

Reportable deaths

Chief Psychiatrist's Guideline

Key message

This guideline is designed for psychiatric services and defines what is meant by a 'reportable death'. It also outlines procedures for reporting such deaths to the Chief Psychiatrist.

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Purpose

The Chief Psychiatrist is responsible for the medical care and welfare of those receiving treatment or care for a mental disorder in Victoria. The *Mental Health Act 1986* establishes a requirement for psychiatric services to forward notification of reportable deaths within the meaning of the *Coroners Act 2008* to the Chief Psychiatrist.

Monitoring and reviewing information relating to the occurrence and circumstances of reportable deaths is one of the mechanisms by which the Chief Psychiatrist ensures that appropriate standards of treatment and care are being provided.

Relevant legislation

Legislation governing the notification of a reportable death is detailed in the Mental Health Act (the Act) and the Coroners Act. Relevant sections of these Acts are located at Appendix 2 of this guideline.

Which health services must report to the Chief Psychiatrist?

Section 106A of the Mental Health Act requires that the death of any person receiving treatment or care for a mental disorder from a 'psychiatric service' that is a 'reportable death' within the meaning of the Coroners Act, is to be reported to the Chief Psychiatrist. In public mental health services the authorised psychiatrist or delegate is responsible for reporting these deaths to the Chief Psychiatrist. In private hospitals, this responsibility lies with the chief executive or delegate.

A 'psychiatric service' is defined in section 106(1) of the Mental Health Act as an organisation that provides one or more of the following services:

- an approved mental health service is any premises or service at which treatment is to be provided to patients and which has been proclaimed by the Governor in Council to be an approved mental health service under section 94 of the Act (the Secretary may also make an emergency declaration under section 94A of the Act that any premises or any service at which treatment is to be provided is an approved mental health service)
- a child and adolescent psychiatry service
- a premises licensed under section 75 of the Act (these are premises licensed to perform electroconvulsive therapy and include both public and private facilities)

- a hospital admitting or caring for people with a mental disorder (this includes public, denominational and private hospitals admitting or caring for people with a mental disorder, whether the person has been admitted to a psychiatric unit or another part of the hospital, for example, an emergency department or a medical/surgical unit managing a person with a mental disorder)
- any mental health service of a community health centre
- a psychiatric outpatient clinic
- a community mental health service, or
- an agency providing community support services (community support services are defined in section 98 of the Act, which includes psychiatric disability support services (PDRSS)).

Most public and private psychiatric services are therefore covered by section 106 of the Act.

Which deaths need to be reported to the Chief Psychiatrist?

Section 106A of the Act requires that the death of any person receiving treatment or care for a mental disorder from a 'psychiatric service' that is a 'reportable death' within the meaning of the *Coroners Act 2008*, is to be reported to the Chief Psychiatrist. The deaths of the following people are reportable.

1. Inpatient

The Chief Psychiatrist requires all inpatient deaths (regardless of legal status, cause and where the death occurs) of persons receiving treatment as an inpatient of either an approved mental health service or a private mental health service be reported so as to understand the level of morbidity related to inpatient treatment and care within Victoria.

2. Persons who are patients under the Mental Health Act

The deaths (from any cause) of all involuntary, security and forensic patients under the Mental Health Act must be reported to the Chief Psychiatrist.

Involuntary patients, security patients and forensic patients are defined in section 3 of the Mental Health Act.

Involuntary patients include those subject to an involuntary treatment order (ITO) under section 12 of the Mental Health Act or a restricted involuntary treatment order (RITO) under section 93 of the *Sentencing Act 1991* or a hospital transfer order under section 16(3)(a) of the Mental Health Act; individuals who are subject to a community treatment order (CTO) under section 14; a restricted community treatment order (RCTO) under section 15A; and those on a leave of absence. It also includes those subject to orders under sections 90, 91 and 93 of the *Sentencing Act*.

Security patients include those detained pursuant to section 93A of the *Sentencing Act* or section 16(3)(b) of the Mental Health Act.

Forensic patients include those subject to a custodial supervision order under section 26 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*.

3. Persons on non-custodial supervision orders

The death (from any cause) of persons in the community on a non-custodial supervision order (NCSO) under the *Crimes (Mental Impairment and Unfitness to be Tried) Act* must also be reported to the Chief Psychiatrist.

4. Other persons in care

The requirement to report all unexpected, unnatural or violent deaths (including suspected suicides) is considered by the Chief Psychiatrist to extend from unregistered clients in the process of assessment to those registered as a current client of a psychiatric service. It also includes those who were previously registered clients and who have been in contact with psychiatric services within six months of their death, where the service is aware of the death.

As well, individuals are deemed to be clients of a mental health service until their case is formally closed and the individual is formally notified of this closure. In those cases where it is not possible for a service to inform an individual of the closure of their case, the service can be considered to have done so once all reasonable attempts to contact the client has occurred.

Any death may be unexpected. For the purposes of the Chief Psychiatrist, an 'unexpected' death includes any death that was not expected at the time by the treating doctor and includes accidental deaths and deaths related to medication.

Which deaths need to be reported to the coroner?

In addition to the reporting of a death to the Chief Psychiatrist, the health service may also be required to report the death to the coroner. If the health service remains unsure whether a death is a 'reportable death' within the meaning of the Coroners Act, they should contact the Coroners Court to make enquiries regarding the definition of a reportable death.

Who else can report a death to the coroner?

The immediate family of a deceased person may also report a death to the coroner, if the person was discharged from an approved mental health service within three months immediately before the person's death. 'Discharged from an approved mental health service' has been interpreted broadly to cover both inpatients and those receiving services in the community.

Contacts

Coroners Court of Victoria
Phone 1300 309 519 (24 hours)

Office of the Chief Psychiatrist
Phone 03 9096 7571 / 1300 767 299 (business hours)

Out-of-hours contact with the Chief Psychiatrist can be made through each health service's appointed authorised psychiatrist, chief executive officer or delegate.

Procedures to be followed in the event of a reportable death

Inpatient deaths

- The body should be disturbed as little as possible.
- Promptly inform relevant parties (authorised psychiatrist, next of kin/carers) of the death.
- Contact should be made with the Coroners Court of Victoria. If the death is a reportable death to the coroner, the coroner's assistant will contact and inform the local police who will attend. The coroner's assistant will require details of the deceased, the circumstances of death and whether a death certificate can be completed. They are responsible, with the police or funeral director, for coordinating the removal of the body.
- Notify the Chief Psychiatrist as all inpatient deaths are reportable to the Chief Psychiatrist.

All deaths

Clinical records

- If the death is also reportable to the coroner, the clinical record should be copied, then the original and any other materials requested forwarded to the coroner. If there is a requirement for further entries to be made in the clinical record, for instance following contact with the family, this should be placed in a temporary file for later incorporation into the original record. Under no circumstances should retrospective entries be inserted into the clinical record, or material removed from the record. It may be useful for health services to discuss the requirements with the coroner's assistant so they can plan for the time it will take for the clinical record to be copied.

Carer and staff support

- Clinical staff involved with the deceased should provide appropriate support and referral to specialist services for people who may have been affected by the death, such as family, friends or others who may have witnessed the death.
- Consideration should be given to a range of factors including but not limited to ethnicity, culture and religion.
- The Coroners Court of Victoria is available for contact by family members to offer support during the process of the coronial review. Health services can provide the contact details in this guideline to family and carers.

Review

- Where the death appears to have resulted from an unnatural, unexpected or violent incident (including suicide), or where there are concerns about clinical practices or procedures, the health service should conduct a review of the person's treatment and management.
- Health services are expected to have their own local detailed policies and procedures to ensure compliance with funding and service agreements, such as:
 - reporting of sentinel events to the Department of Health's Sentinel Event Program
 - funded services (such as PDRSSs) reporting category 1 incidents to the Department of Health.

Reporting requirements

Refer to Appendix 1.

1. Inpatient deaths

In the case of death of a person under treatment as an inpatient, regardless of legal status, staff are required to notify the Chief Psychiatrist within 24 hours by phone. Out-of-hours contact with the Chief Psychiatrist can be made through each health service's appointed authorised psychiatrist, chief executive or delegate.

In addition the MHA 33 Notice of death should be forwarded to the Chief Psychiatrist as soon as practicable, but not later than three days.

The authorised psychiatrist or person in charge of a private hospital is also required to forward a detailed clinical report to the Chief Psychiatrist within 14 days or sooner if specifically requested by the Chief Psychiatrist.

2. Death of patients under the Mental Health Act and those on NCSOs

In the case of a death of a person who immediately before death was a patient within the meaning of the Act or was in the community on an NCSO, there is no requirement to notify within 24 hours. However, a MHA 33 Notice of death should be forwarded to the Chief Psychiatrist as soon as practicable, but not later than three days.

The authorised psychiatrist is also required to forward a detailed clinical report to the Chief Psychiatrist within 14 days.

3. All other reportable deaths

In the case of all other reportable deaths a MHA 33 Notice of death should be forwarded to the Chief Psychiatrist as soon as practicable, but not later than three days. There is no requirement to forward a detailed clinical report unless requested to do so by the Chief Psychiatrist.

MHA 33 Notice of death of a person undergoing treatment or care for a mental disorder

This report may be completed by a relevant clinician or, in the case of private hospitals, the chief executive or delegate and should be endorsed by the authorised psychiatrist or the person in charge of the private hospital. It should include:

- identifying details and legal status of the deceased
- names of the relevant treating clinicians (including the treating psychiatrist or supervising medical practitioner and case manager)
 - diagnosis (primary, secondary and comorbid conditions) and treatment history
 - date of last contact with psychiatric services (where appropriate)
 - mental state at time of last contact
 - date of discharge (where appropriate)
- circumstances of the death including evidence of alcohol consumed or other prescribed/non-prescribed drugs at the time of death
- contact made with the Coroners Court of Victoria.

Detailed clinical report

A detailed clinical report should be completed by the treating psychiatrist and be reviewed by the authorised psychiatrist, chief executive or delegate. It should contain:

- identifying details and legal status of the deceased
- a detailed history of treatment and management prior to death including:
 - presentation/mental state on last visit
 - frequency of contacts and next scheduled appointment
- identified risks and measures taken to address these
- known medical conditions and monitoring/treatment in relation to these
- contact made with next of kin
- any other relevant information.

The requirement to report the occurrence of a ‘reportable death’ to the Chief Psychiatrist cannot be fulfilled through any other reporting requirement, for example, reporting to the Department of Health’s Sentinel Event Program or the coroner.

Contacts

Coroners Court of Victoria
Phone 1300 309 519 (24 hours)

Office of the Chief Psychiatrist
Phone 03 9096 7571 /1300 767 299 (business hours)

Out-of-hours contact with the Chief Psychiatrist can be made through each health service’s appointed authorised psychiatrist, chief executive officer or delegate.

Both the MHA 33 and clinical report should be forwarded to:

The Chief Psychiatrist
Department of Health
GPO Box 4057
Melbourne Victoria 3001

Role of the Chief Psychiatrist

The Chief Psychiatrist:

- receives and reviews MHA 33 Notice of death forms
- maintains a database detailing the occurrence of reportable deaths among clients of psychiatric services in Victoria
- routinely requests the findings of coronial investigations
- reviews the contents of the clinical report forwarded by services, with the aim of identifying systemic/management issues
- may request additional information, including copies of clinical files, from the services in order to perform the task of reviewing individual treatment and care and broader systemic/management issues
- may undertake an investigation pursuant to the Chief Psychiatrist's functions detailed in section 106 of the Mental Health Act
- may respond to the issues raised by any investigation
- may respond to issues raised by the coroner during or following an investigation
- will identify statewide issues and provide appropriate guidance to mental health services.

Health service self-assessment on reportable deaths

Standard 1: Compliance with statutory requirements

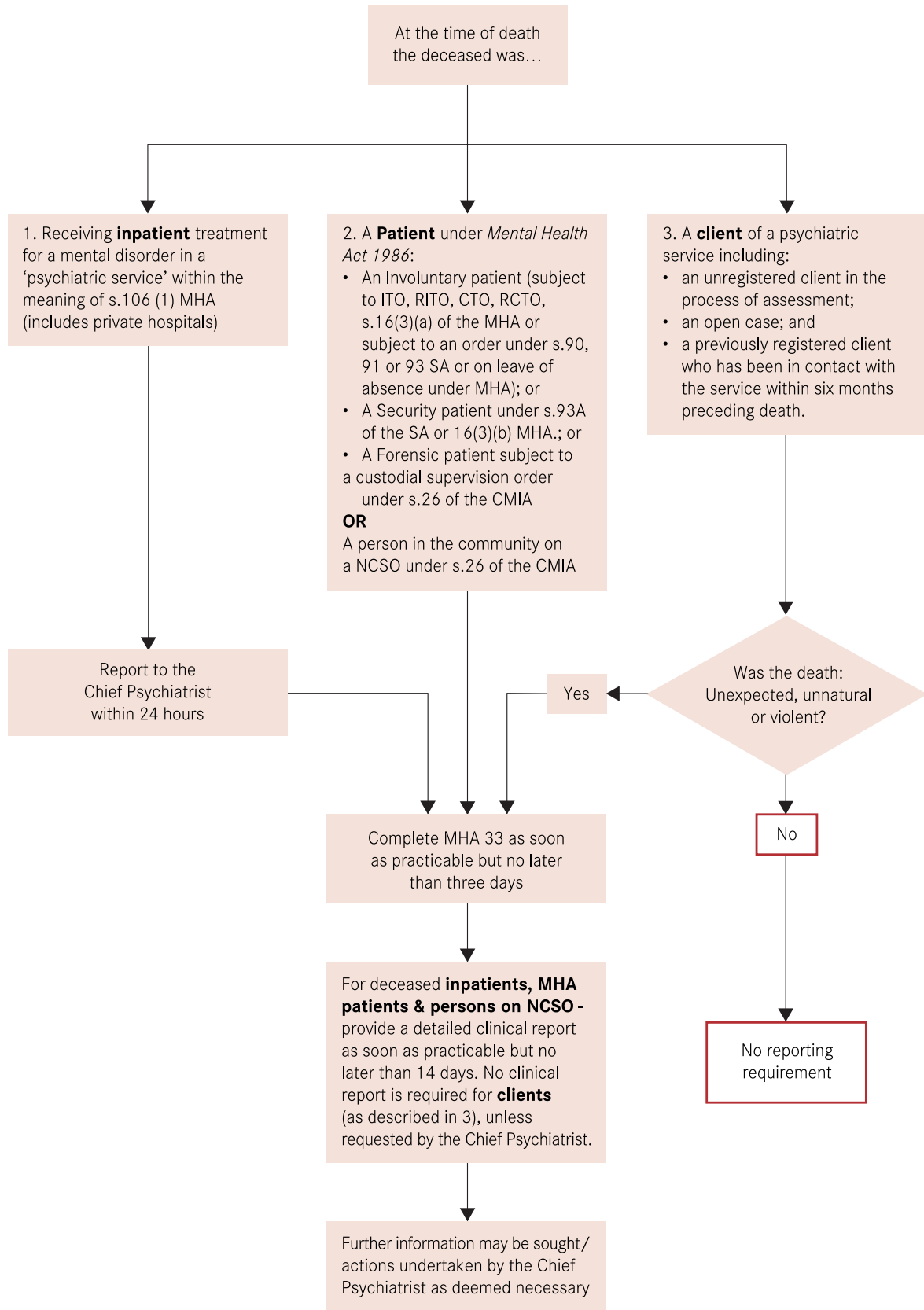
- 1.1 There are established documented procedures to ensure compliance with the requirements specified in this guideline.
- 1.2 Policies and procedures are reviewed by the service to ensure compliance with the above requirements.

Standard 2: Reportable deaths are comprehensively reviewed

- 2.1 There is an established procedure for reviewing deaths of mental health clients of the service.
- 2.2 Practice improvements are made in light of reviewing adverse events via the health service clinical governance framework.

Appendix 1

Reportable deaths – Chief Psychiatrist reporting process



MHA: Mental Health Act 1986

SA: Sentencing Act 1991

CMIA: Crimes (Mental Impairment & Unfitness to be Tried) Act 1997

Appendix 2

Legislative definitions relating to reportable deaths

Mental Health Act 1986

The requirement to notify the Chief Psychiatrist of reportable deaths is established in section 106A of the Mental Health Act.

The authorised psychiatrist of each approved mental health service and the person in charge of any other 'psychiatric service' within the meaning of section 106(1) must report to the Chief Psychiatrist the death of any person receiving treatment for a mental disorder which is a 'reportable death' within the meaning of the *Coroners Act 2008*.

A psychiatric service is defined in section 106(1) as:

- (a) an approved mental health service
- (b) a child and adolescent psychiatry service
- (d) any premises licensed under section 75
- (e) a hospital admitting or caring for people with a mental disorder
- (f) a mental health service of a community health centre
- (g) a psychiatric outpatient clinic
- (h) a community mental health service
- (i) an agency providing community support services.

Coroners Act 2008

The definition of a 'reportable death' is contained in section 4 of the Coroners Act.

Section 4: Definition of reportable death

(1) In this Act, a death of a person is a reportable death if–

- (a) the body is in Victoria; or
- (b) the death occurred in Victoria; or
- (c) the cause of the death occurred in Victoria; or
- (d) the person ordinarily resided in Victoria at the time of death—and the death was a death specified in subsection (2).

(2) For the purposes of subsection (1), the deaths are–

- (a) a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; or
- (b) a death that occurs –
 - (i) during a medical procedure; or
 - (ii) following a medical procedure where the death is or may be causally related to the medical procedure—and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death; or
- (c) the death of a person who immediately before death was a person placed in custody or care; or
- (d) the death of a person who immediately before death was a patient within the meaning of the *Mental Health Act 1986*; or
- (e) the death of a person under the control, care or custody of the Secretary to the Department of Justice or a member of the police force; or

- (f) the death of a person who is subject to a noncustodial supervision order under section 26 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*; or
- (g) the death of a person whose identity is unknown; or
- (h) a death that occurs in Victoria if a notice under section 37(1) of the *Births, Deaths and Marriages Registration Act 1996* has not been signed and is not likely to be signed; or
- (i) a death that occurs at a place outside Victoria if the cause of death is not certified by a person who, under the law in force in that place, is authorised to certify that death and the cause of death is not likely to be certified by a person who is authorised to certify in that place; or
- (j) a death –
 - (i) of a prescribed class of person;
 - (ii) that occurs in prescribed circumstances.

Section 12: General obligation to report death

- 12(1) A person who has reasonable grounds to believe that a reportable death has not been reported must report it without delay to a coroner or the officer in charge of a police station.
- 12(2) A member of the immediate family of a deceased person may report the death to the coroner if the person was a person discharged from an approved mental health service within the meaning of the *Mental Health Act 1986* within 3 months immediately before the person's death.

Section 32: Assistance to coroner in investigation

A person who reported a reportable death or a reviewable death must give the coroner any information or other assistance that the coroner requests for the purposes of the coroner's investigation.

Penalty: 20 penalty units.

Section 33: Registered medical practitioner to assist in investigation

- (1) This section applies to a death that is being investigated by a coroner.
- (2) A registered medical practitioner–
 - (a) who was responsible for a person's medical care immediately before that person's death; or
 - (b) who was present at or after the person's death–must give the coroner any information or assistance that the coroner requests for the purposes of the investigation.

Penalty: 20 penalty units.

About Chief Psychiatrist's Guidelines

The information provided in this guideline is intended as general information and not as legal advice. If mental health staff have queries about individual cases or their obligations under the *Mental Health Act 1986*, service providers should obtain independent legal advice.

Acknowledgements

Published by the Mental Health,
Drugs and Regions Division,
Victorian Department of Health

Also published on
<www.health.vic.gov.au/mentalhealth/cpg>

Document number: CPG100301

Document review cycle

Guideline issued: December 1999

Revised: May 2004

Revised: March 2010

Scheduled for review/rewrite:

Before March 2015

Further information

For further information contact the Chief Psychiatrist on 9096 7571 or 1300 767 299 (toll free).



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