CHIEF PSYCHIATRIST
of Western Australia

Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist

Policy for Public Mental Health Services

Office of the Chief Psychiatrist 2018

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Definitions

Term	Definition
Absence Without Leave (AWOL)	Under the Mental Health Act 2014 (MHA 2014) section 97 Absence without Leave (AWOL) relates to involuntary inpatients, involuntary community patients, patients on an order for assessment, and referred patients that meet the following criteria: i. any forensic patient who leaves the hospital or other place where the person is detained without being granted leave of absence under MHA 2014 s105(1); ii. any detained involuntary or patient referred for examination who leaves from an authorised hospital, a general hospital, including emergency departments, or other place without being granted leave of absence under MHA 2014 s 105(1); iii. the failure of an involuntary patient to return from a period of authorised leave following expiry of leave or on cancellation under MHA 2014 s 110(1); iv. any patient referred for examination who leaves from an authorised hospital, general hospital, including emergency departments, or other place under MHA 2014 s 97(1)(a); v. any involuntary community patient who leaves the place where they are detained under MHA 2014 s 130(2)(b).
Assault / Aggression	For the purposes of this policy, assault is defined as follows: • a person who strikes, touches, moves, or otherwise **applies force** of any kind to a person, either directly or indirectly, without their consent, or with their consent if the consent is obtained by fraud; or threatens to do so, under such circumstances that the person making the attempt or **threat** has actually or apparently a present ability to affect their purpose **Applies Force:** includes the case of applying heat, light, electrical force, gas, odour, or any other substance or thing whatever if applied in such a degree as to cause injury or personal discomfort. Aggression is broadly defined as any verbal, non-verbal or physical behaviour that is threatening to others. A **threat** can be defined, as a statement or behaviour that expressly constitutes, or may reasonably be regarded as constituting, a threat to: i. kill, injure, endanger or harm any person, whether a particular person or not; or ii. destroy, damage, endanger or harm any property, whether a particular property or not; or iii. take or exercise control of a building, structure or conveyance by force or violence; or iv. cause a detriment of any kind to any person, whether a particular person or not.

Term	Definition
Attempted Suicide	Defined as any deliberate self-inflicted bodily injury with the intention of ending one's life. This does not include suicidal ideations which have not been acted upon. It does include incidents which are considered a near miss where an 'incident may have, but did not cause harm, either by chance or through timely intervention.' This includes but is not limited to self-poisoning, overdose, hanging etc.
Authorised Hospital	An authorised hospital is (MHA 2014 s 541) – i. a public hospital, or part of a public hospital, in respect of which an order is in force under s 542 *MHA 2014*; or ii. a private hospital the license of which is endorsed under the Hospitals and Health Services Act 1927 s 26DA(2).
Community Mental Health Service	A community mental health service (MHA 2014 section 4) - means a service that conducts assessments or examinations for the purpose of this Act or provides treatment in the community, but does not include private practices of a medical practitioner or other health professional.
Community treatment order	An order in force under the MHA 2014 s 23 under which a person can be provided with treatment in the community without informed consent being given to the provision of the treatment.
Incapable person	An incapable person, for the purpose of sexual offences against that person, can be defined, according to section 330 of the *Criminal Code Act 1913* as: a person who is so mentally impaired as to be incapable (lacking capacity): i. of understanding the nature of the act the subject of the charge against the accused person; or ii. of guarding himself or herself against sexual exploitation.
Inpatient treatment order	An order in force under the MHA 2014 s 22 which a person can be admitted by a hospital and detained there, to enable the person to be provided with treatment without informed consent being given to the provision of the treatment.
Involuntary patient	A person who is under an involuntary treatment order. An involuntary treatment order is either an inpatient treatment order or a community treatment order (MHA 2014 s 21-23). Please see the definitions for "Inpatient treatment order" and "Community treatment order" within this definition section for more information.
Medication Error	An error in any medication prescribed for, or administered or supplied to, the person that has had, or is likely to have, an adverse effect on the person (MHA 2014 s 525(b)). Adverse effect means to need medical intervention, review or has or is likely to have caused death.
Mentally impaired	Means having intellectual disability, mental illness, brain damage or senility (*Criminal Code Act 1913* section 1).

Term	Definition
Mental Health Service	a) Means any of these services (MHA 2014 s 4): i. a hospital, but only to the extent that the hospital provides treatment or care to people who have or may have a mental illness; ii. a community mental health service; iii. any service, or any service in a class of service, prescribed by the regulations for this definition; *and* b) does not include: i. a private psychiatric hostel; or ii. a declared place as defined in the Mentally Impaired Accused (MIA) Act section 23.
Missing Person	Any voluntary psychiatric patient at high risk of harm who is missing from a mental health service, general hospital or emergency department, without the agreement of or authorisation by staff.
Referred Mental Health Patient	A medical practitioner or authorised mental health practitioner may refer a person under MHA 2014 s 26(2), s 26(3), or s 36(2) for an examination conducted by a psychiatrist, having regard to the criteria specified in MHA 2014 s 25, the practitioner reasonably suspects that the person is in need of an involuntary treatment order.
Sexual Contact and Sexual Assault	The following definitions have been adapted from the Human Rights Commission '*Sexual Harassment (A Code in Practice*)', Chapter XXXI of the *Criminal Code Act 1913,* and the Sexual Assault Resource Centre (SARC) *'Information about Sexual Assault and Sexual Abuse'*. **Sexual Contact** for the purpose of this policy includes any sexual activity/behaviour (including sexual touching) that occurs between people over the age of 16 years where mutual consent has been granted by those involved and they are considered to have capacity to provide consent. **Sexual behaviour/activity:** a person is said to engage in sexual behaviour/activity if the person: • Sexually penetrates any person; or • Has carnal knowledge of an animal; or Penetrates the person's own vagina (which term includes the labia majora), anus, or urethra with any object or any part of the person's body for other than proper medical purposes. **Sexually penetrate:** 1. to penetrate the vagina (which term includes the *labia majora*), the anus, or the urethra of any person with – 1.1 any part of the body of another person; or 1.2 an object manipulated by another person, except where the penetration is carried out for proper medical purposes. 2. to manipulate any part of the body of another person

Term	Definition
	so as to cause penetration of the vagina (term includes the *labia majora*), the anus, or the urethra of the offender by part of the other person's body; or 3. to introduce any part of the penis of a person into the mouth of another person; or 4. to engage in cunnilingus or fellatio; or 5. to continue sexual penetration as defined in paragraph (1), (2), (3) or (4). **Sexual harassment:** is unwelcome sexual conduct which makes a person feel offended, humiliated and/or intimidated where the reaction is reasonable in the circumstances. It can involve, but is not limited to: • unwelcome touching, hugging or kissing; • staring or leering; • suggestive comments or jokes; • unwanted invitations to go out on dates or requests for sex; • unnecessary familiarity; • insults or taunts based on your sex, gender or sexual orientation; or • sexually explicit emails or SMS messages. **Sexual assault** can be any unwanted **sexual behaviour/activity or act** that is threatening, violent, forced, coercive, or exploitative and to which a person has not given or was not able to give consent. It can take many forms including: • Sexual harassment • Exhibitionism – exposing the genital area • Voyeurism – secretly watching people • An unwanted sexual touch • Being forced to masturbate or watch another masturbate • Being forced, coerced or bribed to view pornographic images • Being forced to give or receive oral sex • Being forced to perform sexual acts on themselves or others • Sexual penetration of a person by penis, object or other parts of the body into the vagina, anus or mouth • Sexual coercion • Indecent acts and indecently recording children aged less than 16 years of age (b. below applies). **Special considerations** for children a) a child under the age of 13 years is incapable of giving consent. b) Sexual activity with a child aged less than 16 years, but over 13 years of age is illegal, unless: i. the accused is lawfully married to the child; or ii. the accused is less than three years older and they can prove that they believed on reasonable grounds that the child was of or over 16 years of age; or iii. if the child is under the care, supervision or authority of the accused it is immaterial that they believed on

Term	Definition
	reasonable grounds that the child was of or over 16 years of age and the accused was not more than three years older than the child. c) Sexual activity between a child over 16 years of age and any adult who provides care, supervision or authority of the child is illegal (e.g. health practitioner, step-parent, guardian, foster parent, employer, teacher, coach, priest, etc.) unless the accused is lawfully married to the child. **Sexual coercion:** a person who compels another person to engage in sexual behaviour. **Indecent act:** an act which is: • committed in the presence of or viewed by any person; or • photographed, videotaped, or recorded in any manner. **Indecently record:** means to take, or permit to be taken, or make, or permit to be made, an indecent photograph, film, videotape, or other recording (including a sound recording). **Sexting** of images of persons aged less than 16 years of age is illegal as it is considered child exploitation material.
Suicide	The act or instance of taking one's own life voluntarily and intentionally
Voluntary Mental Health Patient	A person to whom treatment is being, or is proposed to be, provided by a mental health service who is not an involuntary patient or a Mentally Impaired Accused (MIA) requiring detention at an authorised hospital (MHA 2014 s 4).

1.0 Purpose of this Policy

The purpose of the *Policy* for *Mandatory Reporting of Notifiable Incidents to the Chief* Psychiatrist is to inform mental health and other health staff of the statutory requirement to report notifiable incidents to the Chief Psychiatrist under the Mental Health Act (MHA 2014) section (s) 526 (1-3). Under the MHA 2014 s533(2), the Chief Psychiatrist is required to report, on an annual basis, on the performance during the last financial year of the functions conferred on the Chief Psychiatrist under the MHA 2014 to the Minister for Mental Health.

The Western Australian (WA) Department of Health mandatory policies are located at https://ww2.health.wa.gov.au/About-us/Policy-Frameworks. This policy is to be read in conjunction with all relevant WA Department of Health mandatory policy frameworks and policies, standards and guidelines including:

- WA Health Datix CIMS Guides
  http://ww2.health.wa.gov.au/Articles/A_E/Clinical-incident-management-system
- Clinical Incident Management (CIM) Policy
  https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Clinical-Incident-Management-Policy
- WA Health Clinical Risk Management Guidelines
  https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Quality/PDF/WA%20Health%20Clinical%20Risk%20Management%20Guidelines.pdf
- WA Health Complaint Management Policy
  https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/WA-Health-Complaint-Management-Policy
- WA Review of Death Policy
  https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Review-of-Death-Policy
- Employment Policy
  file:///C:/Users/he05106/Downloads/Employment.pdf
- Chief Psychiatrist's Sexual Safety Guidelines
  https://www.chiefpsychiatrist.wa.gov.au/standards-guidelines/sexual-safety-guidelines/
- Mental Health Act 2014
  https://www.legislation.wa.gov.au/legislation/statutes.nsf/law_a147019.html
- Mental Health Regulations 2015
  https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13717_homepage.html
- Chief Psychiatrist's Standards for Clinical Care
  https://www.chiefpsychiatrist.wa.gov.au/
- Guidelines for Protecting Children 2015
  https://ww2.health.wa.gov.au/Articles/A_E/About-child-abuse-and-neglect/Guidelines-for-Protecting-Children

1.1 Purpose of reporting Clinical Incidents through Datix CIMS

Through a Memorandum of Understanding with the Health Department, the Chief Psychiatrist accesses the data for clinical incidents classified in this policy as a notifiable incident, via Datix CIMS (Clinical Incident Management System). Incidents involving mental health patients are identified through the 'Status with respect to Mental Health Act' variable on Datix CIMS and these incidents are then extracted from Datix CIMS. The aims of accessing relevant incidents via Datix CIMS are to:

1. Reduce duplicative reporting for clinicians and staff
2. Increase reporting of notifiable incidents to the Chief Psychiatrist

Every effort has been undertaken to reduce duplication in reporting for mental health clinicians. However, the MHA 2014 s526(3) requires that the names of staff, patients, and others involved in, or witness to, the incident are reported to the Chief Psychiatrist. The CIM Policy does not allow the reporting of names of staff, witnesses, or others to be reported through Datix CIMS. Information outside the scope of the CIM Policy (e.g., names of staff and other witnesses) must not be reported through Datix CIMS. This information along with the CIMS reference number must be reported directly to the Chief Psychiatrist via the Notifiable Incident Form located on the Chief Psychiatrist website https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2017/12/Notifiable-Incidents-Form-for-Public-Mental-Health-Services.pdf and emailed to monitoring@ocp.wa.gov.au.

2.0 Scope

It is a statutory requirement under MHA 2014 s526(1-3) that all notifiable incidents (defined in section 4 below) are reported to the Chief Psychiatrist as soon as practicable, ideally within 48 hours of the event, when they occur in respect to a person referred to in MHA 2014 s524(a)(b).

Reporting to the Chief Psychiatrist is required in addition to all other reporting requirements which may include internal management structures within the service, the Director General of Health, the Minister for Health and Mental Health, Patient Safety and Clinical Quality, Internal Audit and Accountability, the Corruption and Crime Commission and the State Coroner. A notifiable incident where a staff member has/could have been harmed also needs to be reported via the Occupational Safety & Health pathway. If allegations or suspicions of misconduct become evident, the health service Risk Manager/Director of Safety, Quality and Performance, or other relevant manager should be informed and staff should follow the relevant policies in the *Employment Policy* Framework. For incidents involving children, additional mandatory reporting requirements set out in the Children and Community Services *Act 2004* need to be followed.

2.1 In scope of this Policy

Individuals within scope of this policy

The Chief Psychiatrist is responsible for overseeing the treatment and care of the following individuals, as described in MHA 2014 s515(1)(a-e):

a) Voluntary patients being provided with treatment or care by a mental health service;

b) Involuntary patients;

c) Mentally impaired accused (MIA) required under the *Criminal Law (MIA) Act 1996* to be detained at an authorised hospital;

d) Patients referred under s26(2), s26(3)(a) or s36(2) of the MHA 2014 for an examination to be conducted by a psychiatrist at an authorised hospital or other place;

e) Patients under an order made under s55(1)(c) or s61(1)(c) of the MHA 2014 to enable an examination to be conducted by a psychiatrist at an authorised hospital.

Individuals within the scope of this policy- Additional Considerations:

- Individuals who are placed on leave from an authorised mental health facility are still considered to be in the care of said facility. As such, the reporting of all notifiable incidents pertaining to patients placed on leave is the responsibility of the ward in which the patient is currently admitted.

- Individuals admitted to a general health ward or Emergency Department (ED) **whose treatment is informed by a mental health clinician employed by a specialist mental health service** during any part of their inpatient stay are in scope for reporting notifiable incidents to the Chief Psychiatrist as described in section 4 of this policy (e.g. patients undergoing concurrent treatment for eating disorders or drug and alcohol disorders).

- Inpatients discharged from mental health services who are referred as a voluntary patient for follow-up to community mental health services but who have not yet been seen remain the responsibility of the referring service until handover to the receiving service or the

practitioner, or until the consumer decides on an alternative process. This is in line with the Chief Psychiatrist Care Standard 7.

Services within the scope of this policy

This policy applies to all notifiable incidents relating to patients receiving psychiatric care in WA from the following Health Service Providers:

- East Metropolitan Health Service
- North Metropolitan Health Service
- South Metropolitan Health Service
- WA Country Health Service
- Child and Adolescent Health Service

Types of incidents within the scope of this policy

The range of notifiable incidents to be reported are set out in MHA 2014 s525(a-e) and s254(1)(a-c) and described in Section 4 of this policy.

2.2 Outside the scope of this Policy

Types of incidents outside the scope of this policy

- Notifiable events described in MHA 2014 Part 9 are not the same as a notifiable incident as described in this policy and have their own reporting processes that need to be followed, as defined in the MHA 2014.
- Restrictive practices (also termed seclusion and restraint) per se are not included under this policy as notifiable incidents.

  NB: Physical, verbal or sexual behaviour leading to seclusion and/or restraint, and any harm resulting from or during the seclusion or restraint must be reported to the Chief Psychiatrist via the processes described in section 5.
- Recording of each episode of seclusion and restraint is the responsibility of Mental Health Services, as stipulated in the Mental Health Regulations 2015. Under the MHA 2014, mental health staff members are required to report seclusion and restraint events to the Chief Psychiatrist through a separate process using the Chief Psychiatrist's Approved Forms.

Services outside the scope of this policy

Private psychiatrists and General Practitioners treating patients in their private practice are not within scope of this policy. Specific policies have been developed for the use of private hospitals and private psychiatric hostels:

- Private hospitals should use the Policy for Reporting of Notifiable Incidents to the Chief Psychiatrist – Private Health Services https://www.chiefpsychiatrist.wa.gov.au/monitoring-reporting/notifiable-incidents/
- Private psychiatric hostels should use the Policy for Reporting of Notifiable Incidents to the Chief Psychiatrist – Private Psychiatric Hostels https://www.chiefpsychiatrist.wa.gov.au/monitoring-reporting/reporting-notifiable-incidents-private-psychiatric-hostels-2/

3.0 Roles and responsibilities

3.1 Responsibilities of all mental health staff working for WA Health service providers

- To report to the Chief Psychiatrist all known notifiable incidents, as detailed in section 4 of this Policy.
- To follow the CIM Policy and other relevant policies where applicable, including requirements for investigating incidents.

3.2 Responsibilities of the Office of the Chief Psychiatrist

The Office of the Chief Psychiatrist has the responsibility to:

- Monitor all notifiable incidents pertaining to mental health patients.
- Identify incidents and/or trends requiring further investigation by the Chief Psychiatrist.
- Provide feedback to mental health services about trends and other relevant issues.

4.0 Notifiable Incidents

The MHA 2014 s254, 1 (a-c) and s525 (a-e) outline the types of incidents that must be reported to the Chief Psychiatrist. Notifiable incidents must be reported to the Chief Psychiatrist as soon as practicable, ideally within 48 hours of the event.

4.1 Deaths

The Chief Psychiatrist is to be informed as a matter of priority, of any death of a mental health patient while under the care of any mental health or other health service and any death that may implicate or involve mental health or other health services or stakeholders (MHA 2014 s525(2)). The Chief Psychiatrist is also to be advised of deaths, that mental health services become aware of, occurring within 28 days of a person being discharged or deactivated from mental health services, even if the mental health service becomes aware of the death after the 28 day period.

4.2 Other notifiable incidents include, but are not limited to:

1. Assault and/or aggression (patient to any other person(s)) that occurred within an inpatient setting (including emergency department and hospital grounds), on community mental health service premises (this includes incidents occurring during staff assessment of the patient at their home or other premises) or at a private psychiatric hostel.
2. Sexual contact and/or allegation of sexual assault (patient to any other person(s)) that occurred within an inpatient setting (including emergency departments and hospital grounds), community mental health service premises (this includes incidents occurring during staff assessment of the patient at their home or other premises) or at a private psychiatric hostel. Disclosure of sexual assault/abuse that has occurred outside of a mental health service setting is not reportable under this policy. The Chief Psychiatrist expects that clinicians and other staff who become aware of allegations of sexual assault/abuse, will provide appropriate follow–up for the patient, in accordance with any relevant local policies.
3. Attempted suicide.
4. Absent without leave (AWOL).
5. Missing person.
6. Medication error.
7. Unlawful sexual contact reasonably suspected to have occurred with the patient by a staff member of a mental health service (includes staff members of a private psychiatric hostel) or another person within a hospital setting that is not a mental health patient.
8. The patient is harmed by suspected unreasonable use of force by a staff member of a mental health service (includes staff members of a private psychiatric hostel).
9. Any allegation of homicide committed by a current mental health patient or a mental health patient who was discharged or deactivated from mental health services within 28 days prior to the alleged homicide needs to be reported to the Chief Psychiatrist, even if the mental health service becomes aware of the alleged homicide after the 28 day period.
10. Any notifiable incident described above, that may receive media attention.

The clinical deterioration of a mental health patient receiving psychiatric care that results in the patient physically, verbally or sexually assaulting a staff member, patient or other person is considered a clinical incident (*CIM Policy*, section 5.2). The outcome of this clinical deterioration, such as physical, verbal or sexual behaviour, needs to be reported to the Chief Psychiatrist.

5.0 Reporting Processes for Notifiable Incidents

Notifiable incidents must be reported to the Chief Psychiatrist, ideally within 48 hours of the event. Reporting of clinical incidents is via the Datix Clinical Incident Management System (Datix CIMS) and for notifiable incidents and data outside CIM Policy, reporting is through the Chief Psychiatrist Notifiable Incident form (Table 1).

The reporting of notifiable incidents has been streamlined to reduce duplicate reporting for mental health clinicians and staff, whereby the Chief Psychiatrist can access relevant data on clinical incidents from Datix CIMS. Reporting to the Chief Psychiatrist is as required under the MHA 2014.

Clinical incidents listed as 'notifiable incidents' in section 4, are extracted from Datix CIMS using the Mental Health Status variable to identify patients who are either a referred, involuntary, or voluntary mental health patient. All notifiable incidents for referred, voluntary and involuntary mental health patients are extracted, regardless of the Severity Assessment Code (SAC) rating.

Serious notifiable incidents such as those involving the suspected suicide of a mental health inpatient or other serious incident that may receive attention by the media or the wider community, need to be reported to the Chief Psychiatrist immediately via email to monitoring@ocp.wa.gov.au providing the Datix CIMS reference number (if reported on Datix CIMS) *in addition to* the relevant reporting process highlighted in sections 5.1 and 5.2.

Where a notifiable incident requires the URGENT attention of the Chief Psychiatrist, the consultant psychiatrist or the executive director or their delegate should report directly to the Chief Psychiatrist and/or the OCP manager in addition to the reporting process listed in sections 5.1 and 5.2. The phone number for communication of urgent matters during office hours is (08) 6553 0000.

5.1 Datix Clinical Incident Management System

Datix CIMS should be used by hospital and community health service staff to notify the Chief Psychiatrist of incidents suspected to relate to healthcare:

1. Notifiable incidents 1-8 as listed in section 4 that are related to clinical care;
2. All deaths of mental health patients that may be related to clinical care;
3. All deaths of mental health patients due to suspected suicide or overdose.

See Appendix A for a guide to completing Datix CIMS notifications and Appendix B for a guide to completing Datix CIMS for senior notifiers. For senior staff confirming the incident details, under the section 'Notification to Statutory/Other Bodies,' the item *'Chief Psychiatrist: Is this a mental health notifiable incident'* must be ticked 'yes'.

Information required by the Chief Psychiatrist that is outside of the CIM policy,[1] such as staff names, must not be reported in the Datix CIMS report (refer to section 5.2 for reporting details).

Information that becomes available after the initial Datix CIMS report is completed can be provided to the Chief Psychiatrist, at a later date, via email to monitoring@ocp.wa.gov.au ensuring that the CIMS reference number is included in all correspondence.

[1] Clinical Incident Management (CIM) Policy http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=13224

Table 1. Overview of how to report to the Chief Psychiatrist

Notifiable Incidents	Datix CIMS	CP* Notifiable Incident form	E-mail† to CP* and/or OCP** Manager
Deaths related to clinical care	✓		
Deaths due to suspected suicide or overdose	✓		
All other deaths of active mental health clients		✓	
All deaths within 28 days of a patient's discharge/ deactivation from any Mental Health Service (community or inpatient)		✓	
Assault and/or aggression (patient to any other person(s)) that occurred within an inpatient setting (including emergency department and hospital grounds), on community mental health service premises (this includes incidents occurring during staff assessment of the client at their home or other premises) or private psychiatric hostel	✓		
Sexual contact and/or allegation of sexual assault (patient to any other person(s)) that occurred within an inpatient setting (including emergency departments and hospital grounds), community mental health service premises (this includes incidents occurring during staff assessment of the client at their home or other premises) or private psychiatric hostel	✓		
Attempted suicide	✓		
Absent without leave (AWOL)	✓		
Missing person	✓		
Medication error	✓		
Unlawful sexual contact reasonably suspected to have occurred with the patient by a mental health service staff member (includes staff of private psychiatric hostels) or another person within a hospital (including emergency department) that is not a mental health patient	✓	✓^	
The patient is harmed by suspected unreasonable use of force by a staff member of a mental health service (includes staff members of a private psychiatric hostel)	✓	✓^	
Any allegation of homicide committed by a current mental health patient or a mental health patient who was discharged within 28 days prior to the alleged homicide		✓	✓
Any notifiable incident described above that requires urgent attention by the Chief Psychiatrist[a]			✓
Any notifiable incident described above, that may receive media attention[a]			✓

*Chief Psychiatrist; **Office of the Chief Psychiatrist; †monitoring@ocp.wa.gov.au [a]to be completed in addition to reporting of notifiable incident; ^Consult CIM Policy for reporting through Datix CIMS; Staff identifiable information MUST be reported on OCP form only. Staff conduct to be reviewed in accordance with local policy.

5.2 Chief Psychiatrist's Notifiable Incident Form

Notifiable incidents and information outside the CIM policy, and allegations of homicide committed by a mental health patient/client are to be reported directly to the Chief Psychiatrist through the reporting form located on the Chief Psychiatrist's website (http://www.chiefpsychiatrist.wa.gov.au). The completed form should be emailed to monitoring@ocp.wa.gov.au. This includes:

1. All deaths of patients within 28 days of their discharge/deactivation from mental health services, if known, even if the health service becomes aware of the death after the 28 day period.
2. All deaths of active patients which do not fall within in section 5.1, category 2.
3. All other notifiable incidents that are not considered to be related to health care.
4. Names or personally identifiable characteristics of staff and others (who are not a patient) involved in, or witness to, the reported incident (include CIMS number).
5. Any alleged homicide committed by a current mental health patient or a mental health patient who was discharged within 28 days prior to the alleged homicide, even if the health service becomes aware of the alleged homicide after the 28 day period.

6.0 Information Required by the Chief Psychiatrist

The reporting procedures described in sections 5.1 and 5.2 should be completed in full either through Datix CIMS or the Chief Psychiatrist's Notifiable Incident Form, as relevant.

If the information requested below is not available at the time of completing either the Datix CIMS notification or the Chief Psychiatrist Form, it can be emailed to monitoring@ocp.wa.gov.au at a later date or where relevant, the Datix record updated. For notifications made via Datix CIMS where there are no specific fields in Datix CIMS for the required information, use the 'Describe the actual or potential clinical incident' section.

6.1 Information to be reported to the Chief Psychiatrist

Information required by the MHA 2014 and the Chief Psychiatrist includes:

1. The location where the notifiable incident occurred.
2. Patient demographic details, including patient name and any alias.
3. Mental health status (voluntary, involuntary, referred under the MHA 2014).
4. If the patient is MIA or on a Community Treatment Order (CTO) - this information should be provided using the 'Current and relevant diagnosis/problems' section.
5. Details of the patient's mental state prior to the incident - this information should be provided using the 'Current and relevant diagnosis/problems' section.
6. Date and time when the notifiable incident occurred.
7. Whether the patient's family, carer, guardian, nominated person or support person has been notified. If they haven't been notified the reasons why should be documented.
8. Details of the notifiable incident and the circumstances in which it occurred.
9. For patients AWOL or Missing Persons, the Chief Psychiatrist should be advised of the date and time patient returned, the nature of the assessment performed on the patient's return, and patient outcome, if known at time of report or via email after their return.
10. Provide probable cause of death on current evidence e.g. suicide / accident / physical cause / undetermined.
11. Provide any other information about the incident or death that the notifier or person in charge considers relevant.
12. Medication, if relevant to the incident including any likely problems/factors.
13. For incidents of sexual contact and/or sexual assault allegations include information on the following points in the incident description, where applicable:
    - Does the allegation pertain to sexual assault?
    - Was the sexual contact between non-consenting individuals, between one consenting and one non-consenting individual, or between two consenting individuals?
    - What was the mental health status and capacity to consent of each individual?
    - Could this incident be a delusion caused by the patient's mental illness?
    - Was the allegation substantiated?
    - What immediate action was taken to protect both parties and other patients / staff e.g. observation levels, ward placement, psychiatric care / physical / risk assessment?
    - If police and/or the Sexual Assault Referral Centre (SARC) are involved, provide details. And

if not, state why not.

- The residual impact the incident had on the physical, mental and social wellbeing of each party involved, using the appropriate tools and assessments.

14. Date of most recent risk assessment prior to the incident, identified risks, and measures taken to address these risks
15. Date of the most recent Management Plan or Treatment, Support and Discharge Plan prior to the incident.
16. For community mental health patients, the date of most recent mental health inpatient admission, community mental health contact, and/or mental health emergency department presentation prior to the incident.
17. Any relevant treatment and/or investigations the patient received.
18. Patient outcome.

6.2 Information required by the Chief Psychiatrist that is outside of CIM Policy

Information required by the MHA 2014 and the Chief Psychiatrist that is outside of CIM Policy and therefore, must not be reported through Datix CIMS includes:

1. Where there is a risk of media attention, this should be communicated to the Chief Psychiatrist immediately via the process described in section 5, or the relevant box should be ticked in the Chief Psychiatrist form.
2. The names of any staff members or other people who were involved in and/or witnessed the incident (not to be included in Datix CIMS report, see Note below).

NOTE

The MHA 2014 s526(3) requires that the names of staff, patients, and others involved in, or witness to, the incident are reported to the Chief Psychiatrist.

The CIM Policy does not allow the reporting of names of staff and others to be reported through Datix CIMS. As per instructions in the WA Health CIMS Senior Staff Guide, it is the senior staff member's responsibility to ensure that information in Datix CIMS contains no staff names (only designations) and to amend the information as necessary to meet CIM Policy requirements.

Relevant names, with the CIMS reference number, should therefore be reported directly to the Chief Psychiatrist via completion of the approved form on the website and emailed to monitoring@ocp.wa.gov.au

7.0 Severity Assessment Codes

The CIM Policy outlines the severity assessment rating definitions. A severity assessment rating for notifiable incidents and deaths reported through Datix CIMS must be undertaken prior to the commencement of an investigation of the incident. Details for determining the SAC rating are provided in the Datix CIMS SAC 1 Management Guide. For incidents reported to the Chief Psychiatrist the assessment needs to consider the impact of the incident on all parties involved: for example, if a patient attacks a staff member then the level of harm to the staff member should be considered as an indication of severity of mental health deterioration for the patient.

7.1 Rating for AWOL or Missing Person

All voluntary, involuntary and referred patients who are missing and who are at high risk of causing significant harm to themselves or others, or being harmed by others, are reportable to the Chief Psychiatrist. The assessment of a mental health patient at high risk is based on the patient's mental health condition and is determined by clinical judgment. Refer to Datix CIM Policy, section 5.1 and Table 2 for corresponding information.

The SAC rating for a mental health patient who is AWOL or Missing, is determined by the patient's risk status immediately prior to their absence (e.g. High Risk = SAC1; Medium Risk = SAC2; Low Risk = SAC3). The SAC rating is not necessarily based on the harm that did occur to the patient but the harm that could have occurred in instances where there was a 'near miss'. A near miss is an incident that may have, but did not cause harm, either by chance or through timely intervention. The CIM Policy outlines the severity assessment rating definitions.

Any incidents which occur as a consequence of or subsequent to the patient being AWOL or Missing should be reported as a separate incident. All events relating to the AWOL should be linked to the AWOL event within Datix CIMS.

8.0 Compliance

Failure to comply with reporting notifiable incidents to the Chief Psychiatrist may result in a fine of $6,000 as set out in the MHA 2014 s526(2).

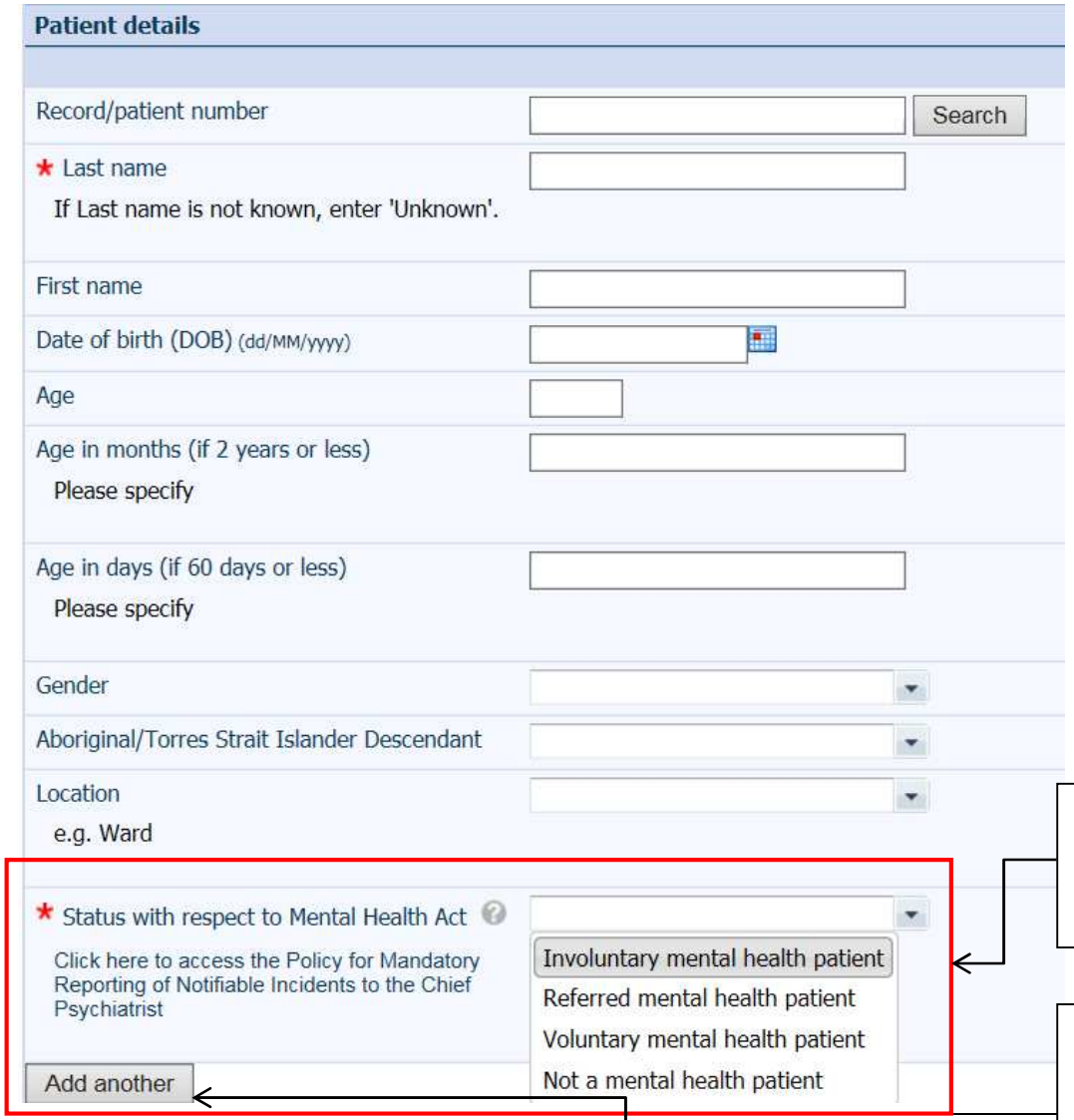
9.0 Relevant Western Australian Legislation

Mental Health Act 2014

Mental Health Regulations 2015

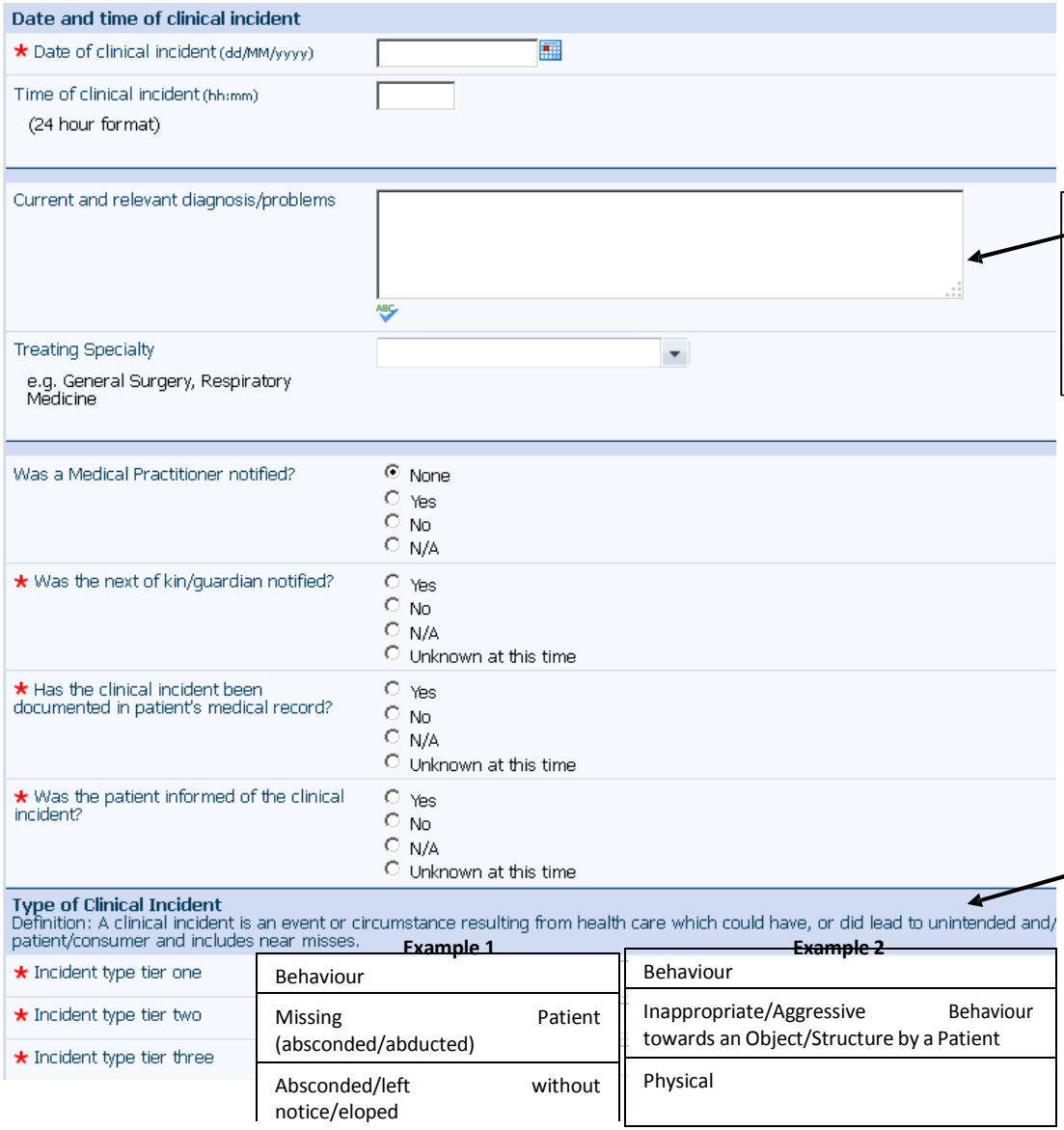
Children and Community Services Act 2004

Appendix A: Guide to completing Datix CIMS report – Notifier



Notifiable Incidents involving mental health patients are identified and extracted for the Chief Psychiatrist using the variable 'Status with respect to Mental Health Act'.

If the incident involves multiple patients, choose 'Add another' and include the details of the other patient

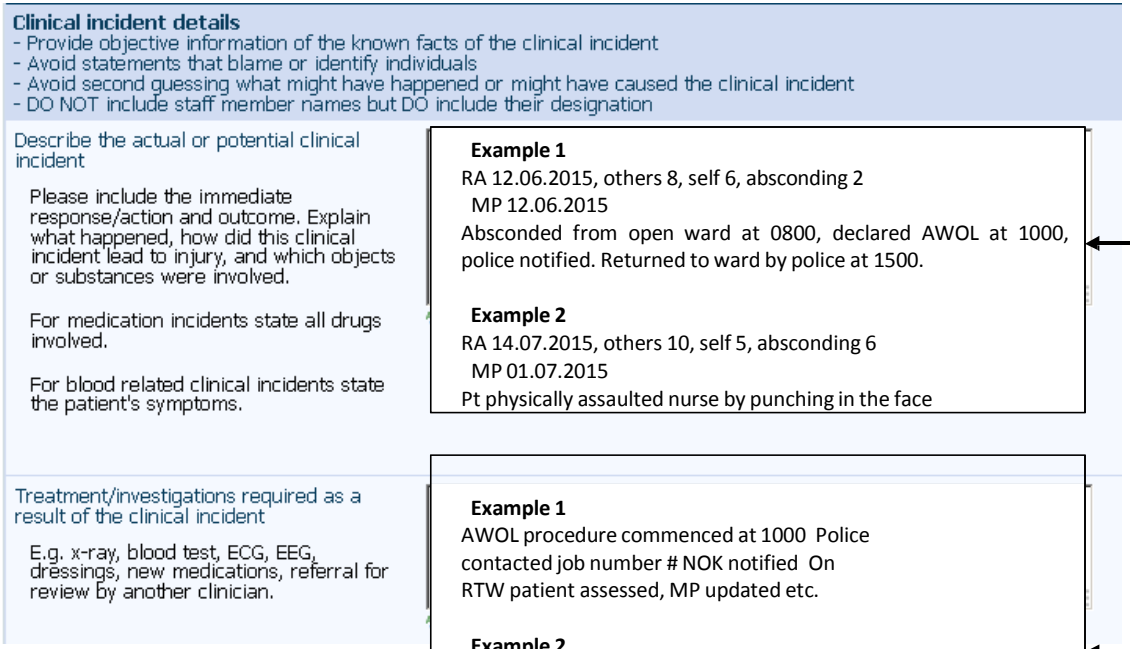


Include supporting information such as:

- If the patient is currently on a CTO or is MIA;
- Mental state of patient at time of incident.

Choose the tiers that best reflect the incident:

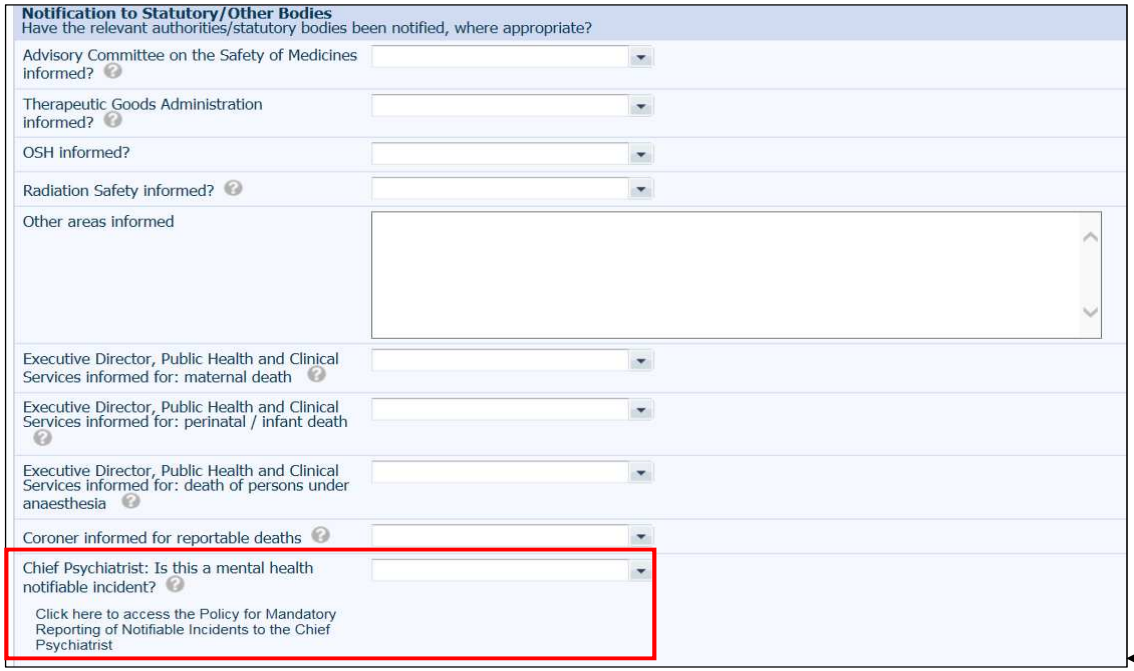
- CIMS Software is an off the shelf product that does not have a tier that directly reflects an incident where the patient assaults or threatens a staff member.
- Recommend using tiers shown in example two for such instances.



Include:

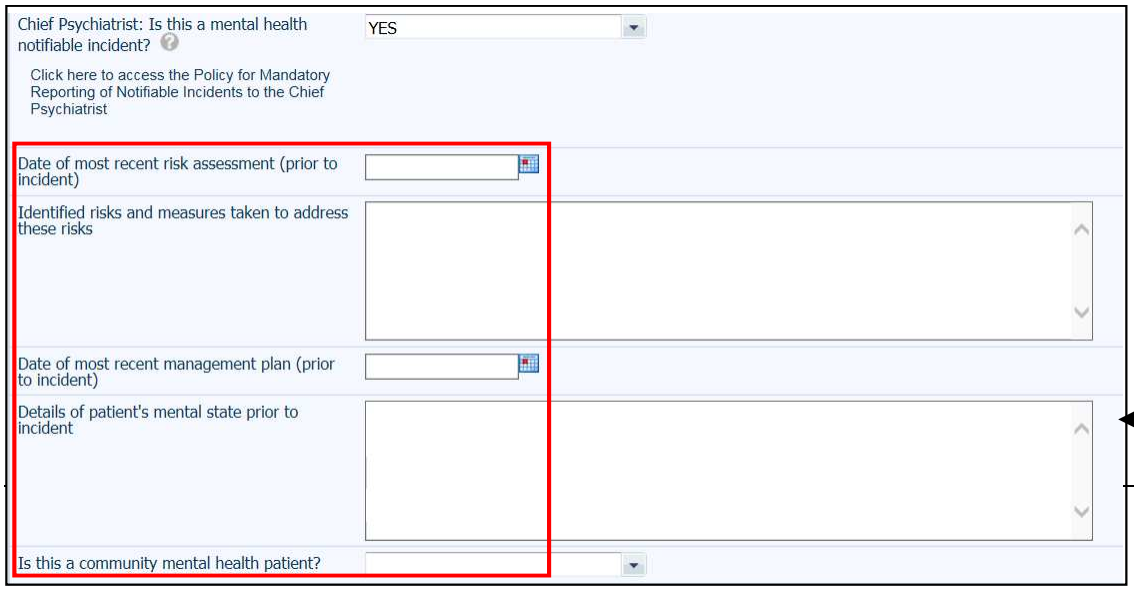
- If community patient, date of last contact with mental health services;
- Description of incident, including details described in section 6 (13-16), if applicable, such as the date and time of return of an AWOL patient if known. When further information becomes available, update Datix CIMS and/or email to monitoring@ocp.wa.gov.au.

Appendix B: Guide to completing Datix CIM report – Senior Staff Member



This item should be ticked YES for all mental health notifiable incidents listed in this Policy.

Once this item in Datix CIMS is changed to YES, mandatory drop-down boxes appear for completion.



Information on Risk Assessment and Management Plans must be provided for all voluntary, involuntary and referred mental health patients and details provided for mental state and community patients, where relevant.