The Hon Ryan Park MP
Minister for Health
Minister for Regional Health
Minister for the Illawarra and the South Coast

NSW GOVERNMENT

Your Ref: 2020/21513
Our Ref: COR23/10

The Hon. Michael Daley, MP
Attorney General
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Coronial inquest into the death of Mr Benjamin Woodhouse

Dear Attorney General Michael.

I write in relation to the findings and recommendations made on 26 May 2023 by Deputy State Coroner David O'Neil regarding the death of Mr Benjamin Woodhouse.

Mr Woodhouse was a 59-year-old male who died on 21 January 2020 in the Parramatta River, Gladesville. The cause of death was drowning, and the manner was ruled as a misadventure.

Mr Woodhouse was on day leave from Macquarie Hospital at the time, where he was an involuntary patient. Mr Woodhouse exited a moving car driven by his carer, who was then unable to locate him. Mr Woodhouse was found approximately five hours later deceased in the Parramatta River.

The Deputy State Coroner made 8 recommendations in total and directed 2 recommendations to Northern Sydney LHD.

The NSW Health response advises Northern Sydney LHD does not support the recommendations and has implemented alternate strategies to meet the intent of the recommendations. Further, the NSW Health response advises state-level actions are also being implemented.

Recommendation 1

The Deputy State Coroner recommended:

That the LHD amend its leave form to be provided to the patient, family, and any third-party carer to record the conditions of leave which must be complied with.

Where it is proposed to send an involuntary patient on leave the LHD provide a written summary to both support coordinators and care providers of a patient's history, diagnosis, trigger points, risk, behaviour management techniques and what to do in an emergency, for example, if the patient absconds.

The Northern Sydney LHD Mental Health Drug and Alcohol (MHDA) service has a number of locally developed leave forms that are provided to consumers, family and/or third-party carers. The forms have information related to conditions of leave and are fit-for-purpose for consumers, family and/or third-party carers.

Further, the MHDA service notes significant strengthening of mental health consumer leave processes and third-party carer handovers processes. There have been several locally developed forms created. These forms allow any leave conditions to be noted and discussed with the patient and/or carer prior to the leave being taken.

Audits are being undertaken of compliance with leave forms to confirm leave arrangements for consumers have been documented using the correct mental health leave form. The January 2023 audit confirmed that Macquarie Hospital was 86% compliant and further auditing will be undertaken.

The Mental Health Design Working Group (MHDWG) includes representatives from the Ministry of Health Mental Health Branch, System Information and Analytics Branch, eHealth NSW, local health districts, and consumers. The MHDWG has approved the design of a new state-wide Mental Health leave plan.

Recommendation 2

The Deputy State Coroner recommended:

Where it is proposed to send an involuntary patient on leave the LHD provide a written summary to both support coordinators and care providers of a patient's history, diagnosis, trigger points, risk, behaviour management techniques and what to do in an emergency, e.g., if the patient absconds.

The Northern Sydney MHDA service notes relevant mental health consumer information is in the NDIS application, that enables an agency to assess a consumer's suitability and the agency's ability to support the consumer. The third-party carer is then verbally advised of any relevant contemporary information about the mental health consumer at the time of leave.

The MHDA service has determined that verbal advice is most appropriate, as it ensures clear two-way communication at handover between the MHDA clinician and carer. This is clearly documented in *PR2008_041, Leave from Inpatient Units by Consumers (MHDA).*

Information pertaining to the patient is provided by Northern Sydney MHDA to the support agency at the time of application for their NDIS service provision for these services to assess the consumers' suitability and their ability to support them, including a risk assessment and training/advice on risk/behaviour management/escalation points and relevant emergency phone numbers. It is the Northern Sydney MHDA's responsibility to notify the support agency/support agency worker if and when there has been any change in a consumer's clinical presentation.

Additionally, the Northern Sydney MHDA has implemented a leave brochure, which was widely consulted on and contains relevant escalation information and contact details.

State-level actions

The Mental Health Alcohol and Other Drugs Serious Incident Review Subcommittee has identified important elements to be included when providing written leave information to patients, families and third parties.

A safety notice is being prepared by the Clinical Excellence Commission Patient Safety Directorate to be disseminated to all NSW Public Mental Health Services.

In addition, the identified elements have been communicated to the Mental Health Branch for consideration in its review of the NSW Health Policy: Discharge Planning and Transfer of Care for Consumers of NSW Mental Health Services (PD2019_045), scheduled to be undertaken in 2024.

I trust that this response confirms NSW Health's commitment to a process of continuous improvement and delivering safe and high-quality care to all patients of the NSW health system.

For more information, please contact Joanne Edwards, Executive Director, System Management Branch, NSW Ministry of Health at moh-systemmanagementbranch@health.nsw.gov.au.

Yours sincerely

Ryan Park MP
Minister for Health
Minister for Regional Health
Minister for the Illawarra and the South Coast

CC: NSW Coroner's Court

Encl. Coroner's report – *Inquest into the death of Benjamin Woodhouse*