NSW Mental Health Sentinel Events Review Committee

Tracking Tragedy

A systemic look at suicides and homicides amongst mental health inpatients

First Report of the Committee

December 2003

“…any man’s death diminishes me…”

"All mankind is of one author, and is one volume; when one man dies, one chapter is not torn out of the book, but translated into a better language; and every chapter must be so translated...As therefore the bell that rings to a sermon, calls not upon the preacher only, but upon the congregation to come: so this bell calls us all: but how much more me, who am brought so near the door by this sickness....No man is an island, entire of itself...any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee."

John Donne
Meditation XVII

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Executive Summary

1. INTRODUCTION

Each death involving a mental health patient in care raises questions about our collective attitudes to life and to each other, and to the supports we can and should provide to those in need. Where any death has been the result of suicide the impact on family and friends is profound and has consequences throughout the social fabric of our communities. A suicide death of a patient in care represents in addition, great distress to the staff of the mental health service and to other patients. Homicide cases represent the worst outcomes of severe mental illness. Such events are an unmitigated tragedy for the victims, their families and their friends, and also result in great distress to the staff of mental health services and to other patients. The fear and concern they raise in the community is significant, and is largely responsible for the continuing and unjustified stigmatisation of the vast majority of people suffering from mental illness who pose no risk except to themselves. And lastly, such events often result in great distress and suffering for the perpetrator, who has to live with the consequences of their actions. These actions may be the result of an abnormal mental state, and commonly a close relative of the perpetrator is the victim. When the perpetrator's mental illness is treated and they are able to understand what they have done they are faced with a lifetime of grief and remorse.

There is a common perception that any suicide death or homicide by a person in contact with public mental health services represents a failure on the part of mental health services. This is not always so, as will be discussed later in the report. Mental health services in general do a very effective job of managing people with severe mental illness, as detailed below, and in all likelihood prevent many incidents of minor and major self-harm, and violence towards others.

Indicative data from NSW Health shows that of 22,061 admitted patients' episodes of care in public psychiatric hospitals and mental health units of general public hospitals in 2002-3, there were 8 possible suicide deaths of patients who were in care as inpatients at the time of their death. In the 3-year period from 2000-1 to 2002-3, there were almost 62,000 admitted patient episodes of care. During this time there were 8 homicides perpetrated by patients in contact with mental health services. While the incidence of death might be extremely low, it is not, as would be preferred, zero.

One of the purposes of the NSW Mental Health Sentinel Events Review Committee (the Committee) is to review these incidents and examine systematic problems within the mental health services that may have contributed to the tragic outcome and to suggest solutions. The Committee is aware that, while systemic problems must be addressed, there is a need to balance deaths with those who do well under current practices.

Clinician Responsibility

The Committee recognises that ultimately, clinical judgement is relied on in every setting within mental health services. While the Committee has no wish to interfere unreasonably with the valuable function performed by bodies that train mental health staff, it will draw attention to matters of relevance raised in the report to be suitably incorporated by training authorities into curricula.

While the Committee recognises that tragic events such as suicide deaths and homicides are not necessarily predictable amongst mental health patients under care, its findings indicate that a level of accountability nevertheless must be accepted.

Resources
The ability to provide a comprehensive range of quality mental health services is limited by the available resources.

It is difficult to estimate the impact of resource limitations – particularly access to inpatient beds and experienced psychiatrists. However, there must be questions over the capacity of many services, using currently available resources, to undertake the most appropriate risk mitigation strategies in response to the identified level of risk.

Admission to mental health beds is widely seen as the most effective short-term risk mitigation strategy in high risk cases. However, anecdotal evidence strongly suggests that on occasions patients are not being admitted, or are being discharged early or without comprehensive follow up, due to an inability to access an available inpatient bed. As the overall number of mental health beds has shrunk in the last decade (although there has been a marginal increase recently), and as demand has increased (in parallel with increased substance abuse and changing social mores) it is now clear that the bar to mental health admission has been raised. In turn this has led to mental health clinicians and Area Health Services having more limited options.

As a result, the risk to the general public is higher, the risk to the patient is higher, the risk to the mental health clinician is higher and the risk to Area Health management being held responsible for not supplying the responsible level of care is also higher.

Any demand for greater use of risk assessment will increase demand on already stretched mental health services, and have the effect of further concentrating resources on those with psychosis, substance use and personality disorders. This will reduce the capacity of services to care adequately for the vast majority of patients with mental illness who have other disorders such as anxiety or depression. This in itself could increase the risk to the community. Thus adequate resources need to be available for effective risk management without undermining current resources and services.

2. ANALYSIS OF SYSTEMIC FACTORS IN A SAMPLE OF SUICIDE CASES

The Committee determined that in its first year it would focus on inpatient suicide deaths. This small subsection of all suicide deaths presented an achievable task and represents the spectrum of highest need and of mental illness where there is the highest expectation of the level of support available. The Committee intends to study other groups sequentially.

The National Centre for Classification in Health (NCCH) undertook a consultancy for the Committee in June 2003. The consultancy's brief was to review a sample of the medical records and related documentation of patients who had suicided while under the care of mental health services in NSW between 1999 and early 2003. The purpose of the review was to identify and explain any systemic factors inherent in care delivery to these patients, which may have had a causal or influential role in the patients' outcome.

The delivery of care to mental health patients is complex, both procedurally and clinically. The patients themselves exhibit a constellation of problems that complicate the delivery of care. Further, it was concluded that although patients may share a number of characteristics (history, diagnosis, assessed risk etc), they are nonetheless a heterogeneous group.

The review was successful in identifying a number of systemic factors which, in concert, impacted on the delivery of care and as a consequence, the patient outcome.

Foremost among these were risk assessment, patient characteristics, environment, care management, communication and documentation, family involvement, staff issues and dissemination and implementation of NSW Health policies and guidelines.

Risk assessment
Assessment of patients and subsequent admission protocols were variable. Some patients assessed as being at high-risk of self-harm were not immediately placed on high frequency observation protocols on admission.

Assessment protocols were not uniformly applied or documented. About one third of patients in the sample group appear not to have been assessed formally, and the instruments and measures used were not standardised.

About half the patients in the sample group who subsequently died by suicide had been assessed as a medium to low risk of self-harm. The assessment instruments may warrant further investigation as their predictive validity appears quite low given that all patients in the sample ultimately suicided.

Patient characteristics
Most patients had a history of mental illness, previous suicide attempts, substance abuse problems, and a diagnosis of schizophrenia, psychosis, depression or personality disorders. Many had experienced previous episodes of care in mental health facilities. Many patients had more than one problem, for instance, schizophrenia and substance abuse issues or personality disorder and malnutrition. Variable levels of family support, interaction with police and other services were also identified.

These characteristics should be referred to as "red flags" for the purposes of identifying cases at heightened risk of self-harm, especially where presented in combination.

Environment
Two major systemic factors of concern refer directly to the physical facilities available to mental health patients. These factors are access to means and methods, and security and egress.

- Access to means and methods

Almost half of those who died by suicide while under care, did so within the mental health facility. This speaks loudly about access to means and methods of inpatient death. More vigilance and preventive action on removing hanging points (coat hooks, door hinges, locks and fittings) and hanging implements in particular (cords, pyjama sashes, other cables), are necessary.

- Security and egress

Approximately 30% of the patients suicided while they were absent without leave (AWOL) from the mental health facility. The systemic factor of security and egress therefore also warrants further attention. If suicidal patients can be prevented from leaving the facility their access to means and methods of death is likely to be reduced significantly. In the view of the Committee the requirements of "duty of care" are paramount.

To avoid the possibility that patients will choose alternate means and methods of death (or take whatever means are most easily available to them), both these issues need to be addressed in parallel.

Care management

- Specialist services

The interaction between mental illness and substance abuse is cited as a complicating and contributory factor in patient care. Documentary evidence suggests that mental health services are ill equipped to treat drug addiction or withdrawal, and specialist Drug and Alcohol units likewise may be not be the best place to manage mentally ill patients. The need for specialist services (or specialised protocols) that can deal with both mental health and drug and alcohol problems should be considered.

- Restrictive practices and the Mental Health Act

The Mental Health Act stipulates that the least restrictive level of care be given to patients with a mental illness or mental disorder, and makes provision for their privacy and dignity. However it is the view of the Committee that the terms of Section 4, sub-section 2, requiring the provision of the best possible care and treatment in the least restrictive environment *enabling the care and treatment to be effectively given* (emphasis added), are often overlooked. Also, this sub-section requires that any interference with patients' rights, dignity and self-respect are kept to the minimum *necessary in the circumstances* (emphasis added). It is the view of the Committee that patients assessed at high risk of self-harm require more restrictive care, and that this is consistent with the letter and intent of the Mental Health Act.

There appeared to be a propensity to decrease observational levels, or to grant leave or other privileges to patients as soon as any minimal improvement was noted in patient symptoms, their behaviour or compliance with treatment. This was sometimes done without record of formal evaluation or assessment of their progress in treatment. It could be inferred that some such decisions were more the result of resource pressures than they were of considered clinical judgements.

Of more concern was that decisions to allow more freedoms and less frequent observations were occasionally made very early in the episode of care, and with no discernible regard to the prior assessment of the level of risk of self-harm.

- Granting leave

Of the 15 patients in the sample who were granted leave throughout their episode of care, three suicided while on leave. Most patients who were granted leave successfully returned to the mental health facility for ongoing treatment. However, the reviewers noted with some concern that there appeared to be variable and inconsistent criteria applied to determine whether leave should be granted.

A more pressing concern is the timing of granting leave. There were several instances where high risk patients were granted leave very early in their episode of care, and often without documentation of further assessment to ascertain their progress in treatment or their preparedness to return.

While the review did not provide clear evidence that leave granting was a major systemic or causal factor within this sample, the variability in its application was of concern.

- Length of stay

The review found that half the sample of patients died by suicide before the tenth day of their stay in mental health facilities, and 30% died within the first three days of their episode of care. While it could be concluded that in general it is the sicker mental health patients, who are more likely to die by suicide, who are being admitted, the timing of events points to the need for more vigilant care management strategies in the early days of patient admissions.

Communication and documentation

The quality of communication or documentation practices did appear to exert a major influence on the ability of staff to co-ordinate and manage care delivery and to make informed clinical decisions. Without a doubt, documentation issues were the most obvious problem and of most concern from a medico-legal, care management and coordination point of view. The quality of about one third of the medical records reviewed was considered poor; a few were appalling.

Family involvement

Issues of clinician-patient confidentiality and patient rights have implications for communication and information exchange with family. Family members complained about the lack of consultation and information received while their loved one was under the care of mental health services. This was especially the case where family was not informed of a patient's admission or change of care management practices (especially granting of leave).

Staff issues

The review identified resource issues including the documented availability of staff. Types and levels of staffing commensurate with level of identified risk were not always immediately available for patients on admission. In terms of the availability of intensive nursing, patients were sometimes transferred to other facilities where intensive (1:1) nursing was available. In terms of delays due to staff availability, in almost half the cases patients had to wait to be appropriately reviewed, assessed or accommodated.

Low staffing levels also had negative implications for handover practices at shift-change times and for the poor quality of communication that sometimes resulted.

Dissemination and implementation of NSW Health policies and guidelines

Reviewers noted with some concern that policies, guidelines and protocols often took a long time between development by NSW Health and dissemination to Area Health Services, and then to implementation by mental health services. There is then a non-uniform approach to these policies and guidelines, the flexibility of which may increase the ability to meet specific local needs, but may also act to impede the efficient provision of a standardised approach to care delivery.

3. ANALYSIS OF SYSTEMIC FACTORS IN A SAMPLE OF HOMICIDES

The Committee commissioned an analysis of its review of a sample of seven cases of homicides perpetrated by patients of mental health services, which had occurred between 1999 and 2002. These cases had been subject to recent detailed review and were able to be further analysed by the Committee in order to explain the possible or probable influence of systemic factors in each of these events and to determine whether there were any discernible trends that point to the need for specific reforms.

The analysis identified the demographics and the risk factors associated with the assailant in

each case, specifying static factors that denote baseline risk and dynamic factors that could potentially have been ameliorated with clinical intervention. The analysis focused on systemic issues and clinical issues. Systemic issues included policies and procedures, resources and environment, and communication. Clinical issues included risk assessment and management, clinical practice and care, clinical staff, and application of the Mental Health Act.

Similar systemic factors were examined in the analysis of homicide cases and the review of suicide cases and it was not surprising that both reviews revealed similar trends, even though the suicide review was based on an analysis of medical records, and the homicide analysis was based on case reviews. Indeed both reports should be read in conjunction.

However some important differences in trends did emerge, and those factors with specific relevance to the analysis of homicide cases, are summarised below.

- Clear policy that defines sentinel and high-risk situations for clinicians, and clear procedure that outlines the minimum clinical response required in the context of high risk and crisis events were not apparent.
- There did not appear to be any available risk assessment tool to assist clinicians in the assessment of risk of harm to others.
- Accountabilities and responsibilities in relation to consultants' and registrars' clinical involvement did not appear to be well defined.
- There did not appear to be mandatory training in the assessment of risk of harm to others and risk management for clinicians in NSW.
- At critical times, especially in rural settings, communication protocols to access specialist consultation in an emergency situation were unclear.
- Communication with outside agencies such as the Department of Community Services was inadequate and was not assertively followed up even when it was clear that the external agencies were failing in their response.
- There did not appear to be standardised communication pathways between clinicians, or between mental health services and outside agencies, nor did there appear to be communication protocols in relation to the transfer of care.
- Inadequate contingency risk management plans were developed in circumstances where an increase in risk was foreseeable.
- Too much reliance tended to be placed on the patient's family to protect the potential victims and there was too little response from the mental health service to implement protective measures.
- Suicidal and homicidal patients were sometimes discharged when clinicians had knowledge that they had access to weapons.
- People at risk of violence by mental health patients, even though aware of threats, tend to minimise or deny or be naive about the risks that they may be under. Clinicians should not expect members of the community to appreciate the relationship between mental illness and violence.
- Forensic psychiatric opinion was never sought in this sample.
- Community Treatment Orders were not considered in this sample even though there was clear evidence of ongoing risk after discharge.
- There was a tendency to rely on Apprehended Violence Orders (AVO) as an adequate risk intervention strategy in those with mental illness. An AVO does not prevent violence - it apportions blame. Admission to a secure Unit using the Mental Health Act does prevent violence.

4. CORONERS RECOMMENDATIONS

The Coroner's Sub-Committee of the NSW Mental Health Sentinel Events Review Committee examined and considered the recommendations made by NSW Coroners flowing from inquests during 2001 and 2002 into deaths falling under the terms of reference for the Sentinel Events Review Committee.

Three central issues emerged and occupied the Sub Committee's focus. These were

1. How to ensure the development of a closer working relationship between Coroners and Mental Health Services.
2. How to ensure Coronial recommendations are implemented appropriately at the coalface.
3. How to ensure that research priority is given to recurring themes raised in recommendations, particularly in the area of personality disorder.

A closer working relationship between the Coroner's Office and Mental health Services should be developed particularly when a Coroner may be considering making recommendations.

A register of 'authorised persons' should be made available to the Coroner's Office for consultation in relation to understanding clinical and/or service delivery systems.

A detailed investigation should be carried out into the pathways followed by recommendations to determine where barriers were encountered with a view to system adjustment. This would indicate how such recommendations travel through the system toward dissemination and implementation. This journey could also be tracked in terms of feedback to the recommending Coroner.

Given the prominence of personality disorders and self-harming behaviours in Coroners' reports, considerable effort to support research in the domain is essential in the future.

5. RAPID RESPONSE AND FAMILY LIAISON

Family involvement in the immediate response to suicide death or homicide, where appropriate, including an appropriate expression or regret or sympathy and the offer of counselling and support will assist them in the management of anxiety and distress. The response should also support staff and assist the broader health system.

Rapid responses should consist of an immediate review of the event to ensure the safety and welfare of other patients and staff, and liaison with the family of the deceased person to offer assistance and support and to make an appropriate expression of regret.

The Centre for Mental Health should develop guidelines and mechanisms for implementing the proposed process immediately. The Centre should conduct research to evaluate the process over a two-year period.

6. REPORTING, DATA COLLECTION AND MONITORING

The Committee favours an open and transparent annual reporting method for possible suicide deaths, and for homicides pertaining to mental health patients. A sound communication and media management strategy is needed. Initial reports of possible suicide deaths should commence in 2004, and cover the last five-year period. Thereafter, annual reports should be published as part of the Chief Health Officer's Report.

An appropriate process for mandatory reporting is needed to capture quality information both for the immediate identification of weaknesses in processes and systems, and for the later more detailed examination of cases and drawing of conclusions. Information needs to be available from the immediate review of the situation for the safety and welfare of other patients and staff, and in view of the public and media interest which sometimes follows these events.

Recommendations

RISK ASSESSMENT AND MANAGEMENT

1. By the end of 2004, NSW Health shall have standardised and implemented statewide risk management systems and processes, which will
    - include risk assessment tools for suicide and for violence to others
    - address dynamic factors such as the allocation of a responsible clinician and timing of reviews depending on need
    - be tested and evaluated by 2006.

2. By the end of 2004, NSW Health shall have established measures and processes to develop and implement by the end of 2004 statewide policy and procedures to govern risk assessments and risk management care plans for the following key points of the clinical pathway for mental health patients:
    - triage
    - admission
    - after critical events
    - at discharge
    - when the family or the community raise concerns
    - when the patient defaults on treatment, or follow up, or goes AWOL.

3. If any 3 "red flags" are present at the time of admission, then a high risk category shall be assigned automatically to the patient, the patient admitted under schedule, placed immediately on high frequency observations and the mental health team alerted that a more detailed risk assessment is to be undertaken. This process should be operationalised by July 2004.

    The following "red flags" are identified as markers for heightened risk of self harm in mental health patients:
    - principal diagnosis of psychiatric disorder
    - previous history of self harm, or suicide attempts
    - suicidal ideation
    - showing evidence of substance use/abuse
    - known to police and/or other service groups in relation to impulsive or aggressive acts or behaviour.

    The following "red flags" are identified as markers for heightened risk of violence towards others in mental health patients:
    - principal diagnosis of psychiatric disorder
    - previous history of violence towards others
    - known to police and/or other service groups in relation to impulsive or aggressive acts or behaviour and/or antisocial behaviours.
    - showing evidence of substance use/abuse [See also Recommendation 21]

4. By July 2004, Area Health Services shall ensure that medical or surgical patients, especially elderly, post-operative and post-natal patients who are being cared for outside mental health units and in whom active mental health pathology is identified, are recognised as at risk of self harm and further appropriately assessed and managed in terms of established level of risk.

5. By July 2004, Area Health Services shall ensure that any Emergency Department assessment identifying active mental health pathology will involve consultation with a member of the mental health team, which includes the patient's GP-VMO in a rural setting, and, if high risk, a psychiatrist.

STAFFING LEVELS

6. By July 2005, to assist health services to provide safe and adequate care, NSW Health shall develop and distribute a guide to safe staffing levels as these relate to the outcomes of risk assessment and the level of staffing required to manage those risks.

7. By the end of 2004, a proposal for a community forensic mental health service shall be developed and will include services for forensic patients released into the community and a consultancy service to community mental health teams.

8. From July 2004 NSW Health shall ensure that specialist forensic psychiatric services to provide specialist consultation, advice and clinical care when required, in complex cases involving risk of violence to others, are available 24 hours a day, seven days per week, statewide.

ENVIRONMENT

9. By July 2004, Area Health Services shall ensure that the level of security of accommodation is commensurate with the level of assessed risk.

10. By July 2004, Area Health Services shall ensure that mental health units in which involuntary patients are cared for are secured.

11. By July 2004 Area Health Services shall have taken preventive action to remove potential hanging points from mental health facilities, especially in bathrooms, and will have implemented recommendations based on NSW Health audits of mental health facilities.

12. NSW Health shall ensure that by no later than 2007, appropriate environments and resources are provided within Emergency Departments to enable appropriate mental health assessments to be undertaken, as required in the Emergency Department Report 1998, Recommendation 9.

13. By the end of 2004, the Director, Centre for Mental Health, shall sign off Health Building Guidelines for Emergency Departments and any proposed alterations or redevelopment plans for Emergency Departments, to ensure that they are able to deal adequately with the management of mental health patients.

FAMILY INVOLVEMENT and APPLICATION of the MENTAL HEALTH ACT

14. The special discussion paper being drafted by the NSW Health Legal Branch in collaboration with the Centre for Mental Health for the forthcoming review of the Mental Health Act, should consider specifically the case of access by families to information under Mental Health Legislation, recognising privacy issues and the requirements of good clinical practice.

15. By April 2004, Area Health Services shall ensure that families and significant others, when recognised as active carers or guardians are given enough information and support to allow them to participate effectively in the assessment process, care provision and supervision of the acutely ill person before admission, during admission and after discharge, despite the current privacy requirements of the Mental Health Act.

COMMUNICATION

16. Effective immediately, Area Health Services shall ensure that the senior attending clinician shall be responsible for ensuring that the transfer of care of a mental health patient from one service to another should always occur with comprehensive communication to ensure adequacy of ongoing care and continuity of care.

17. By the end of 2004 NSW Health shall ensure that there is agreement within the Human Services Chief Executive Officers Forum that processes are put in place such that where there is an escalation in risk protocol, appropriate responses are made between agencies and communicated orally and in writing.

18. Effective immediately, NSW Health shall ensure that high-risk psychiatric patients are not managed in a non-psychiatric ward without prior consultation with the Area Clinical Director of Mental Health.

DOCUMENTATION

19. By July 2004, Area Health Services shall ensure that the requirements of MH-OAT protocols are met so that standards of documentation are improved, especially with regard to
    - the recording of critical information
    - the recording of handover information
    - information received from families
    - legibility and
    - consistency in the recording of author, position title, date, and times of observation.

20. By the end of 2004, Area Health Services shall ensure that preceding case records of patients presenting to Emergency Departments with a mental health problem are routinely available to the treating clinician at the time of assessment, so that re-presentations are recognised and included as part of the assessment.

CLINICAL PRACTICE AND CARE

21. By the end of 2004, Area Health Services shall ensure that once acute mental health pathology is identified in any patient presenting to a health facility, consultation with the most senior mental health clinician occurs and involves a formal assessment as soon as possible, and not later than 24 hours of admission to inpatient care.

22. By July 2004, and consistent with the principles of child protection, Area Health Services shall ensure that all patients with active mental health pathology are asked basic questions about their children at assessment, discharge and follow-up, and their answers recorded. Questions will include, for example, the children's ages, where they are currently and how the patient is coping with them.

23. By July 2005 NSW Health shall develop statewide evidence based clinical guidelines and mandated behaviours pertaining to the admission of mental health patients assessed as being at risk of self -harm and/or violence to others. These will be developed in consultation with clinicians and consumers and will include consideration of
    - levels of staffing
    - levels of security of accommodation
    - frequency of observation
    - aspects of more restricted care in early days of admission, which may include no leave and supervised medication dosing
    - timing of review and follow up arrangements
    - post-discharge supervision of medications until stable therapeutic levels of medication are considered achieved.

24. By the end of 2004, NSW Health shall ensure that specialist services or specialised protocols that deal with dual diagnoses of mental illness and substance abuse are developed and distributed with a specific time frame for implementation and review.

25. From July 2004, Area Health Services shall ensure that in relation to high risk patients, when one of the following events occurs or is being considered:
    - major change in the level of care or supervision
    - discharge
    - follow-up
    - AWOL
    - no show
    - non-compliance

    the senior mental health medical officer responsible for the patient is consulted and a formal reassessment made.

26. By July 2004, Area Health Services shall ensure that, with assistance from NSW Health, a protocol is developed and implemented where in the case of any unresolved conflict amongst the members of the clinical team responsible for the care plan of the patient, another opinion is sought from an experienced mental health clinician. If the conflict remains unresolved, the matter will be
    referred to a higher authority, such as the Area Clinical Director of Mental Health. The operation of this protocol will be evaluated by 2006.

27. By the end of 2004, Area Health Services shall ensure that initial care plans of mental health inpatients includes documentation of
    - the formal assessment process and management goals
    - the identity of the senior mental health clinician with primary responsibility for the patient's care
    - the identity of the clinical team
    - the identity of the patient care coordinator and
    - the development of a time-limited management plan and a review date.

28. Effective immediately, Area Health Services shall ensure that if there is concern about a person at risk of harm from a mental health patient, or if there is evidence that the patient has identified a particular person at such risk, then clinicians must take reasonable steps to mitigate the risk, including taking steps to ensure that such persons are advised and that appropriate authorities with responsibility for protection are so advised.

29. By April 2004, Area Health Services shall ensure that high risk mental health patients will not be discharged subsequently, if it is known that they have access to firearms, until police have acknowledged that the firearms have been removed from the patient's access.

30. Effective immediately, Area Health Services shall ensure that if a patient goes AWOL or defaults on treatment, a determination of risk level by the clinical team responsible for the care of the patient occurs.

31. By the end of 2004, Area Health Services shall ensure that discharge procedures for inpatient units routinely include:
    - formal discharge plan covering conditions of discharge and any supports required
    - nominated carer
    - nominated clinician providing ongoing care
    - formal arrangements for follow up review
    - face to face communication (including video conferencing)
    - a package of written advice for the patient and the nominated carer

    and take into account the issues raised in Recommendation 22.

32. By July 2004, in the case of mental health sentinel events which have had fatal consequences the Root Cause Analysis required under Circular 2003/88 shall be led by an appropriately trained person from outside the Area Health Service where the sentinel event occurred.

33. By the end of 2004, NSW Health shall ensure the availability of video conferencing facilities to enable rural centres to access at short notice metropolitan psychiatrists and other specialist mental health staff for face-to-face interviews within their clinical network.

APPLICATION and REVIEW OF THE MENTAL HEALTH ACT

34. By April 2004, Area Health Services shall ensure that consensus is reached amongst the clinical team responsible for the care plan of the patient (or failing that, the provisions of Recommendation 26 would apply) and reasons documented before any decision is made to change the status of the patient under the Mental Health Act.

35. NSW Health shall ensure that the forthcoming review of the Mental Health Act in relation to privacy considers the importance of consultation with families, especially of patients assessed at high risk of self-harm or violence to others.

36. By July 2004 NSW Health shall obtain legal advice from the State Crown Solicitor or from another appropriate source as to the powers available to staff at a hospital to search and remove property of mental health patients admitted to hospital, and a protocol will be distributed to Area Health Services. If powers are considered inadequate, NSW Health

will commence consultation regarding the appropriate legislative changes needed to address this matter.

37. By July 2004 NSW Health shall obtain legal advice from the State Crown Solicitor or from another appropriate source as to the powers available to staff at a hospital to deal with visitors reasonably suspected of undermining or compromising treatment of a mental health patient and a protocol will be distributed to Area Health Services. If powers are considered inadequate, NSW Health will commence consultation regarding the appropriate legislative changes needed to address this matter.

EDUCATION AND TRAINING

38. By July 2005 NSW Health shall ensure that a training program is developed and provided through Area Health Services to develop the skills and knowledge of all key mental health professionals to engage with families in mental health assessments.

39. High priority shall be given to providing training to all persons involved in the care of mental health patients within a public health service, necessary to support the implementation of the recommendations of this report.

REPORTING, DATA COLLECTION AND MONITORING

40. From 2004, NSW Health shall report annually trend data for possible suicide deaths in mental health care.

41. From 2004, NSW Health shall mandate the implementation of the NSW Mental Health Client Death Report.

42. By July 2004 Area Health Services shall forward information from Root Cause Analyses to the Centre for Mental Health for centralised reporting, data collection and analysis, and the Centre for Mental Health will forward the information to the Committee to assist it undertake its duties.

43. By July 2004, NSW Health shall conduct a gap analysis of data currently collected for suicides of and homicides by patients in care, and advise the Committee and NSW Health on areas for improvement.

44. As a result of the gap analysis, if the need for additional data is evident, NSW Health shall ensure that the implementation of appropriate data collection tools is incorporated into the Root Cause Analysis process.

45. By July 2004, NSW Health and NSW Police shall develop and implement a protocol for the notification to the Committee of incidents of homicide involving a person who has had or is suspected of having recent contact with a mental health service.

RAPID RESPONSE TO SUICIDE DEATH OR HOMICIDE

46. By April 2004, Area Health Services shall make appropriate expressions of regret after a death to families and relevant support persons. The expressions should be made as soon as possible, without admitting liability and should come from the highest relevant level.

47. By July 2004 a rapid response protocol for possible suicide deaths shall by developed by NSW Health for implementation by Area Health Services and will include the following:
    - a rapid safety review to clarify the circumstances surrounding the death which may indicate a continuing safety risk
    - inform NSW Health and the Centre for Mental Health
    - offer of advice and support to the family of the deceased person
    - provision of support for staff involved in the care of the patient.

    The effectiveness of the protocol will be evaluated by 2006. A similar process will be put in place for homicide deaths, within the requirements of initial Police investigations.

CORONER'S RECOMMENDATIONS

48. By July 2004, NSW Health shall establish procedures to ensure bi-annual meetings take place between the Coroners Office and the Centre for Mental Health to ensure a closer working relationship.

49. By July 2004 NSW Health shall make available to the Coroner's office a register of persons from across the State's mental health services authorised to facilitate timely and effective consultation during and following relevant Coronial hearings.

50. By July 2005 NSW Health shall track Coroners' recommendations to enable the Centre for Mental Health to monitor their implementation and identify any barriers to implementation, to allow correction of those barriers.

FUTURE OF THE COMMITTEE

51. NSW Health shall allocate sufficient resources to enable the Committee to fulfil its functions, including the provision of permanent executive support.

RESOURCES

52. High priority should be given to providing additional budget necessary to implementing the recommendations in this report.

Part 1

Introduction

Establishment of NSW Mental Health Sentinel Events Review Committee

Terms of Reference

Sub-Committee Structure, Tasks and Methodology

ESTABLISHMENT OF THE NSW MENTAL HEALTH SENTINEL EVENTS REVIEW COMMITTEE

The New South Wales Mental Health Sentinel Events Review Committee (the Committee) was established in response to an urgent need for an independent body to review and report on morbidity and mortality issues associated with incidents relating to the care, management and control of persons suffering from a mental illness, and on any future sentinel events

The Minister for Health established the Committee on 27 May 2002 by Order of authority under section 23 of the Health Administration Act 1982, as to Specially Privileged Information. It was established as a Ministerial Advisory Committee pursuant to section 20(4) and (6) of that Act, and is comprised of thirteen Ministerial appointees who represent a selection of consumer, carer and professional groups.

Members were appointed for the period from 27 May 2002 until and including 31 July 2005.

The Committee reports directly to the Minister for Health through the Chairman of the Committee. The Committee agreed that it was appropriate to provide to the Minister a yearly report which would include Sub-Committee methodologies, findings and recommendations.

The terms of reference, membership and objectives will be reviewed annually to determine whether the Committee should continue activities under the same conditions. Modifications to the terms of reference of the Committee and membership will require the approval of the Minister.

TERMS OF REFERENCE

1. To review Sentinel Events (that is, events associated with serious injury or death of a person believed to be suffering from a mental illness) where a person suffering or reasonably believed to be suffering from a mental illness is involved, commits or is closely associated with the sequence of events that led to the incident;

2. To review incidents of the death of a person suffering or reasonably believed to be suffering from a mental illness, in circumstances where a public sector agency was involved in that person's care, management or control;

3. To collaborate with and if need be refer matters to the Coroner, Health Care Complaints Commission and relevant professional registration boards in the event that clinician performance is considered to be a contributing factor in respect of any incident reviewed by the Committee;

4. To advise the relevant public sector agency on matters relating to the prevention of incidents described in I and 2;

5. In particular, the Committee will -
   (a) Review aggregate data on mental health sentinel events that have had fatal consequences and make policy recommendations for prevention of these events;
   (b) From time to time, provide advice on clinical policy issues relating to the morbidity and mortality of persons suffering from a mental illness that may be brought to the committees attention from a broad range of public sector agencies; and
   (c) Contribute expertise to the preparation of regular reports of aggregate data on mental health sentinel events and mortality trends;

   in relation to the Sentinel Events -

   (d) classify deaths as direct, indirect or incidental to mental illness;

   (e) examine the circumstances leading to the deaths in order to identify any factors which might have prevented them; and
   (f) provide advice on a *systemic* basis, to public sector agencies on matters arising from the consideration of the fatality by the Committee that might improve the care of persons suffering from a mental illness or decrease morbidity or mortality;

6. The Committee will report directly to the Minister for Health through the Chairman of the Committee.

Craig Knowles MP
Minister for Health

SUB-COMMITTEE STRUCTURE, TASKS AND METHODOLOGY

On 11 October 2002 the Committee agreed that three Sub-Committees would be convened. These were the Homicide, Suicide and Coroner's Recommendations Sub-Committees. It was also agreed that the Sub-Committees would meet separately and that they would report back to the Head Committee in respect of their progress at the subsequent meeting of the Head Committee.

The tasks of the Sub-Committees were to review:

- Suicide deaths in the past five years
- Coronial recommendations
- Homicides over the past 3 years.

Suicide Sub- Committee

The task of the Suicide Sub-Committee was to review the suicide deaths or suspected suicide deaths in the past five years of clients of public health facilities who were suffering or reasonably believed to be suffering from a mental illness, to report on trends and make recommendations based on a review of cases.

In its first year, the Sub-Committee determined that it would focus on inpatient suicide deaths. This does not mean that the Sub-Committee was unaware of other deaths; it adopted this approach to make its task manageable.

Consistent with the Committee's terms of reference, the Sub-Committee's review was restricted to systemic analyses. It did not address the practices of individual clinicians or the mental state of clients at the time of the sentinel event.

Since 1998, NSW Health has recorded the demographics of approximately 698 possible suicides of clients of mental health services, including data as to method and place of suicide. Of these, 68 were identified from Mental Health Service Client Death Reports as possible suicides of public health facility inpatients. It has not previously been possible to link records of patient contacts with different health services, such as community mental care and inpatient care.

It is important to note that Client Death Reports are cases of suspected or possible suicide only. Until confirmed by Coroner's investigation, reported possible or suspected suicide deaths remain unconfirmed. The Committee is aware that not all suicides are so reported. However, inpatients in psychiatric units are more likely to have suicide correctly identified.

Sources of Information

Documentation available to the Sub-Committee included:

NSW Health Department Mental Health Service Client Death Reports
Area Health Service case files
Police Records
Coroners Reports
Coroners Recommendations
Critical Incident Reviews

Method
The Sub-Committee classified suicide deaths into four general categories to assist in developing an approach to the identification of risks associated with those deaths. For the purposes of review the 4 categories were:

1. Inpatient deaths (including deaths within public mental health facilities, deaths of patients on leave and deaths of patients who had absconded — AWOL)
2. Prior inpatient deaths (death occurs within 28 days of discharge)
3. Community outpatient deaths (those who have had an interface with community mental health services)
4. Non-contact deaths (where suicide victim did not have a known interface with any mental health service).

In its first year, the Sub-Committee reviewed Category 1.

While it is likely that the cases of suicide victims who had no prior contact with health services would be outside the terms of reference for the Committee, the Committee considered it important to keep a watching brief, in the event that a link may be established with mental health services. The Committee proposes that this will be one of its future activities.

Following a formal request for reports from the Office of the State Coroner, the Sub-Committee matched the Client Death Report data with NSW Police PA79A forms where these were available. A database of the 68 inpatient suicide deaths (including deaths within public mental health facilities, deaths of patients on leave and deaths of patients who had absconded — AWOL) was developed by combining information from the Department of Health's Client Death Reports and the P79As received by the Coroner's Office.

Selection of sample
A working party convened on 8 May 2003 and decided on a selection method for identifying specific inpatient files to be reviewed in more detail. Two samples were selected, one being a random sample of 20 cases. The second sample was a stratified random sample of 20 cases. Allowing for duplication of cases, two final samples totalling 35 cases were determined from the database of matched P79A reports and Client Death Reports.

Access to data
Area Health Services provided specific records for review. Following a further formal request for reports from the Office of the State Coroner, the Sub-Committee matched the Area Health Service case files with Briefs of Evidence and Coroners findings or opinion where these were available.

Review of cases
A workshop was convened on 29 May 2003 to develop a framework using Ishikawa methodology, of the causal factors associated with sentinel events and identified primary and secondary elements associated with the causal factors. Primary elements were defined as matters which were likely to be identified from the case records. Secondary elements were other matters which were likely to influence the outcome, but which are unlikely to be

identified in the case files.

The National Centre for Classification in Health, Sydney University, was appointed to review the files in accordance with the parameters established at the workshop on 29 May 2003.

Consideration of a proposed reporting tool
The Sub-Committee reviewed the data collection tool developed in the United Kingdom for the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, for completion by the treating clinician following a suspected suicide death by a mental health patient in care. The Committee received expert psychiatrist opinion on its applicability in the NSW context and modifications needed for application in NSW. A final recommendation on use of the tool might be made in subsequent reports, after the completion of the gap analysis of current data collection and reporting practices.

Rapid response and family liaison
The Sub-Committee discussed options and mechanisms for rapid response to cases, including the development of a family liaison and support strategy.

Future work
The Sub-Committee will consider different methodologies for the review of cases in the 3 other categories: prior inpatient deaths, community outpatient deaths and non-contact deaths. For example it may look at all cases over a 6-month period, or a smaller sample over a longer time period. The use of a data-gathering tool will allow the examination of trends as they emerge.

Homicide Sub- Committee

The task of the Sub-Committee was to review Homicides over the past 3 years involving clients of public health facilities who were suffering or reasonably believed to be suffering from a mental illness. As a result of this review, the Sub-Committee was to report on trends, make recommendations based on the review and provide recommendations on tools and processes to be mandated for assessments to be undertaken and cases to be comprehensively reviewed in future.

Harm minimisation in a risk management environment is the philosophical basis for the Sub-Committee's review and its subsequent recommendations. The recommendations of the Sub-Committee would therefore focus on minimising potential causes.

Consistent with the Committee's terms of reference, the Sub-Committee's review was restricted to systemic analyses and did not address the practices of individual clinicians as such, the mental state of clients at the time of sentinel events, or the concomitants of the event itself.

Access to data
The Centre for Mental Health has a data base of 20 homicides believed to have been perpetrated by mentally ill persons who were patients of mental health services in NSW from 1999 to October 2003. The Sub-Committee reviewed a sample of seven homicide

cases which had occurred within this period and had been subject to Critical Incident Review commissioned by NSW Health or the relevant Area Health Service. The Critical Incident Reviews were based on patient files and summaries of clinical history, staff interviews, reviews of related documents and reports to commissioning area health services.

Review process
The Sub-Committee approached its task through the application of a tool to identify causal events. lshikawa methodology was recommended as one of the most robust approaches to the initial identification of systemic risk factors. The results were entered on a database to facilitate data sorting, identification of trends and report-generation. Cases were de-identified as part of the process.

Analysis
The Committee then commissioned an expert analysis of its own review in order to explain the possible or probable influence of systemic factors in each of these events and to determine whether there were any discernible trends in the sample cases that point to the need for specific reforms.

Although the cohort analysed is small, the Committee believes the systemic failures exposed are representative of those which occur in other such cases.

Consideration of a proposed reporting tool
The Sub-Committee reviewed the data collection tool developed in the United Kingdom for the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness,* for completion by the treating clinician following a suspected homicide by a mental health patient in care. The Committee received expert psychiatrist opinion on its applicability in the NSW context and modifications needed for application in NSW. A final recommendation on use of the tool might be made in subsequent reports, after the completion of the gap analysis of current data collection and reporting practices.

Coroner's Recommendations Sub-Committee

The task of the Coroner's Sub-Committee was to examine the mechanisms in place concerning the Coroners recommendations forwarded to the Centre for Mental Health and to analyse the responses, review and identify trends from a systemic perspective, determine appropriate strategies for action and provide documentation to the Sentinel Events Review Committee.

The Sub-Committee examined Coroner's recommendations over the past two years and the Health Department's response, discussed relevant issues and met with a senior officer from the Office of the Coroner. A number of central issues emerged and occupied the Sub

Committee's focus. These central issues were:

1. How to ensure the development of a closer working relationship between Coroners and Mental Health Services.
2. How to ensure Coronial recommendations are implemented at the coal-face.
3. How to ensure that research priority is given to recurring themes raised in recommendations, particularly in the area of personality disorder.

As part of its work the Sub-Committee clarified and identified key trends in Coronial recommendations, overviewed the work undertaken at the Coroner's Court, particularly in respect to Mental Health issues, the Coronial Jurisdiction, decisions to hold inquests and procedures regarding inpatient deaths.

Part 2

Context

Suicide

Homicide

SUICIDE

Where a person's death has been the result of suicide the impact on family and friends is profound and the consequences impact throughout the social fabric of our communities. Each such death raises questions about our attitudes to life, to each other, and to the supports we can and should provide to those in need. A suicide death of a patient in care represents great distress to the staff of the mental health service and to other patients.

The international research into suicide identifies a past history of mental illness as a significant risk factor. However, in the literature a number of risk factors has been identified which reflect wider changes in our social culture including unemployment and financial hardship, broken relationships, violence, and drug and alcohol abuse. These factors are increasingly common in the population of Australians presenting for care through the public health care setting, yet overall rates of suicide have remained fairly constant in the recent years of study.

Although there is some understanding of significant risk factors, it is often difficult to predict which person in a group of people will self-harm or suicide. Also, unpredictable and unforseen events can change a person's level of risk.

The number of suicide deaths in NSW from 1993 to 2001published in ABS Mortality Data ranged from 676 (in 1993) to 946 (in 1997) and 775 (in 2001). Reported possible suicide deaths of patients in contact with health services (as defined by contact within the last 12 months or more), as a percentage of all suicide deaths ranges from 10%, or 68 deaths, in 1993 to 21%, or 159 deaths, in 2001. The following table shows the number of suicide deaths in NSW 1993 - 2001 and the number of reported possible suicide deaths of people who were in contact with mental health services within the last 12 months or more prior to their deaths.

Reported suicide deaths of patients in contact with mental health services, and all suicide deaths in NSW 1993-2001

Year	All Suicide Deaths NSW[1] (ABS)	No. of Reported Suicide Deaths of Patients in Care[2]	Patients in Care as a % of all Suicide Deaths
1993	676	68	10
1994	798	72	9
1995	747	100	13
1996	811	136	17
1997	946	166	18
1998	827	143	17
1999	846	173	20
2000	738	156	21
2001	775	159	21

1. ABS deaths for 2001 (n=775) include an estimate of the small number of deaths (4%; n=30) not registered in 2001, [Source: ABS Mortality data - NSW Department of Health HOIST System; Chief Health Officers Report 2002]

2. The number of Client Death Report forms received by the Centre for Mental Health where suicide was listed as one of the possible causes of death and where the last contact with the service was stated to be **within the last month and up to more than a year**. Data from 1993 through 1995 was collected via the previous Centre for Mental Health notification system.

While the ability to provide a comprehensive range of quality mental health services is limited by the available resources, mental health services in general do a very effective job of managing people with severe mental illness and in all likelihood prevent many incidents of minor and major self-harm. Indicative data from NSW Health shows that of 22,061 admitted patients' episodes of care in public psychiatric hospitals and mental health units of general public hospitals in 2002-3, there were 8 possible suicide deaths of patients who were in care as inpatients at the time of their death. The incidence of death might be extremely low, but not, as would be preferred, zero.

In focussing this initial report on the subset of cases where the suicide death has occurred in the inpatient setting (including those on authorised or unauthorised leave) the cases reviewed by the Committee represent the highest end of mental illness, where admission has been required. They also represent the setting with the highest expectations of the level of support available. The Committee is not unaware of the other classes of people who died by suicide, but chose deliberately to restrict its examination to the identified highest need subset in its first Report.

One of the purposes of the Committee in reviewing these incidents was to examine systematic issues within the mental health services that may have contributed to these tragic outcomes, on the assumption that systemic changes addressing the identified areas may make the most significant impact in improving future outcomes.

It is the intent of the Committee to continue its work focussing on different aspects of mental health care, and consequently different systematic issues, in future reports.

The Committee recognises that Suicide is a complex issue with many factors contributing. There is no single cause or simple solution for suicide. Preventing suicide involves a range of government agencies, non-government organisations, communities and individuals working in partnership.

HOMICIDE

The homicide cases reviewed by the Committee represent the one of the worst outcomes of severe mental illness. They represent an unmitigated tragedy for the victims, their families and their friends. They result in great distress to the staff of mental health services and to other patients. The fear and concern they raise in the community is significant, and is largely responsible for the continuing and unjustified stigmatisation of the vast majority of people suffering from mental illness who pose no risk except to themselves. And lastly, they often result in great distress and suffering for the perpetrator, who has to live with the consequences of their actions. These actions may be the result of an abnormal mental state, and commonly a close relative of the perpetrator is the victim. When the perpetrator's mental illness is treated and the perpetrator is able to understand what they have done they are faced with a lifetime of grief and remorse.

Some facts about homicide as it relates to mental illness need to be borne in mind.

- Only 10% of those suffering mental illness are violent in any way
- Homicide in the community is itself a rare event, with about 110 cases per year in NSW.
- Of all homicides, mental illness is responsible in only 10% of cases. This means that 90% of homicides in the community are committed by those not suffering a serious mental illness.
- Mental health services in general do a very effective job of managing people with severe mental illness, and in all likelihood prevent many incidents of violence. Indicative data from NSW Health shows that there were almost 62,000 admitted patient episodes of care from 2000-1 to 2002-3. During that period there were 8 homicides perpetrated by patients in contact with mental health services.
- Homicide perpetrated by those suffering mental illness is not always motivated by the mental illness symptoms. A person suffering a mental illness can commit a homicide for the same reasons as those not suffering mental illness
- There is a myriad of unpredictable events that can change a person's level of risk. Sometimes we can foresee violence, but sometimes events change and foresight is difficult or impossible.
- The ability to provide a comprehensive range of quality mental health services is limited by the available resources
- The ability to identify who will be violent in a group of people is difficult.

It is these last two points that are of most direct relevance to the report of the Homicide Sub-Committee.

Service capacity

It is difficult to quantify the relationship between resource limitations (particularly access to inpatient beds and experienced psychiatrists) and sentinel events. However, in addition to the identified difficulties in carrying out a comprehensive risk assessment, the capacity of many services operating within available budget to put in place risk mitigation strategies in response to the identified level of risk that would meet community expectations, in questionable.

Admission to mental health beds is widely seen as the most effective short-term risk mitigation strategy in high risk cases. However, anecdotal evidence strongly suggests that on occasions patients are not being admitted, or are being discharged without comprehensive follow up, due to pressure on available inpatient beds. As the overall number of mental health beds has shrunk in the last decade (although there has been a marginal increase recently) and as demand has increased (in parallel with increased substance abuse, changing social mores and population growth), it is now clear that the bar to mental health admission has been raised. In turn, this has led to mental health clinicians and Area Health Services having more limited options. Whereas in previous decades it was possible to admit more easily a potentially dangerous patient for a sustained period of containment, that option is greatly limited now.

As a result, it may be assumed that the risk to the community is higher, the risk to the patient is higher, the risk to the mental health clinician is higher and the risk to Area Health management being held responsible for not supplying the responsible level of care is also higher.

At the same time there is a greater expectation in the broader community and by police services that people with an increased range of behavioural problems (whether as a result of substance abuse, personality disorder or other problem) should be managed by the mental health services.

Furthermore, the move to mainstreamed general psychiatric units has meant that one unit now has to deal with the complete range of patients – from teenagers with psychosis, to young men with severe and dangerous personality disorders, to quietly depressed elderly women. In many instances this can be a volatile mix, and as much effort can be spent in protecting vulnerable patients from the dangerous actions of other patients as is spent in therapeutic interaction. Tragically, there have been cases in which patients have been murdered by other inpatients.

Deaths by homicide are extraordinary events. They point not only to the need for better assessment of the perpetrator's risk to others and better management of that risk, but must also point to the need for clinicians to have much easier access to specialised and super-specialised psychiatric beds as opposed to general hospital psychiatric beds.

Acute psychiatric units need to be safe places for both patients and staff.

Unpredictability

Prediction of risk for violence towards others is difficult. Large studies have identified factors that are correlated with future risk for violence. These factors are however applicable to groups. Based on these factors it is possible to identify with reasonable accuracy groups of individuals who may pose a higher risk of violence than others. However, the difficulty for clinicians is identifying which individuals in the higher risk group will be violent.

There are numerous difficulties central to the identification of the potentially violent patient that makes the process complicated for the clinician. These include the level of risk (high, low, medium), the type of risk (violence, sexual, psychological), the imminence of the event predicted (in the short-term, medium term, long term and how long are these categories). At the same time the clinician has to balance community safety with the person's individual rights. Caution needs to be exercised in criticising the work of any individual mental health service or clinician involved in a case of a mentally ill person who is involved in a serous incident of harm. This is not to say that errors were not made by clinicians in some of the deaths that came before the Committee.

It is worth noting that there are undoubtedly many mental health patients who share a great number of characteristics with mentally ill homicide perpetrators, and yet do not go on to commit homicide or violence. While it is not possible to identify particular individuals in a higher risk group, it is possible to implement risk management strategies to ameliorate any risk that may be present. Various factors have empirical support in their correlation with future violence, and it is possible to identify types of patients who have the characteristics of those with an increased risk of violence. It is in this group that careful consideration of future risk needs to be undertaken and considered management plans need to be implemented.

There is a common perception that any homicide by a person in contact with public mental health services represents a failure on the part of mental health services. This is not always so. One of the purposes of the Committee is to review these incidents and examine systematic problems within the mental health services that may have contributed to the tragic outcome and to suggest solutions.

Some systemic failures can be identified which might have made violence more likely (for example discharge of a violent patient with access to firearms) and it is to these that many the Committee's suggestions are directed.

It is likely (although not proven) that mental health services considerably reduce the overall homicide and serious assault risk by actively treating those thought to be at most risk.

Any demand for greater use of risk assessment will increase demand on already stretched mental health services, and have the effect of further concentrating resources on those with psychosis, substance use and personality disorders. This will reduce services for the vast majority of patients with mental illness who have other disorders such as anxiety or depression. This in itself could increase the risk to the community. Thus adequate resources need to be available for effective risk management without undermining current resources and services.

Part 3

Findings and Conclusions

Suicide – Review of Case Files

Homicide – Report of Analysis of Case Reviews

Coroner's Recommendations

Additional Matters Considered by Committee

SUICIDE

REVIEW OF CASE FILES

Introduction

Deliberately concentrating solely on inpatient suicides in its first year, the Committee commissioned a review of a sample of suicide case files in order to explain the possible or probable influence of systemic factors in each of these sentinel events and to determine whether there were any discernible trends in the sample cases that point to the need for specific reforms.

Specifications for the review

The National Centre for Classification in Health (NCCH) was contracted to review independently a number of cases where patients died by suicide whilst an inpatient under the care of a mental health service. The terms of reference required the reviewers to provide a report that identified causal, systemic factors in each case (without identifying individuals or institutions), and identify trends.

The Committee made available definitions of issues and factors that were thought to have probable or possible influence on the outcome of these cases. The review concentrated on those "causal factors" considered to be systemic issues, namely, the variables and factors concerned only with delivery of care. These "causal factors" defined the variables examined and prescribed the type of information that would be extracted, where available, from all case documentation. Issues related to disease and diagnostic processes, clinical judgment or the efficacy of drug or other treatment protocols were beyond the scope of the review.

The review brief defined the sample size and characteristics. Inpatient status was defined as any patient admission to a mental health facility where the episode of care had not yet been formally terminated by discharge from care. This definition of Inpatient (with an upper-case I) encompassed patients who were either resident, absent without leave (AWOL) or who were on granted leave from care when the death occurred. Specifically, persons who died by suicide within hospital facilities are referred to throughout the report as inpatient (with a lower-case i). Further explication of these variables is given below in a description of the sample selection. Patients who had been discharged and subsequently died by suicide were not considered within the review framework, and are to be considered in future investigations.

The Committee was also interested in determining whether standard protocols, policies and procedures were being utilised in the delivery of care, and whether mental health staff were complying with these recommendations and guidelines. Specifically, the Committee was interested in establishing whether NSW Health Policy Circular 98/31: "Policy Guidelines on the Management of Possible Suicide Behaviour for NSW Health Staff in Private Hospital Facilities" and the NSW Mental

Health Outcomes Assessment Tools and Training Initiatives (MH-OAT) were being used to inform and support decisions and delivery of care.

The review brief did not require that a literature review be undertaken, but a limited one was conducted. It revealed that there is scant evidence of research concerned with systemic issues in the delivery of care to mental health patients, instead concentrating on disease process and clinical judgment issues. Nonetheless some of the literature was informative and guided some of the reviewers thinking and evaluation. The relevant literature is given in a bibliography at the end of the report.

Study method and design

[See Appendix 2 for Tables, Figures and further information]

Sample strategy and selection

The Committee determined the sampling strategy and selected 40 cases from among the 68 notified deaths in care in NSW hospitals. Cases were drawn from notifications to NSW Health between 1999 and 2003.

The sampling strategy involved randomly selecting 20 cases initially from all Inpatients (who at the time of death were formally considered to be in care, and had not been discharged). This selection strategy included all cases, whether they were AWOL or on leave or resident in the hospital facility at time of death. To ensure better representation of all care types, the random sample was supplemented by a further 20 cases, which were chosen from the population of notified deaths, using a stratified sampling selection criteria. The stratification of these additional 20 cases was designed to include proportional representation of cases where patients were resident, AWOL and on leave at the time of death. A further stratification among these subgroups was undertaken to ensure that the sample selection was proportionally representative of cases given the particular methods of death. Fig. 1 (Appendix 2) shows the sampling strategy undertaken to compose the sample for review and the final selection of cases.

The initial strategy was designed to provide 40 cases for review. During sampling procedures, one case was removed from the sample (random selection group) because of incomplete information (39 remaining). Three cases were repeat selections; that is they appeared in both the randomised and stratified sampling selections (2 appeared in the inpatient strata and 1 appeared in the leave strata; 36 cases remaining). One case was identified as not meeting the selection criteria (Case 1074). This person had not been in contact with any mental health service prior to death (35 remaining).

The process for notifying relevant cases appeared to be proficient at identifying and capturing all fatal sentinel events of mental health patients, assuming all suicide deaths had been so classified. But the reviewers found that in some cases there were errors in the details reported, for example as to whether the patient was AWOL, on leave or discharged at the time of death. Therefore cautious analysis of notification data (and subsequent sampling from that population) is necessary because of possible errors in notified case data.

The sampling strategy and the final sample selection were based on this notification data. Review of original documentation from these cases revealed that some

characteristics of patients and their episode of care differed from the information available in the database of notified sentinel events. Hence, the reported results are not directly comparable with data available in the notification database on a case-by-case basis. For example, Case 950 was selected from the notification database in the Leave stratum, but subsequent study of the case records revealed that this patient was actually AWOL at the time of death. After study, nine (9) other such instances of change in status were discovered (shown in Table 1).

Sample characteristics

Given the sampling strategy undertaken, the reviewers verified that the final sample(s) of cases available for study were representative of the population from which they were drawn, and decided the analytic approach most suited to the study.

Table 2 shows the samples and their characteristics and composition, based on four (4) variables: gender, status, method of death, and principal diagnoses. These variables and values were taken from the notification data.

Analysis of these three different samples revealed no statistically significant differences in their composition. That is, the sampling strategy and stratification did not skew or unduly bias either the whole study sample (n=35 cases selected randomly (n=19) plus strata (n=16)), or the randomly selected sample alone (n=19).

Each of these samples accurately represents the characteristics of the population from which they were drawn. Such a finding may justify combining the random and stratified samples (collapsing the sample and conducting the quantitative analysis on all 35 cases). However, it was thought that the stratification strategy might unduly inflate (or skew) the quantitative findings when other variables (apart from gender, status, method of death or principal diagnosis) were reviewed.

It was subsequently decided that for the purposes of quantitative analysis, only the randomly selected portion of the study sample would be used (n=19). For the qualitative analysis, the whole study sample (random and stratification selections) would be examined (n=35).

Design

The specified study design was a retrospective record review and desk research using a collection of documentation relevant to the care and outcome of selected patients. As such, it provides a cross-sectional snapshot view of delivery of care issues. In most cases (33 of 35) the records were photocopies of the original documentation.

The medical records (medical record) contained information on admission, diagnoses, treatment decisions, progress notes and observations, clinical and care management decisions, and related medical issues. Not all records were comprehensive, and information on many of these factors was missing from many medical records.

Police reports (P79A forms) reflected police practices in investigating notified inpatient deaths. These indicated the circumstances of the death and gathered information and evidence about the scene, the witnesses, the immediate precursors to the event, and the nature of the suicide. In most cases, this information was used to establish whether there were any suspicious circumstances, whether there was evidence of foul play, or other criminality evident or implicated in the death.

Coroners' Reports and Inquests (where held) provided a comprehensive overview of both the delivery of care, patient and family experiences of that care, and the means and method of death. These comprised statements and testimony from police, carers and family as well as staff, along with post mortem reports. Where formal inquests were held, Coroners handed down findings of suicide, accidental death, or other and occasionally made recommendations about care and treatment issues, compliance with best practice, problems with protocols and resources.

Any other documentary evidence from hospitals, families, carers, or other health services involved in the care of the patient was also included in the review process. Where available, documents relating to hospital post-incident reviews, independent incident reviews, NSW Health circulars, policy statements and letters were examined. Letters and submissions from family members (to Coroner, to Health Care Complaints Commission, to NSW Health) were also sometimes available. Records of treatment and management of the patient in the community (Community Health Case Workers, Aboriginal Health Services, for example) were occasionally available and considered.

Method

Medical records were obtained from hospitals and police and Coroners' reports relevant to these cases were obtained from their appropriate sources. These source documents were then matched for each patient by name and case number.

Data was also made available electronically by NSW Health. This included some high level notification data about cases pertaining to factors that would help identify and validate information subsequently extracted from paper based records (name, gender, date of birth, hospital, means and methods, diagnoses and the like).

A preliminary analysis of these data revealed that many variables were irrelevant to a great proportion of the sample, and that some variables were non-unique. That is, some variables of interest (as defined by the Committee's specifications of causal factors) e.g. 'Case management and Case Co-ordination' and 'Information from Family about Intuition and Clues' contained overlapping elements and thus were a source of confusion in the coding and statistical analyses. Before statistical analysis, the coded data set was 'cleansed' and variables where duplicate or non-unique data where evident were amalgamated. No information was lost, merely rationalised and coded consistently. NCCH reviewers then undertook this statistical analysis, and results are presented below.

Many of the systemic factors and variables examined in each case progressed or ceased to be influential during the episode of patient care. For example, on admission, the patient may have been scheduled and placed on a high frequency observation regime, but subsequently the observation regime may have decreased (or vice versa). Similarly, patients may have self-admitted as a voluntary patient but were subsequently scheduled.

All efforts were made to determine the exact status of the patient and the care delivered to them throughout their episode of care, and particularly at the time of death. However, this was not always possible to ascertain. In instances where the medical record, P79A form or Coroner's report was silent on these issues, reviewers

concluded that the highest level of observation noted in the record and the most restrictive admission status of the patient during the episode of care applied for purposes of quantitative analysis. These judgments by the reviewers may have skewed the results.

Inferences were occasionally made, information gleaned from nursing notes and from the tone of some review entry notes, and judgments were made about whether or not "causal" factors were important. Clear and definitive statements about issues such as resources, security, and the rationale for decisions were rarely available, but can sometimes be inferred from entries in the medical record. These are, however, subject to some debate.

Further, the pervasiveness of information that was 'missing' and 'not relevant' to some cases meant that the numbers that qualified for analysis of some factors varied considerably. Therefore not all results in the tables included an examination of all cases in the sample.

The heterogeneity of the sample and the pervasiveness of missing information in many variables placed some restrictions on the robustness of the analysis. Further qualitative analysis was undertaken by the reviewers and is based on the investigations of three separate reviewers. In most cases, two or more reviewers examined and discussed the extracted narrative information from specific records. Qualitative information is summarised below, where appropriate. De-identified extracts from the records are inserted or quoted where these are particularly informative or representative of factors identified in the delivery of care (to one or more patients).

Logistical problems and some assumptions

Reviewers took the position that '…if it isn't in the medical record it didn't happen…', which does not do full justice to the skill, knowledge, efforts and care shown by hospital staff. Yet failure to record matters on the medical record is an important issue in itself. The Committee is aware that the escalation in record keeping requirements may compete with time available for direct patient care.

An examination of single cases does not allow investigation of factors such as staffing levels, staff to patient ratios, other stressors in care delivery (for example: how many other high risk patients were on ward at the same time), availability of adjunct resources (police, security, community involvement).

As MH-OAT has only been implemented within the last twelve months (since 2002) and only one case in the sample occurred in 2003, it was not possible to make reasonable judgements about compliance with MH-OAT protocols.

The nature of reports made available for review also imposed some constraints on the findings and evaluations. Medical records in particular were not in original presentation formats, with all the usual and expected demarcations of administrative, pathology, radiology, pharmacy and progress notes. This is likely because most were photocopied, sometimes out of episode order, sometimes out of chronological order, sometimes original double sided notes have been copied single sided, or the quality of the photocopy rendered the document faint and illegible.

Cautions

Cautious interpretation of study findings is needed. Usual practices and procedures might work most of the time, but they failed in the few cases reviewed. To be able to ascertain whether delivery of care to particular patients was appropriate, case-matched controlled studies are needed. Unless otherwise stated, reviewers could not reliably conclude whether systemic factors had a causal role in case outcome. However it can be said, with some confidence, that these factors exerted some influence on the delivery of care and patient outcome. That is to say, the factors may not have been causal.

Results and Discussion

As outlined in the sampling strategy and selection section above, the randomly selected portion of the study sample has been used for the **quantitative analysis**. Nineteen (19) cases were randomly selected, and this includes patients who were inpatients (n=10), AWOL (n=4) and on leave (n=5) at the time of death (as specified in the notification data). See Appendix 2 for tables, figures and further information.

For the purposes of the **qualitative analysis**, all cases provided for review were included (n=35). Many of the factors and variables considered impact on more than one measure. For example, variables of 'criteria for granting leave' or 'required level of observation' influenced the evaluation of both the decisions and judgment involved with case management and with assessment protocols. The qualitative analysis does not strictly adhere to the categories of causal factors defined by the project specifications. The reviewers cite exhibits or case reference numbers where these were particularly illustrative of the evaluations.

Two outstanding features of the cases were notable from preliminary analysis:

- the compelling and often emotive statements and appeals made by families for better care management of their loved ones.
- the complexity of the cases.

Effect on family
Although it was not possible to quantify or analyse trends in systemic factors from the anecdotal evidence available, these examples and extracts are included here because they are representative of some of these issues.

Case 889: It is notable that some staff attended his funeral in their own time, and his family acknowledged their appreciation of this and the care given to their son over the years. The gratitude of his family was also demonstrated by their request that donations to the mental health service be given in lieu of flowers.

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An adolescent girl, had been experiencing emotional difficulties over several months. When V became suicidal, her mother sought assistance from the local hospital. She was informed that there would be appropriate assistance available to her on presentation at the Accident and Emergency Department, however, when they arrived, they had to wait many hours before being seen. After V was examined at the A and E Department, the hospital advised that it did not have a bed available for her. Despite V's mothers initial request that she be admitted, she was discharged. The mother was told tat a Crisis Team would contact her at home to provide support, and to watch V 24 hours a day. The Crisis Team did not visit, and the family maintained contact with private therapists. Following her discharge from the hospital, the mother left V unsupervised for a short period. She returned to find V had killed herself.[904]

Select Committee Report Ref. 904

> I tried over and over again to get him into hospital, but did not succeed. My recollection is that the health workers kept trying to get him up to the community center, or that the crisis team would come and then leave, or that the psychiatrist would tell him he was dose to being scheduled, but did not schedule him etc etc. Finally he was causing a disturbance in a shopping centre and got arrested by Police who realised instantly (thank goodness they did) that he needed to go to hospital. He was scheduled but then discharged after four days. Within a few days he was unwell again and even worse.[905]
>
> **Select Committee Report Ref. 905**

> Our youth, or anyone who suffers mental illness, need more time in hospital and more time for therapy, not just a few visits, not just sit days and a few tablets. Any medication prescribed needs to be monitored regularly, not just dispensed with a pat on the head and then the patient sent off.[907]
>
> **Select Committee Report Ref. 907**

Case complexity

Throughout the review process, reviewers were constantly, often graphically, reminded of the complexity of issues presented in treating patients with mental illness. The nature of the diseases themselves present enormous diagnostic and management problems, but are more often than not exacerbated by social, psycho-social, pharmacological and medical issues that confound and confuse clear options for effective treatment. The fluctuating nature of psychological and psychiatric illnesses makes observations and assessments of treatment progress very difficult. Has the patient's depression improved because of the medication? Or is the noted lifting in mood a function of cycling between manic and depressed states in bi-polar disorder? Is anxiety a better predictor of risk of self-harm than reported ideation? (The literature debates these issues). Can staff judge the significance of fluctuations in mental health illness manifestations?

> Case 2328. The patient is currently an inpatient presenting with agitated depression, a decreasing ability to cope, complies poorly with medication. She has expressed a preference for ECT treatment for the depression. She has social problems with housing, income and exploitation by her boyfriend. There is a family history of depression. She has lost an astounding amount of weight and tests reveal some level of cognitive impairment as well as Hep C infection. She is significantly depressed and constantly mutters " What will I do now… I've done it now". Evidence of low-grade suicidal ideas. At present her presentation is puzzling as in some ways she self-cares and engages in activities. She has been a diagnostic puzzle in the past.
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> **NCCH Case Reviews**

Patient characteristics (See Appendix 2 Tables 3-8)

Results

The sample consisted of 14 males (73.7%) and 5 females (26.3%). The age range of the males in the sample was 18 to 93, with the average age of males being 39.6 years and the median age being 30.5 years. Removing the two outliers (age 93 and age 88) returns a mean and median age of 31 and 27.5 years of age, which is probably more reflective of the expected distribution of ages. The age range of females in the sample was 21 to 48, with an average of 36.2 years and median age of 38 years.

The majority of patients had previous histories of mental health problems and previous suicide attempts, were known to police and/or other community service groups, and showed evidence of substance use/abuse.

The principal diagnosis of over 70% of patients in the sample was some form of psychiatric disorder, while the principal diagnosis for the remainder of patients was a medical or other problem. Psychiatric disorders were present as co-morbidities for nearly half of the patients in the sample.

The Committee was interested to identify factors which might indicate that particular patients could be considered high-risk. Reviewers noted a complex of characteristics that may serve as indicators of patients who present as complex or difficult cases. Tables 5 and 6 show the frequency of risk factors identified and the numbers of patients who demonstrated one, two, several or all of these red flags.

Nearly all patients under 50 had a principal diagnosis of a psychological disorder, with schizophrenia and psychoses the most common forms of psychological disorder for males in this sample. For the three males over 50 years of age, the most common principal diagnoses were medical problems.
For all age groups under 50, most of the patients had both a previous history and previous suicide attempts, whereas for the patients over 50 who had a principal diagnosis of a medical problem, there was no evidence of previous mental health episodes or previous suicide attempts.

The average length of time into the admission when death occurred was 20 days, though this value was skewed by cases where death occurred a considerable length of time into the admission. Nearly half of the cases occurred less than ten days into the admission with three cases occurring on the first day and seven cases occurring within the first three days of admission.

Discussion

Most patients in the sample had previous histories of mental illness and many had previously attempted suicide. There was a pervasive theme of substance use and abuse, either complicating the patient's illness, or providing a substantial management problem on admission. That is, some patients initially presented after an overdose or an illicit drug-taking binge which necessitated a conservative approach to therapy during the early part of the episode (perhaps delaying the desired effect of drug therapies).

There is some concern about how to treat these patients, and whether mental health units are the appropriate place to treat acute cases of drug or alcohol related problems.

There are no dedicated units in the public sector specifically for patients presenting with these multiple problems as a first priority. Despite the fact that there may be underlying psychological or psychiatric diagnoses, there seems to be a conflict in care management protocols when services are required to deal with patients with significant drug and alcohol problems. Allied to this is the experience of patients who, upon entering a secure care unit, are likely to experience significant withdrawal symptoms that exacerbate their psychological or psychiatric disorders.

> An independent review (by Anderson) makes a point about lack of coordination of multiple services, particularly mental health and D&A, note that Circular 98/31 says (p5): "The treatment process and plan is coordinated and integrated across all aspects of service delivery with clear uninterrupted lines of clinical responsibility". Anderson says: "Psychiatric centres are not set up to hold people for a significant period of time purely for drug withdrawal. There should be a dedicated unit that takes people with both of these problems. This however is not the case in 1999 and nor is it the case in 2002."
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Patients who were admitted to medical or surgical wards did not share many (if any) of the characteristics demonstrated by patients with mental health problems.

The reviewers also noted that despite the fact that many patients shared diagnoses and risk assessments, their treatment protocols, behavioural and treatment responses varied considerably. Clearly, neither diagnoses nor levels of assessed risk are enough to adequately determine and justify decisions about delivery of care. Risk factors exhibited by these patients demonstrated that this sample could be considered, overall, to be a high-risk group.

Along with confounding factors of substance use and abuse, issues of previous mental health histories, contact with other services (community health, Department of Community Services, police) each influence and impact care management judgments and decisions. Factors such as whether patients are scheduled, detained involuntarily or not and granting leave and the conditions under which this happens need to be considered in light of these complex issues.

The pervasiveness of drug and alcohol problems among patients, as either an underlying cause or trigger for their episode of care, or the confounding factors this presented for treatment, were almost always recognisable features for these 35 patients. The fact that mental health facilities were not ideal for providing detoxification care was noted.

Admission practices (See Appendix 2 Tables 9-17)

Results

Good handover practices, where good was defined as "evidence of follow-through such as changed risk assessment and care protocols, involvement with family, co-ordination with other services, was shown in notes", were evident for 10 patients. Poor handover practice, where there was a lack of follow-through evidence in the notes, was evident for one patient. (The remaining patients were medical admissions, or the information was not available in the medical record, or the handover practices

were not relevant). Nine of these patients were scheduled for admission, two patients were admitted involuntarily, four patients were admitted voluntarily and informally, and three patients were admitted for medical reasons. A larger proportion of the self-admitted patients were scheduled for admission compared to the patients who were brought in by other services/family.

Resources commensurate with level of risk were provided on admission for about half of the patients in the sample. Three quarters of the patients who were scheduled, and all of the involuntary patients, had resources appropriate to their level of risk. Most of the voluntary patients who were admitted informally had appropriate resources.

With regard to principal diagnosis, patients with schizophrenia and psychoses were more commonly scheduled for admission, while patients with other psychological disorders were more likely to be admitted informally and voluntarily. Patients who were admitted because of suicide attempts or reported intent were more likely to be scheduled for admission as they were to be admitted informally.

Patients who have previous suicide attempts and histories were more likely to be scheduled or admitted involuntarily.

The patient's presentation on admission may also account for some the variation in admission procedures. The reviewers noted inconsistent use of admission criteria for patients who shared similar risk assessments. That is, patients assessed as high risk of self-harm were sometimes scheduled, sometimes not, sometimes detained involuntarily, sometimes not. These variations were difficult to substantiate or justify given the paucity of information in the medical record about the rationale for these decisions. Applications to the Magistrate to schedule a patient were sometimes available, but these tended to be pro forma documents and the reason for scheduling was most often 'high risk of self harm' or 'suicide ideation'. These did not explicate the comparable or relative level of risk, or offer a rationale that could differentiate decisions to schedule (or not) for different patients. Whether resource availability weighed on these decisions is also a matter of speculation.

In the case of one patient, the decision to schedule was explicit. The medical record for Case 881 noted that the patient was scheduled 'to allow police follow-up' when the patient was noticed to be AWOL.

Again, several patients did not fall under usual admission practices for mental health patients. Four patients were medical/surgical admissions and no consideration of their needs for scheduling or detainment was considered necessary at admission.

Each case raised concerns with regard to the co-ordination of appropriate care. These were medical or surgical admissions that did not, prima facie, present mental illness care management issues. Nonetheless, subsequent to or perhaps because of their medical and surgical conditions, these patients all exhibited mental health issues or problems. These ranged from olfactory, visual and auditory hallucinations, disorientation, hopelessness and confusion. Post incident reviews and statements from family and carers suggest that these issues might have been recognised and treated as more serious concerns. Indeed, one review suggests that mental health issues, such as post-operative delirium, are not recognised or dealt with appropriately (cases 986, 1096, 1864, 1964).

> Spigelman report, Case 1864, 2002: "Psychiatry concerned that patient's removal of epidural not identified by staff as a significant cause for concern in terms of behaviour. When psychiatry questioned staff about this they seemed to accept this as a normal event: "Lots of our patients pull out their epidural". Concerned that postoperative delirium is grossly under recognised in the hospital."
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Of particular note is the Case 1964, a medical patient who was admitted to the oncology ward. He demonstrated increasing mental health problems. Among these were olfactory and visual hallucinations and dissociation from reality, probably as a result of an organic and escalating psychotic illness. His sister was an employee, a psychiatric nurse, in the Mental Health Unit at the hospital to which he was admitted. She continued to claim, (and probably still does believe), that the patient was not considered for admission to the Mental Health Unit because she was nursing there. The medical record does not clearly indicate whether or not admission to the Mental Health Unit was initially considered; it does indicate that further psychiatric assessments were requested. Unfortunately, the patient suicided before proper arrangements could be made.

Discussion

Reviewing the experiences of medical and surgical patients in hospital care demonstrated that the appropriate and timely recognition of patients exhibiting symptoms of mental illness while being cared for outside mental health units on general medical or surgical wards is cause for concern. Staff experience, knowledge and preparedness to deal with these unexpected, unassessed, and emerging problems are deserving of further investigation.

Assessment protocols

Results

For almost half the patients no protocol for assessment was used. MH-OAT was used in only one case, where admission was in 2003, after the implementation of MH-OAT protocols. All other protocols were assessed against recommended practices in Circular 98/31. Where it was not evident that a standardised form, format or scoring system was used, reviewers still concluded that a protocol was applied where it was obvious from the records that a standard approach was adopted, and that assessments were complete. In 36% of the sample, or in 7 of 19 cases, there was no assessment by a doctor on admission or use of a protocol recorded..

Assessment protocols varied in form and format, but there was some underlying consistency. Most followed recommendations outlined in Circular 98/31, although some local adaptation of these was evident. Initial assessments done in emergency departments were most often followed up with more comprehensive assessments by psychiatry clinicians shortly after admission.

Some records revealed that more formal scoring or ratings tools were used to assess patients. In one case (Case 1813) the patient was assessed as being high risk, scoring 18 out of a possible 20 points for risk of self-harm, when he first presented. He was

not admitted on this occasion because he left the emergency department before a bed was found for him. He presented at the emergency room again shortly thereafter, was again assessed with the same rating instrument, and was assigned a risk score of 13 out of 20 (ostensibly a medium risk score). On this occasion the medical record notes reveal that he was considered an extremely high risk, despite the lower score, and admitted immediately as an involuntary patient. This suggests a large inter-observer error.

The reviewers were uncertain whether the implied objectivity of scores and rating instruments are enough to guide decisions about risk, and whether clinician judgment and experience could and should be paramount. Although rating instruments are designed to ensure the objectivity of the assessment process, inter-observer differences, or even error, point to a weakness in relying on these to guide decisions about risk, and lead to the question of whether clinician judgement could and should be paramount. The reviewers considered that the admission decisions for this patient were sound judgments even though the assessment protocol itself did not provide such clear or consistent support.

Also noted were variations in the meaning assigned to assessment scores. For some patients, ratings of 5 were considered high risk, and ratings of 1 were considered low risk. In other medical records the 5-point scale was reversed, with 1 representing patients with high-risk characteristics, and 5 representing the lowest risk category. Local variations may well be understood locally, but such variation imposes difficulties in comparisons and reviews across hospitals.

There was variable use of the term 'high risk', by clinicians and nurses, and also in policy documents and supporting guidelines. For instance, there was some concern that high-risk patients being treated in the community setting are formally assessed within 24 hours (Circular 98/31 Attachment B; Suicide Risk Assessment and Management Guidelines in relation to Young People, Consultation Draft May 2003, p14). Given that many suicide events occur within the first two days of admission for this sample, the reviewers were concerned that a 24-hour window for formal assessments may indeed be too generous, especially if these are initially made by community health services, before admission can be arranged. Coroner's recommendation in Case 1033, also suggests that the first 24-48 hours is critical.

> Coroner's report, Case 1033, 2002: "I have heard evidence of two deaths and have particulars of two other deaths. Person A took his life within 16 hours of admission, person B within forty hours of admission……"it would seem that the period when the patients require the most intense care and observation is within the initial 48 hours of admission".
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Considerable variation in review methods was noted. Patients had different experiences of being reviewed and re-assessed through their episode of care. In some instances, reviews and assessments were formal and quite regular (as much as weekly), and concentrated on objective methods of measuring patient response to treatment, diagnoses and other health problems.

Less formal reviews were evident for most patients, and these occurred approximately every second day. Notes by clinicians were identifiable, and these indicated the progress of care and therapy thus far, whether the care plan was working or required adjustment.

Nursing notes were more frequent and less formal. They noted behaviour, dietary and self care habits, observed requests, visits, phone calls, sleeping patterns and leave taking. Any problems with patient care were most often observed and noted by nursing staff, and occasionally by allied health specialists (social workers, occupational or diversional therapists and the like).

Some problems with reviews and assessment throughout the episode were very evident, but mostly with regard to documentation issues, and these are discussed below. However, there were at least two cases where the appropriateness of the review process was questionable. Case 1312 seemed only to receive reviews by the nursing staff, who were apparently determined not to acknowledge or treat her mental health problems, preferring instead to restrict the patient to treatment for her medical problem alone. The other problematic case (Case 881) appeared to have no direct clinician review. Notes in the medical record from the clinician indicated only that she had 'noted above' nursing notes; there was little indication in this record that the treating clinician had directly observed, reviewed or assessed the patient, preferring to rely on reports and documentation from nursing staff.

Discussion

Some of the variability and inconsistency noted in the use of assessments and reviews may be addressed with new guidelines or formatted and standardised assessment instruments. However, the burden of documenting patient information is already high, and the reviewers were unconvinced that requirements for completing additional, pre-formatted, standardised documentation for patient assessment or management will be efficacious in solving existing problems with documentation. Anecdotal evidence suggested that it might exacerbate, rather than solve existing problems.

The limited exposure to cases where MH-OAT was used for assessment or review was insufficient to indicate whether these newly implemented protocols are already achieving a greater uniformity and predictability in assessment.

Care management (See Appendix 2 Tables 18-22)

Results

Management of care often revealed systemic variations and problems. These were evident in factors such as observation regimes, use of seclusion, applying the provisions of the Mental Health Act, decisions to grant leave, and co-ordination of therapy.

The reviewers attempted to categorise the care management regime for each patient. Of the cases that could be assessed against this factor, half received good or fair care management, where good was defined as "evidence of follow-through such as changed risk assessment and care protocols noted and implemented, involvement with family noted and implemented, co-ordination of care with other services, was shown in notes". Two cases were assessed as receiving "poor" care management. Poor care management usually showed a lack of coordination, lack of follow through in notes,

less evidence of regularity of review or re-assessment or a confusion in how visitors, privileges or leave should be (or was) decided, or strategies for dietary or medication compliance. In these cases, the reviewers judged that co-ordination of care (multi-specialty), or communication between staff was notably worse than in other cases examined. Eleven (11) of the patients (where data were available) were under regular daily review by the RMO or registrar, two (2) were under regular review by a consultant VMO, and one patient was under irregular/infrequent review. Therefore in 5 of the 19 cases sampled there was no regular review recorded.

Most patients with scheduled admission had medium to high levels of observation, while the majority of involuntary admissions had high-level supervision. The level of supervision for voluntary/informal admissions was variable.

Five of the nine patients who were deemed to be high-risk, were provided highest levels of supervision. The patient deemed to be a medium-risk was given low level supervision.

This lower level of classification may have seemed correct at the time the assessment was made, but in retrospect it was a mistake to deem a person who later suicided to be of medium risk.

Four of the patients who were AWOL had been missing for one day or less at the time of death, while the remaining two had been missing for between three and ten days at the time of death.

Over half of the patients that were AWOL at the time of death and over half of the patients who were inpatients at the time of death, were required to be under medium-high to high levels of supervision (missing information not shown, 3 cases).

Observation: Factors relating to level of observations recommended and carried out demonstrated a great deal of variation. High levels of observation varied between and 10 and 15-minute intervals, medium observations were most often performed at 30-minute intervals, low or routine levels of observations mostly entailed hourly checks. One to one nursing (1:1) was evident in two or three cases for varying amounts of time, often while the patient was exhibiting extreme risk behaviours (ideation, impulsivity) or was in the acute of florid disease state (Case 966 for example).

In some cases, there was documentary evidence that these observations were undertaken, with tables (timesheets) with time intervals duly noted, dated and signed by the attending nurse. These provided the best evidence that observation levels were decided and enacted, however, they were infrequently available; in many instances nursing notes stated that 'six checks made in last hour', but there was no way of discerning who had made the observations, and whether these were done at regular intervals.

Initial observation levels and changes, upon formal review, are recommended by clinicians and these seem to be implemented by nursing staff. Maintenance and change of observation levels often seem to be a decision of nursing staff. Particularly through longer episodes of care, nursing staff appear to be able to decide whether patients need higher observations, or are deserving of having more privileges and lower observation levels (Case 993). It is unclear from the available documentation,

whether nursing staff consult with clinicians, by phone or otherwise, in order to discuss or approve these decisions. Mostly they appear to be sound judgments at the time, and it is only with hindsight that they become questionable. Reviewers often wondered at the basis of the decision; whether nursing staff felt obliged to reduce observations to be less provocative, to make the patient more comfortable, or whether they felt threatened or under duress from an aggressive patient (Case 1809). It is also possible that patients indulge in manipulative behaviour to secure privileges and small freedoms (Cases 2328, 1312). Impressions only have been gleaned from nursing notes. It is not possible to adequately measure these factors, or expect that the available documentation could reflect the true nature of patient-staff interactions.

Seclusion: Seclusion practices were rarely noted in the medical records. In one case (Case 1809) a patient was secluded for a short period of time soon after admission. Documentary evidence suggests that the rationale for this decision was largely the patient's threat of harm to staff and other patients. He was highly aggressive and required an extremely safe environment where it was hoped that, with a lack of provocation and distraction, the medication would have time to be effective in settling his behaviour. Short duration seclusion entailed removing his own clothes and belongings and having him dressed in hospital pyjamas to reduce the risk of self-harm. He was watched via Closed Circuit TV throughout seclusion, and nursing notes reveal that, because of the availability of camera surveillance, he was observed more frequently than was required. Subsequent problems with seclusion and high observation regimes for this patient are noted in the Coroner's report, with recommendations that policies and procedures be reviewed.

> Coroner's report, Case 1809, 2002: "I mean what is the purpose of close observations? Is it not to ensure that the patient is, to use that expression, 'alive and well' as opposed to, as I said earlier, simply being there 'physically' (in reference to patient who was seen from a distance assumed to be sleeping while in isolation). In this instance it appeared from the nurses testimony that he was fearful of being hurt by the patient who was isolated because of aggressive behaviour so was reluctant to physically check that the patient was alive".
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> **NCCH Case Reviews**

The medical records also demonstrate staff discomfort at having a patient in seclusion; the tone of the entries expresses regret and resignation that this option was a necessary means of managing the patient.

Use of restrictive practices with reference to the Mental Health Act was a theme throughout several records noted by the reviewers. It appeared that there is a commitment to keeping patients on the least restrictive observation regime (in line with the Mental Health Act and management guidelines). Consideration of issues such as patient privacy and dignity play a part in staff decisions about observational level and ward restrictions. Concerns about whether patient dignity and privacy should over-ride patient and staff safety deserve further analysis and would need to rely on more comprehensive evidence than was available here.

Granted leave: Criteria and decisions for granting leave were systemic factors that also demonstrated considerable variation. (Note that reference here is to the criteria and rationale for granting leave, not the patient's experience or response to leave).

Some patients experienced trials of leave taking, for short periods of time (2-3 hours) as long as they were accompanied, and gave an undertaking that they would not take drugs, alcohol, or inflict self-harm (Cases 1034, 993, 1107). Patients were counselled that unless such guarantees were given and abided by, they would not be considered for subsequent leave.

From a systemic point of view, these trial leave takings were not always followed up appropriately. For instance in Case 993, the first short-duration accompanied trial leave was followed immediately, and without further review, by extended weekend leave. This is despite the fact that family members reported to clinicians that the patient was lying about her suicidal ideation and intent. Similarly, negotiated contracts with the patient in Case 1107 were violated continually by his drug taking and dealing. This was noted by staff. However, further leave was not prohibited. Indeed, this patient seemed to be treating the mental health unit as a home away from home, and given his ongoing housing problems, it raises questions about whether this patient was malingering or manipulating staff responses.

> Independent review by Anderson: "…a young person who believes that they are a cause of all the bad in the world because they are depressed or psychotic is unable to give a meaningful assurance that they will not act on their suicidal thoughts".
>
> **NCCH Case Reviews**

Stated criteria for granting leave such as 'if the patient feels safe' (Case 1061) raise concerns about the viability of criteria used for granting leave. Whether the patient is ready for, or able to cope with, leave should ideally be based on clinical assessment, not based on the feelings of a patient, who may continue to be disordered and incapable of making the wisest choice.

However, decisions about granting leave were not always a concern. Contracting with a patient to return from leave and consult staff if he felt increasingly anxious was effective, at least in one case. He returned early from accompanied leave with his mother, and immediately reported to staff his increasing anxiety and paranoia. They responded appropriately with counselling, adjustments to medication and closer observation (Case 1034). The differential factors here might be patient insight, low levels of impulsivity, family support or vigilance, and an understanding of the fluctuating nature of the disease. (This patient had a long history of mental illness and had been successfully managed, so far, in the community).

Co-ordination of care: There were several good examples where community health services worked in concert with mental health unit staff, offering insights, information about previous history and triggers, responses to and compliance with medication (Cases 1034, 1809).

Reviewers found only one clear instance where there appeared to be a breakdown in communication and understanding of patient needs between treating clinicians. Case 1813 was admitted as an involuntary patient pending a formal application for scheduling under the Mental Health Act. Before this could be arranged, the patient was seen and discharged by another clinician. This clinician apparently assessed the patient as a short term risk because of intoxication, that is, he qualified as a drug and alcohol case who needed only immediate care and supervision for drunkenness (or so

we assume from the scant notes), and after an overnight stay, sleep and supervision could be discharged. Indeed this assessment is borne out by the toxicology report undertaken at post-mortem, which found the patient had a blood alcohol reading of 0.19 at the time of death. The time of death was two hours post- discharge, and occurred in the emergency room toilet facilities, where the patient had gone immediately after formal discharge to request re-admittance because he felt suicidal. The patient had clearly been assessed at admission as high risk of self-harm, had reported suicide ideation, had expressed hopelessness and had a probable diagnosis of post-traumatic stress disorder. These assessments appear to have been present and available for subsequent management of this patient. Reviewers could not explain or justify these decisions.

The case represents the only clear-cut example of clinical mis-communication apparent in the documented sample. The lack of care co-ordination was not attributed to a conflict in opinions or disputes between clinicians about the best way to plan treatment for this patient. No evidence was found of any disagreements, just two distinct and separate evaluations. The fact that this patient had no identified next of kin and had refused all treatment in the community are probably the only reasons this case has escaped greater scrutiny and interest.

Discussion

Observational levels: There was a high proportion of patients who at the time of their death were both scheduled and on high frequency observations (as far as could be established). Yet these people suicided in spite of these interventions. It would seem that issues of observational frequency and security are indeed implicated here and warrant further investigation. Equally, however, factors like 'time to active meds', time into the episode, levels of patient anxiety, staff resources and demands at the time of the incident, are also likely to have had some influence. Reviewers did not consider, and in most cases could not consider through lack of documentary evidence, many of these factors.

Granted Leave: While there were some inconsistencies in the rationale and criteria for deciding to grant leave to patients, these practices do not seem to present a major concern. Few patients who were granted leave came to harm while on leave. However, a notable theme was that staff seemed keen to allow patients leave, especially short-duration accompanied leave, even very early in the admission.

The factor 'time to active medication' may prove to interact with some issues of leave-granting. Patient anxiety, depression and 'safety' might be predicated on the effectiveness of drug therapies, may influence their ability to make contracts with staff and to cope with leave taking. Reviewers were unable to clearly establish whether a patient's medication had become active or not. In many cases, patients had been admitted for treatment because they had been non-compliant with their usual medication regime, or they had found that it had become ineffective and required dose adjustment. Others were admitted with significant illicit drug usage, and the interactions between illicit and therapeutic drugs were impossible to judge.

It is noteworthy that many patients were granted leave, or took their own life, very early in their episode of care (less than ten days). This would suggest that if anti-depressant drugs were a factor in their treatment, and they had just begun to receive

this therapy, the medication is unlikely to have been effective. Some of the drugs prescribed are noted to take 10-15 days to reach therapeutic levels.

Occasionally, reviewers noted cases where patients were on high frequency observation and scheduled, but were still granted leave. The wisdom of this appears to be questionable. Preventive measures or reforms might be well served by consistent criteria for granting leave.

Application of the Mental Health Act: Direct appeals to the provisions of the Mental Health Act were not common, but represent an interesting theme identified in many cases. Treating patients under the least restrictive protocol and regime possible was variously noted in medical records and in statements and testimony to Coroners and police. As mentioned before, the reviewers were uncertain whether staff were interpreting the Act and their responsibilities according to the strict letter of the law.

It would seem that the full intention of S4 of the Act, requiring the provision of the best possible care and treatment in the least restrictive environment *enabling the care and treatment to be effectively given* (emphasis added), is often overlooked that is, attending people often give too much significance to the " least restrictive" element at the cost of attention to the "effective" element. Also, this Section requires that any interference with patients' rights, dignity and self-respect are kept to the minimum necessary *in the circumstances (*emphasis added*).*

It appears that the status of the patient (for example, in/voluntary) may bear no relationship to the observation category. This may be appropriate but there is certainly a general perception (evidenced by comments from concerned relatives) that a scheduled patient under close observation will be secure and safe from harm. There was evidence that while some patients were classified under the least restrictive status, the option to schedule was used as an administrative tool to enable the police to apprehend those on AWOL. If the criteria for observation are clear, then perhaps the status of the patient is a secondary matter. In one case, the mother referred to her son being on "suicide watch".

Environment (See Appendix 2 Tables 23-6, Fig. 2)

Results

The most common method and place of occurrence for hospital deaths was hanging in a bathroom or cupboard with half of all hospital deaths occurring in this manner. One death that occurred on hospital premises was of a patient who was AWOL at the time of death, and another was of a patient who was listed as discharged at the time of death. Both of these deaths were from hanging in a bathroom or closet. Both of the medical inpatient deaths occurred by jumping, one of these from a hospital room window and the other from an open area in the hospital. Three of six inpatients who died as a result of hanging were required to be under medium-high to high-level supervision.

The most common means and place of occurrence for hospital deaths were using the patient's own cord/rope/string/clothing and a hospital fixture in a hospital bathroom or cupboard.

The most common methods and place of occurrence of death outside of hospitals was overdose (4), vehicular impacts (2) and hanging in public places (1). For AWOL

patients, the most common method was overdosing, with 3 of these 4 deaths in public places, followed by vehicular impact in public places.

It was not always possible to determine the exact means or place of death. In two cases there was insufficient documentary evidence to ascertain access to means.

The methods of hanging and jumping tended to occur earlier in the hospital admission, with over half of the hanging deaths and three of the four jumping deaths occurring in the first few days after admission. In contrast, vehicle-related and overdosing deaths occurred later in the admission, with all of the overdosing deaths occurring ten or more days after admission, and three-quarters of the vehicle-related deaths occurring more than thirty days after admission. (Note: These methods were only used by patients who were either AWOL or on leave).

Access to means was a concern in the case of inpatient suicide on hospital premises. Fixtures and fittings were rarely identified as a potential source of means prior to the event; indeed, some were never recognised as a problem at all. For example, in Case 1809 a window latch was used as a hanging point. In another instance, a closet clothes rail was used, and would not have been thought to be strong enough to take the weight of a person. (Case 889). In some cases, patient dignity or comfort was considered paramount and they were allowed to have their own clothing and belongings, which ultimately provided them with means (compact mirror-Case 966; own clothes-Cases 2328 and 1809). Two or three patients may have deserved more vigilance in determining access to means. One patient had a belt in his possession (Case 1323). Another patient, who had previously attempted suicide by stabbing himself in the chest with a knife, had access to hospital cutlery (Case 1034).

Several instances were notable for concerns about access to means, especially given the level of observation they required. Coroners commented about means and equipment in a number of cases. Coroners have also noted concerns about patient rights, and query whether staff are intrusive or have the right to search patients.

For some patients it would have been difficult to predict their use of design and fittings. In these cases the suitability of the accommodation was the issue. A medical patient (Case 1964) admitted for investigation and treatment of an inoperable brain tumour and related symptoms was admitted to an oncology ward which had no special preventive fittings or fixtures. He jumped from a fourth floor window which had bars of sufficient width to allow egress. This could not have been predicted and for the usual oncology patient would not have been an issue. Similarly, a patient admitted for post-cerebrovascular accident (CVA/stroke) rehabilitation jumped from the balcony outside his room (Case 1096). It would be usual to expect that an open, airy space would be a benefit to patients, providing the rehabilitating patients an opportunity for mobility beyond the walls of the room. It would be unreasonable to expect that balconies and windows in medical and surgical wards be redesigned to restrict access to all patients.

Coroner's report, Case 1033, 2002: "It would appear that medical practitioners, clinicians and staff within a psychiatric hospital do not have the legal right to carry out a physical body search of a patient who is to be admitted to hospital for the person's own protection from serious harm or for the protection of others from serious harm. Legal advice should be obtained from the State Crown Solicitor or from an appropriate source as to the powers of search available to medical practitioners, clinicians and staff at a hospital of patients to be admitted to hospital. Advice should be obtained as to the necessity and desirability of giving such persons the right to physically search patients in appropriate cases upon admission to a psychiatric hospital."

Coroner's report, Case 1809, 2002: "If they're serious enough to be requiring ten minutes obs one would have – I would have thought that it would have been a wise decision to take those sorts of things off them …"

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Methods of egress were mostly discovered after patients had been noted AWOL, sometimes after a post-incident review. Not easily predicted were window latches that did not work and allowed egress (Case 2221), patient ingenuity in sneaking out of locked, key-card operated doors behind departing service personnel or with visitors (Case 2328), jumping over fences six feet high despite having both arms in plaster casts (Case 881). In most cases, post-incident reviews by hospitals identified real and potential risks, and remedial action was taken (Cases 2221, 1964).

Clearly patients who are AWOL will have more diverse access to means and little control over this access is possible by hospital staff. The issue is the possibility of egress itself which must be considered seriously.

Discussion

Access to means and methods are cause for concern and are to some extent inter-dependent with decisions about observational level, open and closed ward accommodation, granting leave and security.

Given the number of inpatient deaths that occurred by hanging, both access to the means (clothing, cords and so forth) and to hanging points (doors, windows, handles and latches) are deserving of closer attention.

Similarly, the number of deaths that occurred while the patient was AWOL would indicate that closer consideration of security issues, particularly egress, is warranted.

Documentation

Results

In terms of the quality of patient records, seven records (37%) were deemed to be of good quality, as defined by completeness, legibility, with dates, times and signatures recorded. A further six (32%) were assessed as being of fair quality, defined by mostly complete record, some illegibility, missing some dates/times. Five records (26%) were found to be of poor/very poor quality (illegible/incomprehensible, missing dates/times). In the remaining case a medical record was not available for admission to the unit to which the patient had been transferred just prior to their death.

Without a doubt, documentation issues represented the most obvious problem. These also represented the most concern from a medico-legal and care management and co-ordination point of view. The quality of more than a quarter of the medical records reviewed was considered poor; a few were appalling.

Reviewers noted several trends:

- Entries infrequently identified the author (nurse? doctor? allied health specialist?). Signatures and employment designation were often missing, and/or frequently illegible;
- Entries were not always dated (more often by nurses, infrequently by doctors and medical staff). Temporal or chronological order could sometimes only be inferred by backtracking to the last date in the record;
- Entries did not always establish times the patient was seen (almost always by nurses, almost never by doctors or medical staff).

The most notable poorly recorded feature of documentation was frequency of observation. Summary notes such as 'patient seen three times in the last hour' were common. Few patients placed on high frequency observations (and noted as such) had timesheets available in the documentation to establish that these observations were carried out.

Legibility was lamentable. In many cases, the reviewers struggled to decipher entries; often medical record entries were not immediately accessible and understandable to the reader.

Of more concern was missing information. Following the delivery of care through medical record notes, reviewers noticed that recommendations and observations noted in the record were often not subsequently considered, dealt with or acknowledged by other staff (on later shifts, or during later reviews).

This raised the possibility that medical record documentation is not being used as a communication and management tool but rather as a recording instrument. It would seem that significant communication between staff occurred outside the record: in discussions, by phone, by handover notes, in corridor conversations. Problems arose when crucial information was conveyed in this manner, escaping notation that would otherwise benefit all staff involved in treating the patient.

There are significant differences between communication and documentation, and it would appear that a medical record could, and perhaps should, better reflect the corpus of knowledge about a patient and their treatment, rather than merely the routine notations of medication, sleeping and dietary habits, reviews and care plans. The fact that handover information and informal nursing communication is not recorded in the medical record is a concern. In one reviewed case, a nurse reported 'that we shred notes at the end of the shift' and that this is common practice (Case 1033).

On cross-referencing information from other documents it was obvious to reviewers that families and other carers had provided information. This was sometimes noted by nursing staff in the medical record, but most often not.

There were several outstanding examples of good documentation. Multi-disciplinary management teams considered patient treatment and progress, and the thoughts, speculations and outcomes from these team meetings were documented in the record (Case 2328). It is possible for documentation to be performed extremely well, though unfortunately this is often not the case.

The influence of poor documentation was highlighted in several reviews and by Coroners. Several cases (Cases 1033, 1964, 881) triggered action by critical incident review staff in reviewing, or providing up-date training in documentation practice for staff. The criticality of good documentation practice, and the lack of it, was noted in several cases.

> Coroner's report, Case 1033, 2002: In relation to clinician documentation he says: "That was the basis on his admission but he did not clearly and precisely record his assessment of the suicide risk for the benefit of all other staff at the hospital"
>
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Discussion

Documentation was a consistent source of concern. While this problem is not unique to mental health services, it would seem that given the complexity of problems that patients present with, and the difficulty staff face in managing these, even better documentation practices are required here than elsewhere in the health system. Issues of comprehensiveness, legibility, clarity, adequacy of time and date entries and identification of the authors were the major concerns.

There were also conflicts obvious in the role documentation does, or must, play. As a recording instrument documentation could be improved in terms of format, guidelines, protocols, pre-formatted assessment and planning instruments and the like. If these were to replace, rather than be imposed in addition to routine documentation, they may streamline documentation practices. As an instrument of communication, medical records do not adequately capture all the important exchanges that take place during the course of care delivery.

The nub of the problem is that there are competing demands on staff time; and where forced to make a preference for delivering care to patients and writing about that delivery, most staff probably opt to invest their time and skill in the former to the detriment of the latter. Some Coroners' reports indicated that the care provided was satisfactory, which supports the view that the quality of documentation is not necessarily a reflection of the quality of care provided. Conversely, it appeared that there were instances where documentation of critical information would have had a significant impact on the treatment provided.

Staff Issues

Results and Discussion

Availability: In two cases, resources appropriate to level of risk were not available. This necessitated the transfer of a patient or alterations to the treatment protocol provided to them. Case 966 received 1:1 nursing for almost all her admission, but this level of resource intensity could not be sustained. She was transferred to another

facility where 1:1 close supervision could be provided, but this was subsequently downgraded. She then attempted suicide by suffocation with a plastic bag. She was transferred back to her original admitting hospital for intensive care after the attempt; she did not recover and life support was turned off while she was in this facility. Medical records covering the admission to the secondary facility are not available, and it cannot be determined whether intensive nursing resources were available on an ongoing basis, or whether the decrease in observational level was based on clinical improvement. In one other case, seclusion or containment was needed for a patient, but suitable facilities were not available. High acuity nursing was successfully substituted as a method of care for this patient (Case 1239).

Experience: The reviewers noted that some of the nursing staff who were on duty at the time of the incidents were quite inexperienced. In one instance, the two nurses on night duty had respectively five months, and two years experience as nurses, and less experience than this in psychiatric nursing. While the reviewers do not believe this was a causal or contributory factor for the occurrence of the event, the reviewers would be concerned for the staff members who experienced such a traumatic event in the early part of their career. Difficulties in recruiting and retaining qualified staff members for psychiatric facilities are recognized. The number of staff assigned to shifts, and their collective experience, should be considered for safety reasons as well as for collegiate support. There was one instance where, post-event, staff numbers were increased.

Pressures: It was not possible to judge the impact of other pressures on staff. Few of the records or documents available made clear statements about the number of other patients on the ward simultaneously and whether their risk levels were comparable or not. Some fleeting suggestions that 'it was a busy night' are made, but there is no way of judging relative burden.

Problems of conflicting pressures were also noted. Towards the end of the shift, nursing staff were often involved in handover tasks to the next shift, and regular observations during this time appeared to be interrupted by these other duties and demands. Moreover, it is difficult to judge whether the regularity or frequency of observations was possible given undisclosed numbers of high dependency patients simultaneously nursed on the ward.

Accordingly the Committee recommends that:

> By July 2005, to assist health services to provide safe and adequate care, NSW Health shall develop and distribute a guide to safe staffing levels as these relate to the outcomes of risk assessment and the level of staffing required to manage those risks. **Recommendation 6**

Support for nursing staff from doctors: This was evident in several cases. Notes by doctors in the medical record indicated to nurses that they should phone or page a doctor if there were significant changes in patient demeanour or behaviour. There were also several instances where nurses noted that they had phoned a doctor to discuss, check or approve medication or changes to dosage. Largely, the work relationships and responsibilities between doctors and nursing staff were well co-ordinated, notwithstanding the outcome in one instance (Case 1323) where a

voluntary patient requested discharge and the nurse called the treating doctor for a review. The patient took his own life in the half-hour between the call to the doctor and her arrival.

Support systems: Access to duress and distress alarms was mentioned in two or three cases. Those worn by nurses appeared to be the most effective; those located at nursing stations the least effective. It may be useful for Area Health Services to review the effectiveness of the placement and positioning of duress and distress alarms and the procedures followed when distress/ alarm calls are made.

Emergency procedures: The reviewers noted that occasionally some confusion and havoc was evident when distress or arrest calls were made. It was not always possible for staff arriving apace to understand the nature of the problem, or what they could expect to encounter. In one case, they were not even sure of where they should run to, in order to provide assistance. In another case, a nurse reported "I set off the arrest alarm, called the ambulance and waited at the unit doors to direct arriving staff assistance". It was clear that there had been rehearsed and familiar procedures in place, so that staff could act appropriately under extreme pressure. The availability of equipment during these times was also noted. Scissors were kept in a locked area (out of harms way for staff and patient safety) but not readily accessible when staff needed to cut down a patient who had hung himself. One has to balance the need for easy availability of emergency equipment wit the increased risk that ensues if equipment is dangerous itself, or is not locked away for security.

Post event reviews: Post event reviews by staff, critical incident risk managers and independent reviewers were sometimes conducted. These were without exception thoughtful expositions of the incident, were inclusive of staff and did not seek to apportion blame. The reviewers were particularly impressed with efforts of hospital staff in this regard. The review documents are useful instruments for learning about systemic factors and for changing or influencing those factors identified as causal or contributory. Particular mention is made of the branch point analysis and the critical incident report by South East Sydney Area Health Service (SESAHS) that addressed concerns and subsequently addressed the identified needs (Cases 889, 1964).

NSW Health policies and guidelines

Results and Discussion

Less impressive and complimentary were Coroners' findings with regard to Mental Health Services generally, and NSW Health in particular. Coroners made observations of the difficulty in effecting change to policies and procedures and raised concerns about the apparent reluctance to implement change. In one case, it was obvious that the Coroner was aware of the efforts of NSW Health and recommended that certain cases and issues be reviewed by the Committee.

The reviewers were similarly concerned about the time lag between when policies, procedures and guidelines are developed and when they are implemented. Circular 98/31 states that the "Development of model protocols will be facilitated by the Department of Health and will be available from the Centre for Mental Health as they are developed". Reviewers noted that a document called "Suicide risk assessment and management guidelines in relation to young people" was made available in 2003, but in Consultation Draft form only. This is a five year gap – clearly too long - with no

clear indication of implementation. Without a thorough review of policy and procedures, details of dates of development and implementation, the reviewers could not make absolute judgments about this performance. However based on the evidence available, the lack of timely support shown by the Department to hospitals with regard to provision of policies, procedural manuals and guidelines, is a serious concern. Allied to this is the allowance for 'local' policy development. Reviewers questioned whether a central responsibility for policy development would provide more uniform and better-understood protocols.

NSW Health should take immediate steps to improve the lead-time to circulation and implementation of polices and guidelines, and evaluate their impact. Local variability in the application of policy and procedures should be assessed. Area Health Services should ensure that resources are available to ensure policies are implemented and understood by staff on the ground, including agency staff.

Inquest transcript, Case 1809, 2002: "In the 37 years I've been associated with psychiatric hospitals there has never been a handover time." "I guess the practice has always been, for as long as I've been in the service, that you come in fifteen minutes before your shift starts."

Inquest transcript, Case 1809, 2002: "…we've always had a system whereby if a patient needed specialising, if we had a very disturbed patient, the staff could request additional staffing and that additional staff member would be allocated purely to special a disturbed person."

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Statement by Coroner, Case 2042, 2002: "… I did a very large number of deaths associated with James Fletcher Hospital, and despite an enormous number of problems, every recommendation that was made was simply ignored by the Director General of Health and the Minister. It became obvious that there was no point in me making recommendations as a result of everything I heard in Court, without consultation with the health people involved, because unless it was tailored to suit the situation, it was simply ignored".

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Family Involvement

Results

Dealing with family members and others involved in the patient's care was a factor in most cases. The reviewers noted that generally staff was responsive to family needs. They listened and noted reports about clues and intuition from family members. This was especially the case among nursing staff, but less noticeable among clinicians, who on one or two occasions either missed or disregarded information about the patient offered by family members (for example: Case 993).

Discussion

Where communication with family and other carers took place, it was generally done very well. However, there were significant concerns for cases where it was handled badly. The timeliness and notification of information from families may, in some cases, have provided an impetus for preventive action. The flow-on effect of not

dealing effectively with family, carers and other community services attracted interest and criticism from the media, from Coroners and police, and complaints and submissions from the family themselves. This is likely to have an impact on staff, their morale and the mental health service sector generally.

Unresolved in practice is the situation where privacy of the patient, and the wish of families to feed in important information, come into conflict. This matter is dealt with later.

Follow-up procedures

Results

Follow-up procedures for notifying family, significant others and the police were evident in most medical records where patients were AWOL. In one case, staff successfully searched for, found and returned the patient to the ward (Case 2221) within 20 minutes of noticing his absence, and without having to notify family or police. In almost all other cases, staff complied with guidelines and procedures in notifying family and police of absences, within recommended timeframes. For one patient however (Case1282), staff neglected to notify anyone of the patient's absence because they supposed that he 'had just gone home to feed his dogs'. This was indicative of the level of staff concern for this regular patient, because they had also failed to notify his family that he had even been admitted. Hence, his father was unsurprised to see the patient wandering around his (the father's) place of employment, and though 'baffled' as to why the patient would be there, did not think it was a cause for concern.

In one other case, follow-up procedures were enacted, but failed, because the medical record did not contain accurate address, notification or contact details for the patient. While police were searching for her using out of date details, she was taking her own life at her current home address (Case 1385).

Aggression/violence issues

Results

Dealing with highly aggressive patients was also noted as a significant management concern. While this was not a pervasive theme, Case 1809 demonstrates that dealing with highly aggressive and threatening patients present problems for staff and importantly, for other patients on the ward. The forensic psychiatrist consulted on admission for this patient, and consulted again during the Coroner's inquest, makes the point that no dedicated or suitable facilities exist for patients exhibiting this behaviour. Psychiatric facilities for patients who have already committed a crime are available at correctional facilities, but patients like Case 1809, who have not yet committed a crime of violence, cannot gain admission there. They are difficult to treat in usual mental health units, and so often do not receive optimum treatment.

Visitors

Results

Problems experienced with visitors who interfered with care delivery or exerted undue influence on patients, were noted by staff as significant factors in two cases (Cases 2042, 2328). In one case, the patient's cousin drove his car through the Mental Health Unit's doors to effect the "rescue" (or escape) of the patient (Case 2003). Visitors who frequently over-stayed visiting hours, or who were often on the ward also raised concerns. This was particularly so in Case 1107, who perhaps in concert with his visitors (or alone), was allegedly procuring drugs for himself and other patients.

Conclusions

The table below outlines the key systemic factors that were identified as a concern for each case. It is not claimed that these systemic factors played a causal role or contributed directly to the outcome. They do represent the issues and factors of care delivery that reviewers believed could be improved to the benefit of patient experiences.

Several distinct themes emerged from the consideration of systemic factors relevant to the 35 cases. The reviewers have concluded that these are identifiable systemic issues that may have influenced the outcomes for the 35 patients.

Table 27: Systemic factors identified as most relevant to each case

Systemic Factor	Number of Cases
Environment, including means and methods	
Access to means in hospital	11
Egress	9
Access to means outside hospital	7
Care Management	
Criteria for granting leave	6
Contracting	2
Criteria for observation level	2
Communication, documentation and follow up	
Problems with clinical responsibility, communication or follow up	5
Documentation problems	3
Admission and risk assessment	
Assessment problems on admission	3
Assessment problems for discharge or leave	4
Family involvement	
Poor communication with family	4
Visitors	
Problems with visitors	2

Patient Characteristics

Particular attention should be paid during assessments to risk factors demonstrated by these patients, which in this sample, included:

- History of mental illness, previous attempts and multiple co-morbidities (80% of these patients had one or more of these)
- Mental health diagnoses of schizophrenia, psychotic disorders, depression and personality disorders were clearly indicated as risk factors among this sample; over half had psychiatric co-morbidities
- Previous contact with police, DOCS, other community services was also obvious in approximately 60% of these patients
- Substance abuse (70% of patients demonstrated this feature).

While these "red flags" do not uniquely distinguish patients of high suicide risk, they are probably good indicators of the cases in which extra caution and vigilance is warranted. Other predictors of risk should also be considered, and the literature debates the relative value of some of these patient characteristics, in particular, anxiety.

Accordingly the Committee recommends that:

> If any 3 "red flags" are present at the time of admission, then a high risk category shall be assigned automatically to the patient, the patient admitted under schedule, placed immediately on high frequency observations and the mental health team alerted that a more detailed risk assessment is to be undertaken. This process should be operationalised by July 2004.
>
> The following "red flags" are identified as markers for heightened risk of self harm in mental health patients:
>
> - principal diagnosis of psychiatric disorder
> - previous history of self harm, or suicide attempts
> - suicidal ideation
> - showing evidence of substance use/abuse
> - known to police and/or other service groups in relation to impulsive or aggressive acts or behaviour.
>
> **Recommendation 3**

Further examination of the multi-specialty care of patients is warranted. Where medical or surgical patients have unexpected and emerging mental health illness during their episode of care, they are deserving of appropriate and timely assessment by mental health service staff. One case raised concerns about general ward staff ability to recognise and effectively deal with extreme postoperative confusion. The death of a person with a mental health problem is as significant as the death of a patient with a medical or surgical problem.

Accordingly the Committee recommends that:

> By July 2004, Area Health Services shall ensure that medical or surgical patients, especially elderly, post-operative and post-natal patients who are being cared for outside mental health units and in whom active mental health pathology is identified, are recognised as at risk of self harm and further appropriately assessed and managed in terms of established level of risk.
>
> **Recommendation 4**

The Committee discussed the problems arising from the barriers between mental health and substance use services and supported the call for the better integration of service provision, made in Recommendations 68 and 69 of the Select Committee on Mental Health Final Report, Mental Health Services in NSW (Select Committee Final Report).

The frequent interaction between mental illness and substance abuse requires that specialist services or specialised protocols that deal with dual diagnoses of mental illness and substance abuse should be developed and implemented.

Accordingly the Committee recommends that:

> By the end of 2004, NSW Health shall ensure that specialist services or specialised protocols that deal with dual diagnoses of mental illness and substance abuse are developed and distributed with a specific time frame for implementation and review. **Recommendation 24**

Environment, including means and methods, access to means in hospital, outside hospital, and egress

Inpatients: Further risk assessment audits of the physical environment appear warranted. Patients who died by suicide in hospital almost always did so by hanging themselves. Most other access to means (sharp objects, scissors, glass, access to drugs) have been effectively identified and nullified by hospital risk assessment audits.

Accordingly the Committee recommends that:

> By July 2004 Area Health Services shall have taken preventive action to remove potential hanging points from mental health facilities, especially in bathrooms, and will have implemented recommendations based on NSW Health audits of mental health facilities.
>
> **Recommendation 11**

Appropriateness of searching patients should also be investigated. At present it is not clear to some clinicians what their rights are in relation to searching patients and

removing items on admission to hospital. Coroners have commented that legal advice should be obtained as to the powers of search available to medical practitioners, clinicians and staff at a hospital of patients to be admitted to a psychiatric hospital for the person's own protection from serious harm or for the protection of others from serious harm. It is the view of the Committee that searching a patient on admission is sometimes necessary and should be permissible.

Accordingly the Committee recommends that:

> By July 2004 NSW Health shall obtain legal advice from the State Crown Solicitor or from another appropriate source as to the powers available to staff at a hospital to search and remove property of mental health patients admitted to hospital, and a protocol will be distributed to Area Health Services. If powers are considered inadequate, NSW Health shall commence consultation regarding the appropriate legislative changes needed to address this matter.
>
> **Recommendation 36,** and

> By July 2004 NSW Health shall obtain legal advice from the State Crown Solicitor or from another appropriate source as to the powers available to staff at a hospital to deal with visitors reasonably suspected of undermining or compromising treatment of a mental health patient and a protocol will be distributed to Area Health Services. If powers are considered inadequate, NSW Health will commence consultation regarding the appropriate legislative changes needed to address this matter.
>
> **Recommendation 37**

To avoid the possibility that patients will choose alternate means and methods of death (or take whatever means are most easily available to them), strategies for the removal of anchor or hanging points, the removal of means of self-harm and the improvement to security of psychiatric units should occur in parallel, within the context of providing a therapeutic environment.

AWOL: Access to means and methods of death is much greater for patients who are AWOL at the time of their death. The crucial issue here is whether mental health services can prevent such access to means by increasing the level of security. Egress here is particularly important and should be amenable to relatively straightforward security measures. However, care management protocols such as a preference for open wards, and a preference for allowing patients the least restrictive level of care also have some influence on matters of security and egress. Evidentially, those who are on less frequent observational levels and are accommodated in open wards have maximum opportunities for absconding.

The reviewers noted that while this issue appears to be relatively easy to solve with regard to the physical environment, the philosophical and routine daily care practices involved with providing optimum safety and security may prove less tractable.

The Committee considered this point carefully, looking at the two components of the Mental Health Act which deal with this matter. The Committee does not accept the view that voluntary patients cannot be accommodated in locked wards. For a start, many voluntary patients are accommodated now in locked units. Voluntary patients only have to ask for the door to be unlocked if they wish to leave. Second, many homes and public buildings are locked or have limited ingress and egress.

The Committee discussed at length the problems arising from lack of adequate hospital security, and was concerned by the incidence of patients who abscond from hospital care (AWOL). The Committee supported the call for Area Health Services to improve security arrangements at mental health units for the purposes of monitoring and managing mental health patients, in line with the strategy identified in Recommendation 102 of the Select Committee Final Report.

The Committee wants units housing people with mental health problems locked and accordingly recommends that:

> By July 2004, Area Health Services shall ensure that mental health units in which involuntary patients are cared for are secured.
>
> **Recommendation 10**

The Committee recognised that some involuntary patients are not high risk, and that security arrangements need to be commensurate with assessed risk.

Care management - observational levels, open or closed ward, granting leave and contracting

More cautious assessment and case management of high-risk patients may be warranted during the early days of their admission. The majority of patients in this sample died within the first five days of their admission. This has implications for:

- observational levels
- open or closed ward accommodation
- granting of leave, and
- contracting.

Notwithstanding the provisions of the Mental Health Act, Circular 98/31 and favoured ideological approaches to providing optimum care, the greatest risks and the worst outcomes, evidentially occur early in the patient episode. The reviewers concluded that more restrictive care in these circumstances might result in better outcomes for these high-risk patients. This is somewhat at odds with the received wisdom that patients are entitled to 'the least restrictive level of care'. Such a view, in any case, is an incomplete reading of the Mental Health Act.

Reviewers were concerned at the variability of what is meant by high risk and high frequency observation, and how these two systemic factors inter-played with decisions to provide accommodation on open wards or granting leave. Intuitively, and from a common sense point of view, it would seem contradictory that patients requiring frequent supervision should be afforded the least restrictive level of care.

High-risk patients might benefit from more conservative management in the early days of their admission. In some circumstances this may mean the imposition of higher frequency observation, closed ward accommodation and suspension of any consideration of leave – for the time being and subject to review.

Accordingly the Committee recommends that:

> By July 2004, Area Health Services shall ensure that the level of security of accommodation is commensurate with the level of assessed risk.
>
> **Recommendation 9**

The reviewers were of the view that leave granting seemed not be a systemic factor that deserves reform. Fifteen of these patients were granted leave at some stage during their episode of care; twelve successfully returned from leave, three patients died whilst on leave. Of all patients who were granted leave at some time during their episode, six subsequently died while AWOL, and six died while they were inpatients.

However reviewers emphasised caution in the granting of leave early in an episode of care for high-risk patients.

Reviewers did not suggest that a cautious and vigilant approach should be a default position. All risk factors and risk management protocols should be taken into account when assigning observational levels, open or closed ward accommodation and granting leave.

Accordingly the Committee recommends that:

> By July 2005 NSW Health shall develop statewide evidence based clinical guidelines and mandated behaviours pertaining to the admission of mental health patients assessed as being at risk of self -harm and/or violence to others. These will be developed in consultation with clinicians and consumers and will include consideration of
>
> - Levels of staffing
> - Levels of security of accommodation
> - Frequency of observation
> - Aspects of more restricted care in early days of admission, which may include no leave and supervised medication dosing
> - Timing of review and follow up arrangements
> - Post discharge supervision of medications until stable therapeutic levels of medication are considered achieved.
>
> **Recommendation 23,** and
>
> By April 2004, Area Health Services shall ensure that consensus is reached amongst the clinical team responsible for the care plan of the patient (or failing that, the provisions of Recommendation 26 would apply) and reasons documented before any decision is made to change the status of the patient under the Mental Health Act.
>
> **Recommendation 34**

Allied to this trend is the notable use of 'contracting' with patients. These contracts are not always formal, signed documents but care protocols and freedoms negotiated between staff and patients, if patients guarantee that they will (for instance):

- not take drugs while on leave
- return from leave if they feel anxious, and alert to staff to their concerns
- not do anything to harm themselves if their observational levels are decreased or they are granted leave.

The reviewers noted and largely supported contemporary thinking that encourages open communication and the development of trust between clinicians, staff and patients. However they were seriously concerned that the full complexity of patient risk factors did not seem to be considered fully. The evidence available did not support the conclusion that many (if any) of these 35 patients had a reasonable capacity to give such 'contracted' guarantees for their own safety. These patients were reliant on the better judgment of their treating clinicians and could not be expected to rely on their own judgment given the nature of their illness.

Communication, follow up and documentation

Inconsistent practices of communicating and documenting risk assessments, including periodic and regular reviews of patient progress and response to treatment were apparent. These assessments and reviews must be available to all staff involved in the delivery of care. They should be comprehensive, legible, contemporaneous and complete.

Accordingly the Committee recommends that:

> Effective immediately, Area Health Services shall ensure that the senior attending clinician shall be responsible for ensuring that the transfer of care of a mental health patient from one service to another should always occur with comprehensive communication to ensure adequacy of ongoing care and continuity of care. **Recommendation 16,** and
>
> By the end of 2004, Area Health Services shall ensure that initial care plans of mental health inpatients includes documentation of
>
> - the formal assessment process and management goals
> - the identity of the senior mental health clinician with primary responsibility for the patient's care
> - the identity of the clinical team
> - the identity of the patient care coordinator and
>
> the development of a time-limited management plan and a review date.
>
> **Recommendation 27**

However, this does not mean that more documentation is necessarily better documentation. Efficiencies and quality improvements are more likely to provide more benefit.

While the reviewers could not say that systemic factors of documentation and communication practice directly influenced patient outcome in this sample, they believed that it had a major impact on other systemic factors such as care management

protocols and case management decision-making. These alone are not likely to be causal factors, but they could be improved to assist in the co-ordination of care and to make the rationale for case management decisions clear and unambiguous. In this sample as many patients were poorly managed as were well managed. Reviewers believed that the review clearly demonstrated that documentation and its principal role as a communication tool plays a critical role in providing optimum case management.

The reviewers did not find evidence for the need for extra or additional documentation protocols. Rather, they considered that current practice could best be improved by streamlining existing practices, with a view to providing efficiency, clarity and predictability in documentation. They advised that the imposition of new or additional documentation protocols is likely to be counter-productive.

Accordingly the Committee recommends that:

> By July 2004, Area Health Services shall ensure that the requirements of MH-OAT protocols are met so that standards of documentation are improved, especially with regard to
>
> - the recording of critical information
> - the recording of handover information
> - information received from families
> - legibility and
> - consistency in the recording of author, position title, date, and times of observation.
>
> **Recommendation 19,** and
>
> By the end of 2004, Area Health Services shall ensure that preceding case records of patients presenting to Emergency Departments with a mental health problem are routinely available to the treating clinician at the time of assessment, so that re-presentations are recognised and included as part of the assessment.
>
> **Recommendation 20**

Risk Assessment

Assessment procedures were not uniformly implemented, obvious, and comparable across services and patients.

Accordingly the Committee recommends that:

> By the end of 2004, Area Health Services shall ensure that once acute mental health pathology is identified in any patient presenting to a health facility, consultation with the most senior mental health clinician occurs and involves a formal assessment as soon as possible, and not later than 24 hours of admission to inpatient care.
>
> **Recommendation 21**

Assessment protocols may well have improved with the advent of MH-OAT, and further investigation of its implementation and up-take should be undertaken to ensure its efficacy. (MH-OAT may already be solving some of the problematic systemic issues noted here).

It is the view of the Committee that every patient should receive a formal risk assessment using an accepted protocol and accordingly the Committee recommends that:

> By the end of 2004 NSW Health shall standardise and implement statewide risk management systems and processes, which will
>
> - include risk assessment tools for suicide and for violence to others
> - address dynamic factors such as the allocation of a responsible clinician and timing of reviews depending on need
> - be tested and evaluated by 2006. **Recommendation 1,** and
>
> NSW Health shall establish measures and processes to develop and implement by the end of 2004 statewide policy and procedures to govern risk assessments and risk management care plans for the following key points of the clinical pathway for mental health patients:
>
> - triage
> - admission
> - after critical events
> - at discharge
> - when the family or the community raise concerns
> - when the patient defaults on treatment, or follow up, or goes AWOL.
>
> **Recommendation 2**

Family involvement

The reviewers noted the frequency of concerns raised by family and significant others. These were usually about observation levels, leave granting, notification of AWOL and follow-up and the exchange of information about the patient between staff and family members.

The reviewers considered that although all patients in this sample were over 18 years of age and therefore considered independent adults, the concerns and worries of family could still be addressed more comprehensively and sensitively.

The Committee is aware that there can be a conflict between privacy obligations, duty of care obligations and family decisions to be involved in the patient's care. This needs to be addressed in the review of the Mental Health Act.

Accordingly the Committee recommends that:

> By July 2004, and consistent with the principles of child protection, Area Health Services shall ensure that all patients with active mental health pathology are asked basic questions about their children at assessment, discharge and follow-up, and their answers recorded. Questions will include, for example, the children's ages, where they are currently and how the patient is coping with them. **Recommendation 22,** and

The special discussion paper being drafted by the NSW Health Legal Branch in collaboration with the Centre for Mental Health for the forthcoming review of the Mental Health Act, should consider specifically the case of access by families to information under Mental Health Legislation, recognising privacy issues and the requirements of good clinical practice.

Recommendation 14, and

By April 2004, Area Health Services shall ensure that families and significant others, when recognised as active carers or guardians, are given enough information and support to allow them to participate effectively in the assessment process, care provision and supervision of the acutely ill person before admission, during admission and after discharge, despite the current privacy requirements of the Mental Health Act.

Recommendation 15, and

NSW Health shall ensure that the forthcoming review of the Mental Health Act in relation to privacy considers the importance of consultation with families, especially of patients assessed at high risk of self-harm or violence to others. **Recommendation 35**

"Determined to die"

In some cases, it may well be impossible to put in place sufficient measures to prevent inpatient suicide. While the reviewers did not discover any hard markers indicating such a phenomenon in these 35 cases, several cases are worth noting.

There were three examples where, though not predictable, the patients may well have been determined to take their own lives. Post hoc responses from family were the best indicators of these, and almost all these instances occurred in cases where the patient was elderly, was in substantial pain and had an unpromising prognosis. These three were all men aged over 70 and all had terminal diseases (various cancers). Family reports indicated that they were 'sick of the pain', had expressed hopelessness about their recovery and health prospects and were worried about being a burden on family and carers.

Another possible example was a mental health patient who seemed to exhibit a consistent wish to die. She had made four separate attempts while in care, all of them occurring while she was on high frequency observations and accommodated on closed ward. Her fifth, and ultimately successful attempt, came days after she was reassessed and her observation frequency was decreased.

Epilogue

The reviewers noted that it is likely that the 35 patients do not represent unique and distinctive characteristics that differentiate them from other patients who encounter the mental health service. They noted that the systemic factors that showed a strong trend within this sample of patients may actually provide efficacious case management for the great majority of patients. The reviewers stressed cautious action with due regard for the nature of these conclusions which represent at best, correlations between systemic factors important to these 35 cases, but may not necessarily represent identifiable causal factors that impact the care of all mental health patients.

HOMICIDE

REPORT OF ANALYSIS OF CASE REVIEWS

The Sub-Committee reviewed seven cases of homicides perpetrated by mentally ill persons in NSW between June 1999 and October 2003. These cases had been subject to prior Critical Incident Reviews based on patient files and summaries of clinical history, staff interviews, reviews of related documents and reports to commissioning area health services.

The Committee commissioned an analysis of its own review in order to explain the possible or probable influence of systemic factors in each of these events and to determine whether there were any discernible trends in the sample cases that point to the need for specific reforms. Although the cohort analysed is small, the Committee suspects strongly that the systemic failures exposed are representative of those which occur in other such cases.

Demographics

The analysis revealed that all of the assailants were adult males. Five were in a committed relationship and two were single at the time of the events.

All had an Axis I diagnosis of psychosis or mood disorder. One of the seven had a head injury and two were actively engaging in substance abuse. In all but one case the victims were adults. In one case the victim was an 8 year-old child. In five cases the victim was female, in one case male and one case was unknown. In four of the cases the victim was a family member, two of whom were the assailants' wives, one a stepdaughter and one an older sister. Two cases involved co-patients in an inpatient setting and one was an acquaintance of the victim's wife.

Four of the homicides occurred in what could be regarded as rural settings and three within an urban setting. Three of the homicides occurred at Gosford between January 2000 and May 2001.

Two of the homicides reviewed occurred while the assailant was an inpatient within the psychiatric hospital and five occurred while the patient was in the community being followed up by Mental Health Services. The homicides occurred between two hours and two months ten days of last clinical contact. Five of the assailants had a prior history of psychiatric illness. The Committee is aware that there may well be mentally ill people not in contact with the mental health system who perpetrated homicides.

Risk Factors

The analysis of the case records identified risk factors that were associated with the assailant. These included:

Static factors (factors that denote baseline risk):

- Male patients
- Threats to family members
- History of violence prior to admission
- Recent history of violence
- Prior history of aggressive behaviour to family members about whom the individual has psychotic beliefs
- Prior suicide attempts
- Involvement of police
- Breaches of Apprehended Violence Orders (AVOs)

Dynamic factors (factors that could potentially have been ameliorated with clinical intervention):

- Active symptoms of psychosis
- Major depressive disorder
- Substance abuse
- Incorporation of family members (eventual victims) into the delusional system
- Deteriorating mental state
- Suicidal ideation
- Significant psychosocial stressors and losses
- Hopelessness
- Sexual dis-inhibition and inappropriate behaviours
- Poor adherence to follow up
- Non-compliance to medication
- Poor insight
- AWOL
- Access to lethal weapons such as guns
- Proximity to victims
- Impulsivity and aggression, anger
- Intra-familial conflict
- Poor response to treatment
- Access to victim
- Minimisation of symptoms
- Potential victims are intimidated and voice concern.

The Committee discussed the problems arising from the barriers between mental health and substance use services and supported the call for the better integration of service provision, made in Recommendations 68 and 69 of the Select Committee Final Report.

Accordingly the Committee recommends that:

> By the end of 2004, NSW Health shall ensure that specialist services or specialised protocols that deal with dual diagnoses of mental illness and substance abuse are developed and distributed with a specific time frame for implementation and review. **Recommendation 24,** and

If any 3 "red flags" are present at the time of admission, then a high risk category shall be assigned automatically to the patient, the patient admitted under schedule, placed immediately on high frequency observations and the mental health team alerted that a more detailed risk assessment is to be undertaken. This process should be operationalised by July 2004.

The following "red flags" are identified as markers for heightened risk of violence towards others in mental health patients:

- principal diagnosis of psychiatric disorder
- previous history of violence towards others
- known to police and/or other service groups in relation to impulsive or aggressive acts or behaviour and/or antisocial behaviours
- showing evidence of substance use/abuse. **Recommendation 3**

Systemic Issues

Policies and Procedures

There did not appear to be any clear policy that defines sentinel and high-risk situations for clinicians. There did not appear to be any clear procedure that outlines the minimum clinical response required in the context of high risk and crisis events.

Accountabilities and responsibilities in relation to consultants' and registrars' clinical involvement did not appear to be well defined.

There did not appear to be mandatory training in risk assessment and management for clinicians in NSW.

There did not appear to be any clear standardised consensus as to which clinical incidents require review.

Frequently prior psychiatric history and other relevant information that pertains to risk were not available to the assessing clinician.

Often there was no identified responsible psychiatrist and case manager to coordinate management, make key decisions, centralise information and communicate management plans and concerns about risks.

The Committee believes that such deficiencies require a response, and recommends accordingly that:

By the end of 2004, Area Health Services shall ensure that initial care plans of mental health inpatients includes documentation of

- the formal assessment process and management goals
- the identity of the senior mental health clinician with primary responsibility for the patient's care
- the identity of the clinical team
- the identity of the patient care coordinator and
- the development of a time-limited management plan and a review date.

Recommendation 27

An absence of local protocols for risk assessment and the production of a risk management plan were frequently evident.

There did not appear to be protocols for management of outpatients who default or become default to treatment.

There was frequent failure to consult the Area Director of Mental Health in crisis situations.

There was at times an absence of proper communication when patients with significant mental health problems were in non-psychiatric wards.

Accordingly the Committee recommends that:

> Effective immediately, NSW Health high-risk psychiatric patients should not be managed in a non-psychiatric ward without prior consultation with the Area Clinical Director of Mental Health. **Recommendation 18,** and
>
> By July 2004, Area Health Services shall ensure that any Emergency Department assessment identifying active mental health pathology will involve consultation with a member of the mental health team, which includes the patient's GP-VMO in a rural setting, and, if high risk, a psychiatrist. **Recommendation 5,** and
>
> By July 2004, Area Health Services shall ensure that, with assistance from NSW Health, a protocol is developed and implemented where in the case of any unresolved conflict amongst the members of the clinical team responsible for the care plan of the patient, another opinion is sought from an experienced mental health clinician. If the conflict remains unresolved, the matter will be referred to a higher authority, such as the Area Clinical Director of Mental Health. The operation of this protocol will be evaluated by 2006.
>
> **Recommendation 26**

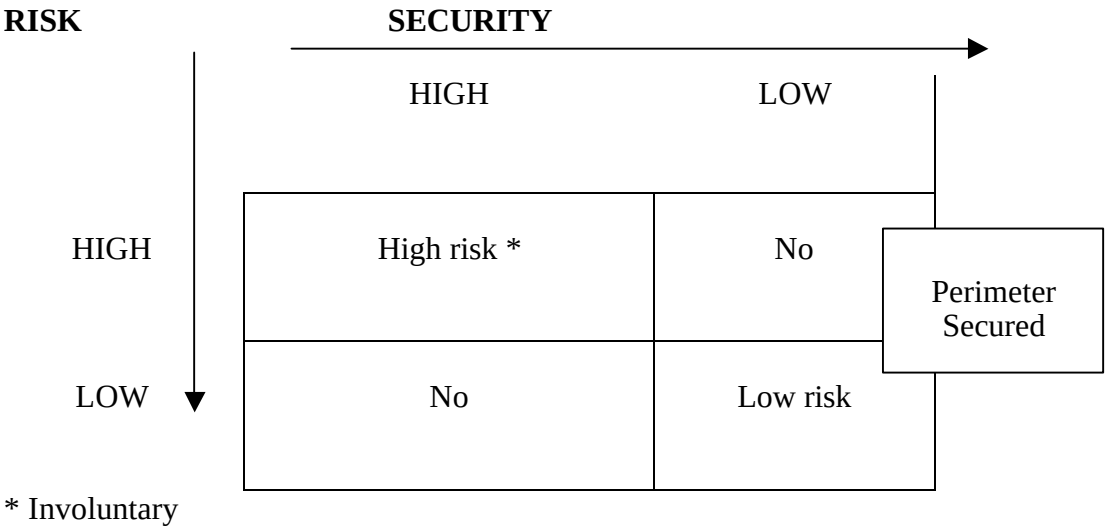
Environment and Resources

For good risk management, the level of security should be commensurate with the risk assessed. High-risk patients were sometimes managed in non-psychiatric wards and Emergency Departments. Accommodation with a range of security level is required to accommodate patients at high, medium or low assessed risk. Security of accommodation ranges from locked or secure ward, to secure perimeter, to open ward, as shown in Figure A. Patients should be accommodated appropriately.

Accordingly the Committee recommends that:

> By July 2004, Area Health Services shall ensure that the level of security of accommodation is commensurate with the level of assessed risk.
>
> **Recommendation 9,** and
>
> By July 2004, Area Health Services shall ensure that mental health units in which involuntary patients are cared for are secured.
>
> **Recommendation 10**

Figure A.

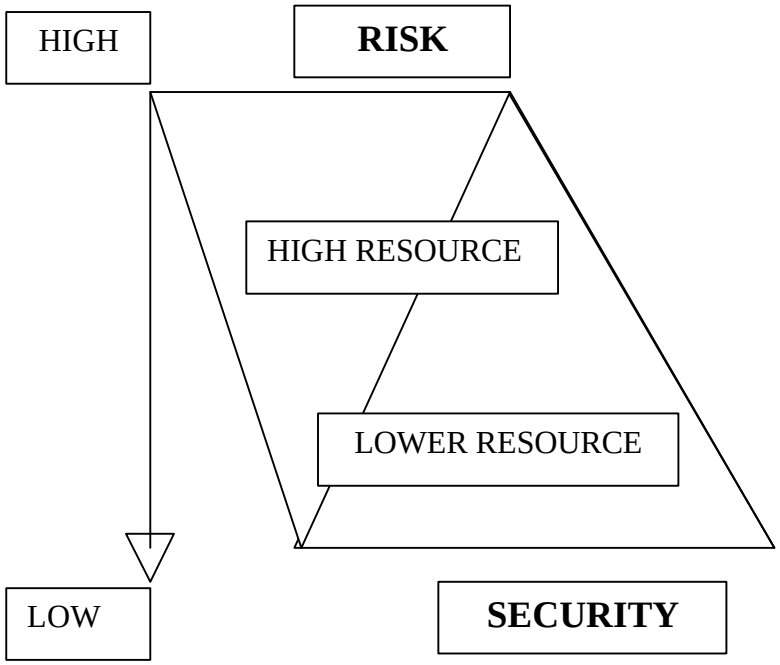


The Committee recognised that some involuntary patients are not high risk and that security arrangements need to be commensurate with level of assessed risk.

The Committee discussed at length the problems arising from lack of adequate hospital security, and was concerned by the incidence of patients who abscond from hospital care (AWOL). The Committee supported the call for Area Health Services to improve security arrangements at mental health units for the purposes of monitoring and managing mental health patients, in line with the strategy identified in Recommendation 102 of the Select Committee Final Report.

Security is often a resource issue, and environments need to have resources commensurate with the level of risk, as shown in Figure B.

Figure B



The Centre for Mental Health, in the Final Report and Recommendations of the Working Group for Mental Health Care in Emergency Departments recommended that NSW Health should ensure that any building or refurbishment of Emergency Departments should involve consultation on design issues with local Mental Health Services and consumers, and reference to the relevant guidelines of the Australian College of Emergency Medicine Standards sub-committee which has responsibility for Emergency Department design (Recommendation 9). This does not appear to have been implemented.

The Committee supports this recommendation, and accordingly recommends that:

> NSW Health shall ensure that by no later than 2007, appropriate environments and resources are provided within Emergency Departments to enable appropriate mental health assessments to be undertaken, as required in the Emergency Department Report 1998, Recommendation 9.
>
> **Recommendation 12,** and
>
> By the end of 2004, the Director, Centre for Mental Health shall sign off Health Building Guidelines for Emergency Departments and any proposed alterations or redevelopment plans for Emergency Departments, to ensure that they are able to deal adequately with the management of mental health patients. **Recommendation 13**

At critical times, especially in rural settings, there was inadequate access to qualified and experienced senior psychiatric staff.

Accordingly the Committee recommends that:

> By July 2005, to assist health services to provide safe and adequate care, NSW Health shall develop and distribute a guide to safe staffing levels as these relate to the outcomes of risk assessment and the level of staffing required to manage those risks. **Recommendation. 6,** and
>
> Effective immediately, NSW Health shall ensure that high-risk psychiatric patients should not be managed in a non-psychiatric ward without prior consultation with the Area Clinical Director of Mental Health.
>
> **Recommendation. 18**

See also Clinical Issues, p.68

Resource limitations were often cited by clinical staff as contributing to clinical decision making. The Committee is aware that medication takes several days to take effect and is concerned if bed shortages influence decisions about early discharge before time to active medication.

Accordingly the Committee recommends that:

> High priority should be given to providing additional budget necessary to implementing the recommendations in this report. **Recommendation 52**

Communication

At critical times, especially in rural settings, there were unclear communication protocols to access specialist consultation in an emergency situation. There are usually psychiatrists on call but there was evidence that they were not always called. Further, psychiatrists on call must perform the duties for which they are remunerated and junior staff must have no qualms about seeking their help.

Communication with outside agencies such as Department of Community Services (DOCS) was inadequate and was not assertively followed up when it was clear that the external agencies were failing in their response. The events that occurred in Gosford, which led to the death of a child because of failure of DOCS to respond to repeated requests for help were particularly distressing. Those events represented a failure of process in which a child died.

Sometimes there were conflicting opinions between members of the clinical team responsible for the care plan of the patient.

At times there were conflicting opinions between clinical teams and family members about the patient. Also, there was a failure to listen to families, and difficulties arose when the patient insisted that their families were not to be contacted. In such situations one had to balance the right of adult patients to make decisions, with the needs of families to have, and give, information about the person.

Documentation was inadequate and did not communicate the issues clearly. It was clear that standards of documentation were often poor. Critical information and instructions in the medical record should be noted and used by all involved in the care of the patient. Since the medical record might be the main record of substance available in any homicide, this inadequacy is not good enough and improvement is required urgently.

When a case manager was allocated there was inadequate communication between case managers and those taking over the care of the patients.

There did not appear to be standardised communication pathways between clinicians and there did not appear to be standardised communication protocols in relation to the transfer of care.

Accordingly the Committee recommends that:

> By July 2004, Area Health Services shall ensure that, with assistance from NSW Health, a protocol is developed and implemented where in the case of any unresolved conflict amongst the members of the clinical team responsible for the care plan of the patient, another opinion is sought from an experienced mental health clinician. If the conflict remains unresolved, the matter will be referred to a higher authority, such as the Area Clinical Director of Mental Health. The operation of this protocol will be evaluated by 2006. **Recommendation 26**, and
>
> Effective immediately, Area Health Services shall ensure that the senior attending clinician shall be responsible for ensuring that the transfer of care of a mental health patient from one service to another should always occur with comprehensive communication to ensure adequacy of ongoing care and continuity of care. **Recommendation 16,** and

By the end of 2004 NSW Health shall ensure that there is agreement within the Human Services Chief Executive Officers Forum that processes are put in place such that where there is an escalation in risk protocol, appropriate responses are made between agencies and communicated orally and in writing.

Recommendation 17, and

By July 2004, Area Health Services shall ensure that the requirements of MH-OAT protocols are met so that standards of documentation are improved, especially with regard to

- the recording of critical information
- the recording of handover information
- information received from families
- legibility and
- consistency in the recording of author, position title, date, and times of observation.

Recommendation 19, and

By the end of 2004, Area Health Services shall ensure that preceding case records of patients presenting to Emergency Departments with a mental health problem are routinely available to the treating clinician at the time of assessment, so that re-presentations are recognised and included as part of the assessment.

Recommendation 20

There did not appear to be standardised communication pathways between mental health services and outside agencies. Clear pathways need to be in place to ensure that appropriate responses between agencies occur, commensurate with the identified level of risk.

Clinical Issues

While the Committee has no wish to interfere unreasonably with the valuable function performed by bodies which train mental health staff, it wishes to draw attention to matters of relevance raised in the report which should be considered by training authorities. They include risk assessment and management, clinical practice and care, clinical staff and application of the Mental Health Act

Risk Assessment and Management
There does not appear to be any available risk assessment tool to assist clinicians in the assessment of risk.

NSW Health should undertake research to develop and validate a risk assessment tool to identify and quantify the risk of assessed mental health patients becoming violent in the month following assessment. Once a satisfactory instrument is developed, it should be made available electronically to all NSW Mental Health staff.

In this small cohort there appeared to have been poor understanding of risk factors that predict violence to others.

It is the view of the Committee that every patient should receive a formal risk assessment using an accepted protocol and accordingly the Committee recommends that:

By the end of 2004 NSW Health shall standardise and implement statewide risk management systems and processes, which will

- include risk assessment tools for suicide and for violence to others
- address dynamic factors such as the allocation of a responsible clinician and timing of reviews depending on need
- be tested and evaluated by 2006. **Recommendation 1**

There appeared to be a lack of understanding of the concept that past behaviour predicts future behaviour. Assessments were generally cross sectional without taking into consideration prior history and prior high-risk behaviour in the presence of a recurring episode of mental illness. There was a tendency to rely on information of the 'here and now'.

There was a failure to appreciate that non-compliance, default and AWOL could be markers for increased risk.

There was little evident consideration of risk for violence to others in cases where patients defaulted on treatment, and there was no assertive response to manage possible risk.

Accordingly the Committee recommends that:

NSW Health shall establish measures and processes to develop and implement by the end of 2004 statewide policy and procedures to govern risk assessments and risk management care plans for the following key points of the clinical pathway for mental health patients:

- triage
- admission
- after critical events
- at discharge
- when the family or the community raise concerns
- when the patient defaults on treatment, or follow up, or goes AWOL.

Recommendation 2, and

Effective immediately, Area Health Services shall ensure that if a patient goes AWOL or defaults on treatment, a determination of risk level by the clinical team responsible for the care of the patient occurs. **Recommendation 30**

Across the board, risk assessments were poor. In this small cohort there was no longitudinal review. When there was consideration of risk, no action was taken to reduce the risk.

Frequently, limited but inadequate risk management plans were developed. When contingency risk management plans were required in circumstances where an increase in risk was foreseeable, they were frequently inadequate.

Accordingly the Committee recommends that:

> By the end of 2004, Area Health Services shall ensure that initial care plans of mental health inpatients includes documentation of
> - the formal assessment process and management goals
> - the identity of the senior mental health clinician with primary responsibility for the patient's care
> - the identity of the clinical team
> - the identity of the patient care coordinator and
> - the development of a time-limited management plan and a review date.
>
> **Recommendation 27**

Too much reliance tended to be placed on the patient's family to protect the people at potential risk of violence and there was too little response from the mental health service to implement protective measures.

Of concern were the findings that suicidal and homicidal patients were sometimes discharged when clinicians had knowledge, or should have had knowledge, that they had access to weapons.

Accordingly, the Committee recommends that:

> By April 2004, Area Health Services shall ensure that high risk mental health patients will not be discharged subsequently, if it is known that they have access to firearms, until police have acknowledged that the firearms have been removed from the patient's access.
>
> **Recommendation 29**

Clinical Practice and Care

There was sometimes a failure by clinical staff to recognise that they were, with certain people with mental illness, in a high-risk situation that needed consultant input.

Frequently psychiatric consultation when it did occur was many days after initial contact with the patient. The Committee believes that early psychiatric consultation might be important sometimes, and should occur.

Accordingly the Committee recommends that:

> By the end of 2004, Area Health Services shall ensure that once acute mental health pathology is identified in any patient presenting to a health facility, consultation with the most senior mental health clinician occurs and involves a formal assessment as soon as possible, and not later than 24 hours of admission to inpatient care.
>
> **Recommendation 21**

Co-ordination of care and follow up was often dislocated and disconnected. It was apparent that the designation of a responsible psychiatrist and a "key worker", responsible for tracking the patient's care, is not standard practice. Key workers are formally identified as having primary responsibility for coordinating care, communicating with external agencies and assimilating information about the patient.

Accordingly the Committee recommends that:

> By the end of 2004, Area Health Services shall ensure that initial care plans of mental health inpatients includes documentation of
>
> - the formal assessment process and management goals
> - the identity of the senior mental health clinician with primary responsibility for the patient's care
> - the identity of the clinical team
> - the identity of the patient care coordinator and
> - the development of a time-limited management plan and a review date.
>
> **Recommendation 27**

Often psychiatric and registrar assessments were of brief duration and questionable quality.

Inadequate assessments resulted in inadequate information communicated to the consultants when consultation did occur.

Reviews by the clinical team occurred rarely and almost never at critical times.

The availability of video conferencing facilities needs to be increased to enable psychiatrists in rural centers to access metropolitan psychiatrists for face to face interviews at short notice.

Accordingly the Committee recommends that:

> By the end of 2004, NSW Health shall ensure the availability of video conferencing facilities to enable rural centres to access at short notice metropolitan psychiatrists and other specialist mental health staff for face-to-face interviews within their clinical network. **Recommendation 33**

Some patients were discharged from care with little to no evidence of change in either clinical or risk status. Their discharge had more to do with pressure for the bed than with any improvement in their clinical status.

Some patients were discharged from care without any face-to-face contact with a consultant psychiatrist.

There is a tendency to discharge patients who default on community follow-ups without consultation with the clinical team and without psychiatric input.

Accordingly the Committee recommends that:

> By July 2005 NSW Health shall develop statewide evidence based clinical guidelines and mandated behaviours pertaining to the admission of mental health patients assessed as being at risk of self -harm and/or violence to others. These will be developed in consultation with clinicians and consumers and will include consideration of
>
> - levels of staffing
> - levels of security of accommodation
> - frequency of observation
> - aspects of more restricted care in early days of admission, which may include no leave and supervised medication dosing
> - timing of review and follow up arrangements
> - post discharge supervision of medications until stable therapeutic levels of medication are considered achieved. **Recommendation 23,** and
>
> From July 2004, Area Health Services shall ensure that in relation to high risk patients, when one of the following events occurs or is being considered:
>
> - major change in the level of care or supervision
> - discharge
> - follow-up
> - AWOL
> - no show
> - non-compliance
>
> the senior mental health medical officer responsible for the patient is consulted and a formal reassessment made. **Recommendation 25,** and
>
> By April 2004, Area Health Services shall ensure that high risk mental health patients will not be discharged subsequently, if it is known that they have access to firearms, until police have acknowledged that the firearms have been removed from the patient's access. **Recommendation 29,** and
>
> By the end of 2004, Area Health Services shall ensure that discharge procedures for inpatient units routinely include:
>
> - formal discharge plan covering conditions of discharge and any supports required
> - nominated carer
> - nominated clinician providing ongoing care
> - formal arrangements for follow up review
> - face to face communication (including video conferencing)
> - a package of written advice for the patient and the nominated carer
>
> and take into account the issues raised in Recommendation 22.
>
> **Recommendation 31**

Telephonic contact with the patient was utilised frequently which suggests that this may be regarded as an acceptable method of assessment, which it is not. Face to face communication is to be regarded as standard practice and telephonic communication is the last choice option.

The Committee discussed the problems arising from poor discharge planning, liaison between services and follow up care and supported the call for improved discharge planning, in line with Recommendations 87 and 88 of the Select Committee Final Report.

Overall, there was inadequate involvement of families even when they pursued involvement themselves and communicated concern.

Frequently the family was not included in discharge planning and follow up. There should be recognition that family members are the most likely individuals within the community to suffer violence at the hands of mentally ill persons. Families therefore need to be involved in discharge.

Accordingly the Committee recommends that:

> By April 2004, Area Health Services shall ensure that families and significant others, when recognised as active carers or guardians are given enough information and support to allow them to participate effectively in the assessment process, care provision and supervision of the acutely ill person before admission, during admission and after discharge, despite the current privacy requirements of the Mental Health Act. **Recommendation 15**

It must be appreciated by clinicians that people at risk of being harmed, even though aware of threats, tend to minimize or deny or be naive about the risks that they may be under. Psychiatrists should not expect members of the community to appreciate the relationship between mental illness and violence.

Accordingly the Committee recommends that:

> Effective immediately, Area Health Services shall ensure that if there is concern about a person at risk of harm from a mental health patient, or if there is evidence that the patient has identified a particular person at such risk, then clinicians must take reasonable steps to mitigate the risk, including taking steps to ensure that such persons are advised and that appropriate authorities with responsibility for protection are so advised. **Recommendation 28**

Forensic psychiatric opinion was never sought in the sample analysed. If certain "red flags" are present and the risk of violence therefore considered high, forensic opinion should be sought and for such cases forensic psychiatrists should be available. The Committee discussed the problems arising from insufficient forensic services and supported the call for increased funding to employ additional psychiatrists to meet the need for increased forensic mental health assessment, consultation and treatment, in line with Recommendation 107 of the Select Committee Final Report.

Accordingly the Committee recommends that:

> By the end of 2004, a proposal for a community forensic mental health service shall be developed and will include services for forensic patients released into the community and a consultancy service to community mental health teams.
> **Recommendation 7,** and
>
> From July 2004 NSW Health shall ensure that specialist forensic psychiatric services to provide specialist consultation, advice and clinical care when required, in complex cases involving risk of violence to others are available 24 hours a day, seven days per week, statewide. **Recommendation 8**

Clinical Staff

On at least one occasion when non-psychiatric trained medical personnel requested urgent assessment, there was reluctance on the part of Mental Health Services to respond.

There was an over-reliance on junior psychiatric registrars and untrained Medical Officers to make difficult decisions with limited resources in complex circumstances, throughout the assessment, admission, discharge and follow-up process. Often they seemed to have limited expert backup.

Those with the least expertise in assessment of mental illness and risk, medical officers and junior registrars, conducted risk assessments at the coalface in Emergency Departments. Generally, there appeared to be a mis-match between the numbers and level of expertise of staff, and need.

Accordingly the Committee recommends that:

> By July 2005, to assist health services to provide safe and adequate care, NSW Health shall develop and distribute a guide to safe staffing levels as these relate to the outcomes of risk assessment and the level of staffing required to manage those risks.
> **Recommendation 6**

Application of the Mental Health Act

The decision to schedule under the Mental Health Act was frequently not taken when there were clear criteria to apply it, and when instigated, the Mental Health Act was frequently enacted at a later rather than an earlier stage, often later that indicated.

Accordingly the Committee recommends that:

> By April 2004, Area Health Services shall ensure that consensus is reached amongst the clinical team responsible for the care plan of the patient (or failing that, the provisions of Recommendation 26 would apply) and reasons documented before any decision is made to change the status of the patient under the Mental Health Act.
> **Recommendation 34**

Mental Health Act assessments, when made, were frequently cross sectional with a failure to seek collateral information and/or background clinical history.

In the sample reviewed, Community Treatment Orders (CTOs) were not considered even though there was clear evidence of ongoing risk after discharge.

There was a tendency to rely on Apprehended Violence Orders (AVOs) as an adequate risk intervention strategy in those with mental illness. AVOs should never be relied on in lieu of the application of the Mental Health Act as an adequate risk intervention strategy for people with mental illness who are at risk of committing violence towards others. Put simply, an AVO does not prevent violence - it apportions blame. Admission to a secure Unit using the Mental Health Act does prevent violence.

As previously stated, the Committee is aware that there can be a conflict between privacy obligations, duty of care obligations and family decisions to be involved in the patient's care. This needs to be addressed in the review of the Mental Health Act

Accordingly the Committee recommends that:

> The special discussion paper being drafted by the NSW Health Legal Branch in collaboration with the Centre for Mental Health for the forthcoming review of the Mental Health Act, should consider specifically the case of access by families to information under Mental Health Legislation, recognising privacy issues and the requirements of good clinical practice. **Recommendation 14,** and
>
> NSW Health shall ensure that the forthcoming review of the Mental Health Act in relation to privacy will consider the importance of consultation with families, especially of patients assessed at high risk of self-harm or violence to others.
>
> **Recommendation 35**

CORONER'S RECOMMENDATIONS

REPORT OF THE SUB-COMMITTEE

Introduction

The Coroner's Sub-Committee examined and considered the recommendations made by NSW Coroners in relation to deaths falling under the Committee's terms of reference. The Sub-Committee examined recommendations flowing from inquests during 2001 and 2002.

Discussion

There are in excess of one hundred Coroners throughout NSW and from time to time individual Coroners are called upon to inquire into the death of a person who may fall within the interest of the Committee. That is, a person under treatment for a psychiatric illness whom the Coroner subsequently determines died by suicide. The Sub-Committee also examined the Coronial recommendations where the death of a person was determined by the Coroner to have been brought about by a person with a psychiatric illness.

During the period under consideration (2001-2002) there were sixteen deaths that were the subject of subsequent Coronial recommendations. These included nine suicide deaths, one death caused by another person and six where the details of the cause of death were not stated.

- 2 deaths were from falls from high structures.
- 2 from gunshot wounds.
- 6 from hanging.
- 1 from multiple drug toxicity.
- 1 from multiple causes.
- 4 unspecified.

Where a Coroner determines a finding in any matter, he/she may make recommendations to or about individuals and/or organisations. When a recommendation is made in a matter involving a person with a psychiatric illness, the recommendation is forwarded to the NSW Centre for Mental Health where a response is prepared and appropriate action taken. The response is forwarded to the recommending Coroner.

Overall, 64 recommendations were made and while the average number of recommendations per case was four, the range was from one to twelve. Some of the recommendations provided quite specific guidelines while others were very general and seven were duplicates.

Recommendations were made to 13 different bodies during the period. Forty recommendations did not specify a person or organisation to be responsible for follow up. The Centre for Mental Health assigned lead officers to pursue any remedial action

necessary. The types of action required by the recommendations could be categorised as follows.

• Establish new services or extra funding for current services	6
• Review systems or safety	9
• Review or develop guidelines/protocols	15
• Implement new resources or training	11
• Improve management of patient files	3
• Improve management of patients	14
• Conduct research	3
• Send reports to a specified organisations	3
Total	**64**

The Sub-Committee examined Coroner's recommendations over the past two years along with NSW Health's responses. The Sub-Committee also discussed relevant issues and met with a senior officer from the Office of the Coroner. A number of central issues emerged and occupied the Sub Committee's focus. These central issues were threefold:

1. How to ensure the development of a closer working relationship between Coroners and Mental Health Services.
2. How to ensure Coronial recommendations are implemented at the coalface.
3. How to ensure that research priority is given to recurring themes raised in recommendations, particularly in the area of personality disorder.

As might be expected, Coronial recommendations were varied. However, certain recurring themes did emerge. These were:

- The need for bereavement support for the family and friends of victims
- Suicide prevention training
- Systems review
- Development of clinical manuals
- Reviews of protocol
- A more assertive approach to research into the understanding and treatment of persons with borderline personality disorder.

Examining Coroner's recommendations from the past two years, the Sub-Committee was aware that some recommendations were either:

- Beyond the scope or authority of local services. For example, *"That a review of the DSM diagnostic criteria for Borderline Personality and the current overlapping with other diagnosis be undertaken."* Or,
- Beyond the scope of available resources within the near future. For example, *"That a dedicated mental health centre for excellence for children and adolescence be established for XXX to meet the specific needs of the XXX community."* Or,

- Offered in isolation to the wider context of service delivery. For example, *"That the amendments to the XXX Area Health Service Manual be implemented throughout the state."* Or,
- Suggesting services already in place. For example, *"That resources and training in grief counselling be made available to local Area Health Services."*

Conclusions

Closer working relationship

To ensure best value is achieved from the valuable observations of the Coroner, the Sub-Committee was of the opinion that a closer working relationship between the Coroner's Office and Mental Health Services should be developed particularly when a Coroner may be considering making recommendations. The Sub-Committee was advised that Coroners would welcome submissions by NSW Health in matters being heard and would not be compromised in their independence by discussions with NSW Health about intended recommendations where such discussions assisted the likelihood of more effective and helpful recommendations being made.

Accordingly the Committee recommends that:

> By July 2004, NSW Health shall establish procedures to ensure bi-annual meetings take place between the Coroners Office and the Centre for Mental Health to ensure a closer working relationship.
>
> **Recommendation 48**

Register of authorised persons

The Sub-Committee considered that a register of 'authorised persons' located throughout the state be made available to the Coroner's Office. These 'authorised persons' could be consulted in relation to understanding clinical and/or service delivery systems where such understanding would assist the Coroner in his or her deliberations.

Accordingly the Committee recommends that:

> By July 2004 NSW Health shall make available to the Coroner's office a register of persons from across the State's mental health services authorised to facilitate timely and effective consultation during and following relevant Coronial hearings.
>
> **Recommendation 49**

Tracking the pathway of Coroner's Recommendations

The Sub-Committee was conscious that Coronial recommendations may dilute between being recommended and implemented at the coalface. Further, there needed to be some process by which broad dissemination of system-wide relevant recommendations occurred. It was acknowledged that 'many a slip between recommendation and implementation' was possible in a large and complex system.

Such shortcomings may well be the result of resource deficiencies, human error, communication difficulties, service demands, management problems, etc.

The Sub-Committee was of the opinion that a detailed investigation should be carried out into the pathways followed by recommendations to determine where barriers were encountered, with a view to system adjustment. Such an exercise would discover how such recommendations travel through the system toward dissemination and implementation. This journey could also be tracked in terms of feedback to the recommending Coroner.

Accordingly the Committee recommends that:

> By July 2005 NSW Health shall track Coroners' recommendations to enable the Centre for Mental Health to monitor their implementation and identify any barriers to implementation, to allow correction of those barriers.
>
> **Recommendation 50**

Research into personality disorder

Given the relationship between certain personality disorders and self-harming behaviours and the frequent involvement of the Coroners Office in such cases, strong recommendations are made to increase the research effort into such disorders, particularly Borderline Personality Disorder.

The Sub-Committee was aware of some limited research efforts in this area, notably in Sydney and Newcastle, and also of the struggle for research funding to support these and other research efforts. It was felt that given the prominence of these disorders and the regularity of mention in matters of interest to Coroners and the Sub-Committee, considerable effort to support research in the domain was essential. Further, it was considered that cooperation between the Coroner's Office and endorsed researchers, particularly by way of detailed examination of inquiry transcripts similar to work undertaken in the UK, could be fruitful.

ADDITIONAL MATTERS CONSIDERED BY THE COMMITTEE

Rapid Response to Suicide Death or Homicide

The Committee considered the process of responding rapidly to suicide death or homicide. It proposed that the process should consist of an immediate review of the event, including an environmental review, and in the case of a possible suicide death, liaison with the family of the deceased person to offer assistance and support and to make an appropriate expression regret.

In the case of a homicide, the Area Health Service should conduct the reviews within the requirements of initial Police investigations, and should express sympathy to the family of the assailant and the victim's family, if the victim was a patient in care or known to the service. The Area Health Service should offer to refer the victim's family to an appropriate organisation, such as the Homicide Victims Support Group.

The Area Health Service, after consultation with Police, should if appropriate offer the assailant's family referral to an independent support and counselling service with the necessary skills and experience.

People often simply want an explanation and an expression of regret or sympathy for what happened to them or their loved one. If these are not available, people may feel that their suffering and distress are not recognised. The family or carer of a suicide or homicide victim may demand no more than to be listened to, understood, respected and where appropriate, provided with an explanation and expression of regret or sympathy. Where such expression is warranted it can have great impact if given immediately and in a sincere manner. It does not have to suggest or imply fault but is indicative of caring and compassion from the service that was looking after the person.

In the past public sector agencies and public officials were reluctant to express regret as this could be taken as an admission of liability leaving them open to action through the courts from a person seeking compensation.

The *Civil Liability Amendment (Personal Responsibility) Act 2002*, Part 10, Section 68 defines "apology" as

> "an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter whether or not the apology admits or implies an admission of fault in connection with the matter."

Section 69 Effect of apology on liability, stipulates that

> (1) An apology made by or on behalf of a person in connection with any matter alleged to have been caused by the person:
>
> (a) does not constitute an express or implied admission of fault or liability by the person in connection with that matter, and
>
> (b) is not relevant to the determination of fault or liability in connection with that matter.
>
> (2) Evidence of an apology made by or on behalf of a person in connection with any matter alleged to have been caused by the

> person is not admissible in any civil proceedings as evidence of the fault or liability of the person in connection with that matter.

Accordingly, the NSW Ombudsman advises that an expression of sympathy or regret be of a general sense of benevolence or compassion, in connection with any matter whether or not the expression admits or implies an admission of fault in connection with the matter (Appendix 5).

The Committee fully endorses the Ombudsman's statement with regard to expressing regret in these circumstances.

Accordingly the Committee recommends that:

> By April 2004, Area Health Services shall make appropriate expressions of regret after a death to families and relevant support persons. The expressions should be made soon as possible, without admitting liability and should come from the highest relevant level.
>
> **Recommendation 46**

Family liaison is an important part of the management of people at risk in mental health facilities. It is important that family liaison continues and is offered should a tragic incident occur. It should be recognised that an acutely bereaved family in this context may require specialist support, nevertheless all staff should be skilled in providing immediate bereavement support.

Area Health Services should ensure that training resources made available through the Centre for Mental Health, notably *Bereavement Care CD-ROM*, NSW Health 2003 - a general bereavement support training package for staff - are utilised by all clinical staff to enhance their basic skills in dealing with bereavement. *Care and Support Pack for Families and Friends Bereaved by Suicide,* NSW Health 2001 and *Supporting Children after Suicide,* South Western Sydney Area Health Service 2002, are resources for affected persons, although they may be utilised by clinical staff to enhance their knowledge and skills in this area.

Families may be linked with expert counselling within the service or with an external organisation with expertise in this area, should this be considered necessary.

Families may or may not wish to have an ongoing supportive relationship with the service, although they may wish to return with unanswered questions or concerns.

Mental health and other health staff who have been involved with the person who takes his or her life in a suicide death while an inpatient of a service, are likely to be distressed and very concerned about what has happened. While the Root Cause Analysis will look at broad staff issues it is appropriate that support is offered to staff, in line with the recommendations of the NSW Health Circular No. 2002/19 *Effective Incident Response: A Framework for Prevention and Management in the Health Workplace*.

In many circumstances, it is appropriate to have a rapid safety review within 24-48

hours of the event. The purpose of the rapid safety review is to check the circumstances of the death for factors that may have contributed to the heightened risk and that might also apply in other circumstances to other individuals, so that action can be taken swiftly. These factors might include environmental risks such as hanging points, difficulties in observing the person, practices such as failure to carry through and document adequate observation levels, inadequate communication of risk, and staffing issues.

A similar process should be put in place for homicide deaths, within the requirements of initial Police investigations.

Accordingly the Committee recommends that:

> By July 2004 a rapid response protocol for possible suicide deaths shall by developed by NSW Health for implementation by Area Health Services and will include the following:
>
> - a rapid safety review to clarify the circumstances surrounding the death which may indicate a continuing safety risk
> - inform NSW Health and the Centre for Mental Health
> - offer of advice and support to the family of the deceased person
> - provision of support for staff involved in the care of the patient.
>
> The effectiveness of the protocol will be evaluated, by 2006. A similar process will be put in place for homicide deaths, within the requirements of initial Police investigations.
>
> **Recommendation 58**

Risk Assessment

The Committee noted the work in progress by the Centre for Mental Health and Northern Sydney Area Health Service on the development of a Framework for Suicide Risk Assessment and Management, Suicide Risk Assessment Guidelines and Discharge and Follow up Guidelines. This work provides the most up to date and available information for good clinical practice by all health staff in the critical area of assessment and management of suicide risk. The Committee looks forward to receiving advice in the near future on the progress of this work.

Reporting, Data Collection and Monitoring

The Committee recommends an open and clear reporting method for possible suicide deaths of clients of mental health services and for homicides perpetrated by clients of mental health services. It recommends a sound communication and media management strategy for reporting trends in such data.

The Committee is aware of likely underreporting of suicide deaths – that not all suicide deaths are so reported. However, inpatients in psychiatric units are more likely to have suicide death correctly identified.

The incidence of possible suicide death in care should be reported annually as part of the Chief Health Officer's Report. Initial reports should cover the last 5-year period, and thereafter, annual reports should be published.

Accordingly the Committee recommends that:

> From 2004, NSW Health shall report annually trend data for possible suicide deaths in mental health care. **Recommendation 40,** and
>
> From 2004, NSW Health shall mandate the implementation of the NSW Mental Health Client Death Report. **Recommendation 41**

Under the provisions of NSW Health Circular 2003/88 Reportable Incident Briefs to the NSW Department of Health, Area Health Services are required to allocate a Severity Assessment Code (SAC), to an incident. Sentinel events would all be categorised under SAC 1, the highest severity rating. Root Cause Analyses and Reportable Incident Briefs are both required.

To improve further the quality of data collection in NSW, the Committee recommends that

> By July 2004, in the case of mental health sentinel events which have had fatal consequences the Root Cause Analysis required under Circular 2003/88 shall be led by an appropriately trained person from outside the Area Health Service where the sentinel event occurred.
>
> **Recommendation 32**

Where the Root Cause Analysis process identifies a possible suicide death or a homicide, this data should be forwarded to the Committee to enable it to undertake its work.

Accordingly the Committee recommends that:

> By July 2004 Area Health Services shall forward information from Root Cause Analyses to the Centre for Mental Health for centralised reporting, data collection and analysis, and the Centre for Mental Health will forward the information to the Committee to assist it undertake its duties.
>
> **Recommendation 42**

The Committee recognises that the process only captures inpatient information and will in future explore ways this process could be adapted to meet the needs of community mental health patients.

Current processes should be streamlined and linked to provide for complete and timely reporting. A gap analysis of data currently collected for suicide and homicide deaths of patients in mental health care should be carried out.

Accordingly the Committee recommends that:

> By the end of 2004, NSW Health through the Centre for Mental Health shall conduct a gap analysis of data currently collected for suicides of and homicides by patients in care, and advise the Committee and NSW Health on areas for improvement.
>
> **Recommendation 43**

In the case of suicide deaths, the gap analysis will determine what further data are needed in addition to that collected by the Root Cause Analysis.

Data collection tools such as those used for the NSW Death Under Anaesthesia Reports or the questionnaires developed by the *UK National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, appropriately modified for application in NSW, were considered by the Committee to be useful models upon which to base the development of such instruments for application in NSW mental health facilities.

If the gap analysis indicates that further data are needed, a modified version of the UK questionnaire could be incorporated to enhance the data set. The completion of any forms used in addition or as part of the Root Cause Analysis would be the responsibility of the clinical team responsible for the care of the patient, in order to capture the depth of knowledge of nursing staff, especially where the consultant clinician did not have an opportunity to see the patient. Responsibility for implementation would be with the CEO of the Area Health Service. A draft NSW Questionnaire is included in Appendix 4.

Accordingly the Committee recommends that:

> As a result of the gap analysis, if the need for additional data is evident, NSW Health shall ensure that the implementation of appropriate data collection tools is incorporated into the Root Cause Analysis process.
>
> **Recommendation 44**

In the case of homicides the questionnaire would be completed in accordance with a protocol agreed by NSW Health and NSW Police.

Accordingly the Committee recommends that:

> By July 2004, NSW Health and NSW Police shall develop and implement a protocol for the notification to the Committee of incidents of homicide involving a person who has had or is suspected of having recent contact with a mental health service.
>
> **Recommendation 45**

The Committee supports the commissioning of research which aims to identify links between the perpetrator's mental state at the time of the offence and the offence itself.

This is in order to understand the impact of mental illness on homicide, and to understand homicide by those with mental illness in a broader context. It will also serve to provide early warning of any trends or shifts in any association between mental illness and homicide.

Education and Training

An educational program for all members of the clinical team should support the introduction of evidence based clinical guidelines in the assessment and management of risk for violence to others and self-harm. These guidelines should be developed, introduced and incorporated into MH-OAT to assist in the formulation of patient management strategies that result from the assessment, and are consistent with good clinical practice.

Undergraduate medical and nursing training, and psychiatric training do not appear to deal adequately with risk assessment. The Committee noted many instances where risk assessment was incorrectly done. The Committee regards training as life long and important.

Training in suicide risk assessment should be made available to all clinicians involved in suicide risk assessment.

Key personnel in each area should be identified to become responsible for education and ongoing education in their area. A state wide educational strategy should include administration staff.

Emergency Department staff involved in the assessment of psychiatric patients shall be trained in psychiatric risk assessment.

Formal training in the application of the Mental Health Act should be provided to registrars, consultants, medical officers and all key mental health professionals, as there is evidence to suggest that some staff do not avail themselves of the training which is provided. The training should be mandatory. Relevant educational bodies including NSW Institute of Psychiatry, nursing educational bodies and all professional groups who work in mental health should be involved. The training should be provided on induction into a mental health service and in regular training updates.

Accordingly the Committee recommends that:

> By July 2005 NSW Health shall ensure that a training program is developed and provided through Area Health Services to develop the skills and knowledge of all key mental health professionals to engage with families in mental health assessments. **Recommendation 38,** and
>
> High priority shall be given to providing training to all persons involved in the care of mental health patients within a public health service, necessary to support the implementation of the recommendations of this report. **Recommendation 39**

The Committee discussed the difficulties sometimes experienced by police in responding to mental health problems and supported the call for a mandatory comprehensive training program to provide all police officers with training to respond better to mental health problems in the community, in line with the strategy identified in Recommendation 99 of the Select Committee Final Report.

Future Activities of the Committee

The Committee identified several topics for future discussion including the following:

- Discharge of patients from **outpatient** care or case management. Although the Committee limited its deliberations to **inpatient** care in its first year, future discussions will address the view that discharge of patients from outpatient care or case management should never occur without a clinical review that takes into account the opinions of doctors, other clinicians and relevant professionals who have been or currently are involved in the care of the patient.

- Combined clinical case records with a single identifier to facilitate cross agency communication, taking into account privacy and confidentiality considerations.

Other matters for the Committee's consideration may include:
- a framework for collecting information from the private sector
- the development of a data base for suicide attempts.

Homicide Sub-Committee: Future activity with respect to case reviews and methodology will be determined in conjunction with the Head Committee.

Suicide Sub-Committee: Although the Sub-Committee in its first year focused on inpatient suicide deaths, future activity will include addressing the 3 other categories of suicide cases:
- Prior inpatient deaths (death occurs within 28 days of discharge)
- Community outpatient deaths (those who have had an interface with community mental health services)
- Non-contact deaths (those who did not have a known interface with any mental health service).

It is important that the Committee maintain its work as a standing committee, as there is a continuing need for an independent body to monitor emerging sentinel events and analyse systemic failures. It is essential that the Committee be appropriately resourced to enable it to function in an effective manner and produce annual reports for the Minister.

Accordingly the Committee recommends that:

> NSW Health shall allocate sufficient resources to enable the Committee to fulfil its functions, including the provision of permanent executive support. **Recommendation 51**

APPENDIX 1

NSW Mental Health Sentinel Events Review Committee

Members

Privilege

Meetings

MEMBERS

Professor Peter Baume (May 2002 onwards)
Chairman
Peter Baume is Chancellor, The Australian National University (1994 -); Member of Council, Australian National University, 1986-90, 1991 - ; Professor of Community Medicine and Head of the School of Community Medicine, University of New South Wales 1991 – 2000; Director of Sydney Water 1998 - ; Governor Foundation for Development Cooperation; Patron Voluntary Euthanasia Society of New South Wales; Member of editorial board Australian Health Review; Official Visitor to four psychiatric hospitals and two community psychiatric facilities.

Ms Amanda Adrian (May 2002 onwards)
Amanda Adrian is currently Commissioner, New South Wales Health Care Complaints Commission. Prior to that she was a senior officer and manager in the NSW Department of Health, most recently as the Director of the Private Health Care Branch, regulating the private health industry in NSW, licensing, monitoring and managing complaints about safety, care and quality in private nursing homes, hospital and day procedure centres.

Commander Vicki Arender (May 2002 – August 2002)
Vicki Arender is Commander, Newtown Local Area, New South Wales Police Service, a position she has held since 1999. Vicki joined the NSW Police Force in 1983. She is currently one of 80 Local Area Commanders for the NSW Police and was also the Corporate Spokesperson for issues involving mental health until August 2002.

Mr Terry Clout (May 2002 onwards)
Chair of the Homicide Sub-Committee
Terry Clout is currently Chief Executive Officer, Mid North Coast Area Health Service. He has worked in the Health industry for more than 20 years in senior positions in the Department of Health and Area Health Services. Terry is a non -executive director on the Board of the Australian Health Management and is a member of numerous Departmental forums, including the Senior Executive Forum,
Rural Health Taskforce, Rural & Regional Medical Workforce Committee and Reportable Incident Briefs Steering Committee. External memberships include UNSW School of Rural Health Mid North Coast Division Rural Clinical School Community Advisory Board and Commonwealth Coordinated Care Trial Monitoring Committee

Mr Brett Holmes (May 2002 onwards)
Brett Holmes is Assistant Secretary, Nurses Association of New South Wales.

Dr Greg Hugh (May 2002 onwards)
Greg Hugh is currently Psychiatrist, Centre for Mental Health, New South Wales Department of Health.

Ms Martha Jabour (May 2002 onwards)
Martha Jabour is currently Executive Director, Homicide Victims Support Group (Aust.) Inc., a position she has held since 1993. She represents the Homicide Victims Support Group on the victims Advisory Board and the Youth Justice Advisory Committee. And is a member of the Restorative Justice Unit Committee and the Coronial Review committee. She is a community member of the Serious Offenders Review Council. Her interests are to further promote victim's rights and needs and has a special focus on crime prevention, particularly in the areas of domestic violence, mental health and juvenile justice.

Superintendent Terry Jacobsen (December 2002 onwards)
Terry Jacobsen replaced Commander Arender as a Committee member in December 2002. He is currently Local Area Commander, Liverpool Local Area Command, New South Wales Police Service. Terry has been the Corporate Spokesperson for issues involving mental health since August 2002.

Mrs Jennifer MacKellin (May 2002 onwards)
Jennifer MacKellin is the Committee's Carer Community Representative. Jenny has been a carer for seventeen years, and is a mother of four. Although a Licensed Real Estate Agent, Jenny made the change in career to mental health in 2002. She is currently working as Carer Consultant for Central Coast ARAFMI. She is also a member of the Management Committee for NSW CAG.

Ms Leonie Manns (May 2002 onwards)
Leonie Manns is mental health care consumer representative

Dr Louise Newman (May 2002 onwards)
Louise Newman is Director, New South Wales Institute of Psychiatry, Chair, New South Wales Branch of RANZCP and Chair, Faculty of Child and Adolescent Psychiatry, RANZCP. She is currently involved in a review of the training of psychiatrists and child psychiatrists in New South Wales and the development of innovative approaches to psychiatric and menta health eduction. In her RANZCP roles she is involved in workforce development and promoting collaborative work practices between psychiatrists and other mental health professionals. Her clinical focus is on the prevention of child maltreatment and development of interventions for early parenting difficulties.

Mr Peter Matthews (May 2002 onwards)
Peter Matthews is Manager Coronial Services New South Wales and Executive Officer to the State Coroner. He was appointed a Coroner in 1967 and commenced duty at the State Coroner's Office, Glebe in 2001. Prior to that Peter Matthews was Chamber Magistrate at Waverley, and had previously been responsible for training Local Courts staff. He

developed a training program and wrote a manual for all new Coroners being appointed at country centres. He has trained all new Coroners appointed since 1990 and pioneered the introduction of client service training in Local Courts in 1997.

Dr Susan Page-Mitchell (May 2002 onwards)
(Chair of the Suicide Sub-Committee)
Sue Page-Mitchell is a Rural GP currently in General Practice at Lennox Head Medical Centre. She is also a Visiting Medical Officer at St Vincent's Hospital Lismore and at Ballina District Hospital, where she is a member of the Trauma Team and the Antenatal Clinic. Sue Page-Mitchell currently holds positions as RACGP Examiner, RACGP Rural Registrar Supervisor, RDN Rural Chapter Representative for North Coast, RDA Representative for Ballina Region, GP Executive Manager of Northern Rivers Division of General Practice, RDN Representative to NSW Medical Board Assessment Panel for Overseas Trained Doctors.

Professor Trevor Waring (May 2002 onwards)
(Chair of the Coroner's Recommendations Sub-Committee)
Trevor Waring is Con-Joint Professor, Psychology, University of Newcastle. He also currently holds the positions of Deputy Chancellor University of Newcastle, President New South Wales Psychologists Registration Board, Director Hunter Institute of Mental Health, Member New South Wales Victims Services Professional Advisory Panel, Member New South Wales Children's Court Clinic Professional Advisory Panel, Member New South Wales Institute of Psychiatry Academic Advisory Committee.

PRIVILEGE

Under section 23 of the Health Administration Act 1982 the Minister by order published in the Gazette authorised the Committee appointed under section 20 (1) or (4) to conduct research or investigations into morbidity or mortality occurring within New South Wales. Any person disclosing information obtained in connection with the conduct of this research or investigation without the approval of the Minister or the consent of the person who provided the information is guilty of an offence against the Health Administration Act 1982. By virtue of this provision, none of the committee members are deemed to be competent or compellable to produce or give evidence in respect of matters placed before the committee.

MEETINGS

The Committee ordinarily meets six times a year for three hours on dates agreed by its members. The Committee has met on eight occasions to December 2003, on the following dates:

2002:	**2003:**
30 August	06 February
11 October	24 April
	11June
	25 September
	23 October
	10 December

Homicide Sub-Committee

Membership

The membership of the Homicide Sub-Committee is as follows:
Mr Terry Clout (Chair)
Ms Amanda Adrian
Professor Peter Baume
Superintendent Terry Jacobson
Dr Greg Hugh
Mr Peter Matthews

The Sub-Committee has met on seven occasions to December 2003, as follows:

2002:
2 December

2003:
06 February
24 April
11June
11 August (Teleconference)
28 August
25 September

Suicide Sub-Committee

Membership

The membership of the Suicide Sub-Committee is as follows:
Dr Susan Page Mitchell (Chair)
Ms Amanda Adrian
Professor Peter Baume,
Mr Brett Holmes,
Ms Jennifer Mackellan
Mr Peter Matthews

The Sub-Committee has met on seven occasions to December 2003, as follows:

2002:
15 November

2003:
17 March
24 April
08 May (Teleconference)
29 May (Workshop)
11June
25 September

Coroner's Recommendations

Membership

The membership of the Coroner's Recommendations Sub-Committee is as follows:

Professor Trevor Waring (Chair)
Ms Martha Jabour
Superintendent Terry Jacobson
Ms Leonie Manns
Dr Louise Newman

The Sub-Committee has met on 3 occasions to December 2003, as follows:

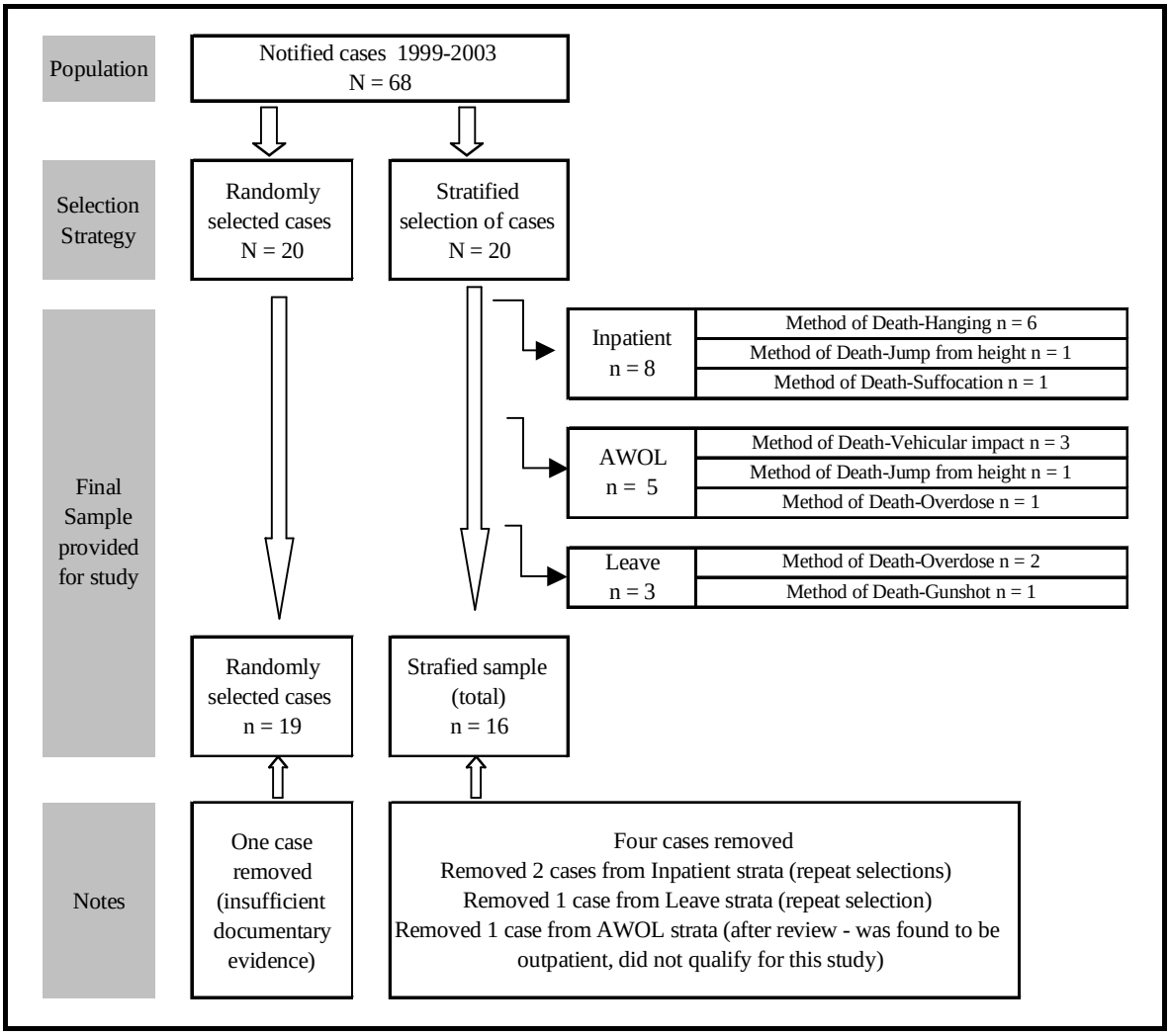
2002:
29 November (Teleconference)

2003:
28 February
24 March

APPENDIX 2

Tables and Figures

Figure 1: Sampling strategy and final sample selection



Preliminary review revealed that some cases did not accurately reflect the sample selection criteria. For example, one person (Case 2235) had been discharged while AWOL and committed suicide 12 days after discharge. Another person (Case 1813) was also found to be a doubtful qualifier case for this sample, as he too was discharged from care before the suicide incident (but only two hours before the incident occurred, which happened on hospital premises). Four cases were ostensibly medical admissions, not mental health patients, and as such were not subject to the usual guidelines and protocols of care delivery. (Cases 1096, 1864, 986 and 1964). The six (6) cases were left in the sample because the reviewers considered that issues of discharge decision-making and judgment, as well as multi-specialty care issues would be worthy of further examination.

Table 1: Differences in patient status between notification data and after study results

Case Number	Notification data and selection strategy	After study finding
950	Leave strata	AWOL
1107	Leave strata	AWOL
1734	Inpatient strata	Leave
1813	Random (inpatient)	Discharged
1827	Inpatient strata	AWOL
1854	Leave strata	AWOL
2003	AWOL strata	Leave
2042	AWOL strata	Leave
2080	Leave strata	AWOL
2235	AWOL strata	Discharged

Table 2 shows the samples and their characteristics and composition, based on four (4) variables: gender, status, method of death, and principal diagnoses. These variables and values were taken from the notification data.

ANOVA: analysis of variance between each sample (population n=68, whole sample n=35 and random sample n=19):
Gender: F=0.634, p=0.532-not significant
Status: F=0.027, p=0.973-not significant
Method of death: F=1.031, p=0.360-not significant
Principal diagnosis: F=1.850, p=0.162-not significant

		Population (all cases)	Whole sample (collapsed across strata)	Randomly selected portion of study sample
N =		68	35	19
Gender				
n	Male	48	28	14
%		70.6	80	73.7
n	Female	19	7	5
%		27.9	20	26.3
n	Missing Info	1	0	0
%		1.5	0	0
N		68	35	19
%		100	100	100
Status				
n	Inpatient	34	18	10
%		50	51.4	52.6
n	AWOL	21	9	4
%		30.9	25.7	21.1
n	Leave	13	8	5
%		19.1	22.9	26.3
N		68	35	19
%		100	100	100
Methods				
n	Hanging	25	14	8
%		36.8	40	42.1
n	Stabbing, cutting	2	2	2
%		2.9	5.7	10.5
n	Overdose	13	7	4
%		19.1	20	21.1
n	Jump from heights	9	4	2
%		13.2	11.4	10.5
n	Suffocation	4	2	1
%		5.9	5.7	5.3
n	Gunshot	1	1	
%		1.5	2.9	
n	Vehicular impact	8	5	2
%		11.8	14.3	10.5
n	Other	3		
%		4.4		
n	Missing Info	3		
%		4.4		
N		68	35	19
%		100	100	100
Diagnosis				
n	Schizophrenia	17	9	4
%		25	25.7	21
n	Depression	10	3	2
%		14.7	8.6	10.5
n	Psychosis	15	9	6
%		22.1	25.7	31.5
n	Substance abuse	5	1	1
%		7.4	2.9	5.3
n	Personality disorder	2	2	1
%		2.9	5.7	5.3
n	Dysthymia	1	1	1
%		1.5	2.9	5.3
n	Other psych prob	2	1	
%		2.9	2.9	
n	Medical problem	9	6	3
%		13.2	17	15.8
n	Poisoning	1	1	1
%		1.5	2.9	5.3
n	Injury	2	2	
%		2.9	5.7	
n	Missing Info	4		
%		5.9		
N		68	35	19
%		100	100	100

Table 2: Comparison of Sample Composition

A spreadsheet was constructed using data from medical records, police and Coroners' reports, matched for each patient by name and case number with high level notification data made available electronically by NSW Health. This spreadsheet was extended by adding variables so that information relevant to causal factors could be tabulated appropriately. The reviewers then read and analysed every record and extracted information pertinent to these variables, collecting and cross referencing information and entering narrative extracts into the database constructed for the study.

After collection, the reviewers examined the narrative study data and, where possible, coded this in a way suited to quantitative analysis. For example; coded values of 1, 2, 3 were assigned to narrative that expressed whether: yes, the patient expressed suicidal intent during admission (=1); no, the patient did not express any suicidal intent during admission (=2); unknown, the record is silent about whether the patient was asked about his/her suicidal intent (=3). These data were then transferred out of

MS® Excel and imported to a SPSS spreadsheet for a frequency analysis for each of the variables.

Table 3 shows the patients' histories in terms of previous episodes and attempts, whether the patients were known to police, and evidence of drug use/abuse.

Table 3: Patients' histories

Patient history	n	%
Previous episodes and attempts		
Previous history and previous attempts[1]	11	57.9
Previous history, no previous attempts[1]	4	21.1
Medical history only, no mental health history	3	15.8
No history available	1	5.3
Known to Police, DOCS, Courts		
Known to police	10	52.6
Known to DOCS/other community services	2	10.5
Known to two or more of the above groups	2	10.5
Not relevant	3	15.8
Not known	1	5.3
Missing information	1	5.3
Substance use/abuse		
Evidence of substance use/abuse	15	78.9
No evidence of substance use/abuse	2	10.5
Not relevant	1	5.3
Missing information	1	5.3

1. Refers to previous history of mental health episodes or care, and suicide attempts.

Table 4 shows the number and percentage of patients with each type of principal diagnosis and/or co-morbidity.

Table 4: Patients with each type of principal diagnosis and/or co-morbidity

Diagnoses	Principal diagnosis		Co-morbidity	
	n	%	n	%
Schizophrenia	4	21.1	nil	nil
Psychotic	2	10.5	1	5.3
Depression	6	31.6	4	21.1
Personality disorder	1	5.3	1	5.3
Dysthymia	1	5.3	1	5.3
Other psychological disorders	nil	nil	2	10.5
Manic	nil	nil	3	15.8
Poisoning	1	5.3	nil	nil
Injury/attempts	nil	nil	nil	nil
Substance abuse	1	5.3	2	10.5
Medical problem	3	15.8	nil	nil
No co-morbidities	na	na	5	26.3

Diagnoses were taken from notification database and grouped into major categories

Table 5: Types of risk factors exhibited by numbers of patients in this sample

Type of red flags	No. of patients demonstrating
Trigger event	6
Suicidal ideation	8
Substance abuse	6
Previous attempts	9
Known to police	4
Family support	1

Table 6: Frequency of risk factors

Number of red flags demonstrated per case	No. of patients
6	0
5	1
4	1
3	2
2	5
1	7
0	3

Table 7 reports the principal diagnoses of males and females by age groups. Nearly all patients under 50 had a principal diagnosis of a psychological disorder, with schizophrenia and psychoses the most common forms of psychological disorder for males in this sample. For the three males over 50 years of age, the most common principal diagnoses were medical problems.

Table 7: Principal diagnoses of males and females by age groups

Age groups and diagnoses	Males	Females
20 years and younger		
Schizophrenia	2	
21-30 years		
Psychotic	3	1
Dysthymia	1	
Poisoning	1	
31–40 years		
Schizophrenia	1	
Depression		1
Psychotic	1	
Personality disorder		1
41–50 years		
Depression	1	
Psychotic	1	
Schizophrenia		1
Substance abuse		1
50 years and older		
Medical problem	3	
TOTAL	14	5

Table 8 shows the principal diagnoses of patients with different histories by age groups. For all age groups under 50, most of the patients had both a previous history and previous suicide attempts, whereas for the patients over 50 who had a principal diagnosis of a medical problem, there was no evidence of previous mental health episodes or previous suicide attempts.

Table 8: Principal diagnoses of patients with different histories by age groups

Age groups and diagnoses	History and attempt	History, no attempt	Medical history only
20 years and younger			
Schizophrenia	1	1	
21–30 years			
Psychotic	2	2	
Dysthymia	1		
Poisoning	1		
31–40 years			
Schizophrenia	1		
Depression	1		
Psychotic		1	
Personality disorder	1		
41–50 years			
Schizophrenia	1		
Depression	1		
Psychotic Substance abuse	1		
Over 50 years			
Medical problem			3
No history available	1		
TOTAL	11	4	3

Table 9: How patients were brought into the facility

Brought in by	n	%
Self-admitted	5	26.3
Brought in by other services/family	3	15.8
Transferred from other services	2	10.5
Medical admission only	3	15.8
Poor handover information	1	5.3
Not relevant or missing data	5	26.3
TOTAL	19	100

(Note that information was incomplete, irrelevant or missing for some cases).

Table 10: How patients were brought into the facility by admission type

Brought in by	Scheduled	Involuntary	Voluntary/ Informal
Self-admitted	4		2
Brought in by other services/family	2	1	
Transferred from other services	2	1	
Incomplete information	1		2
TOTAL	9	2	4

Table 11: Resources available at admission

Resources	n	%
Appropriate and available resources	9	47.3
Available, but wait or transport necessary	3	15.8
Problem with availability of staff or seclusion	1	5.3
Medical or mental health admission problem	3	15.8
Inappropriate resources	1	5.3
Missing information	2	10.5
TOTAL	19	100

Table 12: Resources available at admission by admission type

Resources	Scheduled	Involuntary	Voluntary/ informal	Medical admission
Appropriate and available resources	4	3	2	
Available, but wait/transport necessary	2		1	
Problem with staff availability/seclusion	1			
Inappropriate resources	1			
Medical/mental health admission problem				3
Missing information	2			
TOTAL	8	3	3	3

Most restrictive admission status assumed for some of these patients

Table 13 shows that only 63% or so of patients had a protocol applied as part is risk assessment and 21% of patients appear not to have had a protocol applied.

Table 13: Assessment protocol

Assessment	n	%
Dr assessed, used protocol, high risk	9	47.3
Dr assessed, used protocol, medium risk	2	10.5
Dr assessed, used protocol, low risk	1	5.3
Dr assessed, no protocol, high risk	1	5.3
Dr assessed, no protocol, medium risk	1	5.3
Dr assessed, no protocol, no risk stated	2	10.5
Not relevant and missing information	3	15.8
TOTAL	19	100

Table 14 demonstrates that information was available only for 16 patients, of whom 2 scheduled patients had no protocol recorded while 4 patients were recorded as 'involuntary' and had no protocol recorded.

Table 14: Assessment protocol by admission type

Assessment protocol	Scheduled	Involuntary	Voluntary/ informal
Dr assessed, used protocol, high risk	5	2	2
Dr assessed, used protocol, medium risk	1		1
Dr assessed, used protocol, low risk	1		
Dr assessed, no protocol, high risk			1
Dr assessed, no protocol, medium risk		1	
Dr assessed, no protocol, no risk stated	2		
Medical cases and missing information	3		
TOTAL (19)	9	3	4

NB. Medical admissions are not shown as the assessment protocol is largely irrelevant to this group.

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Table 15: Principal diagnosis by admission type

Principal diagnosis	Scheduled	Involuntary	Voluntary/ informal
Schizophrenia	3	1	
Depression		1	1
Psychotic	4	1	1
Substance abuse			1
Personality disorder	1		
Dysthymia			1
Poisoning	1		
TOTAL (16)	9	3	4

Three medical admissions are not shown as the principal diagnoses of these were not mental health issues

Table 16 shows that of 19 patients who died by suicide, 7 had either a suicide attempt or self-harm recorded.

Table 16: Reason for admission by admission type

Reason for Admission	Scheduled	Involuntary	Voluntary/ informal	Medical admission
Suicide attempt	1			
Reported self harm-intent	6	2	3	
Transfer	1			
Police-homeless, criminality	1			
Illness, medical condition				3
Aggression, violence	1	1		
TOTAL (19)	10	3	3	3

Table 17: Patients' histories by admission type

Patients' history	Scheduled	Involuntary	Voluntary/ informal	Medical admission
Previous history and previous attempts	7	2	2	
Previous history, no previous attempts	2	1	1	
No previous history available			1	
Medical history only				3
TOTAL (19)	9	3	4	3

Table 18 shows that in only 42% of patients who died by suicide was care management considered to be 'good'.

Table 18: Care management

Category	n	%
Good	8	42.1
Fair	2	10.5
Poor	2	10.5
Too early in episode to judge	2	10.5
Not relevant or missing data	5	26.4
TOTAL	19	100

NB: In 5 cases, documentary evidence did not support care management review

Table 19: Level of supervision by admission type

Level of supervision	Scheduled	Involuntary	Voluntary/ informal	Medical admission
High, constant (CL1), 1:1 nursing	1	2	1	
Medium-high (CL2) 15min obs	5			
Medium (CL3) 30min obs			1	
Medium-low (CL4) 60min obs, open ward	1			
Low (CL5) regular obs, open ward			1	1
Other	1	1		
Missing or irrelevant	4			
TOTAL (19)	8	3	3	1

These categories were not always clearly documented. Where necessary the reviewers have inferred observation frequency from nursing notes, from clinician recommendations or from other documentation sources (family, police or Coroner statements).

Table 20 shows that only 4 out of 13 who died by suicide had high levels of supervision, and that 4 out of 9 high risk patients had high level supervision.

Table 20: Level of supervision by risk assessment

Level of supervision	High risk	Medium risk	Low risk	Risk unstated
High, constant (CL1), 1:1 nursing	4			
Medium-high (CL2) 15min obs	4			1
Medium (CL3) 30min obs	1			
Medium-low (CL4) 60min obs, open ward				1
Low (CL5) regular obs, open ward		1		
Other	2			
Missing	2			
TOTAL (19)	9	1	0	2

NB: Medical admissions not shown as none of these patients received a mental health risk assessment.

Table 21: Patient status at the time of death

Patient status	n	%
AWOL	6	31.6
Discharged	1	5.3
On leave	3	15.8
Medical inpatient	2	10.5
Scheduled inpatient	7	36.8
TOTAL	19	100

Table 22 shows that of this group of 14 people who died by suicide, 5 were AWOL.

Table 22: Level of supervision by admission status at death

Level of supervision	AWOL	Discharged	Leave	Medical inpatient	Other inpatient
High, constant (CL1) 1:1 nursing	1				3
Medium-high (CL2) 15min obs	2		1		2
Medium (CL3) 30min obs	1				
Medium-low (CL4) 60min obs, open ward		1			
Low (CL5) regular obs, open ward	1			1	
Other			1		1
TOTAL	5	1	2	1	5

Table 23: Methods by place of occurrence: Hospital [1]

Method	Bathroom/ cupboard	Hospital room	Open area[1]
Hanging	4	1	1
Jumping		1	1
Stabbing, cutting, slashing		1	
Suffocation		1	

[1] Includes lounge, courtyard etc

Table 24: Methods by place of occurrence: Outside of hospital

Method	Public place: park/garden	Public place: shops/road	Home
Hanging	1		1
Overdose	2		2
Vehicular impact (train, car, traffic)		2	
Jumping			
Stabbing, cutting, slashing	1		

Table 25: Means by place of occurrence: Hospital [1]

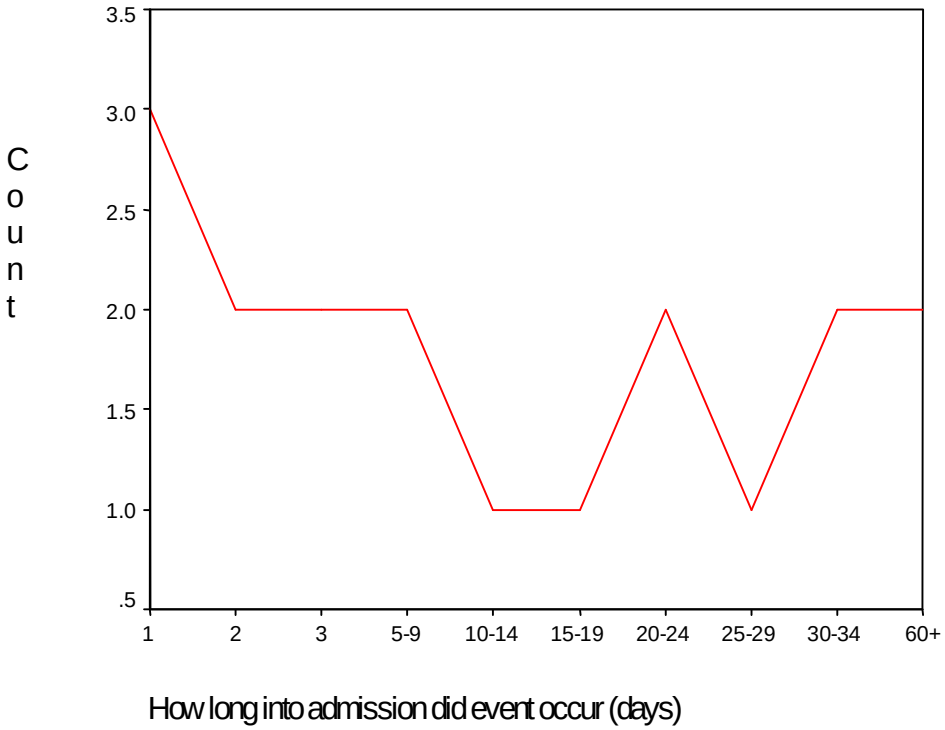
Means	Bathroom/ cupboard	Hospital room	Open area[1]
Own cord, rope, string-hospital fixture	2		1
Hospital cord, rope, string-hospital fixture	1		
Heights (from hospital building)		1	1
Hospital knife		1	
Plastic bags (own)		1	
Other	1		

[1]Includes lounge, courtyard etc.

Table 26: Means by place of occurrence: Outside of hospital

Means	Public place: park/garden	Public place: shops/road	Home
Drugs	2		1
Own knife	1		
Own cord, rope, string-own fixture			1
Other vehicle (train, traffic etc)		2	
Heights (outside hospital premises)	1		

Figure 2: Number of deaths by number of days after admission



APPENDIX 3

References

Relevant Policies Guidelines and Reports

Suicide

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3. Reportable Incident Briefs to the NSW Department of Health. NSW Health Quality and Safety Circular No. 2003/88.
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14. Bereavement Care. CD-ROM, NSW Health 2003
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18. NSW Civil Liability Amendment (Personal Responsibility) Act 2002.

Homicide

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15. Bereavement Care. CD-ROM, NSW Health 2003.
16. Effective Incident Response: A Framework for Prevention Management in the Health Workplace. NSW Health Circular No. 2002/19.
    2002.
17. NSW Civil Liability Amendment (Personal Responsibility) Act

APPENDIX 4

Cover sheet of Homicide Questionnaire of the UK National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

Modified UK Homicide Questionnaire for possible application in NSW

Brief report of application of Suicide and Homicide Questionnaires in UK

APPENDIX 5

NSW Ombudsman

Public Sector Agencies Fact Sheet No. 1