Quality and Safety Bulletin

Office of the Chief Psychiatrist

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OFFICIAL

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Message from Sophie

Dear Colleagues,

The Chief Psychiatrist's Quality and Safety Bulletin gives important information to guide clinical leadership in the mental health sector. Please forward this on to all staff so they can understand and contribute to quality and safety processes at every level. Safety is everyone's business.

Best wishes,

Sophie

Associate Professor Sophie Adams Chief Psychiatrist MBBS, MBioethics, MHLM, PhD, GAICD, FRACMA, FRANZCP

News – Key updates

OCP Quality and Safety Forums

The Office of the Chief Psychiatrist (OCP) hosts 4 mental health quality and safety forums each year as part of the Chief Psychiatrist's statutory oversight to support delivery of high-quality care to people receiving mental health and wellbeing services. Forums are designed to explore big topics, improve engagement and collaboration, and provide a space to safely discuss challenges and opportunities for change. These are in-person forums, and every service is provided with 5 places for leadership and local thought leaders. **It is expected that all services participate**.

Recap

OCP–VACCHO Forum: Cultural Safety and Leadership in the Mental Health Sector – 14 May

The OCP partnered with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) to deliver a forum highlighting the importance of cultural safety in our designated mental health services (DMHS). The forum provided an opportunity to work collaboratively to identify actions that each service could take to strengthen practice.

This year, cultural safety is a Statements of Priorities target for all health services. To support this work, the OCP delivered the forum in partnership with VACCHO's Balit Durn Durn Centre, and the Balit Marrup Unit within the Department of Health's Mental Health and Wellbeing Division. The OCP has also requested services to invite First Nations staff to participate in Chief Psychiatrist site visits.

We hoped to inspire mental health leaders to lead and promote culturally safe practice and to guide clinical mental health leads to reflect on their own practices, attitudes and beliefs about Aboriginal history, identity, culture and peoples. We also sought to create space for reflection on how these influence practice when working with Aboriginal consumers, carers, kin, families, Aboriginal organisations, Aboriginal staff and Aboriginal mental health clinicians. The intent is to transform cultural safety from an add-on to a core competency in DMHS.

Please see more information about the commitments identified by the forum in the **Clinical focus section** of this issue. We hope all services will pick 2 commitments to action in the next 12 months.

Workshop: Improving Sexual Safety in Mental Health Services – 24 March

The sexual safety forum brought together attendees from across a range of services to engage in thoughtful discussions and reflections around sexual safety and quality improvement. Attendees heard from health service representatives who shared current practices and projects underway to improve sexual safety. Attendees participated in an interactive benchmarking activity to assign an Incident Severity Rating (ISR) to a simulated scenario and explain their reporting considerations. More information about this forum, including some reflections from the facilitators, can be found in the Clinical focus section of this issue.

Upcoming Quality and Safety Forums

Mental Health and Wellbeing Act: Risks and Ethics – 12 August

This forum will be delivered in collaboration with Safer Care Victoria. It will explore risk and ethical issues and how they inform our use of the Mental Health and Wellbeing Act (MHWA). One of the key roles of the OCP is to oversight the use of the MHWA. Victoria has one if the highest rates of compulsory treatment in the world. We want to think about how we should be addressing this and where meaningful change should best occur.

Transforming Mental Health for Older Adults – 16 November

This forum will be designed to improve engagement and collaboration within the older adult's mental health sector and to discuss current challenges especially post the Royal Commission into Victoria's Mental Health System and the transformation to adult and older adults services. There will be opportunities to listen and engage with lived experience representatives, an interactive workshop and a thought-provoking debate.

OCP site visits to statewide DMHS

Site visits are an opportunity for connection and collaboration between the OCP and DMHS to:

- showcase quality and safety improvements
- raise clinical and operational challenges
- discuss strategies and activities for meeting the needs of specific groups
- raise any other matters services would like to advocate for.

This year we are focusing on First Nations people and support in the tertiary sector. We strongly encourage services to invite Aboriginal and Torres Strait Islander mental health staff to join site visits, particularly Koori Mental Health Liaison Officers, Aboriginal mental health graduate clinicians and Aboriginal mental health trainees (for services that have these roles).

Monash visit – March

The Monash site visit was highly supported by senior leadership, who wanted to focus on flow and access challenges they have across multiple sites. As the largest mental health provider in the state, providing a great range of mental health services, Monash faces notable access challenges and is significantly committed to addressing them. A range of opportunities to address these challenges were discussed, and staff went on a tour of the existing wards, including those that may have the capacity to be repurposed. A meeting with the CEO demonstrated executive commitment to mental health leadership and a shared focus on providing good access to high-quality mental health care.

Latrobe visit – April

The Chief Psychiatrist visit to Latrobe mental health and wellbeing service highlighted a range of changes in quality improvement and safety approaches across the organisation. The day started with a high-level meeting with senior Latrobe Regional Hospital executives and mental health and wellbeing service leaders demonstrating senior leadership commitment to mental health. This was followed by tours of the alcohol and drug hub, the Latrobe Valley community clinic and the newly refurbished Traralgon Youth Prevention and Recovery Care. While visiting these sites the Chief Psychiatrist and colleagues heard directly from many on the ground clinicians. Clinical, operational and lived experience initiatives were showcased including the remote mental health connectivity strategy. The day was filled with a high level of enthusiasm and program area staff eager to discuss sophisticated data sets reflecting innovation and improvements.

New publications

Chief Psychiatrist's reporting directive – Reporting a failure to comply with the Mental Health and Wellbeing Act or other serious incidents

The OCP is finalising a reporting directive for Authorised Psychiatrists or their delegates when there are breaches of the *Mental Health and Wellbeing Act 2022* or serious quality and safety incidents in DMHS.

The directive will:

- outline three categories of breaches: major, moderate and minor
- define serious quality and safety incidents
- explain how to report major breaches and serious quality and safety incidents to the OCP.

Further information will be provided when the directive is released.

As One - our ways of working

Strengthening quality and safety for children and young people

As One - our ways of working: between Child Protection and ICYAMHWS | health.vic.gov.au

As One – Our Way of Working (*As One*) is a joint initiative of the Department of Health, the OCP and the Office of the Professional Practice (OPP) within the Department of Families, Fairness and Housing (DFFH) that was developed post system level reviews and several inquiries including a group child death inquiry by the Commission for Children and Young People (CCYP). Implementation reflects a shared commitment to improving outcomes for children and young people with complex and intersecting needs.

One of the recommendations from the group death inquiry was that:

> ***DFFH, together with the Department of Health, consider opportunities—within the context of the Royal Commission into Victoria's Mental Health System—to improve outcomes for adolescents with a mental illness who are child protection clients.***

This initiative provides a statewide framework for how Child Protection and Infant, Child and Youth Area Mental Health and Wellbeing Services work together to support children and young people who are involved with both. *As One* responds directly to this recommendation by strengthening cross-sector collaboration, clarifying shared responsibilities and supporting safer, more coordinated care for children and young people. The document sets out shared roles, responsibilities, guiding principles and governance arrangements to support consistent, coordinated and safe practice across Victoria.

Why this matters?

Children and young people known to both Child Protection and ICYAMHWS often experience heightened vulnerability, trauma, complexity and risk. Inconsistent communication, unclear responsibilities or delayed escalation can compromise safety and contribute to poor outcomes. *As One* provides a shared, cross-sector framework to reduce these risks by strengthening collaboration, clarifying expectations and supporting integrated responses at case, local area and statewide levels.

MHWA forms

Services are advised that the following revised MHWA forms are being released on the Department of Health website on July 1st, 2026.

- Authority for use of Restrictive Interventions – MHWA 145 and
- Restrictive Interventions Observations (Continuation) – MHWA 145A

Thank you to all services who provided feedback and contributed to the revision of the forms.

The current versions on the website will be archived once the revised forms have been published.

Clinical focus

Principles of the Mental Health and Wellbeing Act

The Act outlines fundamental principles related to mental health and wellbeing. It requires mental health and wellbeing service providers to take all reasonable steps to adhere to these principles and thoughtfully consider them when making decisions under the Act.

As part of raising sector awareness of the principles, the Chief Psychiatrist will reflect on 2 principles in each issue of the quality and safety bulletin, highlighting key considerations from the standpoint of clinical practice.

Family and carers principle

The MHWA recognises the importance of involving families and carers in a person's mental health care. Families, carers and chosen family are an intrinsic part of human experience and can offer important insight into who a person is, particularly during periods of acute illness when the person may find it more difficult to advocate for themselves. The Act requires us to recognise, support, and actively involve families and carers in a consumer's treatment, care and recovery alongside the consumer's autonomy.

Often this is straightforward and involves working alongside consumers to support family involvement. At other times, this is more complex, particularly when a consumer prefers not to worry family members, rely on them, or share personal information for understandable and valid reasons. In these situations, our role is to respect the consumer's autonomy while looking for safe and appropriate ways to involve family without disclosing information the consumer does not want shared. This may include inviting family members to contribute their concerns and experiences as collateral history, while gently explaining that the consumer is not ready to share more. At the same time, we can continue working to understand the consumer's perspective and seek opportunities to support reconnection as trust and treatment progresses. In supporting reconnection, Tandem and Independent Mental Health Advocacy may play an important role.

Lived experience principle

Victoria's *Mental Health and Wellbeing Act 2022* places people with lived experience at the centre of the mental health and wellbeing system. This principle moves beyond deciding what is in a person's best interests. It requires us to listen to people's experiences, understand what it feels like to receive mental health care, and gives this equal weight alongside clinical perspectives and outcomes. It calls on us to be therapeutic in every interaction and to seek out diverse perspectives at every level of the system. We also know that agency, autonomy and living in line with one's values are foundational to mental health and wellbeing.

At its core, this principle is:

- valuing people with mental health issues or distress as essential leaders and decision makers in the system at every level; and
- working in active partnership with lived experience perspectives and clinical understandings.

Bringing these elements together ensures that consumer preferences, values and goals meaningfully guide care and decision-making. This is not replacing one set of approaches with another. It is about drawing on multiple perspectives to better understand the person and provide more responsive, respectful and effective care. Afterall, if you were unwell wouldn't you want your values and preferences respected, even where they differed from those of your treating clinicians?

The OCP has an active role is supporting lived experience leadership and work in our sector. During our site visits last year, we asked to meet with as many lived experience staff as possible. We recognise that lived experience roles and leadership are at differing levels of development across the sector, with varying levels of staffing and organisational maturity. We are working with lived experience members of the Mental Health and Wellbeing Division to strengthen, support and elevate these roles and perspectives in all aspects of our work.

Supported decision making

Both the MHWA 2022 and the Mental Health Act 2014 highlighted the ongoing importance of **supported** decision making. However, the term shared decision making is still commonly used across the sector.

This distinction matters. Shared decision making does not address the power imbalances inherent in the clinician-consumer relationship and assumes equal autonomy is present. Supported decision making more accurately recognises the power imbalance and the mental health services' history of substituted decision making.

Supported decision making aims to enable consumers to make their own decisions, with services providing the support needed to make this possible. It strengthens agency, challenges the inherent power differentials, and reduces the risk that a person's right to make decisions will be overridden. It requires clinicians to identify and respond to barriers that may limit a person's ability to participate autonomously. Not taking autonomy at face value; rather exploring and addressing the factors that hinder it. This allows for better decision making that is more aligned with the consumer's values and preferences.

Ways to promote supported decision making include:

- Presume capacity to give consent to treatment
- Views and preferences of the person given priority
- Advance statements of preferences
- Nominated support persons
- Non legal mental health advocacy
- Second psychiatric opinion
- Legal advice

This is not an exhaustive list. At its core, supported decision making recognises the responsibility we have as clinicians and ensures strong patient centred communication as central to good clinical care.

Practising supported decision making may reduce the need for compulsory treatment and supports the MHWA's objective that compulsory treatment be used as a last resort. When compulsory treatment is required, supported decision making should still be used for as many decisions as possible. Each decision should be approached as an opportunity for the person to make their own decision, and services should work actively with consumers to cease compulsory treatment as soon as possible.

We understand that all DMHS have IMHA supported decision making e-leaning modules available through their learning system. IMHA can also run workshops to support implementation. If you would like to access the IMHA workshop, please contact Helen Makregirogos – helen.makregiorgos@vla.vic.gov.au

OCP – VACCHO Cultural Safety and Leadership Forum: actions for services

The OCP partnered with VACCHO to deliver a forum highlighting the importance of cultural safety in our DMHS and working together to identity actions each service could take.

We thank our wonderful facilitator, Kerry Arabeena, Sheree Lowe and Karen MacAleer from VACCHO, Lang Baulch from the Balit Marrup Unit and all the Aboriginal clinicians and workers, especially those from Bendigo who participated in a robust panel discussion, and those who challenged us in the hope that we can start to do things differently.

The following commitments were made by participants at the forum. We ask all services to pick two to action in the next year

Service Commitments	Service commitment to incorporate social and emotional wellbeing into practise, employing a person-centred approach to care regardless of acuity
	Develop and/or implement anti-racism and racial dignity frameworks
	Increase Aboriginal representation in leadership and decision-making
	Transform organisational culture to shift responsibility from a local issue to an organisation-wide responsibility
	Ensure leadership advocates for SEWB funding and prioritisation
	Include cultural safety as a standing agenda item at leadership meetings and monitor progress against organisational commitments (and health service SOPS)
Training	Develop and deliver training beyond e-learning, with a focus on empathy, reflection, and creating the space and permission to connect. Training should be co-designed and delivered by Aboriginal people
	Include SEWB training in staff orientation. Provide opportunities for continuous learning and professional development
	Organise a SEWB Grand Round- consider advertising to staff in larger health service
Relational	Build ongoing relationships with local Aboriginal communities and Elders.
	Establish and strengthen partnerships with local Aboriginal Community Controlled Health Organisations and other Aboriginal organisations (e.g. Dardi Munwurro). Explore opportunities for partnership, clinical pathways or other support
	Work collaboratively with other health services and peak bodies, including VACCHO, to align strategic priorities and discuss solutions to workforce and funding challenges
Workforce	Increase the Aboriginal and Torres Strait Islander workforce and expand traineeships and career pathways in the mental health sector. Monitor rates as part of workforce data reviews
	Identify staff with SEWB training or if none, identify staff with interest and sponsor them to have training
	Identify all staff who identify as aboriginal or torres straits islander and consult with them on strategies to make recruitment more attractive
	Visit a site where they have Aboriginal liaison trainees to learn how to do and how best support
	Apply for an aboriginal liaison trainee
Accreditation	Establish a cultural safety accreditation or assessment processes; identify areas for improvement
Quality and Safety projects	Identify the current barriers to establishing care relationships, such as time pressures and clinical-first approaches, and explore strategies to address them
	Increase incentives to recognise and value relational care as part of clinical practice; embed within funding models
	Review and/or update first nations art and safe spaces
	Have a session with Q and S team to brainstorm ideas to enhance first nations wellbeing in service
	Consider making an aboriginal safe space that all can use on ward and learn from

Remember all health services in their annual Statement of Priorities 2025-2026 have a SOP target to improve Aboriginal health and wellbeing and strengthen cultural safety in Victoria's health service system by fostering strong connections to Aboriginal culture, creating a holistic, accessible, and empowering health system.

See individual SOPs here: https://www.health.vic.gov.au/funding-performance-accountability/statements-of-priorities

Sexual Safety Workshop: benchmarking exercise

On 24 March 2026, the Office of the Chief Psychiatrist (OCP) brought mental health and wellbeing services together for a Sexual Safety Workshop focused on strengthening sexual safety through collaboration, connection and shared learning. Services from across Victoria attended, including lived experience leaders, and contributed thoughtful discussion throughout the day.

We thank Eastern Health, Monash Health, Albury Wodonga Health and Peninsula Health for sharing practical learnings and local quality improvement initiatives that are helping strengthen sexual safety. Joe Ball, Victorian Commissioner for LGBTIQA+ Communities, spoke about the experiences of people of diverse genders and underscored the importance of creating safety for people of all genders. SCV also reflected on the Mental Health Incident Prevention (MHIP) – Improving Sexual Safety work and outlined the program’s future direction.

During the workshop, participants worked through practical benchmarking scenarios to test consistent decision-making and trauma-informed responses. A recurring discussion point centred on sexual activity described as ‘consensual’ in an inpatient setting.

The following scenario and discussion should be considered by each DMHS to ensure we are all reporting in the same way.

Scenario: Consumer to Consumer sexual safety incident

- Incident occurred on a busy night in an **acute mental health unit**. Several competing clinical demands occurred overnight, including medication requests and an unrelated incident elsewhere on the unit, which intermittently diverted staff attention.
- In the preceding days, Consumer A presented with acute symptoms of psychosis and relapse of schizophrenia. Consumer B was admitted experiencing a manic episode of bipolar affective disorder. He presents with disinhibited behaviour and there was tension with co-patients who found his behaviour intrusive.
- Both were subject compulsory orders under the MHWA in the intensive care area.
- In the early hours of the morning, routine observations found Consumer A and Consumer B together in Consumer A's room in a state of undress.
- When separated and spoken to individually, both consumers stated they had consensual sexual intercourse and denied any distress.
- However, staff identified uncertainty regarding the capacity of either consumer to provide meaningful consent at the time, given acute mental state symptoms and the intensive care context.
- Both consumers refused any interventions including STI screening, pregnancy test or forensic examination. Neither party wanted the police involved or anyone notified.

Three days later…

- Consumer A approaches a nurse stating that she felt uncomfortable about what had occurred and that she felt coerced and fearful.
- She now sees that she had been sexually assaulted and is very distressed. She discloses previous history of sexual assault which she has not previously disclosed.
- Consumer B maintains that the sexual activity had been consensual.

Discussion focused on preventing harm, identifying and responding, and reporting and follow up, and is summarised below:

Preventing Harm
- Orientation: explain rights, expectations and supports clearly.
- Workforce: maintain visible staff presence and match skill mix to observation and acuity.
- Assessment: assess sexual safety vulnerability at admission and throughout care.
- Early intervention: act as soon as concerns emerge.
- Environment: use gender-sensitive care areas.
- Handover: share vulnerabilities, protective factors and agreed safety strategies.

Identifying and Responding
- Safety: separate consumers and speak with each person privately about safety, choice, support and immediate needs.
- Trauma-informed response: listen, acknowledge, avoid judgement, and support choice and control.
- Escalation: notify senior clinicians and governance pathways promptly and arrange medical and psychological support without delay.
- Observation: increase observation when needed and document clearly.
- Support: involve LEW and IMHA where available. Consider whether, when and how to involve nominated persons, family, carers or supporters, in line with preferences, safety and legal requirements. Offer counselling and other supports.
- Assessment: update care plans and interventions as risk and clinical circumstances change.

Reporting and follow up
- Documentation: record observations, actions and reasons clearly, factually and contemporaneously.
- Reporting: complete VHIMS reporting and notify the Office of the Chief Psychiatrist as required.
- Communication: involve nominated persons, families, carers and supporters in line with the person's preferences, privacy and safety, and undertake open disclosure in accordance with organisational policy.
- Debriefing and wellbeing support: for all involved.
- Police: consider police referral where appropriate and consistent with the person's wishes, safety needs and legal obligations.
- Health follow-up: revisit STI screening, pregnancy testing and other health supports, recognising that consent may change over time.
- Discharge and community: plan post-discharge support and follow-up for those affected. Provide a comprehensive handover, arrange community follow-up where relevant, and update risk assessments and care plans.
- Future planning: develop safety plans for future admissions, including advance statements and ongoing risks and supports for both consumers.
- Workshop discussion highlighted some variation in initial incident severity ratings (ISR1, ISR2 and ISR3) for this scenario. Most participants selected ISR2, noting that the rating may change as further information becomes available. Some selected ISR1, reflecting a precautionary approach, while others selected ISR3 based on the absence of reported immediate harm at the time. Where there is uncertainty, it is appropriate to assign a higher initial rating and then review and update the rating as part of quality and safety processes. Discussion was more consistent as the scenario evolved, upgrading to ISR1 following Consumer A's disclosure.

Clinical reasoning must be applied in this scenario when considering the capacity of consumers to consent to sexual activity whilst acutely unwell and receiving compulsory inpatient in intensive mental health care units.

Services should also consider coercion, vulnerability and the potential for future harm, and respond to all sexual safety incidents without making judgements about whether staff believe the activity was consensual.

OCP recommendations

In this scenario, when the incident first came to attention, the OCP supports an initial rating of ISR2, with an upgrade to ISR1 following Consumer A's later disclosure. Services should use the rating guide to support decision-making, noting the following:

- In bed-based environments where sexual activity is prohibited, treat all sexual activity as a sexual safety incident and respond in line with this guideline.
- Sexual activity, **even when it seems consensual**, is not appropriate in nearly all bed-based mental health service settings and is prohibited. **Staff need to respond to all sexual safety incidents without making judgements about whether they believe the activity was consensual**.

As One - our ways of working

As One - our ways of working: between Child Protection and ICYAMHWS | health.vic.gov.au

What *As One* expects of ICYAMHWS

The Chief Psychiatrist expects all ICYAMHWS to embed *As One* into everyday clinical and operational practice, including:

- **Shared responsibility for safety and wellbeing**
  Recognising the joint responsibility of ICYAMHWS and Child Protection for children and young people, particularly those with multiple and complex needs or high risk of harm.
- **Routine and timely consultation**
  Using established local and statewide consultation pathways to support clinical decision-making, escalate concerns early and avoid fragmented responses.
- **High-quality information sharing**
  Ensuring information sharing is timely, relevant and lawful, and supports risk assessment, care planning and coordinated action across mental health and wellbeing services and child protection services.
- **Clear governance and escalation**
  Participating in local area arrangements and consultations to manage complex needs and risk, support accountability.
- **Trauma-informed and culturally safe practice**
  Applying trauma-informed principles and cultural safety in all engagement with children, young people, families and carers, including Aboriginal children and young people.

Next steps for services

ICYAMHWS leaders and clinicians are encouraged to:

- Review **As One – Our Way of Working** and the associated information pack; you can access this document via https://www.health.vic.gov.au/as-one-our-ways-working-child-protection-infant-child-youth-area-mental-health-wellbeing-services .
- Ensure local policies and practice, and clinical pathways align with *As One* expectations.
- Support clinicians to apply routine and responsive ways of working in day-to-day practice.
- Provide ongoing feedback at ICYAMHWS Clinical Leaders meetings, enabling OCP to work with OPP in statewide governance meetings to ensure the initiative's effectiveness.

The OCP strongly supports *As One* as a core quality and safety initiative. Embedding *As One* is critical to strengthening quality, safety and collaboration across ICYAMHWS and Child Protection, and is essential to managing risk and supporting sound clinical decision-making to achieve better outcomes for children and young people.

Operational focus

Reminder to all DMHS to report confinement

On March 1st, 2026, the OCP commenced a 12-month pilot to capture episodes of confinement in DMHS.

This practice – which is distinct from seclusion – is defined as consumers being left in locked rooms or enclosed spaces without staff physically present.

The OCP has met with several services, the Directors of Nursing and HACSU to discuss confinement practice and the requirement for reporting. Authorised Psychiatrists and Directors of Nursing have been sent the Information Sheet and Confinement Notification Form which outlines how to report confinement through the OCP Data Sharing Portal. Monitoring confinement is a component of the safeguards under the Mental Health and Wellbeing Act.

Thank you to those services who have commenced reporting to help us understand the extent of this issue and the systemic improvements and safeguarding measures that may be required. All DMHS are reminded to report episodes of confinement occurring in practice. If your service wishes to discuss any aspect of the pilot, please contact ocp@health.vic.gov.au

Drug detection dogs - interim advice

The Office of the Chief Psychiatrist is currently undertaking a review of the *Criteria for searches to maintain safety in an inpatient unit* policy to ensure processes and procedures are consistent with the Mental Health and Wellbeing Act 2022.

Following requests from clinicians and stakeholders for clarification on the role of sniffer dogs in mental health services, the Office of the Chief Psychiatrist is providing initial guidance. This guidance is designed to support services to undertake searches with consideration for consumer and staff safety, as well as best practice clinical care.

The following advice is interim. Further consideration of the use of sniffer dogs will be included as part of the review into *Criteria for searches to maintain safety in an inpatient unit*.

Health services manage the presence of illicit drugs in mental health units with a variety of measures to maintain safe environments for consumers, visitors and staff.

Health services may choose to use drug detection dogs to help manage the impacts of having illicit drugs on mental health units, but they should be limited in their use, with consideration given to maintaining a safe therapeutic environment that promotes the wellbeing and recovery of patients.

Remember that any search-related practice must be consistent with the Chief Psychiatrist guideline, the Mental Health Intensive Care Framework, local policy, and human rights obligations. Searches should only be considered where there is a documented clinical risk assessment, a tangible risk to safety, and a reasonable belief that the search may identify items or substances that could cause significant harm.

Services should consider less intrusive alternatives first and ensure any action is proportionate, time-limited, clinically authorised, documented and reviewed.

Where sniffer dogs are being considered, services should also consider consumer communication in advance to encourage safe removal, trauma-informed safeguards and arrangements for people with phobias, cultural concerns or other vulnerabilities.

Coronial themes

This coronial information has been taken from the **Coroners Court of Victoria Recommendations Report - Edition 9** for the period from 1 October 2024 – 30 September 2025 and published on the 28 April 2026.

For more information or to see the full report, please visit the Coroners' website: Coroners Court of Victoria

Finding into death of TK

Full report - COR 2021 001470 Form 38 - Finding into Death without Inquest_Signed_Redacted.pdf

Recommendation

To the Office of the Chief Psychiatrist: Noting that mental health and wellbeing services need to minimise the risk of harm to patients being discharged to sexually unsafe environments, I recommend the Office of the Chief Psychiatrist consider extending the 'Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units guideline' (2012) to incorporate managing situations whereby vulnerable patients may be discharged into environments whereby their sexual safety may be at risk.

Response from Chief Psychiatrist of Victoria

"The Coroners Court of Victoria recommended that the Office of the Chief Psychiatrist consider expanding existing sexual safety guidelines—which currently apply to adult acute inpatient units—to also address the discharge of vulnerable patients into environments where their sexual safety may be at risk. The Office of the Chief Psychiatrist accepted this recommendation in full."

Case summary

The Coroners Court of Victoria reviewed the death of TK, a young adult with a diagnosis of borderline personality disorder and a history of chronic suicidality. TK died by suicide soon after discharge from an acute mental health inpatient service. Key risk factors included a history of childhood trauma, repeated suicide attempts, mental illness, recent psychiatric hospitalisations, and homelessness. At discharge, TK was placed in an environment with potential sexual safety risks, specifically involving an individual previously alleged (though not substantiated) to have perpetrated sexual abuse, and who was involved in her discharge planning and nominated as next of kin.

Conclusion

TK's death highlights the intersection of chronic suicidality, trauma history, housing instability, and the need for robust sexual safety planning at all stages of care, including discharge. The acceptance and implementation of the coroner's recommendations by the Office of the Chief Psychiatrist, including the extension of sexual safety guidelines to discharge settings, is a critical step. However, ongoing attention to housing, culturally safe supports, and comprehensive discharge planning is required to reduce risk and improve outcomes for vulnerable individuals in the public mental health system.

Key learnings for clinical practice and policy:

- Always assess and manage sexual safety risks in discharge planning.
- Integrate housing stability as a core component of suicide risk management.
- Ensure culturally appropriate and ongoing community supports post-discharge.
- Foster interagency collaboration to address complex social and clinical needs.
- Systematically monitor and evaluate the implementation of policy changes to ensure they translate into improved patient safety and outcomes.

Finding into death of DM

Full report - COR 2022 005266 Form 38 - Finding into Death without Inquest - DEIDENTIFIED_Signed.pdf

Recommendation That the service reviews its practices to ensure that discharge summaries for patients who have received treatment for self-harm are promptly prepared and forwarded to their general practitioners as soon as possible.
Response from designated mental health service "The service accepted the recommendation in full and committed to reviewing its practices to ensure that discharge summaries for patients who have received treatment for self-harm are prepared promptly and provided to general practitioners as soon as possible."
Case Summary DM was a 43-year-old woman with a complex psychiatric and medical history, including schizoaffective disorder, borderline personality disorder, post-traumatic stress disorder, chronic pain, anxiety, depression, and a longstanding pattern of suicidal ideation and self-harm. She had multiple hospital admissions and was prescribed several psychotropic and analgesic medications. DM died by intentional overdose of prescription medications shortly after discharge from hospital, following a recent episode of self-harm and hospital admission.
Conclusion DM's death highlights the critical importance of timely and effective communication between hospital and community providers, particularly following episodes of self-harm. The lack of prompt discharge summary transmission to her GP contributed to gaps in continuity of care and risk management. The service's implementation of secure messaging for discharge summaries is a positive step, but ongoing attention to care coordination, risk communication, and guideline expansion is required to improve outcomes for vulnerable patients.
Key learnings for clinical practice and policy: • Discharge summaries for patients who have self-harmed must be sent to GPs immediately after discharge. • Secure electronic communication should be standard for clinical documentation. • Care coordination and risk communication at discharge are essential for patient safety. • Medication safety depends on timely and accurate information sharing between providers.

Finding into death of CL

Full report - DEIDENTIFIED - COR 2023 005124 Form 38 - Finding into Death without Inquest_Signed.pdf

Recommendations:

- That the service reviews its accommodation support services provided to eligible patients after discharge from hospital, to ensure that they are available to be allocated towards accommodation that may be required subsequent to an intervening "step down" admission to the Prevention and Recovery Centre (PARC).
- The service reviews their discharge process for mental health in-patients, and associated policies and procedures, to ensure that they are consistent with the Chief Psychiatrist's guideline: Transfer of care and shared care and the Department of Health's guideline: Transfer of care from acute inpatient services.
- The service reviews their policies and procedures in relation to the reporting of Sentinel Events to ensure they are consistent with Safer Care Victoria's Victoria sentinel event guide (Version 2).
- The service reviews their policies and procedures in relation to their reporting obligations in response to patients who have died by suicide within 24 hours of discharge to ensure they are consistent with Response from the service Accepted in full Safer Care Victoria's Adverse Patient Safety Event Policy.

Responses from designated mental health service:

- The service accepted the recommendation in full and committed to reviewing its accommodation support services for eligible patients following hospital discharge, to ensure support remains available where accommodation is required after an intervening "step-down" admission to a Prevention and Recovery Centre (PARC).
- The service accepted the recommendation in full and committed to reviewing its mental health inpatient discharge processes, including associated policies and procedures, to ensure alignment with the Chief Psychiatrist's *Transfer of care and shared care* guideline and the Department of Health's *Transfer of care from acute inpatient services* guideline.
- The service accepted the recommendation in full and committed to reviewing its policies and procedures for reporting Sentinel Events, to ensure consistency with Safer Care Victoria's *Victorian Sentinel Event Guide (Version 2)*.
- The service accepted the recommendation in full and committed to reviewing its policies and procedures relating to reporting obligations following the death by suicide of a patient within 24 hours of discharge, to ensure consistency with Safer Care Victoria's *Adverse Patient Safety Event Policy*.

Case summary

CL was a middle-aged man with a long history of treatment-resistant depression and chronic suicidality. Despite ongoing support from his family, a private psychiatrist, and multiple inpatient admissions, his risk of suicide remained high. CL died by suicide shortly after discharge from hospital in September 2023. The coroner found that the clinical care provided during his last admission was reasonable and appropriate, including the decision to discharge, which was made with senior clinical consultation. However, the case highlighted several areas for systemic improvement, particularly regarding discharge planning, accommodation support, communication with families, and internal incident review processes.

Conclusion

CL's death underscores the complexities of managing treatment-resistant depression and chronic suicidality, particularly in the context of accommodation instability and limited patient engagement.

While the clinical care provided was reasonable, the case reveals important opportunities for service improvement in discharge planning, access to step-down care, family engagement, and incident review processes. The full acceptance of the coroner's recommendations by the service is a positive step, but ongoing vigilance and system-wide learning are required to reduce risks for similar patients in the future.

Key learnings for clinical practice and policy:

- Ensure flexible access to step-down care services for patients with unstable housing.
- Commence discharge planning early, with multidisciplinary input and timely referrals to all relevant community supports.
- Strive for family engagement in risk assessment and care planning, within legal and ethical frameworks.
- Align all discharge and incident review policies with best practice guidelines and ensure rigorous internal reviews after critical incidents.
- Promote transparency, organisational learning, and family communication following adverse events.

Finding into death of JN

Full report - COR 2021 005194 Form 38-Finding into Death without Inquest_Signed.pdf

Recommendations:

- Review its mental health service's escalation policy/protocol for its community mental health team to escalate the above circumstances to mental health senior/leadership for advice on how to address the clinical risks and needs of the client and to ensure appropriate information and training is undertaken to ensure that senior staff are familiar with the policy.
- In circumstances where the decision is made to discharge the patient to the care of another practitioner that all reasonable attempts are made to directly contact that practitioner to ensure that they are aware of the patient's current presentation; and
- In circumstances where the decision is made to discharge the patient, that the community mental health team or other member of the service, contact the patient's family or next of kin about the implications of the decision (subject to the patient's consent to their personal health information being released to their nominated family member / next of kin).

Responses from designated mental health service:

- The service accepted the recommendation in full and committed to reviewing its community mental health escalation policy and processes, to ensure circumstances of clinical risk are escalated to senior mental health leadership for advice, and that appropriate information and training are provided so senior staff are familiar with the policy.
- The service accepted the recommendation in full and committed to ensuring that, where a decision is made to discharge a patient to the care of another practitioner, all reasonable efforts are made to directly contact that practitioner, so they are aware of the patient's current presentation.
- The service accepted the recommendation in full and committed to ensuring that, where a decision is made to discharge a patient, the community mental health team or another appropriate service representative makes reasonable efforts to contact the patient's family or next of kin to explain the implications of the decision, subject to the patient's consent to the disclosure of their personal health information.

Case summary
JN was a man with a history of mental health presentations, including requests for admission and engagement with community mental health services. In September 2021, JN presented to emergency departments with complex psychosocial stressors but was not assessed as experiencing acute psychiatric illness or psychosis. His engagement with the community mental health team was limited and ultimately terminated due to aggressive and threatening behaviour towards staff. He was discharged to the care of his GP without a comprehensive psychiatric assessment, meaningful family engagement, or direct communication with his GP. JN died by suicide days after his discharge.
Conclusion
JN's death highlights the risks associated with discharging patients with complex psychosocial needs and challenging behaviours from community mental health services without comprehensive assessment, escalation, and communication. While the care provided was broadly within the expected standard, the case demonstrates the need for robust escalation processes, proactive communication with other practitioners and families, and strict adherence to follow-up protocols. The service's acceptance of all coronial recommendations is a positive step, but ongoing vigilance and system-wide learning are essential to prevent recurrence.
Key learnings for clinical practice and policy: • Escalate complex or high-risk cases to senior leadership when comprehensive assessment cannot be completed. • Ensure direct, documented communication with GPs or other practitioners at discharge. • Engage family or next of kin, with patient consent, in discharge planning and risk management. • Rigorously adhere to post-discharge follow-up requirements, especially for high-risk individuals. • Regularly review and update policies in light of adverse events and coronial findings.

Further information

Read about the statutory role of the Chief Psychiatrist to uphold quality and safety in Victoria's mental health and wellbeing system under the Mental Health and Wellbeing 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 Mental Health and Wellbeing 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 Mental Health and Wellbeing 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

To receive this document in another format, phone 1300 767 299, using the National Relay Service 13 36 77 if required, or email Office of the Chief Psychiatrist, <ocp@health.vic.gov.au>.

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Available at Office of the Chief Psychiatrist's website <https://www.health.vic.gov.au/chief-psychiatrist/resources-and-reports>