Quality and Safety Bulletin

Office of the Chief Psychiatrist

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OFFICIAL

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Reportable deaths and definitions

The Chief Psychiatrist (CP) is responsible for clinical leadership in ensuring quality and safety of the public mental health and wellbeing sector. In meeting this responsibility and in accordance with the Mental Health and Wellbeing Act 2022 (the Act) the OCP monitors reportable deaths of persons receiving care from designated mental health services (DMHS).

Deaths reportable to the OCP include all mental health inpatients, those on approved leave, those discharged in the preceding 24 hours and those transferred to a non-mental health unit whom subsequently die, all compulsory patients, and unexpected deaths for consumers receiving care in DMHS and within 3 months of contact with the service. The OCP looks at the details of individual deaths as well as the aggregated, de-identified data related to all reportable deaths in Victoria. About 350-400 deaths are reported each year.

In doing so the OCP aims to:

- assist services and the Mental Health and Wellbeing Division (MHWD) with particular deaths as needed.
- identify various mortality themes across the broader service sector to help identify modifiable factors within the sector to improve quality and safety.

The OCP collaborates with various partners and statutory authorities with responsibility for quality and safety providing a more complete picture of mortality across the mental health and wellbeing sector and the wider community.

These include:

- Safer Care Victoria (SCV) including the SCV Sentinel Events Program
- Coroner Court of Victoria
- Suicide Prevention and Response Office (SPARO)
- Mental Health and Wellbeing Commission (MHWC)

Please be aware you may have reporting responsibilities to these organisations separate to your reporting responsibility to the OCP.

The OCP is considering various improvements to our reportable death processes with the aim of:

- maximising the benefit of this data set for the mental health and wellbeing services and ultimately consumers and their families.
- ensuring the reporting burden on services is proportionate to regulatory need and potential benefit for the sector and community.

The OCP is aware the examination of deaths is challenging and often difficult and aims to develop a cooperative and constructive approach to oversight of reportable deaths.

The first step in improving the process is to clarify various definitions to ensure consistency in reporting across all services. Below is a discussion on some common definitional themes which may be helpful.

Definitions of inpatient death

The OCP's definition of an inpatient death is the death of a person who is a registered mental health consumer and is a mental health inpatient in a designated mental health service or a bed-based mental health unit in a custodial setting. All inpatient deaths need to be reported to the OCP regardless of cause and are deemed sentinel events.

Note that the definition of a sentinel event to SCV refers to an "unexpected and adverse event that occurs infrequently in a health service entity and results in the death of, or serious physical or psychological injury to a patient as a result of system and process deficiencies at the health service entity".

This includes all mental health inpatient deaths and an additional category specific to Victoria: All other adverse patient safety events resulting in serious harm or death related to clinical process or procedure, falls, deteriorating patients, self-harm, communication of clinical information, medical device or equipment, nutrition, resource or organisational management, healthcare associated infection or patient accidents.

A sentinel event (SE) includes serious harm form self-harm and not only death on an inpatient unit.

In Victoria, sentinel events are a subset of serious adverse patient safety event (SAPSEs), which include all adverse events that result in serious harm to, or death of a patient and fit into the sentinel event categories 1 to 11. A SAPSE occurs when a consumer has suffered a serious adverse patient safety event while receiving health services. The OCP co-chairs the SCV Sentinel Events Committee.

It is important to recognise that the OCP reportable death definition is wider and more inclusive temporally than the SE definition as it includes deaths of persons on approved leave, absence without leave, who have been discharged in the preceding 24 hours and those transferred to a non-mental health unit and whom subsequently die.

The OCP reportable death category includes acute, semi acute and rehabilitation wards such as acute inpatient units and SECUs. It does not include alternative residential services such as HITH, PARC, YPARC or CCU. Deaths in these facilities are considered differently in line with their Models of Care. For more details see Chief Psychiatrist Reporting Directive: Notification of reportable deaths 2023 and SCVs Revised Victorian Sentinel Events Guide.

Each year, there are approximately 25-30 inpatient deaths, primarily due to medical illnesses, and some resulting from suicide. These cases receive focused attention, allowing for careful examination of modifiable factors such as ward environments, unit procedures, staffing, leave, and discharge arrangements.

Inpatient deaths occur in settings where services have significant influence over the context, providing greater potential to enhance safety measures. This differs from most reportable deaths, where the ability to manage the context is often more limited. This distinction is acknowledged and recognised.

The OCP has the expectation that the office is notified of all reportable inpatient deaths by telephone call or email ocp@health.vic.gov.au within 24 hours.

The purpose of this is to assist services in a timely manner. Additionally, such deaths are often raised with the OCP from other sources, and it ensures the OCP is informed and able to assist.

Definition of expected and unexpected deaths

The deaths of mental health inpatients and all compulsory patients must be reported to the CP, regardless of whether they are expected or unexpected. In contrast, for patients receiving community care, only unexpected deaths are reportable.

Distinguishing between expected and unexpected deaths requires judgement particularly in some clinical settings such as older persons mental health services and consultation liaison (CL) services. For example, the death of an elderly person receiving mental health care for advanced dementia who suffers a fall and dies of the injuries sustained from the fall might be considered an expected death and only reportable if the person is a mental health inpatient or compulsory patient.

At the same time an example of a middle-aged person receiving treatment for a persisting psychotic illness with known physical morbidities associated with an abnormal metabolic profile who dies, might be considered unexpected, even though a certain expectancy was present with worsening of medical comorbidities.

We are aware of the premature deaths of those with chronic mental health illness and recognise preventable factors we can influence, as such we see such a death as unexpected and therefore reportable. A CL example is a consumer may be seen for adjustment issues to severe illness such as a malignancy which then deteriorates leading to the death of the person, and this would be an expected death and not reportable.

The authorised psychiatrist needs to exercise nuanced judgment. If you are uncertain, you are encouraged to submit an MHWA 125 form for the OCP to review or to contact the OCP and discuss the case before completing the MHWA 125 form.

Definition of deaths associated with access to DMHS

The Royal Commission into Victoria's Mental Health System (RCVMHS) made recommendations about access to mental health services. The OCP is keen to better document and understand deaths associated with help seeking to the system in order to identify modifiable factors as targets for continuous quality improvements and to support better experiences of entry into the mental health system.

Mental health and wellbeing services do not have the same level of influence over these contexts compared to inpatient units there are nevertheless many identifiable modifiable factors that make focus on this cohort important.

The entry points to mental health care offer significant definitional challenges about who should be reported. There are substantially different practices across services and the OCP is keen to develop greater uniformity of practice regarding reporting deaths.

There is significant capacity, complex risk decisional and operational complexities existing at the front end of systems. The OCP's white paper on the principles of mental health risk assessment is an attempt to improve practice at this interface.

All deaths of compulsory patients enroute to or in Emergency Departments (EDs) are reportable as well as those registered as mental health consumers accessing care. In addition, reporting encompasses all consumers who have had more than trivial contact with a service and who have had some level of assessment.

This may be a Triage phone call or a person seeking mental health support in an ED. For those not registered mental health consumers, deaths in the 7 days following mental health contact in ED or Triage services are reportable

This is an area the OCP plans to take greater interest in considering the challenges it presents to mental health and wellbeing services and the degree of change with current transformation of the mental health and wellbeing services post Royal Commission.

The OCP is happy to engage in further discussions or ideas on how to best do this.

For more information, refer to the Chief Psychiatrist's Reporting Directive: Notification of reportable deaths

Themes of recent reportable deaths reviewed by Sentinel Events Review Committee

The Chief Psychiatrist's Sentinel Event Review Subcommittee is supported by a panel of senior clinicians of various disciplines and consumer and carer representatives.

The subcommittee meets every six weeks to review reports classified as sentinel events by Safer Care Victora. The panel makes recommendations to services to reduce the possibility of a recurrence and may also make recommendations to enhance the rigor of service review processes.

Recent themes from reportable deaths include:

- People referred or engaged in Emergency Departments or Triage who have subsequently ended their own lives and highlights the lack of linkages into and out of the health sector.
- Deaths suspected to be due to combination of medical morbidity, medication use and psychiatric history highlighting the importance of proactive management of medical conditions alongside psychiatric illness.
- Comorbidity of substance use complicating mental health assessments and difficulties with behaviours that fluctuate with substance use.
- Deaths associated with YPARC and PARC highlighting ongoing risk later in stay as a need.

Questions to ask your service

- Do we have a good system for tracking presentations to ED and Triage and do we have opportunities to review such presentations clinically and escalate of reach out where we are not clear the person has been adequately linked into another service?
- What support or relationship does your AMHS have with medical teams in and outside hospital to support our consumers getting access to proactive medical care?
- How integrated is our substance use work in business as usual? Do we feel confident our regular case managed clients are also being regularly offered substance use awareness, motivational support or treatment?
- How do we best discharge plan from sub-acute and create meaningful connection with community services?

Recent Coronial recommendations

Below are recent recommendations from the Coroners Court to services for your consideration.

Transgender and gender diverse cluster review

The Coroners Court identified common features in relation to the circumstances of the deaths of five transgender and gender diverse (TGD) people. The deceased were all young people who had affirmed or were on a journey to affirming their gender identity as female, and who had experienced mental ill health.

Some had been linked with service providers from a young age, and also faced a degree of social isolation during the COVID-19 lockdown periods. Given these common factors the Coroner convened an Inquest into the five deaths.

The inquest proceeded on 27-29 November 2023 and 21 February 2024. Dr Neil Coventry, the then Chief Psychiatrist, was a witness. The Coroner handed down their findings on 29 August 2024.

Recommendations to the Victorian Department of Health included:

- Increasing resourcing to meet the growing demand for publicly funded health services delivering gender-affirming care.
- revising the existing framework for delivery of gender-affirming healthcare and supports to TGD Victorians.
- Devising and implementing a statewide framework for the provision of culturally appropriate care to TGD people in public hospitals and health services, including in rural and regional Victoria, with additional training to support staff in delivering culturally appropriate care to TGD patients.
- Consideration of ongoing funding options to ensure that TGD people and their families have appropriate access to culturally appropriate; social and emotional wellbeing supports, and suicide prevention, postvention and bereavement supports.

Recommendation to the Royal Australian College of General Practitioners (RACGP) and Royal Australian and New Zealand College of Psychiatrists (RANZCP):

- Under the guidance of experts from TGD communities, develop and offer training and support to all healthcare professionals under their remits with the aim of ensuring cultural safety for TGD people accessing health services across these settings, including training on the factors that can contribute to the risk of suicide in these communities.

White Paper - On the principles of mental health risk assessment

Risk assessment is a foundation skill for all mental health clinical practice. It involves identifying risk factors and synthesising, integrating and formulating risk to adequately understand the person at risk. The purpose of risk assessment and formulation is to address risks and enable people to have fuller, more meaningful lives.

There is a need to standardise how risk is assessed across and within healthcare settings. In this paper the Office of the Chief Psychiatrist aims to offer guidance to service providers in the context of the tensions that arise as a result.

This paper describes an evidence-based approach to risk to inform thinking in the mental health sector. It describes the key shared principles of risk formulation and mitigation for the sector and explains clinical approaches for non–mental health people who want to understand how decisions about risk are reached.

The Risk Assessment White paper has been developed by the OCP with key input from Associate Professor Andrew Carroll and Dr Dominika Baetens in consultation with all the Authorised Psychiatrists in Victoria. The paper will soon be published and made available on the OCP website.

ECT for non-psychiatric illness

The OCP established the ECT Complex Consultation Expert Panel, as part of the recommendations from the Mental Health and Wellbeing Commission, to review and advise on cases with significant clinical complexities in ECT administration.

Recent case review

A young person with New Onset Refractory Status Epilepticus (NORSE) in Intensive Care Unit, a rare syndrome with high mortality. Despite no psychiatric history, the Head of Epilepsy requested ECT be provided by the mental health team as a treatment of NORSE, supported by limited published evidence but good clinical indication.

After extensive consultations and discussion with family members, ECT was administered, unfortunately with no improvement. The patient later died due to multi-organ failure and shock.

The panel went on to discuss the role of the Mental Health Tribunal (MHT) in approving ECT for non-psychiatric conditions, recognising the need for clarifications and guidelines in such matters.

Other medical disorders where ECT maybe considered such as Parkinson's disease, movement disorders, neuroleptic malignant syndrome, and delirium are recognised, and limited literature exists. Similar questions might arise about these disorders in the future.

Chief Psychiatrist's comment

This case underscores the need for thorough consultations and informed decision-making when exploring ECT for non-psychiatric illnesses.

Key decision makers need to balance clinical opinion, the evidence base, the preferences of the individual and family where known and the likely best interests of the person in light of the MHWA Principles. Services must ensure families have the opportunity to fully understand the risks and processes involved.

There should be a low threshold for secondary expert opinions.

It is understood that MHT has conducted its own legal review to determine their jurisdiction for matters like this. While MHT does have jurisdiction in approving ECT for non-psychiatric conditions, in such circumstances, health services should carefully evaluate the necessity and implications of such treatments, especially in urgent scenarios.

Collaboration, consultation and clear communication among different teams within the health service, as well as external stakeholders are vital in navigating complex cases involving ECT outside traditional psychiatric practice.

Mental Health and Wellbeing Act 2022 - Principles in practice

The Act reached its first-year milestone on September 1, 2024, and services have embedded significant changes into their practice and reporting. The OCP recognises the significant role of the Act Implementation Leads (AILs) have provided in supporting services delivery of the Act. As the AIL positions are winding up, a reminder that any further questions regarding the Act can be directed to the Office of the Chief Psychiatrist, via email ocp@health.vic.gov.au.

As legislated in the Act, we turn our focus to the mental health and wellbeing principles in practice. In short, we need to start to think about, upskill staff and ensure documentation reflects these principles. Clinical decision making should be referencing the principles where they apply and explaining decisions considering safety, treatment and the principles both in medical records and in conversations and documentation given to consumers and carers.

The OCP is working closely with Independent Mental Health Advocacy (IMHA) and key stakeholders who have been funded to provide education on the principles. Please attend an upcoming training and support staff to attend so we can ensure we are all thinking about them the same way.

A reminder the Principles of the Act are:

Dignity and autonomy principle

The rights, dignity and autonomy of a person living with mental illness or psychological distress are to be promoted and protected and the person is to be supported to exercise those rights.

Diversity of care principle

A person living with mental illness or psychological distress is to be given access to a diverse mix of care and support services.

This is to be determined, as much as possible, by the needs and preferences of the person living with mental illness or psychological distress including their accessibility requirements, relationships, living situation, any experience of trauma, level of education, financial circumstances and employment status.

Least restrictive principle

Mental health and wellbeing services are to be provided to a person living with mental illness or psychological distress with the least possible restriction of their rights, dignity and autonomy, with the aim of promoting their recovery and full participation in community life.

The views and preferences of the person should be key determinants of the nature of this recovery and participation.

Supported decision making principle

Supported decision making practices are to be promoted. People receiving mental health and wellbeing services are to be supported to make decisions and to be involved in decisions about their assessment, treatment and recovery including when they are receiving compulsory treatment.

The views and preferences of the person receiving mental health and wellbeing services are to be prioritised.

Family and carers principle

Families, carers and supporters (including children) of a person receiving mental health and wellbeing services are to be supported in their role in decisions about the person's assessment, treatment and recovery.

Lived experience principle

The lived experience of a person with mental illness or psychological distress and their families, carers and supporters is to be recognised and valued as experience that makes them valuable leaders and active partners in the mental health and wellbeing service system.

Health needs principle

The medical and other health needs of people living with mental illness or psychological distress are to be identified and responded to, including any medical or health needs that are related to the use of alcohol or other drugs.

In doing so, the ways in which a person's physical and mental health needs may intersect should be considered.

Dignity of risk principle

A person receiving mental health and wellbeing services has the right to take reasonable risks to achieve personal growth, self-esteem and overall quality of life.

Respecting this right in providing mental health and wellbeing services involves balancing the duty of care owed to all people experiencing mental illness or psychological distress with actions to afford each person the dignity of risk.

Wellbeing of young people principle

The health, wellbeing and autonomy of children and young people receiving mental health and wellbeing services are to be promoted and supported, including by providing treatment and support in age and developmentally appropriate settings and ways.

It is recognised that their lived experience makes them valuable leaders and active partners in the mental health and wellbeing service system.

Diversity principle

The diverse needs and experiences of a person receiving mental health and wellbeing services are to be actively considered, noting that such diversity may be due to a variety of attributes including any of the following:

- gender identity
- sexual orientation
- sex
- ethnicity
- language
- race
- religion, faith or spirituality
- class
- socioeconomic status
- age
- disability
- neurodiversity
- culture
- residency status
- geographical disadvantage.

Mental health and wellbeing services are to be provided in a way that:

- is safe, sensitive and responsive to the diverse abilities, needs and experiences of the person including any experience of trauma
- considers how those needs and experiences intersect with each other and with the person's mental health.

Gender safety principle

People receiving mental health and wellbeing services may have specific safety needs or concerns based on their gender. Consideration is therefore to be given to these needs and concerns and access is to be provided to services that:

- are safe
- are responsive to any current experience of family violence and trauma or any history of family violence and trauma
- recognise and respond to the ways gender dynamics may affect service delivery, treatment and recovery
- recognise and respond to the ways in which gender intersects with other types of discrimination and disadvantage.

Cultural safety principle

Mental health and wellbeing services are to be culturally safe and responsive to people of all racial, ethnic, faith-based and cultural backgrounds.

Treatment and care is to be appropriate for, and consistent with, the cultural and spiritual beliefs and practices of a person living with mental illness or psychological distress.

Regard is to be given to the views of the person's family and, to the extent that it is practicable and appropriate to do so, the views of significant members of the person's community.

Regard is to be given to Aboriginal and Torres Strait Islander people's unique culture and identity, including connections to family and kinship, community, Country and waters.

Treatment and care for Aboriginal and Torres Strait Islander peoples is, to the extent that it is practicable and appropriate to do so, to be decided and given, having regard to the views of Elders, traditional healers and Aboriginal and Torres Strait Islander mental health workers.

Wellbeing of dependents principle

The needs, wellbeing and safety of children, young people and other dependants of people receiving mental health and wellbeing services are to be protected.

Further information

Read about the statutory role of the Chief Psychiatrist's responsibilities to uphold quality and safety in Victoria's mental health and wellbeing system under the Act.

Important information is available for clinical mental health and wellbeing services to understand their core obligations around delivering safe and high-quality treatment and care, and information on reporting a failure to comply with the Act.

Further resources

Helpful resources have been developed by the department, and additional resources are available to assist clinical mental health and wellbeing service providers, consumers, carers and families with information about the new Act.

Refer to the links below.

Chief Psychiatrist | health.vic.gov.au
Mental Health and Wellbeing Act 2022 Handbook | health.vic.gov.au
Statement of Rights | health.vic.gov.au
Mental Health and Wellbeing Act 2022 | legislation.vic.gov.au

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