2021

THE LEGISLATIVE ASSEMBLY FOR THE

AUSTRALIAN CAPITAL TERRITORY

GOVERNMENT RESPONSE TO CORONER'S REPORT - INQUIRY INTO THE DEATH OF ANTHONY LEIGH BEARHAM, NICOLA JOY FISHER AND OTHERS

Presented by
Ms Emma Davidson MLA
Minister for Mental Health
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I table for the information of Members, the Coroner's findings into the death of Mr Bearham, Ms Fisher and Others and the ACT Government's Response to the Coroner's findings and recommendations submitted to me under *section 57(3) of the Coroners Act 1997*. I ask the Assembly to note that the Coroner's report has been redacted to remove the names of two individuals as requested by their families.

I would like to thank Coroner Hunter for her extensive and comprehensive report. She made seven recommendations in relation to matters of public safety, and the Government agrees to all these recommendations.

I want to be very clear that the Government and Canberra Health Services are dedicated to implementing Coroner Hunter's recommendations. Canberra Health Services is dedicated to the safety of patients and staff and recognise that Mental Health is a specialty area that requires additional training.

The actions that have been taken to date were to simplify and clarify the process of Police having access to Canberra Health Services staff who are potential witnesses where a death occurs and education of staff to engage with and assist Police.

Several of the Coroner's recommendations were to improve the safety of patients and staff concerning searching and monitoring of patients, not only those under the care of Mental Health services but across other clinical areas, several activities have commenced.

A working group has been established to inform and update a Canberra Health Services wide procedure that will complement the Searching of a Consumer's Person or Property policy. This procedure will be provided to staff as part of their training and orientation. As a procedure, searching must be balanced with Human Rights legislation regarding patient privacy. Canberra Health

Services adheres to this legislation, while also placing a high importance on staff understanding when it is appropriate to undergo a search, for patient and staff safety. Consumers may have cultural practices or previous experiences that will require sensitivity and consideration in relation to searching of their person or property.

The Coroner also recommended there be a review of the use of CCTV in general areas; this has commenced. This review process will include consultation with key stakeholders including the community. The review is due for completion in February 2022. Also, within the Acute Mental Health Unit, it is planned by 30 November 2021 a Registrar scholarship program project will have investigated the efficacy of Pulse Oximetry monitoring.

To address the Coroner's recommendations concerning staff knowledge and adherence to the Clinical Risk Assessment and Ligature Risk Management, Operational Procedures were reviewed and amended after the incidents in 2015 and 2016. They are currently undergoing another review as part of a broader Mental Health services evaluation to ensure these procedures are strengthened and embedded across Canberra Health Services.

This broader evaluation includes a combined inpatient operational manual to cover all Mental Health units. This combined operational manual is currently undergoing the Canberra Health Services policy review process and will be in use by 30 October 2021.

I again thank Coroner Hunter for her findings in this matter. I would also like to express my sympathies to the family and friends of Mr Bearham, Ms Fisher and Others. I know how difficult the unexpected loss of a loved one is and having to go through a Coronial Inquest can make it all the more difficult. My thoughts are with their family and friends.