Lynn Desmond Ernest CHURCH

At the time of his death, Lynn, aged 64 years, was admitted as an involuntary patient following a long history of psychiatric care and two separate suicide attempts. The decision was later made to transfer him to an open ward with increased monitoring. He committed suicide overnight by covering his head with a plastic bag. It was ultimately felt that the decision to transfer was appropriate but the coroner noted that the concerns of his family members were not recorded or communicated to the treating team.

The Joondalup Mental Health Unit have reported to the Department of Health that processes have been developed that will improve the recording of communications with carers, including the use of telephone log books with adhesive labels that can be easily removed and placed in a patient's case notes. This process will be supported by policy and education and orientation programs.

The Coronial Recommendations Working Group has confirmed that health services have re- circulated the Chief Psychiatrist's *Clinical Guideline: Communicating with Carers and Families* to all mental health clinicians within their service. All health services have policies in place relating to carers, particularly relating to documentation of carer concerns.

Furthermore, the *Mental Health Act 2014* provides statutory direction for services in working with carers and families in the patient treatment process.

The coronial recommendation from the Lynn Church inquest has been reviewed, actioned appropriately and marked as complete.