Recommendation Response from Department of Health Biannual Report – February 2018

Radinka MIHAJLOVIC

Radinka Mihajlovic, aged 47 years, died on 1 May 2012 from multiple injuries. Ms Mihajlovic had been diagnosed with bipolar affective disorder and post-traumatic stress disorder and her care was managed through both the public and private mental health sectors. Due to Ms Mihajlovic's perceived association between her medication and somatic symptoms, she was non-compliant with oral medication and was subject to a community treatment order at the time of her death.

The Department of Health's Coronial Review Committee has reviewed these findings and made enquiries with relevant stakeholders across the WA health system. The Committee considered that introducing a community liaison person (coordinator) would risk creating another silo and further compromise patient care.

Health Service Providers reported a number of existing mechanisms in place to facilitate continuity of care for mental health patients transferring or transitioning between mental health inpatient services into the community, including policies and procedures for assigned case managers and care coordinators, and follow-up with patients.

The Coronial Review Committee acknowledges the proclamation of the *Health Services (Information) Regulations* on 28 November 2017.

The Mental Health Commission provided advice to the Department of Health in relation to this matter. It made reference to the legislative changes around confidentiality and information sharing with the enactment of the *Mental Health Act 2014*, which came into effect after the death of Ms Mihajlovic. Further, the need for improved integration, system navigation and continuity of care was addressed in *WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives*, with Action 80 referring to the development of communication and information flow protocols. The Mental Health Commission has developed the *Information Sharing: Clinicians' Powers and Responsibilities* fact sheet to guide clinicians in the acceptable conditions for sharing patient information.

Of the three recommendations made by the coroner, all have been duly considered and deemed closed.