undertaken of the AWH mental health service policy relevant to risk assessment, patient observation and documentation to ensure compatibility with both NSW and Victorian policies. Where those policies are not compatible, draw this to the attention of NSW Health and the Department of Health, Victoria, in accordance with the process described in the AWH Memorandum of Understanding.

AWH's response:
During and following the inquest into Mr Schnelle's death, AWH reviewed its policy, procedures and clinical tools relevant to risk assessment, patient observation and documentation and the relevant NSW and Victorian policies. The initial review identified a lack of clarity regarding authority to reclassify a person's mental health risk level which was rectified, subsequent reviews did not identify any inconsistent settings across the policies. In addition to this review, AWH has undertaken actions to support risk assessment, multidisciplinary team management and communication of risk status across the care team:

- Ongoing review and refinement of risk assessment and management processes for people admitted to an inpatient unit (mental health unit or general ward).

- Installation of a large computer screen in the 'handover' room of Nolan House (AWH's inpatient mental health unit). This supports real time documentation and communication of persons' risk level at each clinical handover/multidisciplinary team review. This drives clinical response including observation requirements and care setting allocation of the multidisciplinary team review.

- Improved auditing of clinical documentation to ensure routine recording of a person's risk level and mental state examination is adequately completed.

- Community mental health teams now attend inpatient unit multidisciplinary team meetings and provide collateral information regarding baseline presentation to inform risk assessment and management.

- People who present with or develop suicidal behaviours/risk factors during an admission complete a suicide prevention plan, which encourages open discussion between staff and patient including family/carer perspectives.

- Any discrepancies between nursing, medical, and/or allied health risk ratings are openly discussed at daily multidisciplinary team meetings.

The Coroner's recommendation has been implemented.

3. To the Chief Executive Officer of AWH:

   That consideration be given to implementing Risk Assessment Tools that focus on assessment, formulation, and importantly management of risk and consider risk indicator factors that are associated with an increased suicide or suicidal behaviour, as set out in the expert evidence of Dr Eagle.

   AWH's response:

   Across 2021 and 2022, AWH Mental Health Service developed and adopted clinical governance tools that ensure the mental health risk assessment process is conducted in the manner advocated by Dr Eagle. Additionally, AWH has implemented a multidisciplinary team approach to inform risk-management approaches, as set out in our responses to recommendation 2 above.

   AWH routinely reviews its approach to risk indicator identification, assessment, management, multidisciplinary response and documentation. AWH has partnered with Safer Care Victoria in the *Adopting the Zero Suicide Framework*[1] project, which aims to support health care services to successfully implement the Zero Suicide Framework, therefore improving the pathway of care and reducing incidences of suicidality and self-harm through evidence based clinical care practices.

   To date, AWH has reviewed and modified safety care plans in conjunction with consumers to provide a plan that has meaning to them. Another review of our risk assessment tools has commenced as part of this work, and we are continuously testing and evaluating additions around risk formulation and risk mitigation/protective factors.

   The Coroner's recommendation has been implemented, with the ongoing continuous improvement project that continues to be supported and progressed by AWH.

4. To the Chief Executive Officer of AWH:

   That consideration be given to ensuring that the induction processes for locum and visiting staff members clearly identify relevant policy and practices in relation to the assessment, formulation and management of risk documentation and patient observations.

   AWH's response:

   AWH has undergone a process of reviewing the orientation program for medical staff to ensure key safety and quality roles and responsibilities are communicated. Orientation documents for medical staff are in place.

   An orientation handbook has been developed which provides new medical staff with information relating to the mental health service structure, key mental health and clinical quality and safety personnel, escalation of care processes and key policies, procedures and

[1] https://www.safercare.vic.gov.au/sites/default/files/2023-07/zsf_webinar_faq_sent_out_to_attendees.pdf

practice guidelines, including risk management and patient observation approaches and attendance at multi-disciplinary team meetings.

This handbook is provided to new medical staff prior to their commencement, via the Medical Workforce Unit in addition to an email from the Medical Director upon commencement, identifying this role as a point of escalation, guidance and assistance.

The Coroner's recommendation has been implemented.

Yours sincerely,

Bill Appleby
Chief Executive Officer
Albury Wodonga Health

cc. Dr James Mackie, Chair of Board Patient Safety, Quality and Service Review Committee