Coroners Court of Victoria

Fact or fiction: The link between risk assessment practices and the Coroner's expectations

Mental Health Quality and Safety Forum

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Outline

- Disclaimer & preliminary matters…
- Fact = What Coroners do…
- Fiction = What Coroners do not do…
- Some data for context
- Risk assessment in coronial findings…

Disclaimer & preliminary matters…

- Judicial independence: Coroner's or Coroners'?
- Invitation to speak at this forum, echoing the Chief Psychiatrist's Audit of Inpatient Deaths 2011-2014
- *"At present, nurses complete a written risk assessment tool for every mental health inpatient on two or three occasions each day. It is widely believed, rightly or wrongly, that this practice evolved in Victoria a couple of decades ago in response to adverse finding by Coroners of services' assessment and management of patient' risk of suicide. We anticipate that mental health service providers will feel cautious about changing what is now a time-honoured system, especially if it exposes them to risk of criticism…" Fact or fiction?*
- *Do what you do well and don't worry about Coroner!*

Fact=What Coroners do…

The coronial system of Victoria plays an important role in Victorian society. That role involves the independent investigation of deaths and fires for the purpose of finding the causes of those deaths … and to contribute to the reduction of the number of preventable deaths … and the promotion of public health and safety and the administration of justice.

[Preamble to the Coroners Act 2008]

What Coroners do…

they only do in relation to “reportable deaths”, that is

A death that has a jurisdictional nexus with Victoria AND satisfies one of the clauses in section 4(2) of the definition…

(type of death) appears to have been unexpected, unnatural or violent, or has resulted, directly or indirectly, from an accident or injury OR

(status) of the deceased (relevantly)

“a person placed in care” = a (in) patient in an approved mental health service within the meaning of the Mental Health Act 2014; OR

a patient who immediately before death was a patient within the meaning of the Mental Health Act 2014

What Coroners do…

they do in order to "find" = make a determination based on evidence (written statement, oral testimony in court, documentary evidence, expert evidence)…sufficient to satisfy the civil standard of proof (balance of probabilities)

- (a) the identity of the deceased
- (b) the [medical] cause of death; and
- (c) unless sub-section (2) applies, the circumstances in which the death occurred;
  - Proximate and/or causally relevant circumstances
  - NOT any part of a narrative culminating in the death
  - *Often the last episode of care or most recent therapeutic engagement*

Fiction=What Coroners do not do…

- Determine criminal culpability (guilty or not)
- Determine rights between parties (eg estates)
- Determine civil liability (compensation or damages)
- Look for fault or look to blame individuals or institutions…
  - But the evidence may support an adverse finding or prevention-focused comment or recommendation…*Case authorities establish that Coroners should not make adverse findings about individuals or institutions, unless the evidence establishes that they materially departed from the standards of their profession and in so doing, caused or contributed to the death.*
  - Coroners accord natural justice so notice should be given of a potential adverse finding and parties given a "hearing"…

Some data for context…

- Currently 11 Coroners in Victoria
- ~ 6,500 reported/reportable deaths/year
- ~600 deaths investigated/Coroner year
- ~ 650 deaths found to be suicides = "intentionally caused their own death"
- ~60 suicides/Coroner year, mostly middle aged males & most commonly by hanging…
- Skewed perspective + challenge of hindsight

Coronial suicide data for 2017…

- 677 in total – 495 (73%) male/ 182 (27%) female
- Age at death: 406 (60%) aged between 25-54
  - 133 b/w 25-34; 131 b/w 35-44 and 142 b/w 45-54…
  - [3 b/w ages of 10-14]
- Suicide method (disregarding gender)
  - 338 (50%) by hanging
  - 107 (16%) drug toxicity*
  - ~ 30 (4.5%) each by engine exhaust gassing; jump from height; train incidents; firearms*; irrespirable atmosphere

2009-2014 suicide data…

- Coronial data for six years where N = 3495
- 1843 (52.7%) had a diagnosed mental illness
  - ***41.7% for mood disorder**
  - 7.4 % for schizophrenia
- 2183 (62.5%) Tx for mental ill health @ 12 mths/1653 (47.3%) @ 6wks
  - ***59.3% as a voluntary community patient** (43.7%); 15.7% as a voluntary inpatient (7.1%); 6.2% as a compulsory inpatient (2.9); 5.4% as a compulsory community patient (3.5%).
- 2183 (62.5%) treated for mental ill health w/in 12 mths by provider
  - ***1611 (46.1%) from a GP;** 1088 (31.1%) psychiatrist; 846 (24.2%) from "other mental health practitioner"; 591 (16.9%) ED; 539 (15.4%) psychologist; 355 (10.2%) CATT
- *No treatment w/in 12 mths 37.5%; w/in 6 wks 52.7%

Risk assessment in Coronial findings…

- Search of coronial findings pre 2000 is very difficult. "Suicide register" provides good search capacity from 2000 to date but inherent limitations…
- Comment made in a finding regarding "tick box" RAx on a private mental health inpatient unit. In this case the Wyndham Clinic advised that *"a number of areas, including suicidal thought, past suicide attempts and protective factors now have space for staff to record detail of incidents and thoughts to assist in safely managing the patient, rather than just tick the box."* The Coroner stated that these documents and the associated training should improve the assessment and response to risks in patients at the Wyndham Clinic. (COR 2015 3693)
- In two separate findings recommendations were made that RAx and risk *management guidelines be developed specific to bed-based adult acute units, which reflect evidence-based best practice* and are inclusive of the range of vulnerabilities and risk exposures in adult acute inpatient settings. (COR 2009 2156; COR 2010 4610)

Cont.,

- In one finding, a recommendation was made for clear instructions to be developed for inpatient staff to produce consistency in the requirement for a formally documented and notarised rationale explaining the determination of a patient's "low risk" rating. (COR 2012 4587)
- A common theme of recommendation regarding RAx, both inpatient and in the community, was the inclusion of holistic information about a patient's risk, including the identification of inconsistencies in presentation and documentation that may influence the risk assessment, rather than relying heavily on the self-report of the patient regarding their risk. (COR 2006 0652; COR 2006 2201; COR 2007 0346: COR 2008 3288; COR 2011 3385)

And finally,

- Several Coroners have made reference in findings to a comment made by DSC West in the matter of DENNIS (COR 2001 3310) –

  "This tragedy highlights the dilemma facing health professionals who manage and treat individuals with mental illness and their difficulty in predicting when a patient is at risk of crossing the suicide threshold. The patient's actions are frequently impulsive. Prior attempts and risk factors may well be documented, however such material can rapidly go out of date and thus be less helpful as an indication of future behaviour."