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THE LEGISLATIVE ASSEMBLY FOR THE

AUSTRALIAN CAPITAL TERRITORY

Government Response to Coronial recommendation from the Inquest into the Death of Kaitlin O'Keefe McGill

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Table of Contents

Executive Summary

On 7 May 2021, ACT Coroner Morrison delivered their report on the Inquest into the death of Kaitlin O'Keefe McGill.

Coroner Morrison found that Ms McGill died on or between 21-22 March 2016 at her residence in the ACT. The manner and cause of death was morphine toxicity, and her death was accidental.

The *Coroners Act 1997* permits the Coroner to make recommendations about the promotion of general public health and safety. In this case Coroner Morrison made one recommendation: that the ACT Government consult families and carers of persons subject to Psychiatric Treatment Orders (PTOs), as well as those 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 ACT Government supports the recommendation.

Coroner's recommendations and key issues

At the time of her death, Ms McGill was subject to an involuntary PTO made under the *Mental Health (Treatment and Care) Act 1994* (under the law as it then stood).

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*[1] (the Act) and therefore an inquest into her death was required to be held.

Section 75 of the Act requires the Coroner, after completion of the Inquest to report the findings to the agency that the deceased person was in the care or custody of when the death happened and the Minister responsible for the agency. For the purpose of section 75, the responsible agency is the ACT Health Directorate, and the responsible Minister is the Minister for Mental Health.

Section 76 of the Act requires the ACT Health Directorate to provide the Minister for Mental Health, no later than three months after the date of receipt of the report, a written response to the findings contained in the report. The response must include a statement of

[1] *Coroners Act 1997* (ACT), s.52(4)

the action (if any) that has been, or is being, taken in relation to any aspect of the findings contained in the report.

The final legislative requirement is for the Minister for Mental Health to provide the response to the Coroner as soon as practicable after receiving it. The ACT Health Directorate received the Report of the Findings on 7 May 2021. To meet the three-month legislative timeframe under section 76 of the Act, the Coroner must be provided with the written response by 6 August 2021.

Coroner Morrison found that there was no matter of public safety in connection with the Inquest. Coroner Morrison also found that there was no evidentiary basis for the making of a finding that the quality of care, treatment and supervision provided to Ms McGill contributed to the cause of her death and that no adverse comment was warranted against ACT Mental Health, or any of its clinicians.

Section 3BA(1)(d)(ii) of the Act permits the Coroner to make recommendations about the promotion of general public health and safety. A Coroner's power to make recommendations is not limited to cases where a matter of public safety is found to arise.

Coroner Morrison made one recommendation, that the ACT Government consult families and carers of persons subject to PTOs, as well as those 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. However, 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 that are included in the *Mental Health Act 2015* (MH Act).

Previous ACT inquests have also discussed similar issues and recommendations relating to information dissemination to family and carers to support the care and treatment of persons subject to such orders:

a. *Inquest into the death of Mark Rodney Jolliffe [2015] ACTCD 2.*

b. *Inquest into the death of Adrian Pitman [2019] ACTCD 13.*

ACT Government response to the recommendations and key issues

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 this is mind, there is value in exploring the legislative mechanisms or procedural reforms available to enable family and carers to access relevant information about the treatment of the person they care for in circumstances where that person is unable to provide informed consent.

The principles of the 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.

Four of the points of Principle (j) of the MH Act relate to carers. These are:
Services provided to a person with a mental disorder or mental illness should -

a. facilitate appropriate involvement of close relatives, close friends and carers in treatment, care or support decisions in partnership with medical professionals; and

b. acknowledge the impact of mental disorder and mental illness on the close relatives, close friends and carers of people with a mental disorder or mental illness;

c. recognise the experience and knowledge of close relatives, close friends and carers about a person's mental disorder or mental illness; and

d. promote inclusive practices in treatment, care or support to engage families and carers in responding to a person's mental disorder or mental illness.

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 *Mental Health Act 2015*:

a. PTOs;

b. Community care orders;

c. Forensic psychiatric treatment orders; and

d. Forensic community care orders.

Phase two and three of the review of the MH Act are due to commence.

The ACT Government supports Coroner Morrison's recommendation that the ACT Government consult families and carers of persons subject to PTOs, as well as those 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. It is anticipated that this recommendation can be included as part of this review process.

Conclusion

The Government acknowledges the tragic death of Kaitlin O'Keefe McGill in March 2016 and the effect that this loss has had on her family and friends.

The Government recognises the importance of the issues raised by Coroner Morrison in relation to the inquest reinforcing similar recommendations previously handed down.

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