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

NSW GOVERNMENT

Your Ref: 2019/60363
Our Ref: COR23/21

The Hon. Michael Daley, MP
Attorney General
52 Martin Place
SYDNEY NSW 2000
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Coronial inquest into the death of Matthew Grieve

Dear Attorney General Michael

I write in relation to the findings and recommendations made on 15 August 2023 by Deputy State Coroner David O'Neil regarding the death of Matthew Grieve.

Mr Grieve died on 14 October 2019 at 27 years of age at Wellington Correctional Centre, NSW. His death was intentionally self-inflicted while in lawful custody.

Magistrate O'Neil made 2 recommendations to Justice Health NSW, which are both supported.

First recommendation

The Deputy State Coroner recommended:

That Justice Health NSW (JHNSW) consider updating its policy/procedure to require review of a patient's Health Problem Notification Form (HPNF) specifically as it relates to recommendations which may guide Corrective Services NSW (CSNSW) cell placement decisions, when the patient stops taking prescribed mental health medication for a clinically significant period.

JHNSW notes that review and update of the patient's Health Problem Notification Form (HPNF) policy in relation to cell placement recommendations is essential as it provides guidance to CSNSW, and further enhances a culture of shared accountability and collaboration between JHNSW and CSNSW in delivering integrated care services.

JHNSW and CSNSW formed a HPNF/Cell Placement working party. The working party's program of work included cell placement decisions when a patient stops taking prescribed mental health medication for a clinically significant period. The working party developed an electronic HPNF (e-HPNF) that outlines the patient's health problem and cell placement recommendations, with sign off by a JHNSW clinician and the receiving Custodial Officer.

The e-HPNF has been provided to the JHNSW electronic Health system vendor who will finalise the e-form build before progressing to user testing in early 2024. The JHNSW and CSNSW Online Training Module, and Policy 1.231 *Health Problem Notification Form* and 6.051 *Psychotropic Medication Prescribing Guidelines* will be updated accordingly.

Second recommendation

The Deputy State Coroner recommended:

That Justice Health NSW consider the implementation of audit processes for HPNFs so as to ensure that they are appropriately completed and current.

JHNSW notes that evaluation of the HPNF process supports accurate, safe, high quality, reliable health advice is provided to CSNSW.

JHNSW will develop an audit to ensure e-HPNFs are completed appropriately and reflect current clinical concerns, recommended health advice and appropriate receipt from CSNSW. The audit process will be included in JHNSW Clinical Audit Schedule and reported through JHNSW governance structures. Further, Policy 1.231 *Health Problem Notification Form* will be updated to highlight completion of e-HPNF audits to inform quality improvement activity.

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 Matthew Grieve*