

2021

**THE LEGISLATIVE ASSEMBLY FOR THE
AUSTRALIAN CAPITAL TERRITORY**

**GOVERNMENT RESPONSE TO THE CORONIAL RECOMMENDATION FROM
THE INQUEST INTO THE DEATH OF KAITLIN O'KEEFE MCGILL**

STATEMENT

**Presented by
Emma Davidson MLA
Minister for Mental Health
5 August 2021**

Madam Speaker, I rise to table the ACT Government's Response to the Coronial recommendation from the inquest into the death of Kaitlin O'Keefe McGill.

I would firstly like to acknowledge the tragedy of Kaitlin O'Keefe McGill's death. I acknowledge the deep grief, loss, and profound sadness that those who loved and cared for Ms McGill have experienced and continue to deal with. I offer my sincere condolences to her family and friends for their tragic loss.

Coroner Morrison found Ms McGill died on 23 March 2016 at her residence in Garran, caused by morphine toxicity, and her death was accidental. At the time of her death, Ms McGill was subject to a Psychiatric Treatment Order (PTO) made by the ACT Civil and Administrative Tribunal under the *Mental Health (Treatment and Care) Act 1994* (as it then stood) on 12 November 2015, for a period of six months. As Ms McGill died while subject to an order under mental health legislation, her death is to be treated as a death in care for the purposes of the *Coroners Act 1997*.

The Government has considered the Coroner's report and supports the recommendation to consult with families and carers of persons subject to PTOs, as well as mental health consumers subject to such orders, to explore the desirability of legislative or procedural reform about information dissemination to family and carers to support the care and treatment of persons subject to such orders.

The evidence in this case discloses that members of the McGill family were engaged by ACT mental health workers to assist in treatment by bringing Ms McGill to appointments and reinforcing treatment instructions of clinicians, yet they were not given key information about Ms McGill's condition and treatment. The Coroner did not receive evidence about the difference which the involvement of Ms McGill's family may have made to the cause of her death.

It must be noted that at the time of Ms McGill's death the *Mental Health (Treatment and Care) Act 1994* did not allow for the appointment of a nominated person, advanced care plans or advanced care directives. These are now provided for in the *Mental Health Act 2015* (MH Act).

The principles of the current MH Act recognise the importance of Carers and promote and encourage communication between clinicians, other health practitioners, people with mental disorder or mental illness and their Carers.

Notwithstanding the principles of the MH Act, the right to privacy in section 12 of the *Human Rights Act 2004* states that everyone has the right not to have his or her privacy interfered with unlawfully or arbitrarily. A person's human right to privacy and equality before the law can only be subject to reasonable limitations.

With the human right to privacy in mind, there is value in exploring any legislative mechanisms or procedural reforms available that would allow family and carers to access information that could assist them to better support the person that they care for, where that person is under an involuntary order of the MH Act.

The MH Act is undergoing a number of phases of review. In early 2019, the ACT Government consulted on involuntary orders that can be made under the MH Act.

The Government is due to conduct phase two and three of the review of the MH Act. It is anticipated that Coroner Morrison's recommendation can be included as part of this process.

I would also like to acknowledge advocacy from mental health and carer organisations and representatives on this issue. I am glad that the MH Act review will provide a mechanism to ensure that people with mental disorder or mental illness can be well cared for and supported.

In accordance with the ACT Government's obligations under the *Coroners Act 1997*, I commend the response to the ACT Legislative Assembly.

ENDS