Recommendations from the Coroner

Board: Psychology Board of Australia

Finding Date: 5 April 2017

Details: Coronial inquest into the death of an adolescent (KP), the State Coroner of Victoria

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From time to time, a state coroner may refer a finding of an inquest to AHPRA or the Board to bring to the attention of the profession. AHPRA will publish a case summary of each referral from the coroner on its website, naming the deceased person, with the coroner's recommendations in full. A link will also be provided to the coroner's website. Practitioners are encouraged to access the AHPRA website at www.ahpra.gov.au to keep up to date with these cases and the coroner's recommendations.

When the Board decides that a referral from the coroner has wide-reaching implications for practitioners, it may publish a summary of the case, and highlight particular issues relevant to the profession.

Summary

KP was an adolescent (15 years old) who took his own life on 7 June 2014. KP had a history of depression and was under treatment by a registered psychologist. The Coroner highlighted that psychologists must understand their obligations of confidentiality and information sharing when treating minors.

Introduction and background

KP was an adolescent who took his own life on 7 June 2014. He was aged 15 at the time.

KP had a history of depression starting at the age of eight. His family had taken him to attend various psychologists and psychiatrists, with KP sometimes refusing to attend sessions.

In March 2014, KP's parents became concerned after KP experienced a relationship breakup and when he became intoxicated with friends one weekend and ambulance officers needed to attend the party.

His family took him to see a clinical psychologist in April 2014. KP saw this psychologist several times over the next few months, however did not attend some sessions. At the time, KP indicated that he did not have suicidal intentions and the psychologist assessed KP's suicide risk as 'low-moderate', subject to close follow-up.

At that time, the clinical psychologist did not involve the parents or GP of KP, choosing not to inform them due to the likelihood of breaking the therapeutic relationship with KP. The clinical psychologist noted to the Coroner that KP was reluctant to attend treatment and was often silent during sessions.

KP did not attend a session scheduled in May 2014, and the clinical psychologist followed up this non-attendance by phoning the family home phone number, and then calling one of KP's parents. The clinical psychologist informed the parent that she was concerned about KP but no detail was provided, and an appointment was booked for the following week, although KP did not attend that appointment.

KP attended an appointment on 3 June 2014, and the clinical psychologist assessed his suicide risk as 'low', with him stating he did not have plans to take his life in the coming days. A further session was arranged for a fortnight later, however, KP took his life in the meantime.

The Coroner noted in her comments that the case 'illustrates the difficulty mental health practitioners face in balancing the imperative of forming a trusting relationship with a patient who is a minor against the rights and/or desires of parents to be informed about their children'. The Coroner highlighted the importance of establishing 'clear ground rules at the commencement…in relation to her communication with his parents and GP'.

The Coroner noted that while she understood the clinical psychologist's reasons not to report information to KP's parents, there was no documentation indicating that KP did not wish to have information shared with his mother. The Coroner also noted it is 'desirable' for a clinical psychologist to note in a letter to the referring GP comments about suicide risk if that is part of the reason for referral, and that the psychologist should ask the GP about any previous or currently psychiatric clinical input or medication.

Coroner's recommendations and outcome

The Coroner made one recommendation as a result of her review:

To improve the safety of minors, the Australian Health Practitioner 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.

The above recommendations were considered by the Psychology Board of Australia (the Board). The Board acknowledges the recommendation from the Coroner, and notes that the Board approved the Australian Psychological Society (APS) Code of Ethics (the Code) to provide guidance to psychologists.

The Code provides specific guidance about confidentiality and information sharing, including with other practitioners, where clients may be at risk. Additionally, it references the APS Guidelines for working with young people, which provide more specific guidance on confidentiality and the use of psychological tests. These guidelines are available for APS members on the APS website.

The Board also outlines specific knowledge and skills required by clinical psychologists in working with young people and with different treating practitioners in the Board's Guidelines on Area of Practice Endorsement.

The Board will also bring attention to the issues raised by the Coroner through its quarterly newsletter to psychologists.

For support

If you are concerned about the content or nature of this report, you can contact support services like Lifeline on 13 11 14.