

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 1 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 committee's 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. Ishikawa 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 unforeseen events can change a person's level of risk.

The number of suicide deaths in NSW from 1993 to 2001 published 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, is 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 serious 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.