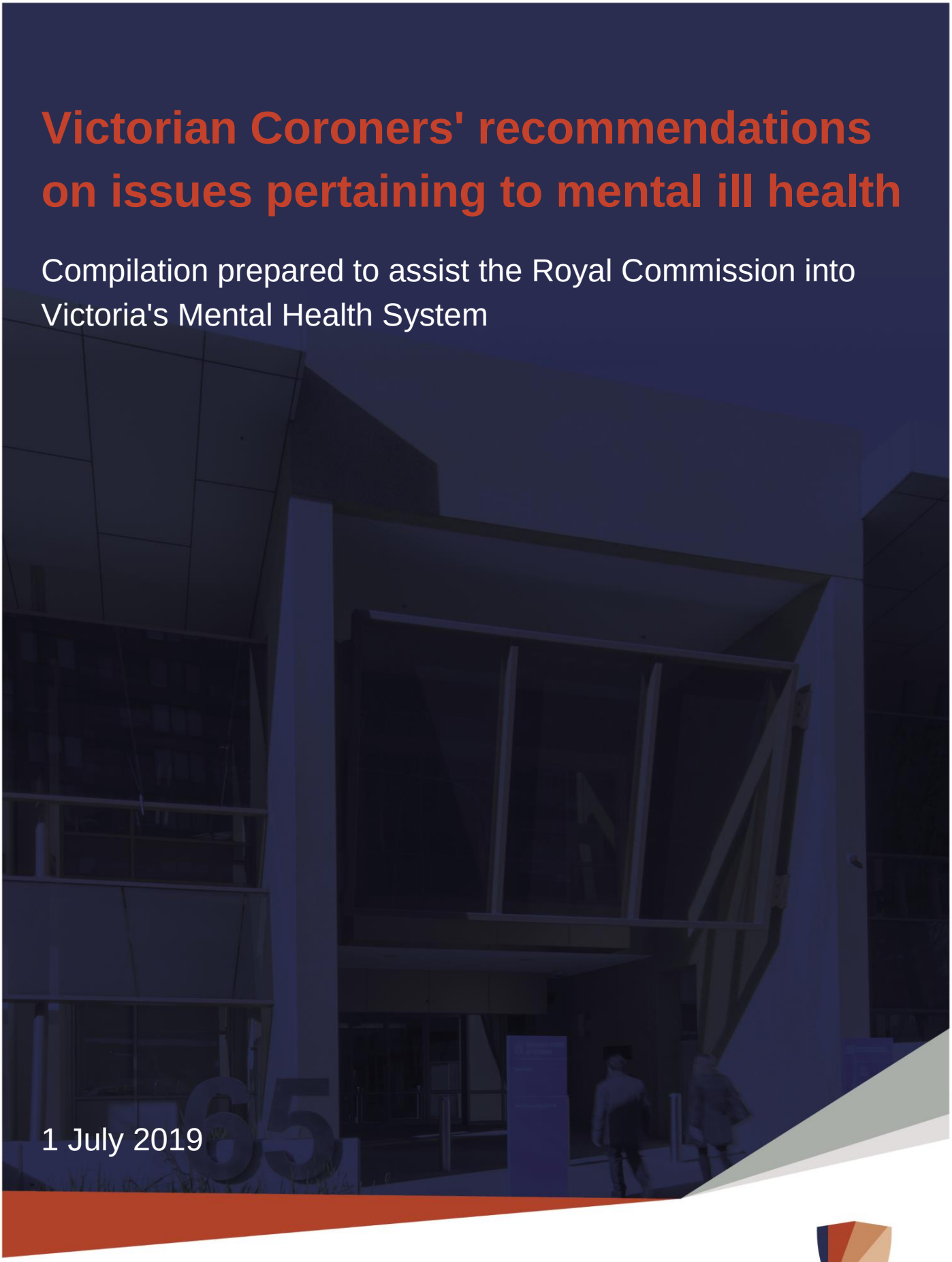
Victorian Coroners' recommendations on issues pertaining to mental ill health

Compilation prepared to assist the Royal Commission into Victoria's Mental Health System



1 July 2019

Coroners Court of Victoria

www.coronerscourt.vic.gov.au

Contents

Overview

The purposes of the Coroner's investigation as described in the preamble to the *Coroners Act 2008* (Vic) ('the Act') include to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. A primary means by which this purpose is achieved, is through making recommendations in findings that are delivered at the completion of an investigation.[1] Under Section 72(2) of the Act:

> *A coroner may make recommendations to any Minister, public statutory authority or entity on any matter connected with a death or fire which the coroner has investigated, including recommendations relating to public health and safety or the administration of justice.*

This document contains a thematically organised compilation of 430 Coronial recommendations made in 180 findings since the Act came into operation on 1 November 2009. These recommendations address Victoria's mental health system and the treatment, care and support of mentally ill people in Victoria. The recommendations were compiled to assist the Royal Commission into Victoria's Mental Health System to provide the Victorian community with a clear and ambitious set of actions that will change Victoria's mental health system and enable Victorians to experience their best mental health now and into the future.

Identification of recommendations

The Coroners Court of Victoria maintains a database of recommendations made by Victorian Coroners in deaths investigated from 1 January 2000 onwards. The database was searched on 17 June 2019 to identify relevant recommendations.

Inclusion and exclusion criteria

A recommendation was generally deemed to be relevant and was included if it addressed any aspect of mental ill health, the mental health system, and/or suicide prevention.

The main exception was recommendations regarding drug dependence and misuse. If a recommendation in this area focused on drug dependence and treatment within a mental health context (for example, dual diagnosis services) it was included, but otherwise it was excluded on grounds of potential irrelevance.

Themes

Relevant recommendations were compiled by theme. The organising principle for the themes was the area of the health system to which the recommendation was addressed (for example, community mental health, inpatient mental health, emergency department or general practice). Within each theme, recommendations were listed in chronological order by the date they were made.

Please note that each recommendation was only listed under a single theme. If a recommendation addressed multiple themes, a decision was made as to which theme was the best fit in the context of

1 A Coroner is not required to include recommendations in a finding, and the overwhelming majority of findings do not include recommendations. In financial year 2017-2018, for example, Coroners completed investigations and made findings in approximately 6500 deaths; recommendations were included in 48 of these findings.

the Coroner’s finding. Therefore, when searching for relevant recommendations on a particular topic, it is important to be aware that they might be spread across multiple themes. For example, a recommendation regarding a patient absconding from an emergency department might be listed under the Emergency Department theme, or Police, or New Guidelines and Processes, depending on the Coroner's focus.

Summaries

A brief one line summary outlining the nature of each death was prepared to assist readers to understand the context in which the recommendations were made. Please note that these summaries are selective and reductive and are not intended to be substitutes for the findings themselves. If a reader is interested in any particular recommendation contained in this compilation, the reader is urged to review the complete Coroner's finding rather than relying on the summary for context.

Community mental health treatment

Coordination of care and transition of care

23 March 2012 - Coroner John Olle	
Case	20085605
Summary	Man suicided whilst under care of a Community Treatment Team.
Recommendations	1. That North Western Mental Health Service ensure at every first contact with MCCT there must be a telephone call with the general practitioner or service with whom care is shared.

12 October 2012 - Coroner Audrey Jamieson	
Case	20071735
Summary	Suicide of man who absconded from inpatient psychiatric unit.
Recommendations	1. With a view to consistency with the National Mental Health Care Plan 2009-2014, "Priority area 3: Service access, coordination and continuity of care", I recommend that North Western Mental Health Services review its model of delivery of psychiatric care with a view to implementing one that provides greater continuity of care by the psychiatrists, such as described by [the psychiatrist] in his evidence. The review should incorporate a comparison of other regions and jurisdictions that have adopted similar models.

22 April 2013 - Coroner Pauline Spencer	
Case	20113385
Summary	Woman who suicided after emergency department assessment.
Recommendations	6. That the Minister for Health and/or Secretary to the Department of Health investigate ways to prevent Mental Health Service patients from being prescribed additional medication from general practitioners without notification to the Mental Health Service.

10 September 2013 - Coroner Paresa Spanos	
Case	20074142
Summary	Man who died from clozapine toxicity.
Recommendations	1. In order to improve the safety of patients and their continuity of access to Clozapine, I recommend that SHMHS and PHMHS review their existing policies and procedures related to Clozapine to address what is required in relation to patients' own supplies of medications at the point of transfer, and the change from one brand of Clozapine to another. 2. In order to improve the safety of all patients, I recommend that Peninsula Health includes information on the restrictions of Clozapine prescribing in the training and/or orientation of all medical officers, to decrease the risk of inappropriate and unsafe patient access to Clozapine.

3. In order to improve the safety of patients who are prescribed Clozapine, I recommend that PHMHS reviews its guideline to increase frequency of review of such patients in the initial weeks following transfer from another mental health service on the basis that this is a recognised high-risk period.

2 July 2014 - Coroner Ian von Einem	
Case	20131916
Summary	Woman who suicided after mental health treatment.
Recommendations	1. To improve the safety of clients with a recognised arrangement for care that involves a public mental health service and a private psychiatrist, the Office of Chief Psychiatrist and the Royal Australian and New Zealand College of Psychiatrists collaborate to develop a statement or guideline to outline what is a reasonable level of formal communication regarding an individual client: - By a private psychiatrist to the involved public mental health service; and - By the public mental health service to the involved private psychiatrist.

12 September 2014 - State Coroner Judge Ian Gray	
Case	20104337
Summary	Man killed by another man who had been discharged from a Community Treatment Order.
Recommendations	1. I recommend that the Royal Australian College of Psychiatrists, or other relevant professional body, either mandate, or at least strongly recommend, that those responsible for the provision of psychiatric treatment and care of a patient who is being transferred to a general practitioner, prepare a discharge summary, taking into account input from the psychiatrist, or psychiatrists who have been providing care to the patient.

20 July 2017 - Coroner Gregory McNamara	
Case	20155061
Summary	Suicide of man who experienced serious mental ill health.
Recommendations	1. I recommend to the Office of the Chief Psychiatrist and to the Royal Australian and New Zealand College of Psychiatrists that they develop a shared protocol or guidelines to provide guidance for clinicians who share the responsibility for the care of patients across the public and private sectors. Matters that should be addressed include communication, transparency of arrangements with patients and carers, clinical responsibility in periods of crisis and negotiated care planning.

Treatment compliance and patient engagement

14 February 2013 - Coroner Jane Hendtlass	
Case	20073375
Summary	Man experiencing mental ill health who drowned in unascertained circumstances.
Recommendations	2. That the Royal Australian and New Zealand College of General Practitioners encourage its members who administer regular depot antipsychotic medication to maintain active communication with their patients' mental health treating team, particularly when they fail to keep appointments.

21 May 2013 - Coroner Jane Hendtlass	
Case	20064595
Summary	Man died following medication overdose.
Recommendations	1. That Eastern health review their procedures for monitoring mental health clients' compliance with the requirements of their Community Treatment Orders to encourage early collateral monitoring of their blood medication levels when they present with otherwise unexplained or continuing deterioration in their mental state. 2. That the Chief Psychiatrist advise authorised psychiatrist of the approved mental health services in Victoria of the circumstances of [the deceased's] death and encourage early collateral monitoring of blood medication levels when clients on Community Treatment Orders present with otherwise unexplained or continuing deterioration in their mental state. 3. That the Royal Australian and New Zealand College of Psychiatrists advise its members of the circumstances of [the deceased's] death and the important of collateral evidence of compliance with treatment conditions in the context of otherwise unexplained or continuing deterioration in patents' mental state.

21 August 2013 - Coroner Paresa Spanos	
Case	20103708
Summary	Woman with emerging depressive illness who suicided.
Recommendations	1. That to increase the safety of patients with an emerging depressive illness, Eastern Health Mental Health Services review its policy and clinical guidelines to ensure monitoring of therapeutic effectiveness in the high-risk commencement period for antidepressants is assessed according to best practice principles.

2 December 2015 - Coroner Paresa Spanos	
Case	20130653
Summary	Man who suicided while experiencing acute deterioration in mental health.
Recommendations	1. I recommend that the Royal Australian and New Zealand College of Psychiatrists develop specific practice advice or guidelines regarding patient "dropouts" or "disengagement" (including defining these terms) to assist private psychiatrists to make an appropriate decision regarding the need to follow-up of patients who unexpectedly disengage from treatment.

Monitoring and supporting patient safety in the community

16 August 2011 - Coroner Heather Spooner	
Case	20075119
Summary	Woman suicided after leaving an emergency department.
Recommendations	2. To improve the safety and engagement of the patient, and to mitigate the risk of clinical deterioration, Eastern Health Mental Health Services should review current guidelines regarding how best to support a case managed patient on a Community Treatment Order when there are custody issues pertaining to the patient.

23 March 2012 - Coroner John Olle	
Case	20085605
Summary	Man suicided whilst under care of a Community Treatment Team.
Recommendations	2. That North Western Mental Health Service ensure clinicians must be provided an opportunity to make important notes prior to commencing subsequent consultation. 4. That North Western Mental Health Service ensure the MCCT creates a Crisis/Emergency plan at the first consultation, ideally to encompass a crisis pathway for families.

9 October 2014 - Coroner Caitlin English	
Case	20103033
Summary	Suicide of a man who was subject to a family violence intervention order.
Recommendations	2. To improve the safety of patients referred to the North West Area Mental Health, a process should be developed to formally re-contact Victoria Police after requesting a welfare check in response to a third party crisis referral. This should also include a formal communication of the referral and the outcome of the patient's general practitioner.

18 March 2015 - Coroner Phillip Byrne	
Case	20140430; 20140431
Summary	Deaths during extreme heat of two people with diagnosed schizophrenia.
Recommendations	1. The Chief Psychiatrist issue a directive requiring all public mental health services to develop and introduce an appropriate guideline that identifies, among other things, the clinical responsibilities for case managed and at-risk clients at times of extreme weather conditions.

13 July 2018 - Coroner Phillip Byrne	
Case	20172628
Summary	Man who suicided during acute deterioration in mental health.
Recommendations	1. I recommend Eastern Health, if it has not already done so, develop and implement a formal procedure/practice/protocol to the effect that if a call for assistance is put through to a CATT clinician and for whatever reason is not answered, then the call is automatically re-directed back to the initial call taker so that an initial risk assessment can be undertaken.

Treating younger people

12 June 2014 - State Coroner Judge Ian Gray	
Case	20104396
Summary	Suicide of adolescent boy receiving mental health treatment in the community.
Recommendations	1. That Monash Medical Centre consider reviewing its Crisis Assessment Review policies to include the requirement for an experienced Child and Adolescent Psychiatrist to review Adolescent Crisis Assessments, particularly those undertaken by adult mental health clinicians, before clinical decisions are made regarding their admission, treatment or otherwise.

25 July 2016 - Coroner Paresa Spanos	
Case	20133136
Summary	Young woman being treated for eating disorder who suicided.
Recommendations	1. I recommend that Monash Health/ELMHS undertake a review of the training it provides staff in relation to the risk assessment to ensure that it incorporates guidance specific to the risk assessment of adolescents. 2. Monash Health/ELMS may benefit from clarification of the responsibilities of clinicians in the assessment of risk, including exploration of suicidal ideation, when disparate clinical teams are jointly involved in management of adolescents with eating disorders. Therefore, I recommend that Monash Health/ELMS review its processes in these areas to ensure that they address the frequency of risk assessments and how this clinical information is documented and shared.

3 February 2017 - Coroner Rosemary Carlin	
Case	20142874
Summary	Young man (mid-teens) who suicided.
Recommendations	1. To improve the safety of minors, the Australian Health Practitioner Regulation Agency (Psychology Board) develop advice for clinical psychologists regarding the establishment of 'mature minor' status and subsequent information sharing, confidentiality and clarification of boundaries, relating to attendance and any emerging risks for adolescents.

Housing and residential support

25 May 2010 - Coroner Edwin Batt	
Case	20070197
Summary	Man with diagnosed depression who suicided in community care.
Recommendations	1. That consideration be given to a Gippsland Prevention & Recovery Care Service (PARCS) being constructed at Warragul. The deceased in this case clearly needed admission to a stepdown unit which is less clinical than an inpatient facility but could provide a psychiatric nurse 24 hours a day and monitoring of medication.

Whilst it is accepted that progress in getting well from psychiatric illness is sometimes better achieved at home than in a hospital, the move from hospital to home in this case, like in many others, needed a more supported bridge than relying on loving and well meaning family members.

15 November 2010 - Coroner Jane Hendtlass	
Case	20040805
Summary	Son killed mother while experiencing exacerbation of psychosis.
Recommendations	1. That the State and Federal Ministers for Mental Health and Housing cooperate to increase the range of low cost independent and shared housing options available in order to provide more opportunities for early integration into the community of people newly diagnosed with an episodic mental illness. 2. That the State and Federal Ministers for Mental Health address the needs of familial carers of people newly diagnosed with an episodic mental illness to ensure that they are provided with emotional, physical and mental support in making decisions about accommodation which are in the long-term best interests of both the carers and their family members with mental illness. 4. That the Minister for Mental Health in Victoria assess the residential needs of newly diagnosed patients with episodic mental illness subject to Community Treatment Orders so that social and domestic barriers to their long term integration into the community can be managed more effectively.

14 February 2013 - Coroner Jane Hendtlass	
Case	20073375
Summary	Man experiencing mental ill health who drowned in unascertained circumstances.
Recommendations	3. That the Office of Housing review the criteria for provision of public housing to mentally ill people who, despite having adequate income, are unlikely to obtain long-term, private, rental accommodation because of their illness and circumstances.

14 May 2015 - State Coroner Judge Ian Gray	
Case	20121620
Summary	Man stabbed by roommate in Supported Residential Service.
Recommendations	1. Given that 59 per cent of pension level SRS residents were reported to have a psychiatric illness or disability, I recommend that the Department of Health and Human Services give consideration to mandating mental health training for staff, (or at least for more senior staff) in Supported Residential Services. The training should be at least sufficient to enable staff to recognise serious threats, interpret threats and take appropriate action. 2. I further recommend that the Department of Health and Human Services give consideration to incorporating in the Supported Residential Services compliance regime a requirement that proprietors insist on relevant staff undertaking such training.

28 March 2018 - Coroner Peter White	
Case	20160180
Summary	Man who suicided while residing at a supported residential service (SRS).
Recommendations	1. That the Department of Health and Human Services, in conjunction with Supported Residential Services, Mental Health Services, Mental Health Community Support Services and Consumer Representation, develop a guide that improves the safety of SRS residents with an acute deterioration in mental state with associated acute risks who are engaged with acute or continuing care teams, rehabilitation-recovery focused or other community mental health services. The guide should address the following, namely: (a) SRS staff are provided with a current safety plan for the resident during a period of deterioration; (b) SRS residents are, wherever possible, engaged in the development of the safety plan developed for a particular episode of deterioration; (c) Refusal by a SRS resident to engage in the development of a safety plan does not preclude the engaged mental health service from completing a safety plan for a specific episode of deterioration with a view to engaging with the resident when s/he is willing; (d) The elements to be included in a safety plan, including clear details and advice for SRS staff about when and whom to contact in particular circumstances; (e) The response the SRS may reasonably expect from the engaged mental health service(s); (f) Reflect the staffing levels and limits of SRS staff skills; and (g) Include a requirement that at the resolution of an acute deterioration of mental state and cessation of any associated acute risks (as assessed by the engaged mental health service), that the SRS resident and the SRS staff are informed that the safety plan is no longer current.

Carer involvement

15 November 2010 - Coroner Jane Hendtlass	
Case	20040805
Summary	Son killed mother while experiencing exacerbation of psychosis.
Recommendations	3. That the Minister for Mental Health in Victoria give immediate priority to identifying and assisting ageing or frail carers of mental health patients subject to Community Treatment Orders with a view to commencing housing transition plans as early as possible in their illness.

7 February 2014 - Coroner Jacqui Hawkins	
Case	20081067
Summary	Man with acute psychotic illness died of unascertained causes.
Recommendations	1. I recommend that NorthWestern Mental Health consider implementing a policy, procedure or guideline in relation to dealing with third party referrers as quasi customers or clients. The policy, procedure or guideline should require the triage clinician to provide information about mental health including possible symptoms and how to engage with the affected person, particularly when they are resistant to receiving help. It should also require the clinician to establish a clear action plan for the third party referrer, if the affected person's mental health deteriorates.

25 July 2016 - Coroner Paresa Spanos	
Case	20133136
Summary	Young woman being treated for eating disorder who suicided.
Recommendations	3. In order to increase the safety of its patients, I recommend that Monash Health/ELMHS encourage its Family Based Therapy clinicians to engage with patients with eating disorders and their families early in the treatment process to develop two safety plans, one tailored to suit the needs of the patient, and the other addressing the needs of the family.

Inpatient mental health treatment

Admission

8 October 2010 - Deputy State Coroner Iain West	
Case	20074970
Summary	Woman who suicided in inpatient unit.
Recommendations	2. Protocols be established to ensure family members, willing to be involved in the psychiatric care of their loved one, are engaged at the outset and be given the opportunity to contribute to ongoing management options.

17 May 2012 - Coroner Jane Hendtlass	
Case	20070791
Summary	Suicide of man after discharge from inpatient psychiatric unit.
Recommendations	1. That clinicians remain attentive to the contribution able to be made by the patient's family and carers and incorporate into their decision making process their knowledge of his or her behaviour and thinking. 2. That the Chief Psychiatrist facilitate development of a tailored information package to all patients, their family members and carers on first admission to an approved mental health service 3. That the Chief Psychiatrist inform herself about the preferences of clients, families and carers before she determines how best to communicate with them about what they can expect to experience during and after their first admission to an approved mental health service.

22 February 2013 - Coroner Kim Parkinson	
Case	20101251
Summary	Man who died while being restrained in an emergency department.
Recommendations	1. That upon revocation of mental health community treatment orders, that the patient be transferred to a dedicated mental health facility in-patient unit and that they not be admitted to acute hospital emergency departments unless there are sound medical reasons for such admission. 2. That the timing of apprehension of patients pursuant to a revoked community treatment order be determined (where possible having regard to the urgency of the apprehension) by reference to the availability of in-patient mental health beds.

8 May 2013 - Coroner William Gibb	
Case	20080732
Summary	An Aboriginal woman who suicided after absconding from an inpatient psychiatric unit.
Recommendations	1. When an Aboriginal person is taken into police custody, police are required to inform the Victorian Aboriginal Legal Service of that fact without delay in order to ensure that person's legal rights are protected. It is recommended that whenever

an Aboriginal person is admitted to a mental health facility, that as part of the process, the Aboriginal Liaison Officer (or any other person holding a similar role) be notified without delay so that all necessary services can be actioned.

2. Whilst satisfied that [the deceased] was taken to the nearest and most appropriate mental health facility given her involuntary patient status, the importance of 'country' to Aboriginal people must be acknowledged. That being so, it is recommended that where circumstances permit, that Aboriginal involuntary patients always be located at a Mental Hospital as close to their country as possible.
4. At the time of [the deceased's] death, [worker] was employed as Aboriginal Health Liaison Officer at Bendigo Health. Her hours of employment were 8.30 am to 5.00 pm Monday to Friday. It is recommended that this role be extended to include on call duties so that all times outside of the normal working week will also be covered. This would enable a 24 hour notification and support service for Aboriginal patients admitted to psychiatric hospitals.

Providing appropriate care in inpatient settings

8 October 2010 - Deputy State Coroner Iain West	
Case	20074970
Summary	Woman who suicided in inpatient unit.
Recommendations	3. That protocols be established to ensure detailed and accurate notes are maintained of a patient's psychiatric assessment, diagnosis and management plan.

27 April 2011 - Coroner Jane Hendtlass	
Case	20073645
Summary	Man who suicided after discharge from inpatient psychiatric unit.
Recommendations	2. That the Attorney General and the Minister for Mental Health consider the specific implications for suicide prevention of requiring authorised psychiatrists, medical practitioners and mental health practitioners to accurately assess patients' "imminent and significant risk of serious harm" in the new mental health legislation to further limit their capacity to impose involuntary treatment orders.

22 July 2011 - Coroner Audrey Jamieson	
Case	20064204
Summary	Man with diagnosed schizoaffective disorder died from cardiomegaly.
Recommendations	1. I recommend that St. Vincent's Hospital (Melbourne) Limited continue to implement all the matters actioned from the findings of the Root Cause Analysis with particular regard to: the provision of periodic education sessions for staff involved in mental health care with emphasis on the importance of timely, accurate, contemporaneous and comprehensive documentation in accordance with the Medical Record Documentation Policy; and the provision of periodic education sessions on the roles and responsibilities of nurses who undertake the role of primary nurse or contact nurse as outlined in the Primary Nursing Manual; and the continuation of the annual file audits of clinical files from the mental health service for the purposes of monitoring and ensuring continued compliance with the Documentation Policy.

14 October 2011 - Deputy State Coroner Iain West	
Case	20102384
Summary	Suicide of woman in inpatient psychiatric unit.
Recommendations	1. That the Northern Area Mental Health Service, Melbourne Health examine the level of observation (with a view to harm minimization) that is possible within the Northern Psychiatry Unit, when the patients have full access to their single occupant bedrooms. 2. That staff remain vigilant in obtaining collateral information from sources such as family, medical records and other health professionals, and that consideration be given to introducing an electronic case note system, to facilitate dissemination of the information.

10 April 2013 - State Coroner Judge Ian Gray	
Case	20123776
Summary	A man who suicided while in care of community mental health services.
Recommendations	2. That patient's notes are the official record of the patient's care. They are the medico-legal record of the interaction between the patient (including family) and the health service. In this respect, I note that the Progress Notes Report Documentation lists a number of guidelines that should be followed in completing the Progress Notes, however, formal consideration should be given to include in the guidelines the types of information that should be documented including reasons for decisions to be set out on the patient's file.

18 June 2013 - Coroner John Olle	
Case	20104610
Summary	Man who suicided in an inpatient psychiatric unit.
Recommendations	4. Implement Recommendation 7 made in the report titled "Chief Psychiatrist's Investigation of inpatient deaths 2008-2010" that: "The Department of Health and health services ensure there is clear and consistent process and documentation for nursing observations, and that any change in required observation level is made after suitable discussion and consideration. The frequency of observations over the night shift should be congruent with daytime observations unless otherwise decided and documented." 5. The process and documentation of nursing observations should incorporate supervision and accountability to ensure that there is no doubt as to a Nurses responsibility to conduct observations as clinically indicated. 6. Develop Risk Assessment and Risk Management Guidelines specific to inpatient/bed-based Adult Acute Units. The assessment and guidelines should reflect the evidence-base and be inclusive of the range of vulnerabilities and risk exposures present in the adult acute inpatient setting.

29 January 2014 - Coroner Heather Spooner	
Case	20102062
Summary	Woman suicided after absconding from inpatient psychiatric unit.
Recommendations	3. To improve the safety of patients who are involuntary under the Mental Health Act 1986 (Vic) and who are tobacco dependent and who do have approved leave, the John Cade Unit should: a) Review the available body of evidence-based guidelines regarding

withdrawal from tobacco, including best practice in the assessment, prevention, and management of withdrawal symptoms.

b) Undertake a programme of education with the medical and nursing staff that addresses not only the administration of the rules of a smoke free environment, including staff and patient safety, but best practice in the assessment, prevention, and management of withdrawal symptoms from nicotine as a substance of addiction and prevent or manage the symptoms.

4. The John Cade Unit should review the appropriateness of maintaining minimal frequency of nursing visual observations of a patient who is an involuntary patient under the Mental Health Act 1986 (Vic) and who has absconded from and returned to the unit in any previous 24 hours and remains in the low dependency unit until when practicable, is reviewed by a consultant psychiatrist.
5. To increase the safety of patients, the John Cade Unit should undertake an evaluation of the current system for the allocation and implementation of visual sightings in the low dependency unit. The evaluation should include an assessment of risk associated with a contact nurse with responsibility for coordinating the ward round having to negotiate and reallocate responsibility for the visual sighting of their allocated patients to staff members.

28 May 2014 - Coroner Phillip Byrne

Case	20113133
Summary	Woman who died from pharmaceutical drug overdose in inpatient psychiatric unit.
Recommendations	1. To increase the safety of patients in the Northern Hospital Psychiatric Unit, the training program for the safe use of opioid therapies should be referenced to the 2013 Department of Health Policy for maintenance pharmacotherapy for opioid dependence, and the 2003 National clinical guidelines and procedures for the use of methadone in the maintenance treatment of opioid dependence. Specifically, the training program should address the knowledge and skills of medical and nursing staff regarding: a) Informed consent and patient information b) Safe prescribing of methadone pro re nata (PRN) c) Appropriate monitoring of patients prescribed methadone or alternate pharmacotherapies, especially the level of sedation d) Specific education of the 2011 North Western Mental Health Alcohol and Other Drug Withdrawal Practice Guidelines.

12 September 2014 - Coroner Peter White

Case	20090577
Summary	Elderly woman died from venlafaxine toxicity in a setting of severe renal impairment whilst receiving involuntary ECT.
Recommendations	1. Having considered the evidence given in this inquest I recommend that in all cases where the provision of ECT is scheduled at Caulfield Hospital, that a duty anaesthetist examines and reviews the fitness of the patient to undergo the procedure, at least 24 to 72 hours prior to the scheduled commencement of same. 2. I further recommend that the on duty anaesthetist (again) examines and confirms the patient's fitness to undertake the procedure, on the morning of the scheduled commencement of same. 3. If it is not already the case I would recommend that a checklist should be established to support this procedure.

29 September 2014 - Coroner Peter White	
Case	20073955
Summary	Man who suicided in an inpatient psychiatric unit.
Recommendations	1. I recommend to Alfred Health that in all cases of observation down grade from special nursing level, that a consultant medical officer review the patient concerned in person and record details of the clinical reasons for deciding to do so. 2. I further recommend that in all cases described in recommendation 1 above, where a consultant medical officer is unavailable to see a patient receiving special nursing and recommended for downgrade, that any approval for an observation downgrade by such consultant should only be given through and IT approval system, which includes a time stamped document review, and a further clinical review setting out the consultant medical officers reasons for so deciding.

22 December 2014 - Coroner Jennifer Tregent	
Case	20095950
Summary	Man who suicided while on leave from Prevention and Recovery Care facility.
Recommendations	3. The Bendigo Health Care Group needs to ensure that all policies that do exist are properly and fully explained to the staff. There needs to be regular and mandatory training of staff to ensure they are appraised of the Policies and how to implement them. The Bendigo Health Care Group should consider facilitating a fixed program regarding ongoing education of staff. Inclusive of this training, is not only a familiarisation with the internal policies of Bendigo Health Care Group by which they are governed, but also all of the Chief Psychiatrists guidelines that may have useful application to their care of patients. 4 If not already in place there needs to be a clear chain of responsibility as to who is responsible for overseeing an internal review of a patient's death. 5 A Clinical team meeting should not discuss a patient unless the consultant psychiatrist has actually met with the patient and reviewed his or her file. This should be more readily achievable given the additional days of attendance of a consultant psychiatrist. This is particularly important as ultimately the decisions on leave and other management of a patient are the responsibility of the psychiatrist.

2 February 2015 - Coroner Paresa Spanos	
Case	20124587
Summary	Woman who suicided in an inpatient psychiatric unit.
Recommendations	1. I recommend that NWMH reassess the current Clinical Risk Assessment and Management guideline or policy regarding the level of engagement required for patients rated 'low risk'. Clear instructions should be developed for staff to produce consistency in: a) the frequency of formal documented mental state examinations across each shift, b) the requirement for a formally documented and notarised rationale explaining determination of a patient's 'low risk' rating; and c) the frequency, timing and recording of visual observation of patients. 5. I recommend that NWMH provide focused and detailed training to the nursing and allied staff and medical staff of the BIPU concerning the static risk factors (including those specific to particular diagnosed conditions) and dynamic risk

factors (including changes in perception and increased anxiety levels) of individuals with mental illness.

8. I recommend that NWMH provide focused and detailed training to the nursing and allied staff and medical staff of the BIPU about the procedure for escalation/referral to more senior staff of changes in mental state, dynamic risk factors for suicide (including changes in perception and increased anxiety level) of people with mental illness.

27 May 2015 - Coroner Audrey Jamieson	
Case	20112235
Summary	Man who died from physical ill health in psychiatric inpatient unit.
Recommendations	1. With the aim of minimising risk and preventing like deaths, I recommend that Mercy Mental Health amend their definition of 'visual observation' so that it includes but is not limited to recording the patient's/client's activity level, and if the patient/client is assumed to be sleeping, that a notation of chest movements and/or other signs of respiration are recorded consistent with good clinical practice. 2. With the aim of minimising risk and preventing like deaths, I recommend that Mercy Mental Health implement compulsory training (and ongoing refresher training) to inform staff about the new risk assessment and visual observation forms, policies and procedures implemented by Mercy Mental Health, and implement compulsory training about the Prompt system, including how to use it to access all current and future policies and procedures implemented by Mercy Mental Health.

1 June 2016 - Coroner Audrey Jamieson	
Case	20110260
Summary	Man who suicided after absconding from an inpatient psychiatric unit.
Recommendations	1. I remain unpersuaded following this extensive investigation that there was effective communication between staff about [the deceased's] precarious position between voluntary and involuntary patient status. I therefore recommend that Orygen Youth Health provide specific periodic training on the use of the Clinical Risk and Management (CRAAM) guidelines, including but not limited to the expectations of night staff to engage with patients in circumstances such as [the deceased], where there is likely to be a significant delay between admission and assessment by a consultant psychiatrist. 2. With the aim of providing greater assistance, clarity and guidance to mental health clinicians, I recommend that the Chief Psychiatrist review whether there are or whether there should be guidelines issued by the Office of the Chief Psychiatrist, which provide guidance to clinicians on the appropriate engagement with clients in multifactorial situations, such as [the deceased], and in particular, but not limited to, on night shifts.

7 November 2016 - Coroner Audrey Jamieson	
Case	20130855
Summary	Man fatally overdosed in an inpatient psychiatric unit.
Recommendations	1. Healthscope amends Policy 9.07 'Risk Assessment and Observations - Patient' to include greater guidance to nursing staff regarding the intensity of purposeful visual observations, especially overnight.

7 February 2017 - Coroner Peter White	
Case	20124823
Summary	A woman who suicided in an inpatient psychiatric unit.
Recommendations	4. I further recommend that Upton House nursing staff be counselled as to the importance of making clinical notes and completing clinical records.

14 September 2018 - Coroner Jennifer Tregent	
Case	20104793
Summary	The woman was diagnosed with a treatment resistant psychotic illness and was struck by a car when on day leave from a complex community care unit.
Recommendations	3. That staff are provided with regular and refresher training on the how to conduct risk assessments to ensure uniformity in approach. 4. That nursing staff be required to make comprehensive and contemporaneous patient notes prior to the conclusion of their shift.

Restraint and seclusion

13 March 2013 - Coroner Peter White	
Case	20071478; 20074293
Summary	Two deaths of male psychiatric inpatients who were being physically restrained.
Recommendations	1. That the current review of the Mental Health Act considers the inclusion of regulation, which endorses the following seven principles for safe physical restraint, with a view to reducing the possibility that death or serious injury may result from psychiatric patient restraint: a) General approach to psychiatric patient restraint. Physical restraint is only to be employed after a consideration of all available options and as a last resort, to prevent immediate harm to the patient or others. b) Training. Approved physical restraint techniques should not include the putting of any pressure at all on the trunk of the patient's body; that is the taking of a patient to the floor in a prone position, or the pressing of his or her abdomen from above, while a patient is on the floor. c) All staff members who could potentially be involved in restraining a patient, including clinical staff, security staff and patient services assistants, should be trained insofar as is practicable together, by Hospital contracted personnel (in approved restraint techniques). d) All such staff training to include specific direction concerning the dangers of positional asphyxia during physical restraint, how to recognise the condition and what to do if a patient appears to be succumbing to the condition, or to any related condition or syndrome. e) Aggression management in an inpatient unit is a clinical issue, and as such, a senior clinical staff member should always lead any physical restraint. f) While a patient is being physically restrained, a clinical staff member must be and remain present to manage the staff engaged in the restraint, while also monitoring the patient's breathing and general wellbeing, this for the duration of the physical restraint. g) As per principle 2 above, an approved physical restraint should not involve

the taking of the patient to the floor, unless such a course is unavoidable. In the event that it is determined prior to the restraint, that a patient must be taken to the floor, or where a patient is unintentionally forced to the floor during restraint, this should only be permitted to continue for the minimum amount of time required to achieve restraint, and concurrently, only while the patient's respiratory condition remains uncompromised. Determination of these matters, both before and during restraint, is the exclusive responsibility and is to remain at all times under the control and direction of the senior clinician present.

2. Following a review of all relevant practise and having regard to existing contractual obligations, a practise guideline should also issue from the Office of the Chief Psychiatrist, which guideline should broadly direct the adoption of a single manner of physical restraint guideline, for the consideration of respective hospitals and their training managers. Of those now in place at Dandenong and Frankston Hospitals and those additionally reviewed below in Attachment 1, it appears to this Coroner that the MOVAIT [Management of Violence and Aggression Training] Techniques Manual, deserves particular consideration.

Restricting access to items that can cause harm

8 October 2010 - Deputy State Coroner Iain West	
Case	20074970
Summary	Woman who suicided in inpatient unit.
Recommendations	1. Rooms in the Mother Baby Unit at Northpark Hospital that are to be occupied by patients with high or intensive levels of suicidality, be fitted with a nurse call button apparatus that is incapable of being used as a ligature. Potential hanging points within the rooms need to be identified and removed.

14 October 2011 - Deputy State Coroner Iain West	
Case	20102384
Summary	Suicide of woman in inpatient psychiatric unit.
Recommendations	3. That the Northern Area Mental Health Service, Melbourne Health develop and implement protocols aimed at monitoring and or restricting, potentially harmful items being taken into the psychiatry unit.

21 February 2013 - Coroner Ronald Saines	
Case	20110660
Summary	Woman who suicided in psychiatric inpatient unit.
Recommendations	1. The Chief Psychiatrist in Victoria has regularly published Information Bulletins regarding practice and patient management issues. I am satisfied that bulletins published in 2004, 2005, 2007 and 2010 included best practice advice and other Coronial recommendations in the Mental Health sector which information was of relevance to issues which arose in Mrs Scott's admission, management and death. It appears these bulletins were published on the internet and were able to be examined there. However I am satisfied that the Clinical Director of the Hospital's Mental Health Service and his staff were not, in February 2011, aware of these bulletins. Examination of agenda and minutes of records of different committees at the Hospital do not disclose any reference to them. It is an important step for these bulletins from the Chief Psychiatrist to be widely

distributed and widely considered, such that if improved distribution practices have not already been implemented, online and/or by direct hard copy delivery, then I do recommend the Chief Psychiatrist take steps to immediately review distribution practices.

22 October 2013 - Coroner Clive Alsop	
Case	20121880
Summary	Suicide of male in inpatient psychiatric unit.
Recommendations	1. THE NECESSITY TO ENSURE THE WARD IS FREE OF POTENTIALLY HARMFUL MATERIALS. It is recommended that specific protocols be developed to ensure that all areas open to patients who may have suicidal tendencies, be kept free of all and any materials that could feasibly be used by a patient intent on self harm. 2. DOOR DESIGN. This finding will not go further that suggesting consideration he given to altering the design/shape/location of the glass panel to provide greater visual access to the rooms occupied by patients with an assessed high level of suicidal ideation. Such action would directly affect the issue of patient privacy and would require consideration of the consequent impact on voluntary patients' willingness to participate in treatment. 3. CLOSED CIRCUIT TELEVISION. The recommendation is that the installation of appropriately discrete CCTV cameras in units occupied by patients with an identified high risk of suicide be again considered by the Chief Psychiatrist.

23 January 2014 - Coroner Paresa Spanos	
Case	20113855
Summary	Suicide of woman in inpatient psychiatric unit.
Recommendations	1. That The Melbourne Clinic undertake a ligature audit of the wards in which any psychiatric patient is admitted using the Psychiatric Environmental Risk Tool amended to incorporate the Ligature Point Rating from the Worcestershire Mental Health Partnership National Health Service Trust Policy for assessing, addressing and managing ligature risks in inpatient areas, 24-hour off site nursed units and other clinical treatment areas.

2 February 2015 - Coroner Paresa Spanos	
Case	20124587
Summary	Woman who suicided in an inpatient psychiatric unit.
Recommendations	4. I recommend that the cupboards in patient rooms of the BIPU be adapted to remove 'hanging points'. 7. I recommend that NWMH change its policy that presently allows patients of the Low Dependency Unit to retain items that are capable of being used as a ligature to ensure that it complies with the Chief Psychiatrist Guideline on Criteria for searches to maintain safety in an inpatient unit for patients, visitors and staff.

2 April 2015 - Coroner Audrey Jamieson	
Case	20090829
Summary	Woman who suicided in inpatient psychiatric unit.
Recommendations	1. With the aim of minimising risk and preventing like deaths, I recommend Mercy Health develop and implement policies and procedures for the LDU whereby access to items that may be used to self-harm are removed or reduced. Such policies and procedures should include checking patients and the unit for potentially harmful belongings and belongings that could be used for self-harming purposes, monitoring items brought into the unit by visitors and educating visitors on the potential risks associated with such items.

29 May 2015 - Coroner Peter White	
Case	20132761
Summary	Man who suicided in high-security psychiatric inpatient unit.
Recommendations	1. I note with approval that annual reviews are conducted at Thomas Embling Hospital to seek to identify any further hanging points within the hospital. To assist this process and in consultation with the Clinical Director I recommend that an appropriately skilled analyst, who is otherwise independent of the hospital, be invited to join that review.

6 August 2015 - Coroner Rosemary Carlin	
Case	20121503
Summary	Woman who suicided in inpatient psychiatric unit.
Recommendations	1. I recommend that North Western Mental Health re draft their policy Removal of Hazardous Items in Inpatient Units in line with the comments set out above

26 February 2016 - Coroner Caitlin English	
Case	20130655
Summary	Woman who suicided in inpatient psychiatric unit.
Recommendations	1. I adopt Coroner Spanos' recommendation 1 in the Finding Without Inquest into the Death of [deceased] and urge St Vincent's Mental Health to change its current policy that allows patients in the Low Dependency Unit to retain items that are capable of being used as ligature. Further, to avoid confusion it is preferable for acute In-patient Units to take a consistent approach on this point and I urge St Vincent's follows the position adopted by North West Mental Health.

7 March 2016 - Coroner Paresa Spanos	
Case	20094252
Summary	Suicide of woman in inpatient psychiatric unit.
Recommendations	1. In furtherance of the Chief Psychiatrist's responsibility for the safety of patients in the public mental health system, I recommend that the Chief Psychiatrist considers mandating the removal of the particular hook/housing used in the Orygen inpatient unit, particularly from doors or any other placement where they can be utilised as a hanging or suspension point. 2. For the purposes of recommendation 1 above, as the Chief Psychiatrist was not a party to the inquest and by way of assistance, a copy of this finding will be

provided to him together with photographs of the hooks/housing and a copy of pages 105-106 of the coronial brief which is an information sheet from the manufacturer.

3. I recommend that Orygen Youth Health/Melbourne health develop a procedure that addresses the need for scene preservation and/or recording, in circumstances where a serious suicide attempt has taken place in an inpatient facility, in anticipation of a foreseeable coronial investigation. Such a procedure could also assist the health service to undertake its own internal review or root cause analysis (whether mandated or otherwise) and to comply, more broadly, with their duty of care obligations.
4. I further recommend that such a procedure identify roles and responsibilities as clearly as possible, in particular as regards the completion of RiskMan report of the incident or any other tool or software being used from time to time in the health service to manage risk.
5. For the purposes of recommendation 3 above, and for the information and assistance of the health service, I have invited the Chief Commissioner of Police through Civil Litigation to develop a guideline to assist health services in this regard. Pending development and promulgation of such a guideline by the Chief Commissioner, the health service can contact the court for further information.

8 December 2016 - Coroner Caitlin English	
Case	20132320
Summary	Man who suicided while inpatient in psychiatric unit.
Recommendations	1. I recommend that Mercy Health change its current policy that allows patients in the Low Dependency Unit to retain items that are capable of being used as a ligature. Further, to avoid confusion it is preferable for Psychiatric In-patient Units to take a consistent approach on this point and I urge Mercy Health to follow the position adopted by North West Mental Health and St Vincent's Hospital.

7 February 2017 - Coroner Peter White	
Case	20124823
Summary	A woman who suicided in an inpatient psychiatric unit.
Recommendations	1. I recommend that Eastern Health maintains its ligature review process but seeks to ensure that a person properly qualified in psychiatric unit risk management analysis who is not part of Eastern Health hospital administration, is engaged to assist in that work. 2. I recommend that Eastern Health provide direction to senior staff in regard to the nomination of a designated person within each particular unit, to collect, preserve and provide safekeeping of all materials which are or maybe relevant to any (future) investigation into a suspected incident of self-harm. 3. I recommend that Eastern Health amends its protocol to emphasize the dangerous aspects of allowing patients accommodated within the LDU to bring in belts, cords or like, which may be employed as a ligature and henceforward institute admission and periodic search policies, which will help ensure a rigorous management of this amendment.

7 April 2017 - Coroner Rosemary Carlin	
Case	20154329
Summary	Overdose death of woman in psychiatric ward.
Recommendations	1. The Swanston Centre Visitor Information Sheets be amended in the manner outlined in Comment 2 of this finding so that it contains the warning: 'HOSPITAL PATIENTS HAVE AN INCREASED RISK OF OVERDOSE FROM ILLICIT SUBSTANCES'. 2. Barwon Health take steps to ensure that the Swanston Centre Visitor Information Sheets and warning signs are available in other languages or otherwise capable of being understood by persons with non-English speaking backgrounds or poor English literacy. 3. Barwon Health's Searching of a Consumer and their Property/Belongings procedure be amended in the manner outlined in Comment 1 of this finding so that it contains the words: 'Staff should not touch the contents but the visitor should be requested to remove the contents of their bags and their pockets for inspection'.

1 February 2018 - Coroner Rosemary Carlin	
Case	20150531
Summary	Woman who suicided while inpatient in private psychiatric clinic.
Recommendations	1. I recommend that the Albert Road Clinic draft a policy of the removal of potential ligatures from all inpatients with due regard to the comments set out above.

18 March 2018 - Coroner Peter White	
Case	20124865
Summary	Suicide of man in inpatient psychiatric unit.
Recommendations	3. That Peninsula Health creates a new audit team to be responsible for assessment of risk concerning the existence of ligature points, within Ward 2b Frankston Hospital, which team is to be answerable directly to the Chief Executive Officer Peninsula Health, and is to be chaired by an independent person who is possessed of appropriate training and experience in risk assessment in a hospital setting. 4. That the Office of the Chief Psychiatrist reviews its approach to bringing into psychiatric hospital units of any personal items of a potentially dangerous nature. Belts, cords and the like are clearly such items.

Leave and absconding

15 March 2010 - Coroner John Olle	
Case	20070129
Summary	Man died from unascertained cause while on unescorted leave from psychiatric inpatient unit.
Recommendations	1. I recommend that the Chief Psychiatrist guideline entitled "Inpatient Leave of Absence" be distributed to approved mental heath services.

2 December 2011 - Deputy State Coroner Iain West	
Case	20094013
Summary	Suicide of man who absconded from hospital.
Recommendations	1. I am satisfied that [the deceased] absconded by climbing over the courtyard wall. It is recommended that the wall be modified in such a way as to prevent climbing over it and/or to secure any courtyard furniture so that it cannot be used as a climbing aid.

14 June 2012 - Coroner Ian Watkins	
Case	20084075
Summary	Woman suicided during leave from inpatient psychiatric unit.
Recommendations	1. It is recommended that Maroondah Hospital review its approved client leave procedure/policy to ensure it complies with the Chief Psychiatrist's September 2009 Inpatient Leave and Absence guideline, with particular emphasis on the inclusion of requirements for communicating responsibilities to carers who accompany a patient on leave, and recording crisis information. The aim is to increase the safety of both the patient and the carer.

25 February 2013 - Deputy State Coroner Iain West	
Case	20102389
Summary	Suicide of a woman who absconded from inpatient psychiatric unit.
Recommendations	1. That the Alfred Psychiatry Unit implement a plan ensuring the recording of persons (other than hospital staff) entering and leaving the Unit's general ward, when the ward is in 'locked mode'. 2. That hospital staff and ambulance officers ensure an appropriate handover takes place, whenever a patient is delivered directly to the Alfred Psychiatry Unit ward.

8 May 2013 - Coroner William Gibb	
Case	20080732
Summary	A woman who suicided after absconding from an inpatient psychiatric unit.
Recommendations	3. [The deceased] (and others before her) found it relatively easy to abscond from this facility. Whilst accepting that Mental Hospitals are not prisons, it is recommended that regular audits be conducted into the security environment at these facilities with a view to minimizing the risk of patients (particularly involuntary patients) absconding.

20 August 2013 - Coroner Kim Parkinson	
Case	20110291
Summary	Man who suicided after absconding from an inpatient psychiatric unit.
Recommendations	1. That the North Western Mental Health Service review the security arrangements relating to exiting the Broadmeadows inpatient facility, in the context of admission of involuntary patients to the low dependency unit at that facility. 2. That the North Western Mental Health Service review its procedures relating to notifications to police of absconding patients and documentation on patient file and follow up of same with police by the Mental Health Service staff.

4. The Secretary of the Department of Health and/or the Chief Psychiatrist should ensure that a state-wide co-ordinated procedure for notification of and locating absconding mental health patients is adopted in order to ensure that a co-ordinated approach is adopted and follow up occurs. This procedure may appropriately be advised by way of the existing procedures published by the Department of Health in relation to accessing services.
5. In the absence of a state-wide procedure the responsibility for follow up of an absconding patient ought to rest primarily with the facility from which the unauthorised absence occurred. There should be no administrative transfer of care to another facility until the patient has been located.
6. During the course of the Inquest it became apparent that there were limitations upon access by responsible clinicians to the RAPID database in a context of an absconding involuntary patient. Access arrangements to absconding patient details ought to be reviewed in order that all infmmation on that database is available to any mental health clinician state-wide with responsibility for follow up of an absconding patient.

19 September 2013 - Coroner Michelle Hodgson	
Case	20100233
Summary	Woman suicided while on unsupervised day leave from inpatient psychiatric unit.
Recommendations	1. To prevent suicides from patients granted leave from Acute Inpatients Units, I recommend: a) The Department of Health and Human Services ensure there is clear and consistent process, documentation and communication for Leave Plans. Any changes are to be made only after suitable discussion and consideration and such variations recorded and communicated. b) In addition to Recommendation 1(a), the process and documentation of Leave Plans should incorporate supervision and accountability to ensure compliance by all mental health professionals involved in the granting and implementation of leave plans. c) That there be a process for ensuring the accuracy of information provided to the Chief Psychiatrist. d) Implement Recommendation 15 made in the report titled "Chief Psychiatrist's investigation of inpatient deaths 2008-210" that "That the Chief Psychiatrist convene a panel every three years to inquire into inpatient deaths over that time to consider overall practice improvements and issues relevant to the mental health system."

29 January 2014 - Coroner Heather Spooner	
Case	20102062
Summary	Woman suicided after absconding from inpatient psychiatric unit.
Recommendations	1. To increase the safety of patients in the low dependency unit, the John Cade Unit should undertake an evaluation of all aspects of approved leave under Mental Health Act 1986 (Vic), including approval, monitoring and recording. The scope of the evaluation is to include the effectiveness of the reliance of staff being available in the reception area and/or staff base to monitor compliance. 2. To improve out of hours access for patients, the John Cade Unit should install and ensure adequate signage proximate to the intercom at the front doors to the unit with sufficient information to guide patients who return after 9.00pm on both how to use it and how to contact staff.

4 February 2014 - Coroner John Olle	
Case	20091406
Summary	Mother killed by son who was on overnight leave from psychiatric inpatient unit.
Recommendations	1. That Orygen Youth Health (OYH) review its current policy and procedures regarding a patient's failure to return from leave. The purpose of this review is to ensure that staff are immediately made aware of a patient's failure to return, and that the necessary actions described in the North Western Mental Health Service CC3.18 - Absence in Inpatient policy, can be actioned in a timely manner. 2. That Orygen Youth Health (OYH) give consideration to introducing a process of initiating contact with patients and their family members who have been granted a leave of absence (both escorted and overnight leave). This contact should comprise a telephone call or planned visit, to elicit information on the progress of that leave, the emergence of any risk factors and the associated management of any risks identified.

5 September 2014 - Coroner Michael Coghlan	
Case	20121915
Summary	Suicide of man while on leave from inpatient psychiatric unit.
Recommendations	1. That Healthscope conduct regular compliance audits to check whether staff are complying with their policies and if instances of non compliance are identified ensure that the staff involved participate in retraining 2. That Healthscope implement procedures in relation to patient leave that require staff to: a) review the patient leave register at the commencement of hourly rounds; and b) introduce an audible alert system that can be set for the expected return time to prompt staff to check if patients have not returned on time.

5 December 2014 - Coroner Paresa Spanos	
Case	20096039
Summary	Man who suicided while on escorted day leave from inpatient psychiatric unit.
Recommendations	1. That Mercy Mental Health review its Absconded Psychiatric Clients Protocol to ensure it contains a clear process and mandates a timely response to a patient's failure to return from an approved leave of absence. 2. That Mercy Mental Health review its Client Leave Procedure to ensure that it complies with the Chief Psychiatrist's September 2009 Guideline on Inpatient Leave of Absence, with particular emphasis on the inclusion of requirements for communicating responsibilities to leave escorts and recording crisis information. I note that as at the time of inquest in August 2013, Mercy Mental Health had almost completed a significant revision of its leave policy and anticipated that the new policy would be finalised by the end of 2013.

22 December 2014 - Coroner Jennifer Tregent	
Case	20095950
Summary	Man who suicided while on leave from Prevention and Recovery Care facility.
Recommendations	2. The Bendigo Health Care Group should prepare its own policy surrounding the decision making process of granting permission for a leave of absence from PARC. This policy should reflect, to the extent relevant, the considerations as outlined in the Chief Psychiatrists guidelines on Inpatient leave for voluntary and

	involuntary patients. The policy should emphasise the importance of decisions as to periods of absence being made with a full understanding of the patient's background and personal circumstances. The policy should also ensure the patient and (where appropriate) the carer are consulted and involved in the discussion of any absences. In addition the patient and carer need to be provided with a fully informed explanation as to the reasoning behind the decision making process.

20 April 2016 - Coroner Audrey Jamieson	
Case	20130273
Summary	Man who died from undetermined cause on leave from inpatient psychiatric unit.
Recommendations	1. I acknowledge the recommendation made by Coroner Phillip Byrne following the investigation into the deaths of [Coroners case references 20140430 and 20140431], and I reiterate his recommendation that the Chief Psychiatrist issue a directive requiring all public mental health services to develop and introduce an appropriate guideline that identifies, among other things the clinical responsibilities for case managed and at-risk clients at times of extreme weather conditions. 2. It is still not apparent on the basis of the material provided to me that environmental factors have been formally incorporated into risk assessments for approving the day leave of psychiatric inpatients at Monash Health. With the aim of preventing like deaths, I recommend that Monash Health incorporate environmental and climate conditions into their policy 'Mental Health - Leave from inpatient units', that was last reviewed 20 February 2015.

13 May 2016 - Coroner John Olle	
Case	20141172
Summary	Man who suicided while on leave from an Enhanced Prevention and Recovery Care Service (E-PARCS).
Recommendations	1. That the Monash Health PARCS Leave Procedure be amended to include a requirement that in the first overnight or leave event in circumstances where the resident will be alone, PARCS staff encourage the resident to notify family and /or friend/s of the leave, or staff gain consent to notify family and/or friends/s of the leave, or if this fails PARCS staff make telephone contact with the resident while they are on leave for the purpose of support and as an indicator of the resident's safety.

14 September 2018 - Coroner Jennifer Tregent	
Case	20104793
Summary	A woman who died during leave from a community care unit.
Recommendations	1. There should be produced for the CCU patients a clear policy as it relates to the expectations of staff and patients as to what is to occur in the event a patient leaves the grounds of Vahland complex. This policy should not be only provided in written form to the patient but a verbal explanation provided to them at the time of entry to the facility. The relatives and carers should also be informed where appropriate of the expectations of such a policy so they can assist in compliance.

Discharge planning and transition of care

19 October 2010 - Coroner Peter White	
Case	20073728
Summary	Man who died from a fall while intoxicated.
Recommendations	1. I recommend that Caulfield Hospital undertake a review of its procedures for assessing the suitability for discharge of patients with multi-faceted presentations. Such review should be undertaken with a view to ensuring that those patients suffering from mental illness receive a full medical appraisal of that condition, based upon a complete medical history and a consideration of treating specialist's reports. 2. Should a review indicate that release (rather than referral to a psychiatric unit) is appropriate, there remain two further issues for consideration: a) the need to provide the receiving Community Mental Health Service with sufficient time to meet with a patient and evaluate and devise an appropriate post release management plan; b) the need to provide the receiving Community Mental Health Service with sufficient time to arrange appropriate accommodation, either within family provided accommodation, or in some other appropriate situation. 3. In this regard, I recommend that a lengthier period of notice be given to the relevant Community Mental Health Service, and should always include a similar notification to family members. 4. I consider that any notice of less than two weeks in duration, might reasonably be viewed as inadequate.

14 April 2011 - Coroner Kim Parkinson	
Case	20084272
Summary	Suicide of woman following discharge from inpatient psychiatric unit.
Recommendations	1. That the Secretary, Department of Health review mental health service practices in relation to the transfer of management of patients as between the regional mental health services with a view to ensuring provision of accurate and current health status information. 2. That the Secretary, Department of Health review the level of supervision and follow up care required to be in place prior to a mental health patient being discharged to community care. 3. That the Secretary, Department of Health review the process and appropriateness of telephone assessments being undertaken by CAT teams of a mental health patient in the absence of prior direct contact with the assessor and that self reporting of 'well being' not be regarded as a reliable measure of safety in this context. 4. That the Secretary, Department of Health and the Secretary Department of Community Services review mental health service practices in relation to the discharge and supervision of mentally ill persons, where they have care and responsibility for children under the age of 16 years and ensure that adequate supervisory mechanisms, including appropriate protective notifications are in place.

27 April 2011 - Coroner Jane Hendtlass	
Case	20073645
Summary	Man who suicided after discharge from inpatient psychiatric unit.
Recommendations	1. That Northern Hospital psychiatry unit take into account patients' reasons for seeking discharge, personal and cultural background and prior admissions when they determine whether or not to discharge them from an Involuntary Treatment Order without a Community Treatment Order.

23 March 2012 - Coroner John Olle	
Case	20085605
Summary	Man suicided whilst under care of a Community Treatment Team.
Recommendations	3. That North Western Mental Health Service ensure discharge summaries contain all relevant information in respect to treatment and medication plans, provision of medication to the patient and circumstances of discharge and confirmation with co-sharing professionals in the community are contacted by telephone and with follow up discharge plan.

12 April 2012 - Coroner Audrey Jamieson	
Case	20092148
Summary	Man who fatally overdosed after discharge from inpatient psychiatric unit.
Recommendations	1. I recommend [...] that the Alfred Psychiatric Unit and Hanover Welfare Services review the Referral Form/Discharge Plan with the view to including an additional space for "Issues of concern to the patient/client" and "Action Taken". The inclusion of the patient's subjective concerns and the action initiated, if any, will assist the case workers in communicating with the client on their arrival to Hanover House Southbank and empower the case workers to address, as far as possible, the client's concerns.

17 May 2012 - Coroner Jane Hendtlass	
Case	20070791
Summary	Suicide of man after discharge from inpatient psychiatric unit.
Recommendations	5. That the Austin Hospital adult psychiatry unit ensure that discharge plans for first admission patients always include appropriate short to medium term accommodation arrangements and that cohabitants agree to these arrangements before discharge. 6. The Austin Hospital adult psychiatry unit ensure that discharge plans for first admissions always include immediate transfer back to and communication with their known general practitioner. 7. That the Austin Hospital amends its new discharge arrangements to include daily contact by NECATT until patients have consulted their general practitioner and their management has been transferred back to them. 9. That the Austin Hospital acute adult psychiatry unit appoint case managers for voluntary first admission patients to help them manage their discharge arrangements and follow them into the immediate post discharge phase of their therapy.

10. That the designated case managers take responsibility for ensuring that the clinical team maintains contact with first admissions in the early post discharge period until patients have consulted their general practitioner and their management has been transferred back to them and co-ordinate post discharge supports.

10 April 2013 - State Coroner Judge Ian Gray	
Case	20123776
Summary	A man who suicided while in care of community mental health services.
Recommendations	1. That Peninsula Health should ensure all medical, nursing and allied health personnel are adequately trained in, informed of and adhere to the PHMHS Clinical Practice Guidelines.

23 September 2013 - Coroner Paresa Spanos	
Case	20100952
Summary	Man was diagnosed schizophrenia and suicided by hanging.
Recommendations	1. That NWMH implement the changes outlined in its Transfer of patient care from NorthWestern Mental Health to Primary Care and other providers bulletin; and update and upload its Continuity of Care in Transfer and Discharge policy to include the relevant information - or reference thereto - in the Transfer of patient care from NorthWestern Mental Health to Primary Care and other providers bulletin. 2. That to increase the safety of patients who have extensive history of disengagement when discharged from involuntary status under the Mental Health Act, I recommend that NWMH and the Office of the Chief Psychiatrist work together to review the appropriateness of, and opportunities for, including information from NWMH's Transfer of patient care from NortWestern Mental Health to Primary Care and other providers in the Discharge Planning for Adult Community Mental Health Services guidelines.

22 December 2014 - Coroner Jennifer Tregent	
Case	20095950
Summary	Man who suicided while on leave from Prevention and Recovery Care facility.
Recommendations	1. There needs to be mandated minimum requirements of documentation that must transfer with the patient to PARC from an inpatient facility. There needs to be a policy formulated as to what this documentation needs to be. At a minimum it would be an expectation that the patient's records from the previous 7 days (assuming they had been an inpatient for that long) would be made available. There should be minimal reliance on verbal handover of information.

24 September 2015 - Coroner John Olle	
Case	20114255
Summary	Suicide of woman following psychiatric inpatient unit discharge.
Recommendations	1. With the aim of minimising risk and preventing like deaths, I recommend that if a psychiatric inpatient is discharged home and their treating clinicians have an expectation that a family member will be involved in their care, the family member be provided with the hospital discharge summary, if consent is given by the patient.

2. With the aim of minimising risk and preventing like deaths, I recommend that if a psychiatric inpatient is discharged home and their treating clinicians have an expectation that a family member will be involved in their care, the family member be provided with a written document stating who to contact if they have any concerns, and what support services are available to the patient.

14 September 2018 - Coroner Jennifer Tregent	
Case	20104793
Summary	A woman who died during leave from a community care unit.
Recommendations	2. That a minimum of 24 hours before the patient is moved from SECU to the CCU their next of kin or nominated carer is informed of what is to occur to allow them to provide input into the decision. 5. Training for all staff, not limited to psychiatrists, as to what is expected practice as dictated in the Chief Psychiatrists guidelines particularly as they relate to communication and engagement with relatives and carers

Mental health treatment in other clinical settings

Aged care

14 April 2011 - Coroner Kim Parkinson	
Case	20071552
Summary	Nursing home resident died in assault by another resident.
Recommendations	1. That the responsible regulatory authorities, Department of Health (Victoria) and the Aged Care Standards and Assessment Agency (Cwlth) review the arrangements for assessment and management of dementia patients with a propensity for violence and their accommodation with frail elderly persons. 2. That the Aged Care Facility Operator review the arrangements for assessment and management of dementia patients with a propensity for violence and their accommodation with frail elderly persons. 3. That the responsible regulatory authorities, Department of Health (Victoria) and the Aged Care Assessment and Standards Agency (Cwlth) clarify the underpinning principles regarding management of dementia patients, with a view to ensuring that the need to ensure the safety of all residents is prioritised, acknowledged and accounted for in any individuals assessment. 4. That the Aged Care Facility Operator review and clarify its processes and procedures regarding management of dementia patients with a view to ensuring that the need to ensure the safety of all residents is prioritised, acknowledged and accounted for in any individuals assessment and in the implementation of any care or management plan.

21 October 2011 - Coroner Peter White	
Case	20082719
Summary	Elderly man with dementia struck by train.
Recommendations	1. In these circumstances I recommend that all staff at Cardinal Knox Village continue to undertake initial training in regard to dementia policies before their commencement of duty and, further, that each undertake a full retraining in regard to same not less than once every 12 months. 2. Having regard to my discussion with [Cardinal Knox Village general manager], I further recommend that the interim care admission form be amended to include a mandatory dropdown field in reference to strategies to be adopted to protect the applicant. This box would then need to be completed with details of the strategy adopted and implemented, before the remainder of the form becomes active.

4 February 2019 - Deputy State Coroner Iain West	
Case	20151527
Summary	Elderly woman died following a fall in an aged care facility.
Recommendations	2b. That MPH provide internal education to all staff administering medications, as per Point 6 of the MPH Medication Management Policy and Procedure. The internal education should serve as a reminder to staff of the importance of using "professional judgement in determining the appropriateness of a medication

order". Specific high risk medications commonly used in RACFs include insulins, narcotics, sedatives and anticoagulants.

3. That the Australian Aged Care Quality Agency (AACQA) review this case, pertaining to:
   a. The adequacy of clinical governance of medication administration at Park Hill Gardens RACF, which ceased operations in December 2014.
   b. The inappropriate administration of medication ('as required' Oxazepam) by multiple nursing staff at MPH.
   c. The adequacy of communication between RACFs.
4. That the Australian Health Practitioner Regulation Agency (AHPRA) review this case, pertaining to:
   a. The adequacy of clinical governance of medication administration at Park Hill Gardens RACF, which ceased operations in December 2014
   b. The inappropriate administration of medication ('as required' Oxazepam) by multiple nursing staff at MPH.
   c. The significant increase in Oxazepam prescribed by [treating general practitioner], as well as the absence of follow up review provided.

Emergency department

7 June 2011 - Coroner Audrey Jamieson	
Case	20054746
Summary	Man died from probable natural causes in emergency department.
Recommendations	1. I recommend that Werribee Mercy Hospital review all aspects of its security arrangements including the provision of adequate numbers of security personnel and seclusion rooms commensurate to the "better practice" of Austin Health as referred to in [doctor's] evidence. Such a review should by necessity identify what impact, if any, improvements in security will have on resource allocation to other areas of the delivery of health services by the hospital.

16 August 2011 - Coroner Heather Spooner	
Case	20075119
Summary	Woman suicided after leaving an emergency department.
Recommendations	1. To improve the safety of patients with mental health issues who are in crisis, Eastern Health Mental Health Services should review the current guidelines for patients who present to the organisation's Emergency Departments to: a) comply with the Department of Health 2010 Working with the suicidal person Clinical practice guidelines for emergency departments and mental health services. Particular emphasis should be given to ensuring that the assessment of patient risk of self-harm and completion of a mental state examination are identified and clearly articulated; and b) develop clear guidelines for the timely review by community mental health services for patients who have undergone assessment and are consequently discharged.

31 January 2012 - Coroner Jane Hendtlass	
Case	20071142
Summary	Woman who suicided after leaving emergency department.
Recommendations	1. The Chief Psychiatrist advise Emergency Department mental health clinicians to routinely and regularly re-assess patients who present with a history of self harm and with a high blood alcohol concentration in order to more accurately determine the factors likely to predict risk of absconding and suicide. 2. The Minister for Health acknowledge that mental health and overdose patients are over represented in Emergency Department Frequent Presenter populations and accordingly ensure that all Emergency Department mental health and overdose presentations are recorded electronically in databases accessible to subsequent treating mental health clinicians. 3. The Australasian College of Emergency Medicine and the Royal Australian College of Nursing advise Emergency Department triage staff to maintain and access the electronic record of patients presenting with mental health issues as part of their triage assessment.

19 April 2012 - Coroner Jane Hendtlass	
Case	20064308
Summary	Man suicided following presentation to hospital for mental health crisis.
Recommendations	3. That the LaTrobe Health Service ensure that Accident and Emergency Department staff report to police all patients who present in police custody and discharge themselves without assessment by a mental health practitioner.

22 February 2013 - Coroner Kim Parkinson	
Case	20101251
Summary	Man who died while being restrained in an emergency department.
Recommendations	4. That insofar as there continues to be a requirement to receive mental health patients in emergency departments that training modules of the type delivered to Victoria Police in relation to management of mental health patients, including restraint and safety in managing airways in prone positions, be delivered to hospital security staff.

22 April 2013 - Coroner Pauline Spencer	
Case	20113385
Summary	Woman who suicided after emergency department assessment.
Recommendations	1. That the Office of the Chief Psychiatrist, the Minister for Health and/or the Secretary to the Department of Health consider a review of the Risk Assessment tools to prompt clinicians to consider the credibility of answers provided by a patient and to weight these factors accordingly. 3. That the Northern Mallee Area Mental Health Service should review and if necessary modify the Clinician's Reference Guide to Mental Health Treatment & Care to ensure that processes are implemented to ensure that the views of family and friends be given great weight prior to decisions being finalised. Such processes may including meeting with relevant family or friends to discuss the preliminary decision prior to a final decision being made to allow for their further feedback. 4. That the Northern Mallee Area Mental Health Service should review and if

necessary modify the Guide to ensure documented care planning with family and friends who will be involved in the consumer's care post discharge.

5. That the Northern Mallee Area Mental Health Service consider improving documented information available to off-site Consultant Psychiatrists from the CATT Clinicians including relevant medical notes, MHS Screening Register, CATT Clinician Risk Assessment and Assessment Notes via scanning and tablet technology.
7. That the Mildura Base Hospital implements a procedure to record the action taken with regard to patient medication upon discharge.

11 July 2013 - Coroner Kim Parkinson	
Case	20103795
Summary	Suicide of a man who absconded from hospital emergency department.
Recommendations	1. That arrangements be made for the introduction in accordance with the Royal Melbourne Hospital internal review 'HOLS' recommendation, of more securely located emergency department beds which will accommodate the monitoring and security needs of mental health patients who require short term monitoring and assessment for both medical and mental health issues.

17 September 2013 - Coroner Paresa Spanos	
Case	20111852
Summary	Suicide of man experiencing mental ill health.
Recommendations	1. That to increase the safety of patients presenting multiple times for ECATT assessments who have ongoing identified risk factors and/or present with diagnostic uncertainty, Werribee Mercy Mental Health (WMMH) endorses and incorporates its draft procedure titled *ECATT Assessment Review* into practice.

24 April 2014 - Coroner Peter White	
Case	20072518
Summary	Woman who suicided after absconding from emergency department.
Recommendations	1. I recommend that the Department of Health, review existing protocols concerning psychiatric review in Hospital Emergency Departments and seek to ensure that where such delay threatens to lead to a compromise to patient care, that there are arrangements put in place, which will allow for communication at Consultant level and permit such review to proceed either following intra Hospital (patient) transfer to a Hospital's psychiatric unit, or by an addition RPN being sent to the Emergency Department for that purpose.

10 July 2014 - Coroner Rosemary Carlin	
Case	20110293
Summary	Man suicided after being transported to emergency department.
Recommendations	2. Monash Health introduce a clear written procedure whereby patients brought into an Emergency Department by police pursuant to Section 351 Mental Health Act 2014 cannot be discharged prior to a mental health assessment and completion of a Mental Health Assessment Form. 3. Monash Health introduce a clear written procedure in the event a patient brought

into an Emergency Department by police pursuant to Section 351 Mental Health Act 2014 absconds or is discharged without a mental health assessment. Particular consideration should be given to requiring immediate notification of Emergency Services Telecommunications Authority (ESTA) and the on-call consultant psychiatrist.

26 November 2014 - State Coroner Judge Ian Gray	
Case	20122216
Summary	Suicide of man who attended emergency department but left before assessment.
Recommendations	1. I recommend that St Vincent's hospital review, or continue to review, relevant procedures and protocols to ensure that it is clear to hospital staff that they need to ensure that persons presenting on their own in relation to mental health issues are given every reasonable opportunity to ensure that someone they trust is contacted to be with them while they are waiting to assessed, and if necessary, are assisted in making the contact. 2. I recommend that the Department of Health commission a review, in conjunction with relevant hospitals (St Vincent's and Royal Melbourne) of the systems of communication between service providers (emergency departments) for the purposes of providing early communication and notification between Emergency Department about patients who have attended an Emergency Department seeking or requiring mental health treatment or advice, but who leave that Emergency Department without being seen by a relevant medical practitioner. In short, I recommend a consideration of what aspects of the RAPID (or other) communication system could be improved by creating a notification system between Emergency departments.

5 October 2015 - Coroner Audrey Jamieson	
Case	20120414
Summary	Young woman who suicided.
Recommendations	1. With the aim of preventing future lost opportunities to provide its patients and/or their families with the appropriate information in an attempt to link them with supportive services, I recommend Monash Health Emergency Department develop for patients, victims and/ or their families who disclose to their staff or that their staff are aware have made a recent disclosure, of sexual assault, information providing details of Victorian specialist sexual assault or other appropriate services.

7 June 2017 - Deputy State Coroner Iain West	
Case	20153498
Summary	Man who suicided after absconding from emergency department.
Recommendations	1. That Monash Health implement a Behavioural Assessment Room at Casey Hospital and, if appropriate, across the network of Monash Health Hospitals. 2. That Monash Health review its policies or procedures (if any), for incorporating information received from third parties about patients who present to the emergency department, particularly with psychiatric conditions. 4. That Monash Health, in conjunction with Better Care Victoria, implement a Behavioural Health Precinct at Casey Hospital and, if appropriate, across the network of Monash Health Hospitals.

5. That Monash Health review the manner in which clinical histories are obtained by staff when performing mental health assessments for patients presenting at the emergency department.

General practice

31 May 2015 - Coroner Paresa Spanos	
Case	20132276
Summary	Woman with diagnosed schizophrenia who died from ascertained causes.
Recommendations	1. That the Royal Australasian College of General Practitioners consider including in its Standards for General Practices, a section providing guidance to general practitioners about continuity of care and patient follow-up specific to patients with mental health issues who are prescribed and receiving regular psychoactive medications.

21 February 2017 - Coroner Paresa Spanos	
Case	20144216
Summary	Young man who suicided after mental health deteriorated.
Recommendations	1. That the Royal Australian College of General Practitioners draws its members' attention to the National Health and Medical Research Council Clinical Practice Guideline on Depression in Adolescents and Young People (2011).

22 February 2017 - Coroner Rosemary Carlin	
Case	20142501
Summary	Man fatally overdosed on drugs prescribed to treat mental illness.
Recommendations	1. The Royal Australian College of General Practitioners consider the circumstances of this death in the context of its existing guidelines on coordinating care between general practitioners and specialists, and determine whether more practical guidance is required for general practitioners in areas such as: (a) How long a general practitioner should rely on specialist prescribing advice before seeking updated advice. (b) How often a general practitioner should be in contact with a specialist if the general practitioner is relying on that specialist's advice to inform ongoing care. 2. The Royal Australian College of General Practitioners consider the need for further education of its members in relation to the potential for misuse of quetiapine given the circumstances of this death.

4 February 2019 - Deputy State Coroner Iain West	
Case	20151527
Summary	Elderly woman died following a fall in an aged care facility.
Recommendations	5. I recommend that the Royal Australian College of General Practitioners (RACGP) use this case as an educational tool for members to highlight the complexity of care requirements, and to demonstrate the importance of appropriate dementia

management, the importance of early escalation of care to specialist services, adequate communication between health services and practitioners, and appropriate prescribing and follow up.

Hospital (other than psychiatric inpatient)

29 March 2010 - Coroner Peter White	
Case	20073075
Summary	Woman who suicided after discharging self from neurological ward.
Recommendations	1. I note with approval that, partly as a result of this death, a full review of administrative processes has been undertaken at St Vincent's and the integration of (Barbara Walker Centre) pain management patient histories with hospital patient histories has been achieved, through the introduction of the organisation-wide electronic Patient Administrative System. 3. As referred to above [consultant neurologist who provided statement] acknowledges the connection between mental illness and the untreatable nature of some neurological conditions. Over and above the Patient Administrative System, I recommend that a psychiatric consult is actively sought in all cases where neurological inpatients have a current psychiatric history managed by the Barbara Walker Centre.

20 June 2012 - Coroner Audrey Jamieson	
Case	20101406
Summary	Man suicided while in hospital for spinal surgery.
Recommendations	1. Healthscope North Eastern Rehabilitation Centre review the Restorative Rehabilitation Pathway and include greater emphasis on the screening for high prevalence disorders such as anxiety and depression, to increase the early intervention and treatment of psychiatric illness in patients. 2. Healthscope North Eastern Rehabilitation Centre undertakes to develop a delegation procedure specifying the criteria for notifying responsible medical practitioner out-of-hours, over patient's clinical deterioration including mental state, thereby increasing patient safety. 3. Healthscope North Eastern Rehabilitation Centre undertake a review of the quality of the clinical handover process, including written clinical documentation and variable handover formats to improve the communication about, and safety of its patients.

13 December 2012 - Coroner Audrey Jamieson	
Case	20085014
Summary	Man who suicided at hospital where he was receiving treatment.
Recommendations	1. To improve the safety of patients with HIV/AIDS in the Infectious Diseases Unit at The Alfred Hospital, it review the process for the formal follow-up to a referral to the HIV Psychiatric Liaison Service, to establish a clear pathway of accountability for action and communication of outcome. 2. To increase the safety of patients with HIV/AIDS in the Infectious Diseases Unit at The Alfred Hospital, the nursing staff on the Infectious Diseases Unit should undertake training in the assessment of patient's mental states and of the out-of-hours referral process to the HIV Psychiatric Liaison Service.

21 September 2017 - Coroner Paresa Spanos	
Case	20144868
Summary	The man had a complex cardiac condition that required surgery, was upset about his long-term health prognosis and suicided shortly thereafter.
Recommendations	1. That, as part of the initial decision to transition a patient to the Royal Melbourne Hospital, clinicians at the Royal Children's Hospital formally refer a child/young adult to a social worker who remains involved as a support throughout the transition period and until after the first appointment at the Royal Melbourne Hospital. 2. That the Royal Children's Hospital and the Royal Melbourne Hospital introduce the routine, serial administration of an age-appropriate screening tool that measures a child/young adult's capacity and resilience for events such as the transition between health services and the possible future outcomes from Fontan surgery, such as the Royal Children's Hospital's Adolescent Resilience Questionnaire. 3. That the Royal Melbourne Hospital require the Congenital Liaison Nurses to complete mental health training to improve their capacity to identify and respond to their patients' mental health issues, such as Mental Health First Aid training. 4. That the Royal Children's Hospital and Royal Melbourne Hospital review and, if necessary, change their care pathways and systems to ensure there is a focus of the emotional and psychological impacts of the Fontan surgery and its implications for patients' quality of life.

Mental health care outside the health system

Child Protection

14 January 2010 - Coroner Peter White	
Case	20075166
Summary	Fatal overdose of young girl in care of the Department of Human Services.
Recommendations	1. The supervision of the Department must be meaningful and direct. Actions taken should be followed through and acted upon or changed as circumstances dictate. The Department should institute a procedure by which this is achieved effectively and meaningfully. 2. There must be meaningful communication concerning a child under care between the Department, the carer (being the person with whom a child is placed), and the school. This communication should not be restricted by considerations of "Privacy", where the welfare of the child in care is concerned. Each of these three parties should be fully informed of problems suffered by the child and actions taken to remedy the same.

16 May 2011 - State Coroner Judge Jennifer Coate	
Case	20081430
Summary	Young man who suicided.
Recommendations	1. That the Department of Human Services give serious consideration to imposing a mandatory practice standard for Victoria that requires a unit manager or above to review the proposed DHS response to any child protection notification once that child's history accumulates three notifications, but has not resulted in a response beyond voluntary intervention. If a response beyond voluntary intervention is not deemed appropriate the unit manager (CPW5) should record an explicit rationale for this decision on the file. 2. That the Department of Human Services child protection practitioners (CPW 2/3), team leaders (CPW4), and unit managers (CPW 5) working primarily with adolescents, undertake mandatory training at commencement and then every two years thereafter to develop and maintain staff skills in identifying and addressing adolescent mental health issues. 3. That the Department of Human Services develop clear and detailed guidelines outlining when child protection practitioners should make a referral to a specialist mental health professional or service to ensure timely mental health advice and treatment is received when necessary. These guidelines should be incorporated into all the current practice advice within the Child Protection Practice Manual relating to adolescence and mental health issues.

7 May 2015 - Coroner Audrey Jamieson	
Case	20080297
Summary	Fatal overdose of young girl in care of the Department of Human Services.
Recommendations	2. I recommend that the Department of Health and Human Services ensure all of their workers, including Residential Care Workers, who have management and

supervision of high-risk children be given Protective Intervener Powers to detain them when it is considered that they are at risk of immediate and extreme risk of harm. This power would apply to situations such as the one in which [DHS Residential Worker] was faced with at the St Kilda Police station on 19 January 2008.

Immigration detention

26 March 2014 - Coroner Jacqui Hawkins	
Case	20140867
Summary	Man who suicided in immigration detention.
Recommendations	1. To promote the safety and wellbeing of immigration detainees, I recommend that appropriate representatives of the Department of Immigration and Border Protection, Serco and Victoria Police meet to discuss and develop a coordinated transfer of custody process which ensures that all relevant information held by one agency is conveyed contemporaneously with the detainee when transferred. 2. The ensure the efficacy of any interagency coordinated transfer process that is developed, I recommend that Department of Immigration and Border Protection, Serco and Victoria Police each ensure that their employees are aware and appropriately trained in the aspects of the process pertaining to them. 3. To ensure the efficacy of any interagency coordinated transfer process, I recommend that the Department of Immigration and Border Protection, Serco and Victoria Police each independently ensure that any necessary internal polices and procedures are effectively developed and implemented. 4. I recommend that Serco and the Department of Immigration and Border Protection collaborate to amend the Self Harm Assessment Interview to require all detainees to be specifically questioned about their mental health and suicide and self-harm history, to ensure that any relevant information is elicited and recorded at the earliest available opportunity and appropriately actioned. 5. To increase the safety of detainees, I recommend that the Department of Immigration and Border Protection, Serco and the International Health and Medical Service meet to consider the feasibility of, and options around, developing a system whereby qualified mental health practitioners are able to observe and interact with detainees within the common areas of the Maribyrnong Immigration Detention Centre, particularly during periods of higher suicide and self harm risk such as when first detained or when informed about deportation or when identified as someone who is at risk.

Police

8 February 2010 - Coroner Jane Hendtlass	
Case	20082626
Summary	Man who suicided in presence of police.
Recommendations	1. Victoria Police continue to support the review [of personal protection kits] currently being undertaken by their Health Safety and Wellbeing Division - Human Resource Department and take into account the facts surrounding [deceased's] death.

2. Victoria Police include adequate strong scissors and/or other cutting equipment in the personal protection kits carried in police cars.

17 February 2010 - Coroner Kim Parkinson	
Case	20085471
Summary	Man suicided while receiving instruction at pistol club.
Recommendations	1. The expression 'immediate Supervision' in Schedule 3 Item 4 of the Firearms Act 1996, should be defined as requiring: a) one on one training; and b) That the instructor is in such close proximity to the student that the instructor is able to instantly and where necessary physically intervene should the person under instruction act in a manner that poses a threat to either themselves or any other person on the shooting range. 2. The condition referred to in Recommendation 1, should be imposed by the Chief Commissioner of Police when approving private firearms shooting ranges pursuant to s179 of the Firearms Act 1996. 3. The Notification of Receiving Instruction form, should require the provision of a certificate from a GP that there is no medical impediment, psychological or physical to the student receiving instruction and this should be provided in advance of receiving instruction. 4. The expression 'medical conditions' in the Notification of Receiving Instruction form, should be defined to expressly include any physical or psychiatric or psychological ailment. 5. Upon receipt by police of a Notice of Receiving Instruction, a full LEAP system check be made in relation to fitness to receive instruction in firearms. 6. Factors such as reported suicide risk should result in a person being ineligible to receive instruction until medical clearance has been obtained.

23 November 2011 - State Coroner Judge Jennifer Coate	
Case	20085542
Summary	Teenage boy shot dead by police.
Recommendations	1. To equip Victoria Police members to safely and effectively manage vulnerable youth that come to the attention of the police, I recommend that Victoria Police develop and incorporate a youth specific component to the Operational Safety and Tactics Training (OSTT) with particular focus on youth specific skills for risk assessment and tactical communications and conflict resolution. 2. To assist Victoria Police members to safely manage people who may be in crisis or possibly intent on bringing about their own death at the hands of police, I recommend that Victoria Police urgently provide a component in OSTT to assist police to identify and respond to such people.

19 April 2012 - Coroner Jane Hendtlass	
Case	20064308
Summary	Man suicided following presentation to hospital for mental health crisis.
Recommendations	5. That Victoria Police and Ambulance Victoria establish protocol and practical guidelines for transport of patients suspected to have mental illness under section 10 of the Mental Health Act 1986. 7. That Victoria Police arrange for copies of the Mental Disorder Transfer Forms (VP

Form L42) to be forwarded to the Centre for Operational Effectiveness for analysis and consideration in developing the six months curriculum for OSTT.

13 September 2012 - Coroner Susan Armour	
Case	20104056
Summary	Suicide of a man charged with historical sexual assaults
Recommendations	1. That Victoria Police consider the development of guidelines for the welfare management of suspects charged or interviewed in relation to child sexual offences with a view to minimizing the risk of self-harm. Such guidelines might include information about appropriate support and crisis assistance services available to suspects in their locality.

20 September 2012 - Deputy State Coroner Iain West	
Case	20043645
Summary	Man with diagnosed schizophrenia shot by police.
Recommendations	1. Victoria Police review the practice of challenging people with symptoms of mental disorder and consider alternative methods that may reduce the likelihood of weapon discharge. 2. Victoria Police review training practice in mental health awareness to ensure that emphasis is placed on the recognition of irrational behaviour and its possible causes and that this recognition be used in the development of tactics for the management of the incident.

5 March 2013 - Coroner Heather Spooner	
Case	20103294
Summary	Suicide of a man with a long mental health history by gunshot
Recommendations	1. That the Victoria Police convene with the Department of Health, the Royal Australian College of General Practitioners, and the Royal Australian and New Zealand College of Psychiatrists to resolve the issues with the firearm-licensing regime identified as a result of the Inquest into the death of [the deceased]. Actions taken to resolve these issues might include: a) Implementing variable licensing periods for individuals with a mental illness. b) A requirement that all applicants for a firearm license provide a suitable medical report from a medical practitioner who is in an appropriate position to comment on their medical history. c) Attaching to the license application form, instructions for general practitioners about their roles and responsibilities in providing the medical report. d) Establishing a medical review panel for applicants who are identified as potentially unsuitability to hold a license by virtue of the mental illness. e) Guidelines for general practitioners about when to report concerns of mental illness and the use of medical note alerts as a reminder that the patient holds a firearm license.

31 December 2013 - Coroner Jane Hendtlass	
Case	20050581
Summary	Man with history of mental ill health and drug dependence shot by police.
Recommendations	3. The Chief Commissioner of Police provide the Special Operations Group with specialist training in the factors that can influence the success of the operation when the target has a mental illness and/or is under the influence of drugs.

18 March 2014 - Coroner Jacinta Heffey	
Case	20095931
Summary	Man suicided in a police cell.
Recommendations	1. I recommend that Victoria Police institute an "alert" process to be widely broadcast and disseminated amongst members providing information about both deaths and "near-misses" in respect of persons in custody in police cells. Such information should list the specific failures to observe the rules, thereby re-enforcing the importance of compliance, leaving nothing to discretion. The exact mechanism for this to be achieved, I leave Victoria Police to work out. 2. Furthermore, to remove any doubts, it should be stressed that the fact that a person in custody is intoxicated is not a barrier to exercising powers under Section 10 where appropriate and conveying that person to a mental health facility. Whilst this misapprehension did not arise in the circumstances of this case, it was contained in a submission of behalf of Victoria Police and it should be clarified with members so that there is no misunderstanding.

10 July 2014 - Coroner Rosemary Carlin	
Case	20110293
Summary	Man suicided after being transported to emergency department.
Recommendations	1. The Chief Commissioner of Police, Monash Health and the Department of Health investigate the feasibility of requiring the Mental Disorder Transfer Form to record the signature of the person to whom custody has been transferred, as well as the date and time of transfer.

7 May 2015 - Coroner Audrey Jamieson	
Case	20080297
Summary	Fatal overdose of young girl in care of the Department of Human Services.
Recommendations	3. I recommend, with the aim of supporting the Department of Health and Human Services to undertake more informed risk assessments for High Risk Youth, that the Chief Commissioner of Police and the Department of Health and Human Services, if they have not already done so, establish a 'working party' between the two organisations to undertake a feasibility study to determine whether a warning flag for 'high risk' children under the care of the Department of Health and Human Services can be included on the LEAP database. Consideration must include, but not be limited to: a) the criteria and name of the flag for 'high risk' children; b) whether to do so would breach any privacy legislation and if so, whether the perceived risk(s) to the child outweighs privacy rights/principles. c) how the information relevant to the flag would be maintained and updated;

d) the situations in which Victoria Police would be required to notify the Department of Health and Human Services if a 'High Risk Youth' is checked on LEAP; and

e) training of Victoria Police members and Department of Health and Human Services workers in relation to the flag.

4. I recommend, if it has not already been done, the Chief Commissioner of Police provide Academy based training that includes the circumstances of [police officer] and Constable [police officer's] interaction with [deceased] on 17 January 2008 to help prevent Victoria Police members from making the same or similar mistakes in the future such as those made by [police officer].

20 April 2015 and 10 October 2016 - Coroner Caitlin English

Case	20112865 (20 April 2015); 20145550 (10 October 2016)
Summary	Two suicides of men under investigation for alleged sex offences
Recommendations	1. In light of Dr MacKenzie's report, Victoria Police should consider reviewing the training provided to officers involved with the interviewing of persons suspected of child related sex offences. Training should encompass an understanding of the psychological reactions of individuals arrested or interviewed for these types of offences. These reactions include, the loss of psychological defences, difficulties dealing with arrest, isolation, effects on those with children, community attitudes, ignorance of the criminal justice system, and cultural, linguistic and mental health issues. For further details about reactions see Attachment 'A' Excerpt from Dr Rachel MacKenzie's Report to the Coroners Court of Victoria dated 3 October 2014. The purpose of training is to increase police awareness regarding the ongoing risk of self-harm among this cohort of alleged offenders while an investigation is in process. 2. A pamphlet is currently provided by Victoria Police to suspects regarding support information. This pamphlet should also include information about the police investigation, the judicial process regarding police charges, the potential involvement of other agencies, and how to seek appropriate assistance for well-being and mental health. Victoria Police is the obvious point of dissemination for such a pamphlet; however the material should be prepared in conjunction with relevant bodies, such as the Law Institute of Victoria, Victoria Legal Aid, and agencies such as Suicide Prevention Australia and Beyondblue.

23 April 2015 - Coroner Phillip Byrne

Case	20131891
Summary	Death of man while being transported by police to hospital.
Recommendations	1. When, as a last resort, Victoria Police have the onerous responsibility of transporting a mental health patient to hospital under circumstances such as those seen here, then the police officer who makes the decision to transport, prior to endorsing that decision, proactively enquire of family members, and others present, whether the person about to be transported has any medical conditions which may potentially compromise the patient's wellbeing. 2. Adopting an observation of Doctor Dodd, professionals (Victoria Police, Ambulance Victoria and CAT teams under the umbrella of Department of Health) dealing with patients suffering a mental health episode who are, or are about to be restrained, be provided with a special warning, by way of practice direction, of the increased risk of death the condition poses.

19 November 2015 - State Coroner Judge Ian Gray	
Case	20102023
Summary	Woman killed by ex-partner.
Recommendations	1. I recommend that the Chief Commissioner of Police amend the Code of Practice for the Investigation of Family Violence in order to provide more specific guidance about the manner in which family violence incidents might present to police. In particular, I recommend that consideration be given to specifying the following: a) Family violence incidents may not be categorised as such by the person reporting them to police. This may be because the person making the report does not recognise the family violence element of the incident and/or does not want the reported incident to be characterised in that way. b) An incident need not be exclusively characterised as "family violence", in order to enliven the Victoria Police Options Model set out on page 21 of the Code of Practice for the Investigation of Family Violence. c) Police may attend an incident, whether reported as family violence or not, and assess, in respect of a person present, that it is necessary to exercise their powers of apprehension under the Mental Health Act 2014. This does not foreclose the incident also being characterised as a family violence incident, with the Code of Practice for the Investigation of Family Violence followed accordingly. This remains the case regardless of whether the incident involves the suspected commission of a criminal offence or some other form of family violence. d) In order to determine whether an incident should be categorised as a family violence incident, although not reported as such, it may be necessary to obtain information in addition to that gathered from those present. Where evident family violence risk factors are noted, consideration should be given to conducting LEAP checks to determine, amongst other things, whether any of the relevant parties has a history of family violence or whether there are any intervention orders in place. e) The affected family member/family violence victim need not be present in order for a matter to qualify as a family violence incident. For example, threats to harm a family member who is not present should be considered as a family violence incident, notwithstanding that the family member faces no immediate safety risk and, being unaware of the threats, has no consequent fear for their safety or well being. 2. I recommend that the Department of Health and Human Services and the Chief Commissioner of Police address in their shared Protocol of Mental Health the circumstances in which Victoria Police should be notified of the discharge of a person initially apprehended by Victoria Police under the Mental Health Act 2014. Consideration should be given to making such notification mandatory, rather than contingent on an assessment of future or current risk.

18 December 2015 - Coroner Audrey Jamieson	
Case	20095915
Summary	Man died while being transported in a police divisional van.
Recommendations	1. I commend Victoria Police for the introduction of the OSTT training package that addresses the possible presenting signs and symptoms of 'Excited Delirium' however in line with the approach adopted by the Canadian Mounted Police following the Braidwood Commission, I recommend that Victoria Police remove from its' training materials/literature reference to "Excited Delirium" and/or "Excited Delirium Syndrome" until such time that it is recognised by Australian medical

professional bodies as a discreet medical condition/entity. The interpretation of this recommendation by Victoria Police should not be so prescriptive so as to exclude the use of audio-visual materials obtained and already utilised from other jurisdictions such as the United States.

2. With the view to developing a collaborative and coordinated approach to the management of people presenting with delirium, agitation or acute behavioural disturbance by first responders, I recommend that Victoria Police and Ambulance Victoria convene a working group in consultation with the Australasian College for Emergency Medicine with the aim of developing a working protocol/clinical practice guidelines or operational work instructions between the organisations including but not limited to, exploring the development of a readily accessible reference tool such as, but not necessarily limited to, a pocket card such as developed by the NIJ's Technology Working Group on Less-Lethal Devices. The development of such a readily accessible reference tool (which could take the form of an application for telecommunication devices) should be consistent with Recommendation 1 and should instead adopt nomenclature for 'delirium' as it is referenced in the DSM-5.
3. With the view to developing a collaborative and coordinated approach to the management of people presenting with delirium, agitation or acute behavioural disturbance by first responders, I recommend that Victoria Police and Ambulance Victoria develop a joint training package including but not limited to, scenario based training which is focussed on the implementation of any newly developed joint protocol, and the use of the readily accessible reference tool.

11 March 2016 - Coroner Rosemary Carlin

Case	20144172
Summary	Man who suicided using his own registered firearm.
Recommendations	1. That the Licensing and Regulation Division of Victoria Police implement a system whereby answers to relevant questions on firearms licence applications are compared to the same answers on previous applications. 2. That the Licensing and Regulation Division of Victoria Police give further consideration to amending its firearm licence application process to require all applicants to submit a report from a treating health professional as to their fitness to hold a firearm's licence.

4 October 2016 - Deputy State Coroner Iain West

Case	20146492
Summary	Man who suicided by hanging while intoxicated.
Recommendations	1. That the Victoria Police structured call taking manual and ESTA's structured ProQA protocol be reviewed, and where appropriate amended, in order to ensure their workflow procedures reflect a consistent approach in post-dispatch instructions.

5 December 2016 - Coroner Paresa Spanos

Case	20132010
Summary	Man with mental illness who died after being reported missing.
Recommendations	1. That the Chief Commissioner of Police consider revision of Form L18A, and in particular, the Risk Factor Guide that appears in Part 2, so that:

a) Risk indicators include the missing person's status under mental health legislation; and
b) The instructions provide clear guidance for nominal and supervising members assessing the identified risks, especially by resolving the apparent inconsistency between the mandatory instructions applicable to risk indicators 1 to 8 and the general instruction that weighting of risk factors 'will depend on the circumstances of each case'.

2. That the Chief Commissioner of Police consider introducing a process and policy through which risk assessments are reviewed by a supervising officer at specified intervals to account for the likelihood that a missing person's risk of harm is not static over time and which monitors compliance with this process.

14 December 2018 - Coroner Darren Bracken	
Case	20174333
Summary	Man who suicided while under investigation.
Recommendations	1. I recommend that the Victoria Police consider updating the Code of Practice for the Investigation of Sexual Crime and relevant policies procedures and protocols, to explicate the increased risk of suspects engaging in self harm, between notification that allegations have been made against them and the intended interview date and to emphasise the significance of suspect welfare management at the first point of Victoria Police contact. 2. I also recommend that the Victoria Police consider updating the Code of Practice for the Investigation of Sexual Crime and relevant policies, to require that investigating police provide the ISR Brochure to suspects at the first point of contact.

Prison, Corrections, Parole

27 April 2010 - Coroner Jane Hendtlass	
Case	20074824
Summary	Man with diagnosed mental ill health and subject to bail conditions suicided in community care.
Recommendations	1. The Attorney General and the Minister for Mental Health consider the therapeutic appropriateness and the legal implications of imposing bail conditions which require compliance with a Community Treatment Order. 2. The Attorney General refers consideration of appropriate bail conditions for offenders subject to involuntary mental health orders to the Law Reform Commission for their consideration.

20 October 2011 - Coroner Heather Spooner	
Case	20091449
Summary	Suicide of a man on remand in prison.
Recommendations	1. To improve the safety of first time prisoners with additional known self-harm risk factors who are initially assessed with either an unknown or low risk self-harm rating, a follow-up formal and recorded session with either a Forensicare or

Correction Victoria staff member must take place after the first 24 hours of imprisonment to further assess risk and adjustment issues.

27 July 2012 - Coroner John Olle	
Case	20085235
Summary	Suicide of a man in prison.
Recommendations	1. I recommend that the Office of Corrections appoint a Ward clerk for all prisoners discharged from either Unit 13 or the AAU. 2. I recommend that Forensicare provide a discharge sheet to mental health clinical staff upon discharge from Unit 13 or the AAU.

6 September 2012 - Coroner Audrey Jamieson	
Case	20094132
Summary	Suicide of man who was on community-based order.
Recommendations	1. To increase the safety of patients who are also registered sex offenders, the Department of Health Mental Health, Drugs and Regions Division and Department of Justice Community Correctional Services, review their application of the 2008 Protocol between Mental Health, Drugs and Regions Division and Community Correctional Services. Particular emphasis should be given to addressing any perceived barriers to communication between services and a patient's right to privacy. 2. To increase community safety and reduce the risk of sex re-offending, the Sex Offender Management Branch review the process of criteria, assessment, wait listing and commencement of a Sex Offender Program to enable sex offenders who are required to complete the program as part of their parole to participate in the program in a timely manner.

21 September 2012 - Coroner Peter White	
Case	20081277
Summary	Suicide of a man in prison.
Recommendations	1. I recommend that a written discharge note be prepared in respect of all Melbourne Assessment Prison [MAP] prisoners earlier housed in either Unit 13 or the Acute Assessment Unit, for reasons connected to psychosis or suicide/self-harm. Such discharge note to be prepared by a Consultant Psychiatrist or a Psychiatric Registrar or a Psychiatric nurse as deemed appropriate by the Senior Consultant. Further, any psychiatric nurse prepared discharge notes should be reviewed and counter signed by the duty Psychiatric Registrar or above. 2. In conjunction with recommendation 1) above I further recommend that discharge notes for prisoners released from the MAP who have during their present incarceration previously been held in either Unit 13 or the Acute Assessment Unit, - are to be received and acknowledged as read prior to a MAP general prison population admission by: a) Suicide and Self-Harm [SASH] Officers by reference to same in an amended SITUPS or like document. b) The Risk Review Committee, or equivalent at any other such receiving prison, with the documentation employed to record such deliberations, to be amended to include reference to the receipt and reading of, such a discharge

summary.

3. Having regard to this same issue, I further recommend a withdrawal of the stipulation presently found in the Reception Summary form, which suggests that a reference to a psychiatrist for psychiatric assessment or medication review should only be ordered in respect of prisoners classified as PI or P2.
4. I also recommend that the training of Forensicare psychiatric nursing staff should better instruct on this matter, and better emphasize the need to seek advice upwards concerning the position of a prisoner, who like Mr Casey, has a documented history of suicidal behaviour and who demonstrates a fluctuating mental state presentation.
5. In the circumstances, I therefore recommend,
   a) That the Office of Correctional Services Review undertakes a comprehensive review of conditions at Scarborough south and other similarly designed units at the PPP, and advises the State of its findings and recommendations.
   b) That unless or until the State is able to introduce appropriate structural changes at Scarborough South, that the Commissioner of Corrections directs that the housing of 'at risk prisoners' in all unrenovated cells at the PPP, be suspended indefinitely.
6. I recommend therefore that the Office of Correctional Services Review [OCSR] consider staffing arrangements at the Scarborough South Unit, with a view to determining whether staffing levels permit prison officers the opportunity to undertake their duty of care to prisoners, to an appropriate level. I make this recommendation despite the fact that current staffing levels have received the approval of the APOA.
7. I further recommend that the OCSR undertake a review of Exhibits 14(c), 32(d) and (e), and other G4S materials relevant to training reference 'at risk' prisoners, as required, (to include training and update training records), to seek to ensure that both training and training updates are being carried out in a timely way with appropriate course content, having particular regard to the need for all PPP Prison Officers and RRT Staff to fully comprehend:
   a) The role of the caseworker and backup caseworker;
   b) The purpose and ambit of 'meaningful conversations', in regard to a prisoner on observation watch and the recording of that matter;
   c) First principle identification of SASH risk issues, as set out in training manual Exhibit and
   d) The importance of proper minute taking in all Risk Review Team [RRT] meetings, which minutes should fully reflect any division in views, which may occur at any such review meeting.
8. Having regard then to Counsel’s submissions and to the above discussion, and to help best ensure that these roles are understood especially by those who will continue to work on the RRT, I recommend that the suggestions made in the Department of Justice [DOJ] submission outlined above, be formally adopted by the Governor of Corrections Victoria and be included within an amended G4S Operational instruction 107.
9. To avoid doubt on the matter of ordering, I further recommend that a full clinical review, the observations and findings of which are recorded on a properly developed risk assessment tool, should be sought prior to presentation of the particular matter to the RRT or like, and that any recommendation should not go before the RRT unless or until the analysis document tool, recommends with cause, a downgrade of the relevant classification.
10. Instruction 107 should also be amended to reflect this ordering. Port Phillip Prison - 'At Risk' Prisoner medication.
11. I recommend that Pacific Shores Pty Ltd and St Vincent's Corrections Health Service, in consultation with the Commissioner of Corrections and G4S, develop protocols, which recognize that the provision of appropriate drug substitution medication within PPP, is a medical rather than an administrative issue. Further,

such protocols should be developed with a firm steadfastness to the ideals concerning a healer's duty to a patient, to be the driver of decision making in this area.

12. In the circumstances, I recommend that henceforward only those psychologists, who obtain endorsement as clinical psychologists from the Psychology Board of Australia, be permitted to undertake such suicide risk assessment evaluations in MAP and I note with approval that both MAP and PPP, with the support of Corrections Victoria and Justice Health have, in fact, recently downgraded the risk assessment role being undertaken by staff, who are not appropriately endorsed. This, in favour of clinically trained staff employed by Forensicare and St Vincent's Health, respectively.
13. To further support this Department of Justice initiative, I recommend that the Commissioner of Corrections Victoria amend the existing Directive, to reflect this change of approach.
14. I also recommend that both Corrections Victoria and Justice Health henceforward seek to ensure that only those persons who have applied for and received clinical psychologist Board endorsement, are contracted to undertake this specific aspect of the work of psychologists, within Victorian prisons.
15. Finally, I note that the Office of the Chief Psychiatrist has a clinical review programme which is part of its Quality Assurance Committee, and that its jurisdiction extends to Victorian prisons. In the circumstances, I recommend that medically qualified specialist staff, under the auspices of the Chief Psychiatrist, be invited by the Corrections Commissioner to undertake periodic prison visits to both MAP and PPP. Such a course to be undertaken to further support the State's objective that at risk prisoners accommodated within both MAP and PPP, are being provided with appropriate ongoing mental health support.

30 July 2013 - Deputy State Coroner Iain West

Case	20103114
Summary	Suicide of a man in prison.
Recommendations	1. That Corrections Victoria ensure strategies are in place to confirm that all prisoners (including those newly arrived prisoners who are yet to complete orientation) are aware of what to do when they become aware that another prisoner may be at risk of suicide, or self harm. 2. That Corrections Victoria reviews its Director's instructions for "at risk" prisoners, to require staff to engage prisoners in dialogue during observations where possible and practical. 3. That Corrections Victoria explores a means by which staff can make random observations in order to reduce the predictability of regularly timed observations as had been practiced. 4. That the Melbourne Assessment Prison review its prisoner count processes to ensure compliance with obligations established by Director's instructions dated 11 May 2009. 5. That Corrections Victoria increase the number of "building design review project" cells at Melbourne Assessment Prison [which are designed to reduce risk of suicide], to meet the ongoing demand for prisoners under observation for suicide and self-harm.

24 January 2014 - Coroner Peter White

Case	20101114

Summary	Suicide of a man in prison.
Recommendations	1. Having regard to the greater pressure placed upon the system by the number of persons being held on remand and the numbers awaiting remand, while held in Victoria Police cells, and having particular regard to the possible consequences of transferring prisoners through this system and out of Melbourne Assessment Prison (MAP), who are suffering from severe mental illness (untreated) into non Building Design Review Programme (BDRP) compliant cells at Port Phillip prison or elsewhere, and to the need for ongoing consultant supervision of the two nursing practitioners and others, I recommend that Forensicare seek the necessary additional funding to place one further full time equivalent psychiatric consultant, on part time duties at MAP. Up to two consultants might share this work on a part time basis. Further, that these newly appointed psychiatrist(s) and both Nurse practitioners be specifically tasked under the direction of [clinician], to review and medically manage all prisoners who are designated P1 or 2, floridly psychotic or not, this to occur and continue until such time as each such prisoner maybe be safely transferred out of Unit 13 and or BDRP compliant cells at MAP, into what remain as non BDRP compliant cells at MAP, and the reception unit at Port Phillip Prison, and elsewhere. 2. I recommend that arrangements be made for MAP Forensicare staff from the Director down, to visit and review the recent renovation of cells at the MAP, so that they are fully aware of the changes that have been made and the conditions in the cells, which have been made BDRP compliant, as opposed to conditions in cells which have not. 3. I further recommend that arrangements also be made for the same staff to visit the Port Phillip Prison to inspect the Scarborough South Reception Unit and thereby be made aware of the conditions in that place, so that they are fully informed about the unrenovated cells into which at risk prisoners maybe placed, dependent upon decisions that they are now called upon to recommend, about P and S classification downgrading and transfer. 4. I further recommend as follows: a) The current P1 prisoner classification criteria be extended to specifically include those prisoners to be maintained at the Acute Assessment Unit (AAU), for pre-sentence or pre-trial psychiatric reports. b) The approach of remanding such prisoners referred to in a) above exclusively to the AAU, be reviewed by the Unit 13 Director and the prison CEO, to determine whether such prisoners might be safely and conveniently detained in a BDRP compliant cell unit near to or adjacent to, but not necessarily within Unit 13 as currently defined. c) All P1 classified prisoners not covered by category a) above, suffering from what is believed at admission screening, or release from a Muirhead cell to be, 'a serious psychiatric condition, requiring immediate and or intensive care,' be referred directly to the AAU for review, or in consultation with the CEO of MAP, to an adjacent BDRP compliant unit, to await detoxification and or available AAU cell space, in anticipation of a later review and provisional psychiatric diagnosis, by a nurse practitioner under a consultants supervision, or by a psychiatric registrar or above. d) That all P2 classified prisoners be referred as in c) above, for medication review. e) That all Forensicare staff receives ongoing instruction from the Unit 13 Director and such others as she may invite, on all matters pertinent to admission screening and Muirhead cell prisoner review.

2 October 2014 - State Coroner Judge Ian Gray

Case	20093158

Summary	Woman killed by offender on parole.
Recommendations	1. To ensure that the Adult Parole Board is provided with current and complete information regarding a parolee's mental health status, I recommend that Corrections Victoria amend its prescribed circumstances (if not already amended), for Special Reports to the Adult Parole Board to include any psychiatric admissions or contact with an emergency department under the Mental Health Act 2014, and where known, and voluntary psychiatric admissions or contact with an emergency department for psychiatric issues.

30 January 2015 - Coroner Paresa Spanos

Case	20073868
Summary	Suicide of a man in prison.
Recommendations	1. I recommend that Corrections Victoria and/or Justice Health develop a comprehensive yet pithy summary of prisoners' health information, in consultation with all relevant stake-holders, that contains prescribed types of information, including SASH [suicide and self-harm] sensitive information, and is regularly updated, and readily available to all clinicians involved in the prisoner's clinical management and care, including psychologists. 2. I recommend that Corrections Victoria and/or Justice Health take whatever steps necessary to mandate the use of such a document by any person or entity providing health care in any Victorian prison, whether privately or publicly operated. 2. I recommend that Corrections Victoria, Justice Health and Port Phillip Prison collaborate in the development, implementation and resourcing of a case management scheme for all prisoners with complex medical, psychiatric, behavioural issues, irrespective of any diagnosis. Such a case management plan should summarise in an accessible way the known chronic and acute SASH risks of the prisoner, including situational triggers, the clearest and most recent diagnosis available, particular symptoms, signs of relapse or deterioration, and characteristic behaviours and how to manage them. 3. I recommend that Corrections Victoria and or Phillip Prison review SASH. processes and/or practice to further discouraging the rapid or precipitous downgrading of a prisoner's at risk status. Specifically, as regards prisoners placed in the spine of Charlotte Unit, consideration should be given to a requirement that any assessment of their risk by clinicians and/or the RRT should explicitly address the relative isolation and deprivation of their placement, and a requirement for an individually tailored, rather than homogenous observation regime. 4. I recommend that Corrections Victoria and Port Phillip Prison enhance SASH risk training for correctional officers about compliance with the need for meaningful interaction with at risk prisoners rated S3, emphasising the need for the interaction to be meaningful by reference to the prisoner's risk and aimed at enhancing their safety.

New ways to deliver mental health care

New clinical services

15 March 2011 - Coroner Edwin Batt	
Case	20080541
Summary	Death of a man with schizophrenia.
Recommendations	1. In this case the presence of a step-up/step-down facility in the Latrobe Valley may have had a significant impact on the management of the deceased in this time of crisis. If an admission to hospital was not called for in the opinion of the Mental Health Service in this case, an alternative step-up facility where the observations endeavouring to be undertaken by the deceased's mother, could have been managed by a suitably trained person within such a facility. Had the deceased been admitted to hospital and ultimately discharged, his progress upon on going hospital prescribed treatment would have a better chance of success if it could have been initiated through a step-down facility before release back into the general community. Whilst such a step-up/stepdown facility is available in Bairnsdale (in certain cases) that is geographically inaccessible to Latrobe area residents. Funding for such a facility in the Latrobe Region should be seriously considered by the Minister for Mental Health.

27 April 2011 - Coroner Jane Hendtlass	
Case	20073645
Summary	Man who suicided after discharge from inpatient psychiatric unit.
Recommendations	3. That the Chief Psychiatrist encourage allocation of mental health clinicians with relevant language and cultural backgrounds to assist in accurately assessing chronic and acute risk of serious self harm. 4. That the Minister for Mental Health create more positions for community mental health clinicians with an emphasis on recruiting clinicians from multicultural backgrounds.

17 August 2011 - Coroner Kim Parkinson	
Case	20083363
Summary	Man who suicided in setting of untreated mental illness.
Recommendations	1. That public health authorities work towards the development and provision of integrated dual diagnosis services for those with mental illness (including personality disorders) and substance dependency and that those services be made available to those being treated in both the public and private mental health systems. 2. That the provision of mental health services to persons diagnosed with personality disorder be reviewed to ensure that a consistent approach to the characterisation and classification of personality disorder as a mental illness is adopted by public mental health services in Victoria.

3. That the effectiveness of the operation of the Alcoholics and Drug Dependant Persons Act 1968, be enhanced by the provision of long term in patient involuntary and voluntary treatment beds for persons with alcohol and drug dependency.
4. That a review be undertaken of the operation of the Alcoholics and Drug Dependant Persons Act 1968, to ascertain its effectiveness in enabling the detention and enforced treatment of persons unable to function in the community as a result of alcoholism and/or drug dependency.

19 April 2012 - Coroner Jane Hendtlass	
Case	20064308
Summary	Man suicided following presentation to hospital for mental health crisis.
Recommendations	1. That the Minister for Mental Health extend the policy of providing triage and integrated services to patients with dual diagnosis to small regional hospitals like Bairnsdale Hospital. 2. That the Department of Health and Victoria Police review their protocols relating to mental health telephone triage in Gippsland to improve flexibility of communication between mental health service providers including local service agencies, Ambulance Victoria, Victoria Police, Accident and Emergency Department at Bairnsdale Regional Health Service, Bairnsdale Community Mental Health Service and the Mental Heath Triage Service at Traralgon. 4. That the Chief Psychiatrist ensure that the changes recommended by the Mental Health Triage Scale Advisory Committee are consistent with other triage scales and used concurrently in Accident and Emergency Departments of regional health services. 6. That the Minister for Mental Health and the Minister for Police and Emergency Services cooperate to establish an inter-ministerial commission or agency with access to direct service delivery for people with a mental illness and dual diagnosis across the justice and health sectors as recommended by Dr James Ogloff.

17 August 2012 - Coroner Kim Parkinson	
Case	20100500
Summary	Man with serious mental ill health who died in motor vehicle collision.
Recommendations	1. That integrated dual diagnosis services in the public health system for those with mental illness and substance dependency be expanded by the provision of additional inpatient facilities. 2. That the operation of the provisions of the Mental Health Act and the Severe Substance Dependence Treatment Act 2010 be enhanced by the provision of additional long term inpatient voluntary and involuntary public treatment beds for persons with co-morbidity mental illness or disorder and alcohol and drug dependency.

30 November 2012 - Coroner Kim Parkinson	
Case	20085243
Summary	Suicide of young man who had no formal mental health diagnosis.
Recommendations	1. That the operation of the provisions of the Mental Health Act be enhanced by the provision of additional long term inpatient voluntary and involuntary public treatment beds to enable effective assessment, diagnosis and care to be provided to mentally ill patients in Victoria.

22 February 2013 - Coroner Kim Parkinson	
Case	20101251
Summary	Man who died while being restrained in an emergency department.
Recommendations	3. That additional in-patient mental health beds be made available to the public mental health system in Victoria, which include safe and secure assessment facilities to which a mental health patient may be taken for assessment when an order is revoked.

18 June 2013 - Coroner John Olle	
Case	20104610
Summary	Man who suicided in an inpatient psychiatric unit.
Recommendations	1. That every authorised psychiatric inpatient facility endeavour to employ an occupational therapist. 2. That consideration be given to creation of MDU at authorised psychiatric inpatient facilities.

6 March 2014 - State Coroner Judge Ian Gray	
Case	20110097; 20110098; 20110099; 20110100
Summary	Woman experiencing psychotic episode committed homicide then suicided.
Recommendations	1. To improve the access to programs specific to improving mental health literacy for children, teenagers and young adults of parents with a mental illness, the Department of Health, Mental Health, Drugs and Regions review the scope of the FaPMI strategy rollout across all public mental health services and regions in Victoria, including: a) Access by public mental health service families to peer support programs such as CHAMPS and PATS, regardless of where they live in Victoria. b) Access by families from other services that come into contact with families where a parent has a mental illness or significant mental health issue such as alcohol and drug services, family support services, child and youth services, community health, Child Protection, and schools.

14 May 2014 - Coroner John Olle	
Case	20110659
Summary	Woman who suicided after discharge from emergency department.
Recommendations	2. I recommend that the Department of Health and The Office of Chief Psychiatrist consider the development of Psychiatric Emergency Care Centre (PECC) units to service patients in crisis in need of short-term admissions.

6 July 2015 - Coroner John Olle	
Case	20090605
Summary	Man killed by another man who was experiencing psychotic episode.
Recommendations	1. Without undermining the important role of PARC, CRU and SECU, I recommend consideration be given to adapting acute mental health units to incorporate a step down or recovery unit, within the acute setting which offers a therapeutic

environment which enables clinicians to treat the underlying serious mental illness, before safe discharge into the community.

2. Without undermining the important role of Forensic Nursing clinicians, I recommend consideration be given to creating a forensic psychiatric specialist service along the lines of the former Forensicare Community Integration Program.

7 June 2017 - Deputy State Coroner Iain West	
Case	20153498
Summary	Man who suicided after absconding from emergency department.
Recommendations	3. That Monash Health, in conjunction with Better Care Victoria, increase the acute mental health inpatient bed capacity at Casey Hospital and, if appropriate, across the network of Monash Health Hospitals.

New guidelines and processes

14 September 2011 - Coroner Kim Parkinson	
Case	20094964
Summary	Suicide of woman with mental illness.
Recommendations	1. That the Secretary, Department of Health, review mental health service practices in relation to the patient's residential address being the determinant of the location of care. In particular in relation to patients with prior attendance history at an area mental health service. 2. That the Secretary, Department of Health, review the manner in which referrals by General Practitioners to Public Mental Health Services are made and prioritised or triaged, to ensure that General Practitioners as frontline mental health service providers, have access to appropriate levels of support and assistance when making referrals.

13 March 2012 - Coroner Michelle Hodgson	
Case	20092156
Summary	Man who suicided in inpatient psychiatric unit.
Recommendations	1. I recommend that the Department of Health produce guidelines to assist health services to design inpatient units that maximise adequate patient observations and to mitigate risks associated with ligature points.2. I recommend that the Department of Health implement Recommendation 7 made in the report titled "Chief Psychiatrist's investigation of inpatient deaths 2008-2010" that: "The Department of Health and health services ensure there is clear and consistent process and documentation for nursing observations, and that any change in required observation level is made after suitable discussion and consideration. The frequency of observations over the night shift should be congruent with daytime observations unless otherwise decided and documented." 3. I recommend to the Department of Health that […] the process and documentation of nursing observations should incorporate supervision and accountability to ensure that there is no doubt as to a Nurses responsibility to conduct observations as clinically indicated. 4. I recommend that the Department of Health develop Risk Assessment and Risk

Management Guidelines specific to inpatient / bed-based Adult Acute Units. The assessment and guidelines should reflect the evidence-base and be inclusive of the range of vulnerabilities and risk exposures present in the adult acute inpatient setting.

17 May 2012 - Coroner Jane Hendtlass	
Case	20070791
Summary	Suicide of man after discharge from inpatient psychiatric unit.
Recommendations	4. That the Chief Psychiatrist publish clinical practice guidelines to assist approved mental health services concerning practice in relation to case management and discharge planning for all first admissions to acute adult mental health services. 8. That the Chief Psychiatrist amend clinical practice guidelines to advise that the same or similar practices apply to discharge of voluntary patients as already apply to involuntary patients.

18 May 2012 - Coroner Audrey Jamieson	
Case	20084042
Summary	Man who fatally overdosed on multiple prescribed drugs.
Recommendations	2. To reduce the harms and deaths associated with benzodiazepines use in Victoria, the Royal Australian College of General Practitioners should update its guidelines for appropriate prescribing of benzodiazepines in the context of general practise within 12 months. The updated guidelines should explicitly address the following areas: a) general principles for benzodiazepine prescribing; b) appropriate use of benzodiazepines to treat specific conditions such as insomnia, anxiety and panic disorder; c) strategies for identifying and treating patients who are seeking benzodiazepines in excess of medical need; and d) managing the risk of harm and death associated with benzodiazepine use and misuse.

23 August 2012 - Coroner Paresa Spanos	
Case	20101835
Summary	Man died from combined drug toxicity in setting of morbid obesity.
Recommendations	1. In light of the above I recommend that the Minister for Health ensures that the prescribing of antipsychotic medications should attract adjunct processes for the prevention, detection, treatment and monitoring of metabolic, cardiac or other disturbances associated with their use, with the aim of improving the morbidity and mortality of patients who require them for the treatment of serious mental illness.

14 February 2013 - Coroner Jane Hendtlass	
Case	20073375
Summary	Man experiencing mental ill health who drowned in unascertained circumstances.
Recommendations	1. That the President of the Mental Health Review Board review the way in which they obtain information relevant to mental health patients' involuntary status to ensure that they have adequate evidence on which to make a determination.

16 July 2013 - Coroner Paresa Spanos	
Case	20091798
Summary	Woman who suicided after engagement with Crisis Assessment and Treatment Team.
Recommendations	1. That in order to improve the safety of people with a Borderline Personality Disorder (BPD) who are in crisis and referred to CATT/ECATT, Spectrum should assess whether the available BPD specific training meets the needs of CATT/ECATT clinicians, whose focus is on short-term assertive follow-up, and transfer of care back to private practitioners, rather than ongoing treatment and support of people with BPD. 2. If found wanting, that Spectrum work with the CATT/ECATT teams in public mental health services in Victoria, to develop BPD specific training suitable to the needs of CATT/ECATT clinicians, in order to improve the safety of people with BPD who are referred to them in crisis. 3. That all public Mental Health Services encourage CATT/ECATT team member to participate in BPD specific training.

14 May 2014 - Coroner John Olle	
Case	20110659
Summary	Woman who suicided after discharge from emergency department.
Recommendations	1. The following lessons learnt from my investigation are applicable across all Victorian mental health services. I recommend that The Office of the Chief Psychiatrist disseminate the [...] lessons at their own discretion. a. Risk assessment tools must be updated upon each admission; b. Planned follow-up arrangements with CATT must be clearly detailed post-discharge; c. When a patient is discharged to family, clear explanation is required to ensure family members fully understand what is required of them and accept the responsibility to ensure the safety of the patient. Follow up details must be clearly established. In particular, who they can contact in the event that something goes wrong. In the words of Dr Fenn, the plan must be realistic. d. Pressure must not be brought to bear on a family to accept responsibility of discharge of a patient if they express reluctance, discomfort and/or inability to perform a role in the discharge plan. e. If a medical review is not considered necessary upon re-admission of a patient the reasons for this decision must be clearly articulated on the hospital record.

27 June 2014 - Coroner Audrey Jamieson	
Case	20121388
Summary	Woman who suicided in context of mental ill health.
	1. I recommend that the Therapeutic Goods Administration (TGA) consider issuing an alert to prescribers and advise exercising caution when prescribing propranolol to patients at risk of self-harm, particularly self-harm by overdose. Possible countermeasures for prescribers could include: a. if clinically appropriate, a beta-blocker that is safer in overdose could be substituted for propranolol. b. scripts could be provided for small quantities of propranolol, to reduce the amount of propranolol to which the patient has access at once. The reasoning behind above point b. is that at present, propranolol packets contain 100 tablets, and up to five repeats can be included in a single script,

providing patients access to up to 600 propranolol tablets at once- that is, a sufficient quantity for an overdose. For patients who are at risk of self-harm by overdose, providing a script for 50 or 20 tablets at a time with no repeats would inhibit the patient's ability to access fatally large quantities of propranolol at one time.

10 December 2014 - Coroner Michelle Hodgson	
Case	20132766
Summary	Older man who died from complications of lithium therapy.
Recommendations	1. I recommend that the TGA issue an alert to prescribers to exercise caution when prescribing lithium over the long term for ageing patients and patients with medical co morbidities. In particular the alert should draw prescribers attention to the increased risk of toxicity in patients who take the drug long-term, and the possibility that even when target serum concentration of lithium is within recommended parameters, clinical presentation changes (including but not limited to the recognised signs and symptoms of lithium toxicity) may indicate lithium toxicity.

29 May 2015 - Coroner John Olle	
Case	20110503
Summary	Man who suicided in context of mental health crisis.
Recommendations	1. To enhance the knowledge of nurses who complete an Australian Nursing & Midwifery Accreditation Council (ANMAC) accredited course, are registered at beginner level and work in Victoria, I recommend that ANMAC review their Checklist for Mental Health in Pre-registration Curricula and include prompts for inclusion of information regarding: a. Psychiatric diagnoses complexity, the impact of co-morbidities and implications of a diagnosis on clients and families; b. The differences between a provisional, differential and formal diagnosis in psychiatry; and c. The existence of both the International Classification of Diseases (Chapter V) and Diagnostic Statistical Manual, and their continued use in day-to-day practice in public mental health services. 2. To increase the validity and reliability of the diagnostic information recorded in the Client Management Interface/Operational Data Store (CMI/ODS), and to improve the safety of patients of public mental health services in Victoria, I recommend that the Department of Health and Human Services (DHHS) review the current system for recording a diagnosis within the CMI/ODS and make the following changes: a. Provide a clear distinction between a provisional and formal diagnosis during all stages of an episode of care; and b. Remove all provisional diagnoses from the CMI at the end of an episode of care that have not been made formal or validated, and that have not been documented as a formal diagnosis that has been reported to and discussed with the patient. 3. The Nursing and Midwifery Board of Australia (NMBA) submitted that Registered Nurses who are not Nurse Practitioners should avoid making medical diagnoses. To provide greater clarification to Registered Nurses working in Victoria in crisis assessment services in public mental health services, and to their employers, I recommend that the NMBA work with DHHS, including the Chief Mental Health Nurse to formally:

a. Elucidate the responsibilities of Registered Nurses working in crisis assessment services in public mental health services in Victoria in relation to making any psychiatric diagnosis (provisional or formal); and
b. Provide examples of the type of education, knowledge and experience a Registered Nurses in ECATT/CATT would be expected to have before completing a diagnosis.

5 October 2015 - Coroner Audrey Jamieson	
Case	20120414
Summary	Young woman who suicided.
Recommendations	2. With the aim of promoting increased awareness amongst treating Psychiatrists of best practice in clinical treatments of childhood sexual assault victims, I recommend the Royal Australian and New Zealand College of Psychiatrists provide advice to its members and in its training program regarding best practice in responding to disclosure and clinical treatments for the impacts of childhood sexual abuse, including the available Victorian specialist services.

18 December 2015 - Coroner Audrey Jamieson	
Case	20095915
Summary	Man died while being transported in a police divisional van.
Recommendations	4. With a view to supporting first responders and in particular, paramedics with enhancing understanding and knowledge of the constellation of presenting symptoms of persons experiencing the range of manifestations of delirium, I recommend that Ambulance Victoria, if they have not already done so, not only review the Police training material as referred to in paragraph 49 of their written submissions but implement training and/or continuing professional development to its paramedics in this regard.

21 February 2017 - Coroner Paresa Spanos	
Case	20144216
Summary	Young man who suicided after mental health deteriorated.
Recommendations	2. That the National Health and Medical Review Council considers how it might improve the way in which it promulgates clinical guidelines and draws the attention of clinicians to them.

5 April 2017 - Coroner Peter White	
Case	20123465
Summary	Woman stabbed to death by ex-partner.
Recommendations	1. That the existing Australian Psychological Society Code of Ethics and relevant Guidelines, together with the current training protocols provided to psychologists in this State, be reviewed by the Psychology Board of Australia in collaboration with the Australian Psychological Society, with a view to providing greater clarity as to, a) the need to enter into clearly understood arrangements with patients, which arrangements define the importance of patient confidentiality while setting out the circumstances in which confidentiality may be breached under HPP 2.2(h);

b) when it should be reasonably concluded that the psychologist's obligation to disclose confidential Health record information under HPP 2.2(h) arises;
c) whom notification under b) above should be made and with what if any recommendation offered, this with a view to best manage the threatened behaviour under consideration;
d) he need or other for a psychologist to seek to obtain collateral or third party information concerning the progress being made by a patient suffering from mental illness, when undertaking a risk analysis in respect of that patient

3. That the Australian Psychological Society develop a separate online eLearning course specific to risk of harm to include assessment and management similar to the existing suicide prevention professional development training, but focussed on prevention of harm to others.

12 December 2017 - Coroner John Olle	
Case	20154475
Summary	Woman who suicided while inpatient in psychiatric ward.
Recommendations	1. To improve the effectiveness of the required ligature point auditing tools, auditor training and their application in acute care mental health units, the Department of Health and Human Services work with Area Mental Health Services to develop advice and examples of ligature audit tools that are assessed as being appropriate to the task, and effective in meeting their purpose.

18 March 2018 - Coroner Peter White	
Case	20124865
Summary	Suicide of man in inpatient psychiatric unit.
Recommendations	2. That the Office of the Chief Psychiatrist amends the December 2015 guidelines on Electroconvulsive therapy so as to provide greater direction to the mental health profession as to the type, frequency and as to the appropriate manner of calculation of the top end limit to the level of shock delivery, in all instances of delivery of ECT to mentally unwell patients. Direction in regard to the delivery of anaesthesia in connection with the condition under treatment, should also be part of such an amendment.

19 March 2018 - Coroner Phillip Byrne	
Case	20162133
Summary	Suicide of woman in inpatient psychiatric unit.
Recommendations	1. I recommend that the Chief Psychiatrist, as an interim measure, issue a revised guideline in relation to search policy of compulsory patients in high dependency units, to the effect that as part of a search, electronic devices such as Kindles be subject to thorough examination.

5 October 2018 - Coroner Caitlin English	
Case	20154178
Summary	Woman who suicided after suffering a stroke.
Recommendations	1. To the Stroke Foundation: That the clinical guidelines include specific and timely education for family and caregivers of stroke survivors which recognises their risk

for the development of depression, particularly in the year post recovery and the increased risk of self-harm following stroke. It should note that one in three stroke survivors is at risk of developing depression and stroke may double the risk of suicide in the absence of a diagnosed depressive disorder.

2. As half of stroke survivors are likely to experience a change in their mood or mental state, education should also include how family and caregivers can monitor how the stroke survivor is adapting to post-stroke living, what behaviours are attributable to the effects of stroke and the type of red-flags that might indicate the need for referral, and when and where to seek help. In addition, and where relevant, this should include families and caregivers of stroke survivors with dysphasia being made aware:
   (1) the high risk (60%) of developing depression, and
   (2) that if the stroke survivor had a prior history of depression and dysphasia, that these are two major risk factors for depression.

New research and evaluation

13 March 2012 - Coroner Michelle Hodgson	
Case	20092156
Summary	Man who suicided in inpatient psychiatric unit.
Recommendations	5. I recommend that the Department of Health implement Recommendation 15 made in the report titled "Chief Psychiatrist's investigation of inpatient deaths 2008-2010" that: "That the Chief Psychiatrist convene a panel every three years to inquire into inpatient deaths over that time to consider overall practice improvements and issues relevant to the mental health system."

18 June 2013 - Coroner John Olle	
Case	20104610
Summary	Man who suicided in an inpatient psychiatric unit.
Recommendations	7. Implement Recommendation 15 made in the report titled "Chief Psychiatrist's Investigation of inpatient deaths 2008-2010" that: "That the Chief Psychiatrist convene a panel every three years to inquire into inpatient deaths over that time to consider overall practice improvements and issues relevant to the mental health system."

28 April 2017 - Coroner Rosemary Carlin	
Case	20144143
Summary	Man with diagnosed schizophrenia who suddenly died from natural causes.
Recommendations	1. The Victorian Government Department of Health and Human Services promote research into the underlying reasons for and the prevention of sudden death in people with schizophrenia through means such as the multidisciplinary and cross-sectional Mental Illness Research Fund.

1 February 2018 - Coroner Audrey Jamieson	
Case	20164031
Summary	A young man with a serious physical illness who suicided.
Recommendations	1. With a view to improving public health and safety in relation to the prescribing of antidepressants to children, adolescents and young people; I recommend that The

Chief Psychiatrist instigate and perform a supervisory type role in respect of research, with the aim of updating clinical guidelines for the prescription of antidepressant medication to children, adolescents and young people.

2. And, in performing this supervisory type role, I recommend that The Chief Psychiatrist ensure that the aforementioned research contemplates children, adolescents and young people as distinct cohorts.
3. And, in light of the Office of The Chief Psychiatrist's duty to provide clinical leadership, and continual improvement of public mental health services per the Mental Health Act 2014 (Vic), I recommend that The Chief Psychiatrist perform this supervisory type role with a view to providing current and clear clinical guidelines to all medical practitioners who prescribe antidepressant medication to children adolescents and young people, including general practitioners.

18 March 2018 - Coroner Peter White	
Case	20124865
Summary	Suicide of man in inpatient psychiatric unit.
Recommendations	1. That the office of the Chief Psychiatrist reviews all relevant research including its own data, and advises the mental health profession at large as to how patients who are suffering from bipolar affective disorder and are acutely depressed and who have shown themselves to be resistant to ECT over a prolonged period (and have objected to its ongoing use), should be assessed and managed in a hospital setting. Such advice should also deal with such other methods of management, which might be employed in such cases, this having regard the Mental Health Act, 2014 and the Victorian Charter on Human Rights and Responsibilities Act, 2006.

New legislation

17 August 2012 - Coroner Kim Parkinson	
Case	20100500
Summary	Man with serious mental ill health who died in motor vehicle collision.
Recommendations	3. That the provisions of the Mental Health Act be amended to provide for the express power for mental health practitioners to detain persons who are diagnosed with substance abuse disorder and mental illness and that the Act be amended to enable for greater flexibility to enable assessment and treatment even when initial or florid psychotic symptoms have resolved. 4. That a formal process be adopted by public mental health services in Victoria to ensure that families involved in the care and support of a mental health patient, or who are intervention order beneficiaries, are notified when a patient is proposed to be released from in patient mental health admission. In so far as this may require an amendment to any Act of Parliament, including the Mental Health Act 1986 (Vic) or the Privacy Act 1988 (Commonwealth), that amendment ought to be considered.

30 November 2012 - Coroner Kim Parkinson	
Case	20085243
Summary	Suicide of young man who had no formal mental health diagnosis.
Recommendations	2. That a formal process be adopted by public mental health services in Victoria to ensure that families involved in the care and support of mental health patients are notified and consulted when a patient is proposed to be released from inpatient mental health admission. In so far as this may require an amendment of any Act of Parliament, including the Mental Health Act (Victoria) or the Privacy Act 1988 (Commonwealth), that amendment ought to be considered.

22 April 2013 - Coroner Pauline Spencer	
Case	20113385
Summary	Woman who suicided after emergency department assessment.
Recommendations	2. That the Minister for Health and/or Secretary to the Department of Health consider providing a statutory capacity in the Mental Health Act to enable a limited 24 hour assessment and safety order to enable a more thorough assessment of a person's level of risk of suicide and planning for safe discharge if considered appropriate.

7 May 2015 - Coroner Audrey Jamieson	
Case	20080297
Summary	Fatal overdose of young Aboriginal girl in care of the Department of Human Services.
Recommendations	1. I recommend that the Minister for Health review section 162 of the Children Youth and Families Act 2005 with the view to amending the provision to include circumstances where a child has suffered, or is likely to suffer, significant harm as a result of drug taking, self-harm or other high risk behaviours. Such a review should include circumstances where a child is classified by the Department of Health and Human Services as a High Risk Youth. Consequences, of this amendment would expand the mandatory reporting requirements under section 184 of the Children Youth and Families Act 2005 and would have 'caught' the situation which confronted officers [police officer] and Constable [police officer] on 16 January, 2008.

5 April 2017 - Coroner Peter White	
Case	20123465
Summary	Woman stabbed by ex-partner.
Recommendations	2. That the State of Victoria through the Department of Health and Human Services gives consideration to the removal of the requirement that a "serious risk of harm" be also one which is "imminent", this by amendment to the Health Records Act 2001, (Vic), HPP 2.2 (h).

Suicide prevention in the community

Initiatives and actions

6 January 2012 - Coroner Edwin Batt	
Case	20111672
Summary	Man who suicided after losing money in gambling.
Recommendations	1. There is a strong inference arising from the circumstances of this young person's death that the opportunity to access an automatic teller machine located within the gambling venue, operated to feed his gambling addiction and so fuel his depression as to drive him to commit suicide. These findings should be brought to the attention of the Executive Commissioner of the Victorian Commission for Gambling Regulations and to those responsible for formulating and implementing policy on the retention of ATM's or similar cash dispensing machines at gambling venues.

28 November 2014 - State Coroner Judge Ian Gray	
Case	20091426; 20091767; 20093500; 20093966; 20094922
Summary	Suicides among younger people who resided in a particular area
Recommendations	1. That the Department of Health together with Victoria Police, the Municipal Association of Victoria, the Royal Australia College of General Practitioners and the Chief Psychiatrist undertake a review of these reports and develop a policy framework that aligns, where appropriate, with the National Suicide Prevention Strategy.

13 April 2015 - Coroner Caitlin English	
Case	20125106
Summary	Suicide of young woman.
Recommendations	1. Policy makers, funders and service providers in the field of victim support consider how ongoing safe and effective support can be made available to people who have been sexually assaulted, to reduce the incidence of deaths in these circumstances. 2. That Victims Support Agency should consider publicising the role of the Victims Register to the general public so that victims whose cases pre-date its establishment are aware of its existence and the services available.

Between 29 May 2015 and 6 July 2015 - Coroner Audrey Jamieson	
Case	20110999; 20112926; 20113601; 20113703; 20114167; 20114398; 20114546; 20114552; 20120735; 20120760; 20121649; 20122094
Summary	Suicides among younger people who resided in a particular area
Recommendations	1. As part of the Victorian Suicide Prevention Framework, I recommend that the Department of Health and Human Services, Primary Health Networks, Municipals

Association of Victoria, Victoria Police and the Chief Psychiatrist conduct a feasibility study on an information exchange process with the Coroners Court of Victoria.

2. With the aim of assisting local communities to respond to youth suicide, I recommend that the Municipals Association of Victoria in consultation with the City of Casey develop a suicide prevention and postvention response framework for local government, which has the ability to take into account various socio-demographic and geographic profiles of individual local government areas.

9 August 2016 - State Coroner Judge Sara Hinchey	
Case	20150204
Summary	Man who suicided at a train line.
Recommendations	1. THAT the Department of Economic Development. Jobs and Transport and Resources together with Public Transport Victoria, Metro Trains Victoria and Victoria Police (in its capacity as employer for Public Service Officers) ensure that all relevant staff, be trained in identifying and responding to persons whose pattern of behaviour is out of the ordinary when around a train track to ensure vulnerable persons are not at risk of injury of death. 2. THAT the Department of Economic Development, Jobs, Transport and Resources together with Public Transport Victoria and Metro Trains Victoria implement, at all train stations, billboards or signs advising people, if they are concerned about a person's risk taking behaviour around a train station, to either call '000' or to press the red button in the safety zone at train stations or the red button on board the train.

22 March 2019 - Coroner Caitlin English	
Case	20166067
Summary	Suicide of man who was former serving Australian Defence Force member.
Recommendations	1. That the Australian Institute of Health and Welfare engage with the Coroners Court of Victoria to explore whether there are opportunities to share data on Victorian suicides among current and former serving Australian Defence Force members, to inform the design and implementation of suicide prevention initiatives.

10 July 2018 - State Coroner Judge Sara Hinchey	
Case	20163222; 20163223
Summary	Suicide of mother with consequent death of young child.
Recommendations	1. I RECOMMEND that the City of Melbourne Maternal and Child Health Service consider adding "lack of social support/isolation" to the list of risk factors contained in their Risk Assessment Guide.

10 January 2019 - Coroner Audrey Jamieson	
Case	20161035
Summary	International student who suicided while studying at university.
Recommendations	1. I recommend that the Australian Government Department of Education and Training undertake consultation, in whatever form it believes most appropriate, with Victorian international student education providers as well as other

organisations involved in international student education and support in Victoria, to identify strategies to engage vulnerable international students with mental health support.

2. In undertaking its consultation, I recommend the Australian Government Department of Education and Training consider how critical incident reports maintained by education providers under Standard 6 of the National Code of Practice for Providers of Education and Training to Overseas Students, may be brought together to inform interventions to reduce suicide among international students studying in Victoria.
3. I recommend the Australian Government Department of Education and Training amend Standard 6 of the National Code of Practice for Providers of Education and Training to Overseas Students to include a requirement that, when a death of an international student occurs, within four weeks the education provider forward a copy of the written record of the critical incident and remedial action taken to the Coroner in the jurisdiction where the death occurred.

20 April 2015 and 10 October 2016 - Coroner Caitlin English	
Case	20112865 (20 April 2015); 20145550 (10 October 2016)
Summary	Two suicides of men under investigation for alleged sex offences.
Recommendations	3. Victorian lawyers who act for persons who are investigated and charged with child related sex offences have an important role to play to prevent their clients from self-harming. Lawyers should also receive training to understand the psychological reactions of individuals arrested or interviewed for these types of offences. 4. Magistrates and all judicial officers should be made aware that any person who is regarded as a suspect and being investigated or charged with child sex offences is an increased suicide risk. Many suicides take place before the first court date, and in this cluster, one took place after a court date. Judicial officers should be aware of the psychological reactions of individuals arrested or interviewed for these types of offences.

Restricting access to means of suicide

27 May 2010 - Coroner Paresa Spanos	
Case	20084584
Summary	Man who suicided by jumping from bridge.
Recommendations	1. That in the interests of prevention, VicRoads takes into account the risk of suicide when designing modifying or upgrading any infrastructure, particularly bridges, that could be a possible site for jump from height suicide.

4 April 2011 - Coroner Paresa Spanos	
Case	20102254
Summary	Man who suicided by jumping from West Gate Bridge
Recommendations	1. For the reasons outlined in my comments above, I recommend that VicRoads monitors any incidents of jump from height suicides or attempts after completion of the permanent safety barrier on the West Gate Bridge, in order to assess the efficacy of the barrier as a suicide prevention intervention. Monitoring should include analysis of how the barrier was overcome or sought to be overcome, in

order to ascertain if there are any design flaws which can be remedied, and to inform the design of new bridges and/or other roads infrastructure with the potential to attract jump from height suicide activity.

9 October 2014 - Coroner Caitlin English	
Case	20103033
Summary	Suicide of a man who was subject to a family violence intervention order
Recommendations	3. I reiterate the recommendation made by Coroner Spanos made following the death of [Coroners reference 2008 4584]: "that in the interest of prevention, VicRoads takes into account the risk of suicide when designing, modifying or upgrading and infrastructure, particularly bridges, that could be a possible site for jump from height suicide." VicRoads responded positively to the recommendation, though it is not clear whether any action has been taken. An updated response is required in light of this finding.

9 April 2015 - Coroner Audrey Jamieson	
Case	20120990
Summary	Man who suicided in setting of mental ill health.
Recommendations	1. I recommend that VicRoads urgently liaise with the incoming Victorian State Government and the Federal Government in relation to the implementation of their Policy in an effort to secure necessary funding to enable permanent public safety barriers to be installed on the EJ Whitten Bridge to prevent jumping suicides at that location. 2. I recommend that VicRoads urgently liaise with the incoming Victorian State Government and the Federal Government in relation to the implementation of their Policy in an effort to secure necessary funding to enable temporary public safety barriers to be installed on the EJ Whitten Bridge immediately to prevent jumping suicides at that location.

24 April 2015 - Coroner Caitlin English	
Case	20121565
Summary	Suicide of man at rail track.
Recommendations	1. I recommend that consideration be given to fencing the southern side of the railway tracks between Mitcham and Heatherdale stations and gating the steps to the track on the southern side of the tracks approximately 420 metres east of Heatherdale station.

28 June 2016 - Coroner Audrey Jamieson	
Case	20154274
Summary	Man struck by train.
Recommendations	1. The evidence suggests that the availability of Global Positioning Systems (GPS) would have enabled the provision of more accurate information about [the deceased's] location on 22 August 2015, which may have altered the course of the outcome. With view to avoiding like deaths, supporting train drivers and providing precise locations coordinates at any one time, I recommend that Public Transport Victoria both accept, and provide the request for funding for, the Metro Trains Melbourne GPS proposal.

22 August 2016 - Coroner John Olle	
Case	20151808
Summary	Woman with diagnosed bipolar affective disorder who suicided.
Recommendations	1. That the Victorian Department of Environment, Land, Water and Planning implement amendments to the Building Act 1993 and Building Regulations 2006 to provide Municipal Building Surveyor with powers to require modifications to publicly accessible buildings which have been used as a suicide location. 2. That during the next review of the National Construction Code, the Australian Building Codes Board consider the implementation of a requirement for increased jumping suicide prevention measures on commercial, industrial and public buildings under the National Construction Code; with particular attention to car park facilities.

28 February 2017 - Coroner Audrey Jamieson	
Case	20160412
Summary	Man suicided by jumping from a publicly accessible structure in Bendigo.
Recommendations	1. I recommend that the City of Greater Bendigo Council conduct a feasibility study to assess whether safety enhancements can be made to the [jumping suicide location], for example, but not limited to, erecting suicide prevention barriers on each platform.

19 April 2017 - Coroner Audrey Jamieson	
Case	20164013
Summary	Women suicided by inhalation of irrespirable atmosphere (helium gas).
Recommendations	1. In light of recurrent deaths involving helium gas, and with the aim of preventing like deaths, I recommend that the Australian Competition and Consumer Commission consider working to restrict the ease of access to helium gas, by members of the Australian public.