

**NSW Mental Health Sentinel Events Review
Committee**

Tracking Tragedy 2004

A systemic look at homicide by mental health patients and
suicide death of patients recently discharged from mental health
inpatient units

Second Report of the Committee

March 2005

“...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*

NSW Mental Health Sentinel Events Review Committee

Second Report

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Executive Summary

Executive Summary

Introduction

Overview

This is the second report of the NSW Mental Health Sentinel Events Review Committee (the Committee). The Committee continues its work to review independently and report on circumstances associated with homicides and suicide deaths involving patients of public mental health services, and to provide advice on a systemic basis that might improve the care of persons suffering from a mental illness, or decrease morbidity or mortality.

As stated in the First Report of the Committee, 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 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 also represents 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. 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, such events often result in great distress and suffering for the perpetrator, who has to live with the consequences of their actions. The overall effect is loss of confidence in mental health services and greater stigmatisation of those suffering mental illness.

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. One of the purposes of the NSW Mental Health Sentinel Events Review Committee is to review these incidents and examine systematic problems within the mental health services which may have contributed to the tragic outcome, and to recommend solutions.

Mental health services in general do a very effective job of managing people with severe mental illness, preventing many incidents of minor and major self-harm, and violence towards others. Effective hospital care is an essential component of the comprehensive assessment and treatment of mental illness, and the prevention of suicide. The period after discharge from hospital is a critical period, as evidence from studies around the world shows the risk of suicide death is greatest in the days or weeks following discharge from mental health inpatient care.

Mental health units in NSW hospitals report approximately 20,000 overnight separations per year (i.e. discharges or transfers from hospital where the person has been in hospital for at least one night, but excluding same day or “day only” admissions). In the five-year period covered by this review (1999-2003), mental health services reported 102 suspected suicide deaths occurring within one month of discharge, or approximately 20 suspected suicide deaths per year. Therefore the rate of suspected suicide death within one month of discharge is approximately 1 suspected suicide death for each 1000 mental health separations (or 0.1%). This is a low figure, but as discussed later, may be an under-estimate.

From 1999 to 2003, 36 homicide cases were reported by mental health services to NSW Health, or an average of 7 per year. The Committee understands that in any year, reporting of homicide cases may be delayed due to the criminal investigation process.

The Committee is aware of the intrinsic challenges of retrospective review of a series of cases with adverse outcomes. A clinical and systemic review is not a controlled scientific study; the lack of a control group makes the specificity and significance of some observations difficult to assess. Retrospective reviews may easily over-simplify, focusing on simple causes where complex clinical and contextual issues may have been critical. Like all groups, the Committee members bring different perspectives and backgrounds to this task.

At times, the Committee observed poor clinical systems and standards of practice. The development of clinical standards, clinical guidelines and risk assessment tools is a complex task requiring scientific and policy input, and extensive consultation with professional groups and consumers. The Committee has attempted to avoid defining specific clinical standards or methods, instead recommending that NSW Health should take responsibility for the management of such strategies where they are necessary.

While practical and resource issues provide a real barrier to rapid change, the Committee does not accept that these are arguments for not attempting to define minimum standards. The Committee accepts that in some circumstances, the setting of a minimum standard may pose immediate practical and resource issues, for example, defining minimum safe staffing levels for inpatient units, or minimum standards for the extent and timing of consultant psychiatrist involvement in inpatient care. It is not possible to plan for an effective mental health system without articulating some minimum standards that the system should be designed, and resourced, to achieve.

The Committee recognises that some training and workforce development issues go beyond the sphere of immediate influence of NSW Health. Liaison and joint planning with tertiary providers may be necessary.

The Committee also accepts that its recommendations are a representative view, but not the only possible view, of the cases and issues involved. The recommendations of the Committee are not intended to be absolute or non-negotiable. There are a number of ways of meeting the spirit and intent of the recommendations. Meaningful system improvement may be achieved by combining several recommendations into broader policy initiatives, or by evaluating these approaches through piloting and refinement rather than through immediate statewide implementation.

The implementation timeframes incorporated in the recommendations of this Report reflect the Committee's concern about the issues raised and its view of the urgency with which these matters should be addressed.

Levels of Responsibility and Accountability

While the Committee recognises that tragic events such as suicide deaths and homicides are not necessarily predictable, its findings indicate that a level of accountability nevertheless must be accepted by all those involved in the provision of mental health services. In any systems analysis of adverse events a framework is required from which to view the various contributions of different levels of responsibility. The Committee's view is that in relation to the provision of mental health care there are levels of responsibility and therefore accountability from the individual clinician to government. At one end of this continuum the individual clinician is responsible for clinical practice and clinical decision-making. The clinician operates within the matrix of clinical

governance and professional support of the team and service. The Area Health Service is responsible for application of funding, planning of services, policy and procedures. NSW Health and government are ultimately responsible for the level of resourcing, state-wide planning and policy. Such a framework of accountabilities is consistent with the approach of New South Wales Health's Root Cause Analysis Program.

Resources

Recognition of mental health problems and demand for mental health care have increased dramatically. Consumers, carers, clinicians, professional groups and industrial bodies have all raised concerns about the level of strain currently experienced by mental health services. Many services report serious difficulties in recruiting and retaining a skilled mental health workforce, particularly of mental health nurses and psychiatrists. Given the time required for training these staff, urgent action may be necessary to avert a serious and impending crisis in mental health care.

This service context is critical to the review of individual cases of suicide death or homicide. Effective assessment and clinical management of risk in mental health requires an appropriately skilled and supported staff operating within appropriate service structures and with reasonable access to a range of treatment resources including mental health beds.

The overall number of mental health beds in NSW has reduced until very recently, while demand has increased, in parallel with increased substance abuse and other social changes. Most acute mental health units routinely report 100% occupancy, and clinicians report that emergency access to mental health beds is a constant challenge. Effects of difficulty in access include increases in transfers of people to units distant from their communities where a bed may be available and increased numbers of people waiting for longer periods in emergency departments or receiving their entire inpatient care in an Emergency Department. Concerned clinicians also report that on occasions patients are not being admitted, or are being discharged prematurely or without comprehensive follow up, due to pressures on access to available inpatient beds.

These pressures frequently require clinicians to make intolerably difficult judgments regarding relative risk and relative priority for access to inpatient beds. Where the barrier to receiving inpatient care is very high, the limits of clinical judgment mean that clinicians and services will inevitably make errors. These contextual issues may be critical to individual cases but are often not reflected in the material available to this Committee for review.

It is the view of this Committee that there remain too few mental health beds.

Government Response to the First Report of the Committee

The NSW Government Response to the First Report of the Committee was released in December 2004. All but one of the recommendations were accepted. The Committee noted the advice that the vast majority of recommendations were either implemented, were in the process of being implemented, or would be implemented within the future timeframe requested.

The Committee determined that in order to evaluate its work and to assist in preparing future reports, it required advice from NSW Health on progress with the implementation of the recommendations, including the requested timeframes. Accordingly, the Chairman asked NSW Health to provide progress reports on priority matters for implementation.

Review of Post-Discharge Suicide Deaths

Overview

The Committee conducted a review of patients who had died by suicide within one month of discharge from a mental health inpatient service in NSW between 1999 and 2003. The purpose of the review was to identify any systemic factors inherent in care delivery to these patients, and in the transfer of care, which may have had a causal or influential role in the patients' outcome. The Committee appointed consultants in July 2004 to review medical records and related documentation associated with these patients.

The broad issues identified by the Committee in its analysis of the findings of the review were:

- Appropriate access to inpatient care
- Appropriate assessment and documentation of suicide risk
- Contact with family
- Effective communication and handover between inpatient and community care
- Assertiveness of planned follow-up
- Service response to discontinuation/loss of contact
- The review of suicide deaths in Drug and Alcohol Services
- Reporting and review systems.

Conclusions

The conclusions reached, in terms of the factors that may be associated with preventability, were

- Overall the group data provided some evidence for a link between reduced access to inpatient care and higher rates of post-discharge suicide death. Area Health Services with lower numbers of mental health beds relative to their estimated population-based bed requirements had higher rates of post-discharge suicide death. People dying by suicide within one month of discharge had a shorter length of stay than the overall population of people being discharged from mental health services, and in particular, a higher number of short (2-3 day) admissions.
- In individual cases inappropriately short length of stay may have contributed to the poor outcome. In one case the treating clinician documented the absence of available beds as a factor in management. In other cases the file review suggested that the length of stay was inappropriately short for the clinical condition or degree of distress or disturbance. It is not possible to determine from the files whether individual clinical skills or judgement were the primary issue or whether bed pressures may have contributed to these short lengths of stay.
- There appeared to be room for systemic improvement in assessment and documentation of risk, including more frequent direct involvement by consultant psychiatrists, better documentation of risk assessment at the point of admission, better review and documentation of risk at the point of discharge and specific awareness of suicidal ideation and disturbed mood in the 24 hours prior to discharge.
- Quality of documentation of family involvement was poor. However, where the presence of family or social supports was documented and family involved (e.g. the patient was living with their family), some level of family contact occurred in 60-80% of cases.
- The level of contact with the community clinician or GP during admission was variable.
- Discharge summaries contained limited information, with most not including any specific information regarding risk and some omitting information about diagnosis and treatment.
- There was limited communication of the discharge summary to the patient, GP and community services in the time between discharge and suicide death.

- Documentation of follow-up was poor, with 30-50% of records not including documented date of follow-up or planned frequency of follow-up.
- In retrospect, in a number of cases the planned frequency of follow-up did not appear appropriate to the patient's clinical situation.
- Where patients did not attend for planned follow-up, services took action to re-establish contact in the majority of cases.

Analysis of Homicide Case Reviews

Overview

In total, 11 cases were identified by the Centre for Mental Health database for analysis by the Homicide Sub-Committee in 2004: 4 cases from 2002, 6 cases from 2003 and one case from January 2004. One case was a murder/suicide death. Child deaths were involved in 5 of the 2003 cases but none of the other cases. Of the 11 cases identified, reviews were available for only 6 cases, 3 of which involved child deaths. No Root Cause Analyses (RCAs) were available as most of these incidents preceded the implementation of RCAs.

Emergent themes and salient issues that suggest directions for improved clinical effectiveness and greater safety are discussed. The Committee's approach is to consider the cases firstly in terms of whether they convey something about improving the assessment of risk. Secondly, the Committee asks whether they provide information in relation to the prevention of fatalities through the improvement of systems of care.

The absence of external reviews for all cases of homicide by a mental health patient and the poor standard of some of those available for analysis is of concern. The Committee believes that the development of standardised review procedures will assist the thorough assessment of systemic issues that contribute to or fail to prevent homicide deaths (see External Reviews, below).

The ages of these patients ranged from 23-49 years. The diagnostic spread of the cases was consistent with those previously reported for 1999-2001. All suffered from major psychoses or mood disorders complicated by psychosis. The cases included three patients who killed children, two of them women who killed their own children. Lack of engagement with the mental health service was a factor noted in 3 cases overall. Non-compliance with medication was clearly identified in 4 cases. Five patients had approached health services for help prior to the incident.

The Committee takes the position that presenting an analysis of these cases will be informative to clinical practice and to clinical policy and procedural development. The patient statistics are therefore provided not to direct blame at mental health services but to raise the question as to whether important windows of opportunity to alter the trajectory towards a fatal incident are being missed.

The Committee notes that since the last Report NSW Health has developed a framework for suicide risk assessment. A similar framework for assessing and managing risk of harm to others is an urgent imperative.

Analysis of systemic issues was more difficult than expected because of the Committee's lack of access to incident reports or reportable incident briefs, the poor quality of reports of incident reviews, and the exclusion of a clear account of events and timeline even in some of the more thorough review reports. Some external reviews had extensive findings and recommendations in

relation to gaps in performance, policy or procedures in local services that could not necessarily be generalised to other mental health services.

Of particular note is the finding that the medical record was often not utilised as the central instrument for documentation and communication of ongoing assessment, evolving management plans and inter-professional, inter-team communication. The introduction of an electronic health record will significantly strengthen the ability of clinicians to have all the necessary information for complex assessments and clinical decision support across the range of treatment settings.

Clinical practice, clinical governance and poor quality of information and communication were systemic issues identified by the Committee. Much of the clinical practice that was reviewed was of a high standard. Some of the events reviewed were not predictable, even with the benefit of more information than the assessing or treating clinician had access to at the time. However, the nature of the analysis of incidents is to focus on deficiencies and gaps in performance because the intention is to identify what could have been done differently to prevent or mitigate the incident. Following the analyses of these and other cases it is the view of the Committee that clinical practice guidelines, clinical pathways or protocols may provide explicit standards of care that will assist clinicians, consumers and reviewers of incidents.

Issues of clinical governance were raised in every case to some extent giving the impression that this is an area requiring significant development and strengthening in mental health services. A number of the clinical governance issues arising from these cases turn around the role of the psychiatrist or the leader of the clinical team or unit.

An issue of concern to the Committee is the lack of a central register of forensic patients in the community and the Committee recommends that a register should be developed. Its purpose would be to ensure that NSW Health and Area Mental Health Services are aware of which Area Mental Health Services are responsible for these patients. Area Mental Health Services (with the assistance of Justice Health) should report regularly to the Department on the progress of these patients.

The analysis of homicide cases concludes with recommendations around three key areas:

- the need to develop a framework for assessment and management in relation to risk of harm to others
- assessment and management of parents with a mental illness
- the need for strengthening systems of clinical governance.

Risk Assessment and Management

There is no clinical activity that is of greater concern to the Committee than “risk management”. In the absence of a “risk management plan”, a “risk assessment” serves no clinical purpose. With this objective in mind, the whole purpose of any “risk” assessment is to provide an empirically informed clinical basis for a “risk” management plan. The “risk” assessment is not complete until a management plan that addresses the identified risks is developed, communicated and implemented. “Risk Assessment” and “Risk Management” are not separate, discrete procedures, but rather intrinsic components of comprehensive mental health assessment and management. In other words, a mental health clinician does not “conduct a risk assessment”, rather they should conduct a comprehensive mental health assessment of which risk assessment is a vital dimension and a risk management plan the outcome.

While this report focuses on the two most serious adverse events that could potentially affect a patient, namely suicide death and homicide, there are numerous other risks that are of concern to

mental health workers. In the course of any clinical assessment consideration should also be given to the risk of aggression as distinct from homicide, self harm as distinct from suicide, future substance abuse, victimisation, self neglect, non-adherence to treatment suggestions, medical risk, absence without leave and misadventure.

The Committee accepts that identifying risk is a complex task. The frequency of very serious adverse events such as suicide death and homicide occurring in a large group of patients, such as those suffering mental illness, is low. When an adverse event occurs infrequently in a group of people, it is difficult for clinicians to identify those at risk of experiencing that event. However, the incidence of aggression and self harm is higher than homicide and suicide and these behaviours should be easier to predict. Notwithstanding this, determining what constitutes a risk, that is: what behaviours; of what severity; how soon in the future they are likely to occur; who is at risk; and under what circumstances, is difficult in any one clinical interaction with a patient. Risk is dynamic and fluctuates, and can increase or decrease in response to multiple unpredictable circumstances. By improving the ability of clinicians to assess and manage risk for self harm and aggression the incidence of more serious outcomes such as homicide and suicide death may be attenuated.

Suicide death or homicide by a person suffering mental illness has serious consequences. Not only are people severely and fatally injured; but such events add to the stigmatisation of mental illness, reduce public confidence in mental health services and cause significant distress to the community at large. Mental health services should be motivated to improve risk assessment and management procedures to achieve optimal competence in this area.

Assessing and managing risk is one of the critical tasks of a mental health service. Many clinicians are very experienced and provide assessments and care of a high quality. There exists however, an obligation to ensure that clinical practice utilises whatever empirical evidence is available at the time.

Evidence from service effectiveness research and from individual cases and coronial enquiries suggests that – as in other branches of health care – these tasks are often not systematically performed and have a component of preventable error.

However, risk assessment and management cannot be undertaken using a “tick box” approach, where completion of a checklist or rating-scale becomes an alternative to comprehensive assessment, clinical judgment and planning. It is the Committee’s perception that such “tick box” pro formas over emphasize “risk assessment” at the expense of “risk management”. Problems with the reliability and validity of risk rating scales may place individual services and clinicians at risk if these are used in a narrow or uncritical way. It is good clinical practice to adopt technologies as they are introduced. Empirically validated risk assessment tools may provide a valuable support to clinical decision-making. There is at present a comprehensive literature in relation to violence and suicide death available to clinicians including risk assessment tools for violence that could be adopted by mental health services.

The Committee believes that a priority for NSW Health should be to identify appropriate tools for supporting the assessment of clinical risk, and to evaluate rigorously their professional, scientific and ethical appropriateness. The routine implementation of such tools will require a broad strategy for supporting clinical skills and clinical change. This would include properly supported staff training, developed and planned in consultation with appropriate professional bodies. It may also involve changed business processes and information systems, including integration of appropriate

tools into routine clinical forms (such as MH-OAT documentation) or into electronic health records as they develop.

Risk assessment and management for both violence and suicide should be a core clinical skill.

External Review of Homicide Incidents

The Committee developed a draft proposal for a framework for incident reporting and external review of homicide cases involving mental health patients to assist Area Health Services in the public scrutiny of their response to incidents and allow for more detailed and timely case analysis by the Committee. The proposal is currently before NSW Health for consideration and consultation with Area Health Services.

The RCA would remain at the heart of the review process but an external review would be broader, more immediate and would provide more detail to facilitate the work of the Committee. The Committee has proposed that external reviews would comply with agreed terms of reference and a standardised format and content, to ensure consistency. In further development of the proposal, a number of issues including privilege, the relationship of the external review to the RCA process, and the requirement for Ministerial approval would need to be addressed.

The Committee understands that the Centre for Mental Health will continue to manage the overall process of external reviews of homicides perpetrated by patients in mental health care, and that it will continue to maintain a database and inform the Committee of cases as they arise.

Recommendations

Recommendations

	Implementation timeframe	Page reference
REPORTING AND REVIEW SYSTEMS		
1. NSW Health examine the effectiveness of current reporting and review processes for suspected suicide deaths of patients of Alcohol and Drug Services.	6 months	47
2. NSW Health develop and trial a standardised terms of reference and documentation format for the external review of a homicide by a patient of a mental health service.	12 months	54, 64
3. NSW Health work with the NSW Coroner to develop systems for communication between the Coroner and local mental health services to ensure that services receive prompt and comprehensive notification of suspected suicides deaths.	12 months	48
4. NSW Health ensure the development of <ul style="list-style-type: none"> • a unique identifier, and • electronic record systems to ensure the constant availability and prompt transfer of relevant clinical information between services and between service providers.	24 months	48, 57
5. NSW Health evaluate the effectiveness of the current system of reporting and review of suspected suicide deaths. This evaluation should consider whether RCA methodology facilitates meaningful involvement of local clinicians, and consider additional methods for such involvement if necessary.	24 months	48
CHILDREN, FAMILIES AND CARERS		
6. NSW Health commence immediately the development of a clinical guideline for the management of risk to children of a parent with a major psychiatric disorder, for implementation within 24 months.	6 months	59, 60
7. NSW Health implement and audit minimum standards for the involvement and documentation of the involvement of families and carers in mental health care during: <ul style="list-style-type: none"> • assessment • discharge planning from acute mental health inpatient units • ongoing community care • contingency planning and response to escalating concerns or to changing clinical situations. 	12 months	41

	Implementation timeframe	Page reference
ASSESSING AND MANAGING RISK OF HARM TO OTHERS		
8. NSW Health develop an empirically based risk assessment and management framework of risk of harm to others.	24 months	62
9. NSW Health liaise with mental health professional bodies to include in professional development programs defined minimum risk assessment skills.	24 months	63
FORENSIC PATIENTS		
10. NSW Health develop a register of forensic patients in community care.	6 months	62
11. NSW Health develop guidelines for the minimum level of care that should be provided to forensic patients in community care.	12 months	62
CLINICAL PRACTICE AND CARE		
12. NSW Health define standards in relation to the timely review by a senior mental health clinician, of decisions made by members of the multidisciplinary team at critical points in the patient's care, including <ul style="list-style-type: none"> • new presentations • acute exacerbations or relapses of illness • changes in the level of risk of harm to self or others • discharge from the mental health service. These standards should specify the involvement of a treating psychiatrist or most senior attending mental health clinician.	12 months	61
13. NSW Health develop minimum standards for consultation with, and/or direct contact by, consultant psychiatrists <ul style="list-style-type: none"> • in the assessment of emergency presentations to mental health services and emergency departments, and • in the care of inpatients of mental health units, and for the recording of such contact. 	12 months	39
14. NSW Health develop standards for the use and documentation of telephone contact in initial and ongoing assessment, treatment and post-discharge follow-up by mental health services. Reliance on telephone contact in high risk situations should be discouraged.	12 months	45, 59
15. NSW Health implement a procedure for flagging and reviewing patients who are failing to improve.	24 months	60

	Implementation timeframe	Page reference
16. NSW Health ensure that risk assessments and risk management plans are routinely documented in the medical record, and that changes to the level of risk are documented and are accompanied by a specific and appropriate management plan.	24 months	58
FORENSIC AND FOLLOW-UP		
17. NSW Health develop minimum standards for the frequency and duration of follow-up after discharge from an inpatient mental health unit. This should be linked to the level of clinical risk.	12 months	45
18. NSW Health ensure that people with a first episode of psychosis or major mood disorder receive active follow up by the senior attending mental health clinician for at least 12 months following first service contact, in keeping with the National Psychosis Guidelines. Where this is impossible or unnecessary, the case should be reviewed and adequately documented.	12 months	59
19. NSW Health develop mandatory procedures for response to loss of contact or non-attendance at planned follow-up for people who may be at risk of suicide or risk of harm to others. If loss of contact occurs within 28 days of discharge for any patient, or at any time if a person remains at significant risk, then <ul style="list-style-type: none"> • immediate consultation should occur with a senior mental health clinician, and • a considered action plan should be documented by the service. 	12 months	46, 61
SERVICE PARTNERSHIPS		
20. NSW Health ensure that where multiple health providers (eg general practitioner, private psychiatrist, psychologist, non-government organisation) are involved in a shared management plan that there is effective flow of appropriate information between them. Where the patient refuses consent for the exchange of information there is review by the senior clinician.	12 months	58
21. NSW Health ensure the development of policies and training for suicide risk assessment in Alcohol and Drug services.	24 months	47

	Implementation timeframe	Page reference
RESOURCES and DEVELOPMENT		
22. NSW Health establish clear timeframes for delivering on its previously made commitment to reach acute mental health bed targets, to ensure Area Health Services meet their population bed needs in terms of Department of Health accepted planning models. Clear timeframes and targets should also be set for the provision of community mental health services.	6 months	37
23. NSW Health develop a mental health workforce strategy to build the necessary mental health workforce to meet service and quality goals across the life span, by the end of 2006.	6 months	18
24. In order to maximise the effectiveness of existing strategies to build workforce capacity (including resources, policies and protocols), NSW Health develop in partnership with the Institute of Psychiatry, other professional bodies and Area Health Services an educational agenda to progress skill and knowledge development. This collaborative process should identify priorities and set learning goals for each year over the next five years.	12 months	18

Part 1

Introduction

The NSW Mental Health Sentinel Events Review Committee

Terms of Reference

Committee Structure, Tasks and Methods

The Government's Response to the First Report of the Committee

Introduction

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 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.

In June 2004 the Minister approved the appointment of four new members to replace original members who retired or resigned, and of two additional clinician representatives.

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 that would include sub-committee methods, findings and recommendations, and submitted to the Minister in December 2003 its first report entitled *Tracking Tragedy – a systemic look at suicides and homicides amongst mental health inpatients*. The Minister released the report in December 2003.

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 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; and
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 which 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.

Committee Structure, Tasks and Methods

On 11 October 2002 the Committee convened the Homicide, Suicide and Coroner's Recommendations Sub-Committees. The sub-committees would meet separately and report back to the Head Committee through their Chair, in respect of their progress at the subsequent meeting of the Head Committee.

Following the submission of its first report, *Tracking Tragedy*, to the Minister for Health in December 2003 the Committee, commensurate with the terms of its establishment, reviewed its terms of reference and objectives to determine whether it should continue activities under the same conditions. Modifications to the terms of reference of the Committee and membership require the approval of the Minister. The Committee has addressed these matters separately.

The Department of Health made recommendations to the Minister for Health with regard to membership changes due to resignations and retirements and also with regard to the need to enhance clinician representation. The recommendations were agreed by the Minister and new appointments were approved in July and August 2004 (see Appendix 1).

The Committee convened a Planning Workshop in April 2004 to assess its progress and determine its plan of work for 2004. It considered the public response to its First Report to the Minister, reviewed its sub-committee structure and membership, work processes and timeframes.

It determined that the work of the Homicide and Suicide Sub-Committees would continue in 2004. It also determined that the work of the Coroner's Recommendations Sub-Committee was completed in 2003, and that in 2004 the Committee would maintain a watching brief on coroner's recommendations through the work of a new sub-committee, the Implementation and Outcomes Monitoring Sub-Committee.

Suicide Sub-Committee

The role of the Suicide Sub-Committee is to review suspected suicide deaths of patients of public health facilities who were suffering or reasonably believed to be suffering from a mental illness, to report on trends and make recommendations to the Head Committee.

NSW Health records the demographics of suspected suicide deaths of patients of mental health services, including data as to method and place of death. It has not previously been possible to link records of patient contacts with different health services, such as community mental care and inpatient care.

Method

In 2003 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. 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 one month of discharge)
3. Community outpatient deaths (those who have had an interface with community\ mental health services)

4. Non-contact deaths (where the suicide victim did not have a known interface with any mental health service).

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.

In 2003 the task of the Suicide Sub-Committee was to review the suicide deaths or suspected suicide deaths in the previous five years of clients of public health facilities who were suffering or reasonably believed to be suffering from a mental illness (Category 1), to report on trends and make recommendations based on a review of cases. 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. The results of this review were reported in the First Report of the NSW Mental Health Sentinel Events Committee: Tracking Tragedy (December 2003).

In 2004 the aim of the sub-committee was to report on the clarity of the discharge process and the effectiveness of the transfer of care. Recently discharged cases were more complex than inpatient deaths because of multiple providers and longer time frames.

The sample included all suspected suicide deaths reported by mental health services within 28 days of discharge, for the five years 1999-2003. 102 suspected or reported cases of suicide death of patients discharged from a public mental health inpatient unit, or approximately 20 reported suicides per year, were reviewed. Cases were identified from Department of Health Mental Health Service Client Death Reports. **Until confirmed by Coroner's investigation, a reported suspected suicide death remains unconfirmed. It is important to note that Client Death Reports notify cases of suspected or possible suicide death that must be confirmed by coronial investigation.**

Sources of information

Documentation available to the Suicide Sub-Committee included:

- NSW Health Department Mental Health Service Client Death Reports
- Area Health Service case files, including inpatient records of last admission, and community mental health records
- Police Records
- Coroners Reports
- Coroners Recommendations
- Critical Incident Reviews
- Root Cause Analyses and other reviews

Area Health Service case files were matched with reports from the Office of the State Coroner, including Police Records, Briefs of Evidence and Coroners findings or opinions where these were available. It was a matter of concern to the Committee that in many instances, case files, reports and other documentation could not be provided.

2004 Review of cases

The Suicide Sub-Committee reviewed relevant literature and formulated a list of issues to form the focus of review of files. These issues were:

1. Access to and early discharge from inpatient care.
2. The quality of risk assessment, including assessment of depression and hopelessness where primary diagnosis is not of mood disorder.
3. Adequacy of contact with family during and after inpatient care.
4. Integration between hospital and community or follow-up services, and the adequacy of handover between service settings.
5. The assertiveness of planned follow-up, especially within the high risk period of the first 7 days following discharge.
6. The service response to missed appointments or discontinuation of contact during follow-up.

Subsequent stages of the review were conducted by a working party of the Suicide Sub-Committee. Stage 1 of the review comprised a file review of the available records for all 102 suspected suicides. The working party defined data items that could directly or indirectly relate to the above issues of interest.

The QaRNS team (Northern Sydney Area Health Service) was appointed to review the files, and worked with the Suicide Subcommittee to develop the audit methodology and tools. Coders from this team reviewed each file, extracted relevant information, and prepared a one page clinical summary of each record. Summary data and analysis provided by QaRNS form the basis for many of the tables in this report. The subcommittee warmly acknowledges the skill and professionalism of the QaRNS team in undertaking this review.

Stage 2 comprised a review of the 102 clinical summaries by the working party. Each member of the working party independently reviewed each clinical summary, focusing on two issues, firstly identifying and summarizing apparent issues or factors which may have contributed to the suspected suicide, and secondly, assessing the likely preventability of the suspected suicide in each clinical summary. A broad, three level definition of likely preventability was adapted from a definition widely used in review of medical and surgical outcomes, as shown in the table below.

	Medical/ Surgical Definition	Definition adapted by Sub-Committee
Probably unpreventable	Complication that is unpreventable given the current state of medical knowledge or current state of resources, ie exemplary management.	Overall management appears to have been “exemplary” in matters including level of risk assessment, level of consultant review, detailed discharge planning and assertiveness of follow-up.
Potentially Preventable	No error (omission or commission) identified, but it is widely recognised that a high incidence of this complication reflects low standards of care or technical expertise (eg. unexplained wound infection).	There appear to be some departures or omissions from “exemplary” practice but these are few in number, minor in degree or in aspects of care which do not appear directly related to the outcome.
Probably Preventable	Resulting from an error of omission or commission due to failure to follow accepted practices (can include system and process failures).	Apparent clear departure(s) from accepted practices and standards in ways which a reasonable person would see as being likely to have made a substantial contribution to the outcome.

The many limitations of this judgment are acknowledged. The aim of this rating of possible preventability was to calibrate the judgments of the sub-committee against other published data on review of suicides.

Following Stage 2, the aggregated data, individual summaries and review of these summaries were used to draft a preliminary set of recommendations for consideration by the Suicide Sub-Committee.

Stage 3 of the review comprised detailed review of all available records for 12 selected cases. This review was conducted by a working party of the Suicide Sub-Committee, augmented by an additional psychiatrist member of the Committee. The 12 cases were selected on the basis of the rating of likely preventability conducted in Stage 2. Six cases were selected for whom there was the greatest agreement between working party members that the suicide death may reasonably have been preventable. Six further cases were selected on the basis of a high level of *disagreement* between working party members about the possible preventability of the suspected suicide death.

The aim of Stage 3 was to revise and refine recommendations. Impressions of possible preventability derived from clinical summaries were tested against detailed clinical records. Draft recommendations were tested against detailed clinical records to consider whether these recommendations would have been reasonably likely to have resulted in a different outcome. A number of recommendations were modified or deleted during this stage.

Following Stage 3, the Suicide Sub-Committee prepared final draft recommendations for consideration by the Committee.

Homicide Sub-Committee

Harm minimisation in a risk management environment is the philosophical basis for the sub-committee's work and its subsequent recommendations, which therefore focus on minimising potential causes and on systemic analysis.

Method

In 2003 the sub-committee analysed case reviews of homicides that took place in 2000 - 2002, involving clients of public mental health facilities who were suffering or reasonably believed to be suffering from a mental illness.

In 2004 the sub-committee analysed case reviews of six homicides that occurred in 2002 to January 2004. Four were commissioned by Area Health Services or the Centre for Mental Health and were lead by an external reviewer, and two were undertaken internally by the Area Health Service where the perpetrator was a patient. It is the intention of the sub-committee in 2005 to analyse cases which occurred in 2004 and new cases as they arise, although the coronial process will influence the number of cases available for analysis.

Also in 2004, the sub-committee looked specifically at systemic issues around child deaths caused by adults with a mental illness, as a sub-group of homicides.

When analysing emerging cases the opportunity arises to report on individual cases, and to bring them to the attention of the Coroner, Health Care Complaints Commission and relevant professional registration boards if appropriate, in accordance with the Committee's Term of Reference No. 3.

However, it remains the role of the Committee to review incidents, identify systemic issues and to refer on any cases of gross incompetence. In 2004 the practices of individual clinicians or the mental state of clients at the time of the sentinel event were not addressed.

Sources of Information

To assist the sub-committee in its work, the Centre for Mental Health developed a database of homicides perpetrated by patients of the mental health system. This was extracted from the broader NSW Department of Health database that includes information of all reported incidents of homicide or attempted homicide in health facilities, of or by mental health patients. The resulting homicide database included relevant forensic cases and cases of child death.

Through the Centre for Mental Health the Committee requested Area Health Service Chief Executives to make available any reviews and RCAs of homicide cases for analysis by the sub-committee.

The Centre for Mental Health database identified 4 cases which occurred in 2002 and 6 cases, (of which 5 were child deaths), in 2003. One case occurred in January 2004 (not a child death). Of these 11 cases, reviews were available for only 6, of which 3 involved the death of a child. No RCAs were available.

Analysis of case reviews

The Homicide Sub-Committee approached the reviews through a process of discussion and analysis to identify systemic risk factors. A report of factors identified in the analysis is included in Part 4. The sub-committee reported on trends and made recommendations based on its analysis of cases.

Risk assessment and management

As a result of the case analysis the Homicide Sub-Committee developed a number of recommendations specifically addressing the issue of risk assessment and management. These recommendations are also relevant to suicide death. The report is included in Part 4.

External reviews

The sub-committee continued its work of considering and making recommendations on tools and processes for comprehensive case reviews and assessments. Its aims in this regard are to assist Area Health Services in their response to public scrutiny of their response to incidents, ensure adequate reviews of cases to facilitate detailed, timely and thorough analysis by the Homicide Sub-Committee in future and to complement information provided by RCAs.

Implementation and Outcomes Monitoring Sub-Committee

At its Planning Workshop on 17 April 2004 the Committee established the Implementation and Outcomes Monitoring Sub-Committee to review the progress of recommendations made by the Committee, to advise on processes to improve reporting and monitoring of sentinel events and to maintain a watching brief on incoming Coroner's recommendations. The sub-committee held its first meeting on 24 June 2004 and has met on four occasions to date.

The role of the Sub-Committee is to

1. advise the Committee on the implementation of the Committee's Recommendations .
2. advise the Committee on how reporting and monitoring guidelines may be refined to facilitate the efficient flow of information to the Committee
3. maintain a watching brief and advise the Committee on incoming Coroner's recommendations and continue the work of the 2003 Coroner's Sub-Committee in improving the practical implementation of coronial recommendations.

The Committee aims to assist in the definition of standards and processes in reporting so that after retrospective file reviews are completed, possibly in 2005, the system will be able to deliver the information the Committee needs on an ongoing basis. To this end, the sub-committee studied current and proposed Mental Health Incident Reporting and Monitoring processes and structures, including the principles to be followed and proposed time frames for reform.

Sub-committee members identified weaknesses in how information on homicides and suicide deaths is currently reported, and made suggestions about the data recorded for suicide deaths and for proposed external reviews of homicide cases (see Part 4).

The sub-committee commenced a process of considering Coroner's recommendations referred to it and advising where necessary on their implementation. To assist this activity in future the Committee will receive a summary table of recommendations for review from time to time. It noted that the Department of Health has developed a flow chart of the Departmental response process.

The Government Response to the First Report of the Committee

The first report of the Committee, *Tracking Tragedy – a systemic look at suicides and homicides amongst mental health inpatients* was submitted to the Minister for Health in December 2003.

The NSW Government Response to the First Report of the Committee was released in December 2004. All but one of the 52 recommendations of the First Report were supported. The exception was not accepted because of its current form, although its underlying purpose and objective were acknowledged. The Committee noted the advice that the vast majority of recommendations were either implemented, were in the process of being implemented, or would be implemented within the future timeframe requested.

The Implementation Taskforce established as part of the Government's response to the Upper House Select Committee Report on Mental Health also oversees the implementation of the Committee's recommendations.

The Committee determined that in order to evaluate its work and to assist in preparing future reports, it required advice from NSW Health on progress with the implementation of the recommendations, including the requested timeframes. Accordingly, the Chairman asked NSW Health on behalf of the Committee to provide progress reports on priority matters for implementation. He also requested to be advised of any feedback from Area Health Services on the usefulness and practicality of adopted recommendations and on any barriers to their implementation. The first report from the Department is due in March 2005.

This matter will be a standing item for future Committee meetings and reports.

Part 2

Context

General

Suicide Death

Homicide

Context

General

There is a common perception that a suicide death or 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 and one of the purposes of the Committee is to review these incidents and examine systematic problems within the mental health services which may have contributed to the tragic outcome and to suggest solutions.

Service capacity

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

Admission to mental health beds is widely seen as the most effective short-term risk mitigation strategy in high-risk cases. The Committee believes 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 beds in NSW has reduced until very 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. The Committee believes that this has led to mental health clinicians and Area Health Services having more limited options, including less ease in admitting potentially high-risk patients for sustained periods of containment. Whereas in previous decades it was possible to admit more easily a potentially suicidal or dangerous patient for a sustained period of containment, that option is more 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.

Workforce issues are of significant concern. There are fewer medical officers training in psychiatry, nurses do not see mental health as a desirable profession and their workforce is ageing. Mental health services are experiencing increasing difficulties in recruiting and retaining experienced, qualified mental health staff. Overburdened mental health services are particularly at risk of compromised reputation and subsequently find it difficult to attract staff to their service.

As a result, the very services that require better staff are unable to attract that staff and rely on junior staff, who in many circumstances work with little supervision while at the same time are

expected to make decisions about high risk patients. When junior staff are involved in an adverse incident they can then be exposed to legal enquiry with little support from senior staff who are either absent or were not involved in the particular case because of other demands. When outside clinicians observe this situation, confidence in that particular working environment is eroded and the attractiveness of the service to others is reduced.

Professionals, particularly clinical leaders, are not prepared to work in environments that conflict with their ethics, force them to practice at a substandard level to meet demand and put them at professional risk. The lack of clinical leadership contributes to the further erosion of skills in the workplace.

The privately funded sector opts out of providing care to highest-risk patients suffering from mental illness. Thus the entire burden of managing these patients falls on an already overburdened public system. These problems are persistent and need to be urgently addressed.

There is an international shortage of mental health clinicians and NSW is competing in this market. By the end of their training, particularly in NSW, many psychiatric registrars perceive the private sector as more attractive than the public sector. A project that is dedicated to assess and address workforce drivers may assist in dealing with these pressing problems.

Accordingly, the Committee recommends that

NSW Health develop a mental health workforce strategy to build the necessary mental health workforce to meet service and quality goals across the life span, by the end of 2006

Recommendation 23

Implementation timeframe: 6 months

In order to maximise the effectiveness of existing strategies to build workforce capacity (including resources, policies and protocols), NSW Health develop in partnership with the Institute of Psychiatry, other professional bodies and Area Health Services an educational agenda to progress skill and knowledge development. This collaborative process should identify priorities and set learning goals for each year over the next five years.

Recommendation 24

Implementation timeframe: 12 months

Unpredictability

Prediction of risk of homicide or self harm is difficult. Large studies have identified factors that are correlated with future risk for violence or self harm. These factors are however applicable to groups over the long term. Based on these factors it is possible to identify with reasonable accuracy groups of individuals who may pose a higher risk of violence or self harm than others. However, the difficulty for clinicians is to identify which individuals in the higher risk group will self harm or be violent imminently. In addition, unpredictable and unforeseen events can change a person's level of risk.

There are numerous difficulties central to the identification of the potentially self-harming or violent patient that makes the process complicated for the clinician. These include the level of risk (high, low, medium), the type of risk (suicide, self harm, violence, sexual, psychological), the imminence of the event predicted (short-term, medium term, long term). At the same time the clinician has to balance community safety with the person's individual rights. All these factors make risk assessment and management a daunting task for any clinician and even more difficult when confronted with a busy service and pressure on resources.

Suicide Death

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 subsequently 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.

While it is not possible to identify particular individuals in a higher risk group, it is possible to implement risk management strategies to ameliorate risk that may be present, whether high medium or low. Ultimately the risk management question is not "what level risk does this person pose," but rather "having regard to the identified risk factors, what management plan needs to be implemented to manage the risk safely." Various factors have empirical support in their correlation with future violence or self harm, and it is possible to identify types of patients who have the characteristics of those with an increased risk of self harm or violence.

A greater emphasis on risk management 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 could potentially reduce services for other people suffering mental disorders who may pose a lesser risk to themselves or others. This could have the effect of, in the longer term, eventually increasing risk to patient and community as resources are moved from one patient group to another. Thus additional resources need to be available for effective risk management without undermining current resources and services.

As stated in the First Report of the Committee, 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 individuals' attitudes to life, to each other, and to the supports that can and should be provided to those in need. A suicide death of a patient in care represents a further burden in the 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.

Every year in NSW approximately 20,000 admissions are made to public psychiatric hospitals and mental health units of general public hospitals, often following suicide attempts. Approximately 20 times per year, there is a suicide death within one month of discharge. (Source: Mental Health Client Death Surveillance System - includes reporting in RIB and CDRF - Centre for Mental Health.)

Effective hospital care is an essential component of the comprehensive assessment and treatment of mental illness, and the prevention of suicide death. The period after discharge from hospital is a critical period, as evidence from studies around the world shows the risk of suicide death is greatest in the days or weeks following discharge from mental health inpatient care.

Reducing this risk requires a comprehensive mental health service system, which links effective inpatient care with community treatment and responsive emergency support for mental health patients and their carers and families.

In NSW, Privacy Legislation and the Area Health Service structure established with in the Health Services Act do not allow for a centralised mental health case register, or linkage of health records directly with coronial records, as is possible in some jurisdictions. Therefore detection of post-discharge suicide deaths relies on a network of mainly local systems, including links between mental health services, families, police, emergency departments and – in some areas – local coroners' courts. These “suspected suicides” are reported to the Centre for Mental Health by all services.

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 death involves a range of government agencies, non-government organisations, communities and individuals working in partnership.

Homicide

As stated in the First Report of the Committee, the homicide cases reviewed 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 victim's family, and even the perpetrator who has to live with the consequences of their actions.

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

- Only 10% of those suffering mental illness have a history of violence;
- Homicide in the community is itself a rare event, with about 110 cases per year in NSW;
- Of men with serious mental illness who were convicted of an offence of violence, it is estimated that one-third had prior contact with mental health services (Wallace, Mullen et al, 1998);

- The probability that any patient with a serious mental illness such as schizophrenia will commit a homicide is 1:3000 for men and 1:33000 for women (Wallace, Mullen et al, 1998);
- The psychiatric factor that has the strongest association with violence in people suffering serious mental illness is substance abuse;
- 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 violence can be foreseen, 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 of clinicians to identify who will be violent in a group of people is difficult. We are more likely to be right if we predict that the person is not going to be violent than if we predict the person is going to be violent. However, the consequences, when we do not get it right, are severe. We therefore need to try to get it right as often as possible.

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

Of the 6 homicides reviewed by the Committee in 2004, 3 of the victims were children. This has highlighted the risk that not only children but family members are exposed to when another member of the family suffers a serious mental illness. Over 50% of victims of violence perpetrated by those suffering a serious mental illness are family members. Children are the most vulnerable of that group. This is why it is important to take family concerns about risks seriously. The importance of family involvement is imperative. Filicide however, is an extremely rare event and when committed by a female parent, that parent has generally been suffering a serious mental disorder.

One of the purposes of the Committee in reviewing incidents of suicide death and homicide 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. The Committee understands that the same decisions in many other cases would have produced much better 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.

Part 3
Review of Post-Discharge Suicide Deaths

Review of Post-Discharge Suicide Deaths

Summary

- Suicide death on discharge from hospital is a rare event. Each year in NSW there are about 20 deaths from suicide within 28 days of discharge from hospital. There are about 20,000 discharges per year.
- Between one-quarter and one-third of suicide deaths following discharge from hospital could reasonably be prevented.
- There is no mandatory reporting or review of apparent suicides from some high risk health settings, in particular from Drug and Alcohol Services.
- Constraints on the availability of mental health inpatient care may contribute to deaths by suicide.
- People who died by suicide within 28 days of discharge tended to have shorter lengths of stay than other mental health inpatients.
- Area Health Services with fewer mental health beds compared with their population needs had double the rate of death by suicide following discharge.
- More than half of suicide deaths occurred within the first 6 days following discharge.
- The standard of documentation of the assessment of suicide risk was poor.
- There was no examination by a consultant psychiatrist for nearly one-third of patients during their admission.
- Nearly one-quarter of patients had evidence of disturbed mood and suicidal ideation documented in the 24 hours prior to discharge.
- Family involvement was variable.
- Communication between hospital and community services was poor:
 - nearly 30% of files had no discharge summary;
 - nearly 20% of discharge summaries contained no information about follow-up plans;
 - nearly 40% contained no information about medication and
 - more than 80% did not discuss risk;
 - only 21% of files contained evidence that the discharge summary had been or was intended to be forward to the patient's GP and
 - no file contained evidence that a discharge summary or plan had been given to the patient or their family.
- The assertiveness of planned follow-up was variable.

Introduction

The Committee is aware that most suicide deaths in NSW occur in people not in contact with mental health services. Arguably the greatest scope for improved prevention of suicide death lies with strategies aimed at increasing access of people with mental health problems to effective mental health services. However, this is beyond the scope of the Committee's Terms of Reference.

This report confines its scope to people suspected to have died by suicide within 28 days of discharge from an inpatient mental health unit. This represents one important subgroup of suicide deaths. The work plan of the Committee over its first three years is to consider suicide deaths in all service settings. The Committee has divided consideration of these deaths into three groups: inpatients, people within one month of discharge from a mental health inpatient unit, and people in community care (including people who have been discharged from a mental health inpatient unit more than one month previously). Each is equally important. **This report considers only the second group: people suspected to have died by suicide within one month of discharge from a mental health inpatient unit.** The first group was considered in the previous report of this Committee and the third group will be considered in its next report.

Each year in NSW tens of thousands of people receive effective mental health care. Mental health services work hard to provide effective care and to prevent suicide death by people in their care. However, a proportion of suicide deaths of people receiving mental health care is likely to be preventable.

Many studies have demonstrated an increased risk of suicide death in the days or weeks following discharge from mental health inpatient care, and suggested that a proportion of these deaths may be preventable. Reducing this risk requires a comprehensive mental health service system, which links effective inpatient care with community treatment and responsive emergency support for mental health patients, their carers and families.

The Committee would like to emphasise that most encounters between patients and the mental health system are successes. That we are studying the others does not blind us to the successes that the system enjoys.

Detecting and reporting suicide death in community care

The incidence of suicide death of people in contact with community mental health services in NSW is likely to be under-reported, for reasons discussed below.

Detection of post-discharge suicide death in NSW occurs through a network of local systems, including links between mental health services, families, police, emergency departments and local Coroner's courts. Where mental health services become aware of the death of a person who has recently been in their care, they are required to report this death to the Centre for Mental Health, NSW Health. Such deaths are referred to as "suspected suicides", and as the final cause of death cannot officially be confirmed until after appropriate investigation by the NSW Coroner.

In NSW, privacy legislation does not permit a centralised mental health case register, or linkage of health records directly with coronial records as is possible in some jurisdictions. Therefore the rate of suspected suicide death known to mental health services will inevitably be an underestimate; some patients may have lost contact with a mental health service prior to their suicide, and the service may therefore not be notified of their death.

It is the Committee's view that the clinical cost is more than the privacy benefit, but it understands that the issue of ensuring an appropriate balance between competing rights – in this case between the right to privacy and the right to effective treatment and effective health care service monitoring – is a complex one, requiring the careful consideration of legislators. Other jurisdictions appear to have struck a different balance on this issue to that adopted in NSW.

The exact extent of under-reporting of suicide deaths is not known. NSW Health data suggest that in NSW the rate of reporting of suspected suicide deaths of people within one month of contact with a mental health service is similar to that found in Western Australia, where centralised mental health and coronial registers permit more complete reporting. It is likely that the detection and reporting of suspected suicide deaths is more complete in the initial period after discharge than in longer follow-up periods.

Every death by suicide is a tragedy. There is no "acceptable" or standard rate of suicide death following discharge from inpatient care. However, international studies (1-3) have reported rates of suicide death within 28 days of discharge of between 2.9 and 4.3 suicide deaths per 1000 discharges. Every year in NSW around 20,000 discharges occur after overnight admission from NSW mental health inpatient units. This report identifies 102 suspected suicides occurring within one month of discharge from a mental health inpatient unit from 1999 to 2003 inclusive. (As discussed above, this is probably an underestimate of the actual rate of suicide in this period.) Despite the high risk of suicide death in the patients cared for by mental health inpatient and community services, suicide after discharge from mental health inpatient care is therefore a rare event, with approximately one reported death occurring for every 1000 mental health separations.

The number of suicide deaths in NSW from 1996 to 2002 ranges from 811 (1996) to 696 (2002), peaking at 946 in 1997. Over this period the average number of reported suspected suicide deaths per year of patients in contact with health services (as defined by contact within the last 12 months or more) was 155, peaking at 179 in 2002. Most suicide deaths are of people who are not in contact with mental health services¹. There has been an overall downward trend in suicide deaths both in NSW and nationally since 1997.

Preventing suicide death after discharge from hospital

Three studies have examined the care of large groups of people who have died by suicide, and provide an important context for this review. The UK National Confidential Inquiry (4) reviewed all reported suicide deaths and homicides occurring in people in mental health care in the United Kingdom between 1996 and 2000. Information was collected from clinical reviews conducted by the treating services, including judgements of the extent to which the treating clinicians felt – in retrospect – that the death may have been prevented. Pirkis and Burgess (5,6) linked mental health and coronial registers in Victoria to identify all suicide deaths of people in mental health care occurring between 1989 and 1994, and compared them with a group of matched case controls. Three reviewers conducted a qualitative file review, including judgements about preventable factors contributing to the suicide. Lawrence and colleagues (7) linked coronial and mental health case registers to examine all suicide deaths of people in mental health care in Western Australia between 1980 and 1998.

¹ ABS Mortality Data, NSW Department of Health HOIST system; Mental Health Client Death Surveillance System (includes reporting in RIB and CDRF) Centre for Mental Health. ABS deaths for 2002 include an estimate of the small number of deaths (4%; n=27) not registered in 2002. 2003 mortality data were released by ABS in December 2004 but unit record data are not yet available for analysis.

The three studies, despite differing methodologies, arrive at similar conclusions. Together, they suggest that:

1. Patients who die by suicide after discharge probably have few demographic or clinical differences from other discharged inpatients. The predictive power of demographic and clinical variables (eg age, gender, diagnosis) will therefore be low in individual cases. However there is a possible over-representation of complex, difficult to engage younger men with co-morbid substance abuse problems and prior histories of self-harm.
2. There is a consistent association between the risk of suicide death and the time since discharge. The risk of suicide following discharge appears to be greatest in the first week, with a decline in risk over time.
3. Of suicide deaths occurring following discharge, a substantial minority (between one quarter and one third) are preventable, as judged both by the clinicians providing care and by independent reviewers.

These studies also identify a consistent set of issues that may contribute to suicide death after discharge from inpatient care. These include:

1. Access to and early discharge from inpatient care.
2. The quality of risk assessment, including assessment of depression and hopelessness where primary diagnosis is not of mood disorder.
3. Skills in engaging with particular groups, especially high risk groups.
4. Adequacy of contact with family during and after inpatient care.
5. Integration between hospital and community or follow-up services, and the adequacy of handover between service settings.
6. The assertiveness of planned follow-up, especially within the high risk period of the first 7 days.
7. The service response to missed appointments or discontinuation of contact during follow-up.

This review has focused its enquiry around these specific issues. Methods used in this review are described in the Introduction (Part 1) to this report.

Characteristics of the Sample

The sample included all suspected or possible suicide deaths reported by mental health services within 28 days of discharge, for the five years 1999-2003. 102 suspected suicides were reported, or approximately 20 reported suicide deaths per year.

Mental Health units in NSW Hospitals reported more than 95, 000 overnight separations in the period covered by this review. (An overnight separation includes all discharges or transfers from hospital where the person has been in hospital for at least one night, but excludes same day or “day only” admissions). The rate of suspected suicide within 28 days of discharge is approximately 1.1 suspected suicide deaths per 1000 mental health separations (0.11%). Even allowing for a degree of under-reporting of suspected suicide deaths, this rate appears lower than that reported in comparable studies.

The limitations in the data which have been described above mean that there is no way to determine whether differences in the apparent post-discharge suicide rate between years may merely reflect chance variation or differences in detection and reporting.

Table 1 Rate of suspected suicide death within 28 days of discharge

Year	Suspected suicide deaths (1)	Mental Health overnight separations (2)	Suicide deaths/ 1000 separations
1999	12	19306	0.6
2000	19	18178	1.0
2001	19	18181	1.0
2002	29	18764	1.5
2003	23	21142	1.1
TOTAL	102	95571	1.1

Notes (1) Suspected suicide deaths reported by NSW Mental Health Services

(2) Source: HOIST - Inpatient Episode Of Care [EOC], and HIE Datamart, NSW 2002/03

Data for July - Dec 03 may contain duplicate records

Demographic characteristics

Demographic data were available for all 102 persons. 73 (72%) were male and 29 (28%) were female. Mean age at time of suicide death was 41 years (males 41 years, females 42 years).

The age distribution of the group was similar to the age distribution for the population of persons being admitted to mental health services. Younger adults (20 – 39) were slightly under-represented compared with the NSW mental health inpatient population as a whole. Adults aged 40-49 comprised 29% of the post-discharge suicide group compared with 18% of total mental health inpatients.

Table 2 Age distribution, suspected post-discharge suicide deaths compared with all NSW mental health inpatients

Age	Suspected post-discharge suicide deaths		All NSW MH inpatients (1)	Difference
	n	%	%	%
10-19	4	4	7	-3
20-29	21	21	26	-5
30-39	21	21	26	-5
40-49	30	29	18	11
50-59	12	12	10	1
60-69	10	10	5	5
70-79	1	1	4	-3
80-89	3	3	2	1
90-99	0	0	1	-1
TOTAL	102	100	100	

Source: HOIST - Inpatient Episode Of Care [EOC] data NSW 2002/03, NSW Health CMH

People identified as of Aboriginal or Torres Strait Islander background or of Non-English Speaking background were underrepresented compared with the population of NSW admitted mental health patients.

Table 3 Aboriginal, Torres Strait Islander and non-English Speaking background

ATSI or NESB	Suspected suicide deaths		NSW mental health inpatients
	n	%	%
Aboriginal or Torres Strait Islander	2	2.0	4.4
Non English Speaking background	2	2.0	18.8

The available data do not allow exploration of the possible causes of this apparent under-representation. Information for both suspected suicide death and overall inpatient groups has been derived from the medical record, either directly by file review for the suspected suicide group or as coded in that record and recorded in the Inpatient Episode of Care Data. Therefore under-identification or under-recording of ATSI or NESB status is unlikely to be the cause of this difference. It is possible that poorer follow-up in these groups may result in under-detection of post-discharge suicide death. Alternatively, there may be a true lowering of the post-discharge suicide rate in these groups due to improved social supports.

Employment, marital and parental status are summarised below. Absence or loss of social networks appeared to be a common feature of the group: 70% were divorced, separated, single or widowed; 51% of the group were unemployed or pensioners; 42% were parents of whom two thirds were not living with their children at the time of their suicide death.

Such losses are also common in the population of people receiving mental health care.

Comparative data is only available for marital status, and shows that the suspected post-discharge suicide group had lower percentage of single people than the general mental health inpatient population. It is possible that this may reflect the over-representation of older adults in the post-discharge suicide group.

Table 4 Employment, marital and parental status

Marital status	Suspected suicide deaths		NSW mental health inpatients
	n	%	%
Married or de-facto	31	31	21
Single	44	44	61
Separated	14	14	4
Divorced	10	10	8
Widowed	2	2	6
Unknown	1	-	
TOTAL	102	100	100

Employment status	n	%
Employed - full time	19	22
Employed - part time	6	7
Student	3	3
Retired	6	7
Home duties	8	9
Pension	12	14
Unemployed	34	39
Not recorded	14	-
Parental status		
	n	%
Parent - living with children	13	13
Parent - not living with children	30	29
Not a parent	59	58

Clinical characteristics

Diagnostic information was obtained from all available sources, including review of clinical records for all recorded diagnoses.

Table 5 Primary diagnoses

	Suspected suicide deaths		NSW mental health inpatients
	n	%	%
Anxiety Disorder	6	6	1
Eating Disorder	0	0	0
Mood Disorder/Depression	57	56	30
Organic Mental Disorder + Dementia	1	1	2
Personality Disorder	5	5	5
Psychosis	21	21	44
Substance Abuse	12	12	8
Other MH Disorders	0	0	10
ALL	102	100	100

The most common primary diagnosis was mood disorder/depression (56%). This differed from the total NSW inpatient population, with mood disorder/depression being recorded as the primary diagnosis nearly twice as frequently in the suspected suicide group (56% compared with 30% for all NSW inpatients and 32% for inpatient suicide deaths reported by the Committee in 2003).

Psychosis was recorded as the primary diagnosis in 21% of the suspected suicide group, compared with 44% of NSW mental health inpatients and 32% of inpatient suicide deaths reported by the Committee in 2003.

The combination of substance abuse and/or personality disorder with mood disorder or psychosis is an increasingly very frequent clinical challenge. The management of this complex co-morbidity is essential to the prevention of suicide death. The rate of recorded co-morbidity in this group was lower than expected. Seventy two percent of patients had only one diagnosis recorded, 28% two diagnoses and only 1 patient more than 2 diagnoses. Substance abuse disorders were the commonest co-morbid conditions, occurring in 21 cases. Personality disorder diagnoses were recorded in only five cases, three of those as a primary diagnosis.

Table 6 Primary and additional diagnoses

Primary diagnosis	Primary diagnosis only	Additional diagnoses						TOTAL
		Organic mental disorder	Psychosis	Mood disorder/ depression	Anxiety disorder	Substance abuse disorder	Personality disorder	
Organic mental disorder	1							1
Psychosis	11					10		21
Mood disorder/ depression	43	1			1	10	2	57
Anxiety disorder	5						1	6
Substance abuse disorder	10			2				12
Personality disorder	3			1		1		5
TOTAL	73	1	0	3	1	21	3	102

When compared with the total NSW mental health inpatient population, there did not appear to be an increased rate of diagnosis of comorbid personality disorder or substance abuse disorder.

Table 7 Co-morbid substance abuse and personality disorder

Co-morbid diagnosis	Post-discharge suicide group		All NSW mental health inpatients (1)	
	n	%	n	%
Co-morbid personality disorder	3	3	914	5
Co-morbid substance abuse disorder	21	21	3067	16
Total Diagnoses	102	100	19424	100

(1) Source: HOIST - Inpatient Episode Of Care [EOC] data NSW 2002/03, HIE - Datamart, NSW Health Department.

Service characteristics

The Committee believes that these data cannot be used for comparison of Area Health Services, for three reasons. Firstly, post-discharge suicide death is a very low frequency event; in many Area Health Services it was reported less than once per year. Area Health Services differ by a factor of up to 20 in both population size and numbers of mental health separations per year. Therefore large apparent differences between Area Health Services may be the result of a very small number of events, and may reflect chance “clustering” of suicide deaths rather than systematic differences between Area Health Services. Secondly, some Area Health Services have built links with local police and coroners that have been designed to increase the rate of detection and reporting of suicide deaths from those Area Health Services. Other Area Health Services do not have such links. Thirdly, for a proportion of post-discharge suicide deaths, admission was to a unit outside the patient’s Area Health Service of residence, which may lead to under-reporting, as discussed below.

Continuity of care is critical in post-discharge treatment. Only 9 of 102 suspected post-discharge suicide deaths followed admission to a unit outside of the patient’s Area Health Service of residence. This is slightly lower than the overall NSW rate of “Out of Area” admission. However, it is possible that awareness of post-discharge suicide death may be lower following “Out of Area” admission and that suspected suicide death after discharge from “Out of Area” admission is specifically under-reported.

Characteristics of the suicide death

Consistent with other studies, more than half of the suspected post-discharge suicide deaths occurred in the first week following discharge: 41% occurred within 3 days and 53% within 6 days of discharge.

Table 8 Days between discharge and suspected suicide death

Days after discharge	n	%
Same day	5	5
Next day	13	13
2-3 days	23	23
4-6 days	12	12
7-13 days	27	26
14-27 days	15	15
28 days or more	7	7
TOTAL	102	

The method of suicide death was recorded for 99 patients. Two cases had no Coroner’s report or documentation available as to the cause of death and for one person the Coroner was unable to give a finding of the cause of death. The method of suicide death varied by diagnostic group. While

patient numbers are low, there may be a trend towards more violent methods of suicide death in males and those with a diagnosis of Psychoses (see Tables 9 and 10 below).

Table 9 Method of suicide death by sex

Method	Males		Females	
	n	%	n	%
Train	6	9	0	0
Height	8	11	5	17
Firearms	2	3	3	10
Hanging	24	34	8	28
Overdose	13	19	10	34
Cutting	2	3	0	0
Drowning	1	1	0	0
Poisoning	5	7	3	10
Asphyxiation	1	1	0	0
Electrocution	2	3	0	0
Self Immolation	4	6	0	0
Motor vehicle - pedestrian	2	3	0	0
TOTAL	70	100	29	100
Unknown	3		0	

Table 10 Method of suicide death by diagnostic group

Method of suicide death	Diagnostic group											
	Organic mental disorder		Psychosis		Mood disorder/ depression		Anxiety disorder		Substance abuse disorder		Personality disorder	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Train	0	0	4	19	2	4	0	0	0	0	0	0
Height	0	0	4	19	6	11	1	17	1	9	1	20
Firearms	1	100	1	5	3	5	0	0	0	0	0	0
Hanging	0	0	4	19	21	38	2	33	2	18	3	60
Overdose	0	0	3	14	11	20	2	33	6	55	1	20
Cutting	0	0	0	0	2	4	0	0	0	0	0	0
Drowning	0	0	0	0	1	2	0	0	0	0	0	0
Poisoning	0	0	1	5	4	7	1	17	2	18	0	0
Asphyxiation	0	0	0	0	1	2	0	0	0	0	0	0
Electrocution	0	0	1	5	1	2	0	0	0	0	0	0
Self Immolation	0	0	1	5	3	5	0	0	0	0	0	0
Motor vehicle - pedestrian	0	0	2	10	0	0	0	0	0	0	0	0
TOTAL	1	100	21	100	55	100	6	100	11	100	5	100
Unknown	0		0		2		0		1		0	

Factors which may be associated with preventable suicide deaths

For people in contact with mental health services, up to one third of deaths by suicide may be preventable (3-5). The Committee also reached the same conclusion, following independent assessment of each death. Some clinical and service factors likely to be associated with preventable deaths have been outlined above.

For each of the following factors, the Committee attempted to derive a set of measures that could be drawn from the available data. The substantial limitations of the available data should be acknowledged, and therefore any conclusions drawn in the following sections are tentative only. A number of analyses (in particular those relating to access to inpatient care) have required comparison of data from differing time periods, and many assumptions have had to be made in conducting these analyses. The margin of error around most measures is high, and apparent differences between the post-discharge suicide group and all NSW mental health inpatients may be the result of reporting bias or of chance variation.

1. Appropriate access to inpatient care

Reduced access to admission and short lengths of stay have each been identified as factors in post-discharge suicide death (4-7).

With the data available from the review of completed suicides deaths, possible indicators of reduced access to inpatient care may include:

- Reduced average length of stay or increased frequency of short length of stay compared with average length of stay for all NSW inpatients;
- An excess of discharges occurring on Fridays or weekends, potentially indicating precipitous discharge due to bed pressure;
- File entries directly suggesting bed availability as a factor in discharge decisions;
- An increased rate of post-discharge suicide death in services with lower numbers of beds compared with population mental health bed targets, as defined by the Mental Health Clinical Care and Prevention (MH-CCP) model.

Average length of stay for suspected post-discharge suicide death was 10.2 days, compared with the 2003-04 average for NSW acute mental health inpatient units of approximately 17 days. 46% of this group was in hospital for less than four days.

Table 11 Length of hospital stay for admission prior to suicide death

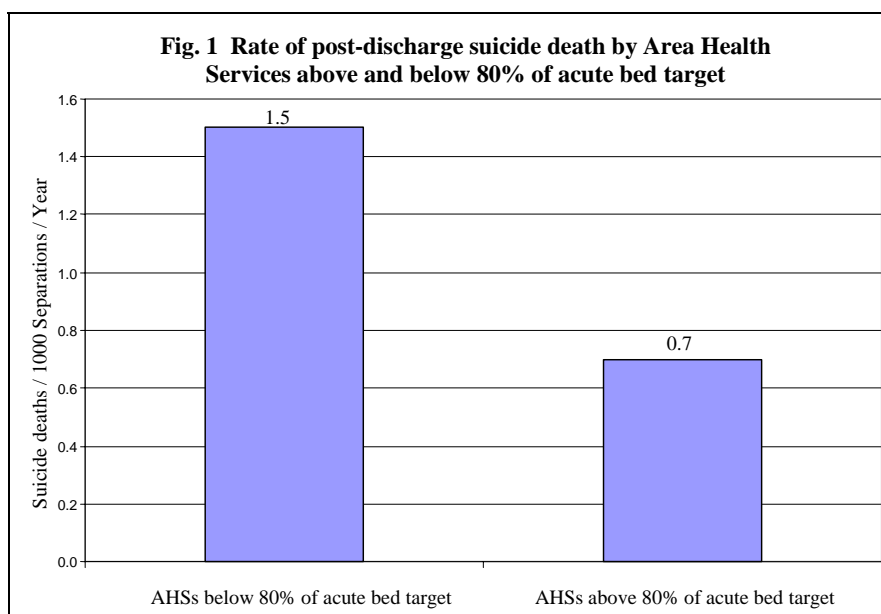
Length of stay	Suspected suicide deaths		All NSW MH inpatients	All NSW MH inpatients (excluding day only)
	n	%	%	%
Day Only	9	9%	40%	
2-3 days	38	37%	10%	17%
4-6 days	19	19%	10%	17%
7-13 days	14	14%	14%	24%
14-27 days	13	13%	13%	22%
>28 days	9	9%	12%	20%
TOTAL	102	100%	100%	100%

Table 11 shows the distribution of duration of the last admission prior to suicide death. Comparison with the typical pattern of admissions for all NSW Mental Health inpatients is complicated by the recording of “day only” admissions by NSW Health. Many day treatment programs, including those for children and for Veterans, are recorded as “day only” hospital admissions. “Day only” admissions comprise 40% of total NSW mental health admissions, therefore most analyses in this report exclude “day only admissions”. Table 11 provides comparison for data for NSW Health separations, both including and excluding “day only” admissions. In either case, there appears to be an excess of people with 2-3 day lengths of stay amongst the suspected post-discharge suicide group.

Most discharges occurred on Mondays (21%), Tuesdays (20%) and Thursdays (21%), with 16% of discharges occurring on Fridays and 9% on weekends.

Only one file contained a file entry linking a discharge decision with bed availability. In several cases the length of stay appeared short for the clinical presentation and degree of risk documented by the treating team and apparent at file review. It is not possible to determine from the files whether individual clinical skills or judgement were the primary issue or whether bed pressures may have contributed to these apparent short lengths of stay.

The NSW Mental Health Clinical Care and Prevention Model (MH-CCP) predicts acute mental health bed requirements based on population size and age distribution. It predicts a requirement for acute adult mental health beds of between 30 and 32 beds per 100,000 population, depending on the age mix within that population. The Committee understands that most Area Health Services fall below this target, and that current NSW Health policy aims to move all Area Health Services to an intermediate target of 80% of MH-CCP bed requirements. For the period of this review, nine Area Health Services fell above and eight below this 80% target. Area Health Services falling below the 80% MH-CCP target had a rate of post-discharge suicide death double that of those falling above (1.5 suspected suicide deaths per 1000 separations, compared with 0.7 per 1000 separations). (See Fig. 1 below.)



Both groups of Area Health Services had identical numbers of separations per bed per year (average 17 separations per bed per year), so this difference should not merely reflect greater activity in services with fewer beds. The available data cannot distinguish whether this apparent difference reflects differences in underlying rate of post-discharge suicide death, or merely differences in

reporting and detection. It is possible that better-resourced services are more effective at providing follow-up and therefore are better able to detect and report suspected suicide deaths.

Case examples

(Note: Throughout this report details of vignettes have been modified to protect the anonymity and privacy of individual patients and their families)

1. A man in his 50s with a past history of alcohol abuse and depression, presented to a metropolitan Emergency Department with depression and suicidal ideation. He was admitted as an involuntary patient to another unit in the same Area Health Service, due to lack of an available local bed, and was discharged on the following day. Four weeks later he presented again to his local Emergency Department, intoxicated and feeling suicidal, but absconded from the ED. The following day he presented himself again. He was assessed and felt to require admission. A psychiatry registrar initiated admission procedures under the Mental Health Act. However the registrar documented that no mental health bed was available for transfer in that service or other services contacted, and revoked the patient's schedule, planning instead to manage the patient in the Emergency Department until a bed became available. While waiting in ED the patient again absconded. He apparently died by suicide three days later.

2. A man in his 80s was admitted to an outer metropolitan unit with recent symptoms of depression, self-neglect, and apparent preparation for suicide. His family expressed concern at his risk of harming himself. Four days later he was described as appearing depressed, and not keen for discharge. He was discharged for daily home visits. On the fourth day after discharge he did not respond to telephone calls and a home visit by the community team. He apparently died by suicide on that day.

3. A man in his 30s was transferred from a surgical ward to a general hospital mental health unit following attempted suicide by stabbing his abdomen. He was admitted as an involuntary patient, and reviewed by a consultant psychiatrist who documented that he felt that he was at high risk. The patient's partner was noted to be concerned about her own safety. He was discharged two days after admission for follow-up by the community mental health team. He was noted to be reluctant to continue taking medication after discharge. He apparently died by suicide 12 days after discharge.

Conclusions

The Committee's own assessment suggested that a substantial number of deaths was preventable.

Overall, the suspected post-discharge suicide group had a shorter length of stay than the NSW average for mental health inpatients, and a higher percentage with short (2-3 day) admissions. In some individual cases length of admission appeared inappropriately short, and in one case a file entry suggests discharge as a direct effect of bed availability issues. Comparing Area Health Services, those above 80% of their estimated population-based acute mental health bed requirements had an apparent rate of suicide following discharge of approximately half that for services with fewer beds.

Taken together, data from this group may suggest that difficulties in access to inpatient care may have been a factor in the suicide of some patients. Improving access to inpatient care, especially by ensuring that Area Health Services have adequate numbers of mental health beds to meet the estimated needs of their populations, is likely to prevent some deaths by suicide.

Accordingly, the Committee recommends that:

NSW Health establish clear timeframes for delivering on its previously made commitment to reach acute mental health bed targets, to ensure Area Health Services meet their population bed needs in terms of NSW Health accepted planning models. Clear timeframes and targets should also be set for the provision of community mental health services.

Recommendation 22

Implementation timeframe: 6 months

2. Appropriate assessment and documentation of suicide risk

Effective post-discharge care must be built on a foundation of adequate assessment, including appropriate assessment of the degree of risk. “Risk assessment” is not a specific and discrete clinical procedure, but an integral component of the overall assessment of the person, their mental health problem and their support system.

Components of a comprehensive assessment of risk include: detailed and comprehensive history; dynamic and flexible review taking into account changing risk factors and social supports or triggers; appropriate direct and supervisory involvement of senior clinical staff; use of structured risk rating tools and “decision support” systems; use of standardised documentation to reduce errors in handover of risk information between staff and settings.

Within the data available for this review, indicators of potentially preventable factors in risk assessment are:

- The presence and type of risk assessment documented at admission;
- Documented involvement of senior clinicians in risk assessment, and in inpatient assessment and management more generally;
- Quality of documented risk assessment prior to discharge during follow-up care.

Consequently, the review looked for documentation of assessment of risk at the point of the admission prior to suicide death. A low threshold was adopted: risk assessment was judged to have been documented if any structured risk assessment tool was used or if admission notes documented any specific risk or attempted to quantify this risk. The review found that:

- 46% of patients had no documented assessment of risk at the point of admission;
- Patients admitted following suicide attempts were only slightly more likely (57%) to have an inpatient risk assessment completed than those whose admission did not follow a suicide attempt (52%);
- Of the 56 patients with documented assessment of risk, 27 included a structured risk assessment tool or scale, and 29 discussed risk in unstructured clinical or admission notes.

The Committee accepts that there is ongoing debate about the utility of structured risk assessment rating scales in clinical assessment, and accepts that risk assessment may have been documented as an integrated part of other clinical notes. However, even taking a broad view of documentation of risk assessment, the Committee regards as poor that more than half of all patients in this group, and nearly half of all patients admitted after a suicide attempt, had no documentation of the assessment of risk on admission.

The review examined the direct involvement of consultant psychiatrists in the management of mental health inpatients. There is a community expectation that the care of people admitted to

dedicated mental health inpatient facilities for complex conditions should be managed by appropriate specialists. The Committee was very concerned that in this review:

- Direct examination by a consultant psychiatrist was documented for 60 cases, 28 had no documented contact and for 14 it could not be determined from the file whether consultant contact had occurred;
- The likelihood and frequency of contact with a consultant psychiatrist was strongly linked to length of stay, with a higher likelihood of being discharged without documented examination by a psychiatrist for those with shorter stays. These figures may reflect the large proportion of public psychiatrists working in part-time roles, and the frequent work pattern for many psychiatric units of a weekly consultant ward round or review. Patients with no contact with a psychiatrist had an average length of stay of 2.4 days, compared with 4.6 days for those with 1 contact, 13 days for those with 2 contacts and 28 days for those with 3 or more contacts.

The review examined the documentation of risk prior to discharge from hospital. It found that:

- 83 patients (82%) were reviewed by a medical officer on the day of discharge;
- Of those patients: 45 had no documentation (either structured or unstructured) about presence or degree of risk, 36 documented an assessment of low risk and 2 of moderate risk;
- In medical and nursing notes for the last 24 hours of admission, 33% of patients were described as having agitated or anxious mood;
- In medical and nursing notes for the last 24 hours of admission, 24% of patients were described as expressing suicidal intent or plans, or as showing signs of suicidal ideation;
- 23% of patients had documented evidence of both suicidal ideation or plans and agitated or anxious mood in the 24 hours prior to discharge.

Case examples

1. A man in his 40s was brought to a metropolitan hospital by police in an agitated and intoxicated state. He had a past history of alcohol abuse and suicide attempts, including an attempt to jump from a building. He was admitted to the hospital's mental health unit. Two hours after admission he was noted to be agitated and demanding discharge. He was reviewed by a psychiatry registrar, and discharged to make his own follow-up arrangements with an Alcohol and Drug service. There was no evidence in the file of discussion of the assessment or the decision to discharge with a consultant psychiatrist. He apparently died by suicide three days after discharge.

2. A woman in her 60s was brought to a metropolitan general hospital after being found attempting to jump from a cliff. She had had 5 admissions over the last decade for treatment of depression. She was admitted to the hospital's mental health unit. Later on the day of admission she was reviewed by a psychiatry registrar. There was no documented discussion with or review by a consultant psychiatrist. She was discharged home to make follow-up arrangements with her private psychiatrist. She apparently died by suicide two days after discharge.

3. A man in his 50s was brought to a metropolitan general hospital with an overdose. He described recent depression and suicidal ideation after the break-up of his marriage, and was due to appear in court for matters related to the separation. He was admitted to a metropolitan general hospital unit as a voluntary patient. Later that day he became agitated and demanded discharge, and was made an involuntary patient under the Mental Health Act. The following morning he was reviewed by a registrar, and discharged. There was no documented review by or discussion with a consultant psychiatrist. He apparently died by suicide on the day following discharge.

Conclusions

There appears to be an urgent need for systemic improvement in the assessment and documentation of risk in inpatient settings. There is an absence of direct examination by a consultant psychiatrist for a large subgroup of patients, and in some instances an apparent lack of systems for ensuring that trainees consult appropriately with more senior staff prior to making discharge decisions. Though consultant psychiatrists might be many kilometres away, they are within a phone-calling distance.

Documentation of risk assessment was variable at the point of admission and even more so at the point of discharge, and there seemed to be limited awareness or consideration of the possible clinical significance of suicidal ideation and disturbed mood in the 24 hours prior to discharge. While in some situations discharge in the presence of continued suicidal ideation or disturbed mood may be clinically appropriate, it would be reasonable to expect that in these situations clinical documentation would reflect appropriate assessment, clinical reasoning and careful management planning. A number of situations involved early discharge of a patient with continued agitation or suicidal ideation who had apparently not been directly reviewed by or discussed with a consultant psychiatrist. In the view of the Committee this is not acceptable practice.

Ideally all persons admitted to specialist mental health inpatient units should be directly examined by a consultant psychiatrist. The Committee recognises that this standard may not be immediately achievable, and may not apply in other health sectors. At the very least, there should be direct involvement of a consultant psychiatrist in a supervisory role, and clear documentation of this involvement, for all admitted patients.

A number of recommendations in the last report of this Committee concerned suicide risk assessment, and the Committee is aware that NSW Health is currently implementing a revised Suicide Risk Assessment Framework.

Accordingly, the Committee recommends that:

NSW Health develop minimum standards for consultation with, and/or direct contact by, consultant psychiatrists

- in the assessment of emergency presentations to mental health services and emergency departments, and
- in the care of inpatients of mental health units, and for the recording of such contact.

Recommendation 13

Implementation timeframe: 12 months

3. Contact with family

Effective mental health care must consider the individual within the context of their social system and supports. Involvement of families or social supports is critical at all stages of care: history taking and assessment, engagement and inpatient treatment, discharge planning, post discharge care and emergency management where required. Many situations require a balance between the need for services to understand and engage with the person's social system and the need to respect the autonomy and privacy of the individual. Rarely, confidentiality can present an insurmountable barrier to family involvement. Where risk exists, and effective care depends on meaningful support from family and carers, then services have a responsibility to find a balance between these competing ethical principles, and not to take an extreme position in either direction.

The review examined the extent of family contact during the admission. Of 102 cases, 16 had no identified family or carer, and for a further 20 the available documents were unclear about whether a family, carer or support was present. The Committee believes that those 20 sets of documents were deficient in that regard. This left 66 cases in which a family, carer or support was identified in the patient's file. For these 66 cases:

- 27 (41%) had no documented evidence of contact between the treating team and the family or carer;
- 22 (33%) had evidence of brief family contact such as a single family meeting or brief telephone contact;
- 17 (26%) had evidence of regular family contact including meetings and/or telephone contact.

These inpatient records therefore reflected poor family engagement, with poor documentation of the presence of a family or supports and evidence of family contact in less than half of all patients.

Where a person is being discharged to live with or be cared for by their families, then they should **always** be involved in those discharges and have information sufficient to allow them to do their task; the available documents suggest that this is not routinely occurring. Of the 66 files with identified families, 38 (58%) contained no documentation of family involvement in the discharge planning process.

Family involvement following discharge was assessed by review of the community file, which was available for 69 patients. The Committee is of the view that such a file should have been available for more patients. Of these 69, the presence or absence of family contact could not be determined from available records for 22, leaving 47 patients in whom the presence or absence of post-discharge family contact could be determined. Of these:

- 25 (53%) had no documented family contact;
- 18 (38%) had evidence of telephone contact with family or carers;
- 4 (9%) had evidence of family meetings or interviews following discharge.

This may reflect poor documentation or poor clinical practice in involvement of families and carers. These figures may also be skewed by the relatively short time between discharge and apparent suicide death for a number of cases, meaning that time for intensive or repeated family involvement may have been limited.

The level of post-discharge contact varied depending on whether or not the patient lived with their family. For the 42 cases where it was possible to determine both the living arrangement and

level of post-discharge family contact, some form of family contact was made with 81% of patients living with their family compared with only 10% of those not living with their family.

Case example

A woman in her 30s with a past history of serious suicide attempts was admitted to ICU with an overdose of antipsychotics and benzodiazepines. She was transferred to the Mental Health Unit where she improved over two weeks. She was discharged for follow-up with her private psychiatrist. Several days after discharge her husband rang the service concerned about a sudden deterioration in her mood. No action was documented by the service. She died by suicide six days after discharge.

Conclusions

The quality of documentation of contact with families and carers was poor. The level of family contact was variable, and appears to fall short of a reasonable standard. Where the presence of family or social supports was documented and the family was involved (eg where a patient was living with their family), some level of family contact occurred in 60 - 80% of cases. While this was better than for some other groups, contact should ideally occur with 100% of families in such situations. The majority of these contacts were brief, and many were limited to telephone contact.

Accordingly, the Committee recommends that:

NSW Health implement and audit minimum standards for the involvement and documentation of the involvement, of families and carers during:

- assessment
- discharge planning from acute mental health inpatient units
- ongoing community care
- contingency planning and response to escalating concerns or to changing clinical situations.

Recommendation 7

Implementation timeframe: 12 months

4. Effective communication and handover between inpatient and community care

Studies of preventable error in health care have identified the interface between hospital and community care as a critical point at which care can break down. Studies of large series of suicide deaths (5-8) have reported similar conclusions. This review looked within the available documents for evidence of effective communication between hospitals and community care.

Contact between hospital and community clinicians

It would be reasonable that some communication between hospital staff and other services - either in gathering information or planning post-discharge care – should occur for all patients. Of the 102 cases reviewed, the records of 8 cases did not allow determination of whether contact between hospital and community staff had occurred. The Committee is of the view that those 8 records were deficient in that respect. For the 94 cases where this could be determined, 70 cases (74%) had documented evidence of contact between hospital staff and community mental health staff or a general practitioner during the admission, and 24 cases (26%) had none.

The quantity of service contact was also assessed. For the 70 cases with evidence of contact, 38 (54%) had minimal contact such as a single brief phone-call, 18 (26%) had brief but detailed contact such as a case meeting or joint interview and 14 (20%) had repeated contact.

Completeness and quality of discharge summaries

The discharge summary is traditionally a key document in communicating diagnostic and treatment information between services and with General Practitioners. Discharge summaries should be completed after all hospital admissions. However, where the time between discharge and suicide death was very short and the service was immediately aware of the death, a detailed discharge summary may not have been prepared.

Only 71% of patients had a discharge summary from final admission in the medical record, primarily in the inpatient medical record. For these files, the discharge summaries contained the following information:

- 94% Diagnosis
- 93% Summary of course of admission
- 82% Details of follow-up arrangements
- 61% Discharge medication
- 18% Specific information regarding risk.

The Committee is very concerned at the following findings and believes the situation should be addressed urgently. Nearly 30% of patients did not have a discharge summary, and that where summaries were present they frequently lacked essential information: nearly 20% contained no information about follow-up plans, nearly 40% contained no information about medication and more than 80% did not discuss risk. In the Committee's view this does not meet minimal acceptable standards of care.

Communication of discharge summary to key parties

The effectiveness of a discharge summary in acute post-discharge care is dependent on its rapid transmission to those services involved in that care. Overall, the Committee was disappointed with the level of communication of the discharge summary, as summarised below.

Only 33 (48%) of 69 records with a community file had a discharge summary from their last inpatient admission in that file. Only 15 files (21%) had evidence that the summary had been or was to be forwarded to the patient's GP. These figures may also partly reflect the short time between discharge and suicide for a number of cases. No file had evidence that a copy of the summary had been given to the patient or their family.

Case examples

1. A man in his 30s was admitted to a regional hospital after attempted suicide by carbon monoxide poisoning. He was diagnosed as having a first episode of psychosis, with persecutory delusions and depressed mood. He improved during a two week involuntary admission. Follow-up was planned with the Community Mental Health team from the same service. However the service's usual procedures were not followed. The community team were not aware of the referral, and no contact was made with the patient after discharge. He apparently died by suicide 8 days after discharge.

2. A man in his 40s with chronic schizophrenia and recurrent depression, and a history of impulsive and violent behaviour was admitted for six weeks to a metropolitan psychiatric hospital for treatment of depression and psychosis. He was discharged on a Community Treatment Order to a hostel in another Area Health Service. No follow-up contact occurred from the local mental health service. He apparently died by suicide three days following discharge.

Conclusions

The Committee was concerned at the poor standards of communication reflected in these files. Contact between inpatient and community services during admission remains variable, and for a substantial minority there was no evidence of such contact.

The quantity and quality of discharge summaries was lower than would be reasonably expected. In particular, most did not include any discussion of risk issues. Prompt communication of these summaries to other services appears poor. Less than 50% of community files contained the most recent discharge summary, communication of discharge summaries to GPs was evident in only 20%, and no file contained evidence that a discharge summary or plan had been provided to the patient or their family.

The Committee is aware that the NSW Suicide Risk Assessment Framework currently being implemented and the Draft Discharge and Follow-Up Protocols for NSW Mental Health Services include a number of strategies aimed at improving communication between services, and at ensuring a more consistent standard of documentation in discharge summaries. For this reason the Committee has not made specific recommendations on this issue. However the Committee urges NSW Health to be extremely vigilant on this issue. It should ensure that the policies currently being implemented give a high priority to effective communication, and that tools and systems under development support patients, carers and clinicians.

The Committee believes that all Area Health Services should be expected to have systems in place to ensure effective communication between their services and with other health providers, and to conduct appropriate review and clinical audit of these systems.

5. Assertiveness of planned follow-up

The days and weeks following discharge are known to be a period of particular risk. It is essential that planned follow-up is appropriate to the individual's clinical needs, their level of risk and their level of family and social support.

Documentation of the planned timing of follow-up was poor. For 32 cases (31%) the date of planned follow-up could not be determined from the available records. For a further 6 cases (6%), no follow-up was planned. For the 64 cases where a follow-up date was recorded, 46% had planned follow-up on the same or next day, 31% had follow up planned within 2-6 days and 21% had follow up planned for 7 days or longer.

Table 12 Date of first planned follow-up after discharge

Follow-up plan	Suspected suicide deaths	
	n	%
Cannot be determined	32	31
No follow-up planned	6	6
Follow-up date identified:		
Same day	5	5
Next day	25	25
2-3 days	10	10
4-6 days	10	10
7 days or more	14	14
Total	102	100

Documentation of the frequency of planned follow-up was also poor. Of 102 cases, 50 (49%) included no documentation of the frequency of planned follow-up. Of the remainder, 26 planned daily follow-up, 20 weekly follow-up, and 6 identified a single appointment date or planned follow-up of less than weekly.

In examining individual records an unexpected and prominent theme was the extensive use of the telephone in the assessment and management of many cases. Telephone contact has an important and legitimate role in triage, assessment and follow-up. For rural services and in all services after-hours it may be an effective way of maximising access to specialist advice. However, interviews by telephone have intrinsic limitations, including in the assessment of new patients and the assessment of the level of distress or risk of known patients. Exclusive reliance on telephone contact in these situations therefore poses an increased risk. This risk may be acceptable in some situations, but should require careful consideration.

Case example

A man in his 80s with a past history of depression, was admitted with symptoms of depression, anxiety and suicidal ideas to a specialist older persons' mental health inpatient unit. He remained in hospital for three weeks, and was noted to have improved in mood. Ten days after discharge he contacted the community team complaining of suicidal ideas, insomnia and anxiety. He was assessed by phone, with a plan for further telephone assessment later in the day. He did not answer the return phone call. No review or action plan was documented by the team in response to the inability to contact the patient. A further phone-call was made on the following day, with no answer. He apparently died by suicide on the day of the initial phone-call.

Conclusions

The Committee views the documentation of follow-up as unacceptably poor, with 30-50% of records not including documented date of follow-up or planned frequency of follow-up. Where follow-up is documented, many patients amongst this group of suspected post-discharge suicide deaths received assertive and regular follow-up.

For a smaller number of individuals, services planned no follow-up, or follow-up a week or more after discharge. It is clearly possible that more assertive follow-up in these cases may have prevented a proportion of these deaths. The appropriate timing and frequency of follow-up after hospital care is influenced by many factors. However, it is reasonable to expect that in a high risk group (many discharges followed admissions for suicide attempts, or involved continued suicidal ideation and mood disturbance), services should be expected to err on the side of assertive follow-up. There is clear evidence for increased risk in the first week after discharge. The accurate prediction of which individuals will be most at risk of suicide death is known to be difficult. Therefore, the Committee believes that an argument can be made for adopting a "universal precautions" approach that ensures that all patients receive a minimum level of follow-up during the critical initial period following discharge.

The Committee is aware that some mental health services have adopted such an approach, introducing post-discharge or transitional "packages" requiring daily contact with all patients for a specified period following discharge. Such an approach is likely to prevent some suicide deaths. Implementation of such an approach would require substantial resources, and would clearly not prevent all post-discharge suicide deaths.

Accordingly, the Committee recommends that:

NSW Health develop standards for the use and documentation of telephone contact in initial and ongoing assessment, treatment and post-discharge follow-up by mental health services. Reliance on telephone contact in high risk situations should be discouraged.

Recommendation 14

Implementation timeframe: 12 months

NSW Health develop minimum standards for the frequency and duration of follow-up after discharge from an inpatient mental health unit. This should be linked to the level of clinical risk.

Recommendation 17

Implementation timeframe: 12 months

6: Service response to discontinuation/loss of contact

Community management requires the recognition of the rapidly changing nature of risk. Loss of contact with a service, eg through non-attendance at planned follow-up or non-response to telephone or home visit may frequently have an innocent explanation but may also be a signal of a serious change in clinical condition and level of risk. This creates an immediate dilemma for the service, and in some situations further action by the service may be neither necessary nor possible. However, previous studies and incident reviews frequently identify the point of loss of contact as a potential branching point in the trajectory of some preventable suicide deaths.

For 42 patients, no follow-up date was documented. In the Committee's view, this was a disappointing result. Of 60 patients where a follow-up date was documented, 47 (78%) attended their first post-discharge appointment. Of the 13 who did not attend, in 9 cases the service took action and re-established contact, in 3 cases the service attempted unsuccessfully to re-establish contact and in 1 case no action was taken by the service.

Case examples

In review of individual cases, a frequent theme was a lack of critical reflection or considered action by a service in response to difficulties in contacting a person.

1. A man in his 20s with a history of psychosis and substance abuse was admitted to a rural hospital because of medication non-compliance and a breach of his Community Treatment Order. He was admitted for 14 days and discharged for community follow-up. The team visited the patient's home five times over two weeks, on each occasion finding the television on and door open but no answer. The team did not enter the home. No review or action plan was documented. He apparently died by suicide 12 days after discharge.

2. A man in his 50s was brought to hospital following an overdose. He had a history of substance abuse and many previous admissions following suicide attempts. He was admitted for 12 days to a metropolitan general hospital unit, then discharged for community follow-up. One week following discharge he was seen by a psychologist and psychiatrist who documented concerns at his low mood and suicidal ideas, and referred him to the service's emergency mental health team for daily follow-up. He was visited daily, but did not answer his door on the sixth day of follow-up. The team continued daily home visits with no response for one week. There was no documented review or action plan by the team. He apparently died by suicide at an undetermined time during this period.

Conclusions

Where people did not attend for their first planned follow-up, nearly all services took action to re-establish contact, and this action was mostly successful in re-establishing contact.

Service response to loss of contact during ongoing follow-up was more variable. The Committee believes that it is important, - especially where the level of risk is known to be high – that any loss of contact should prompt thought and discussion about its possible significance, and consideration of possible actions. Persistence with unsuccessful attempts at contact, eg daily phone calls or home visits over extended periods, may be appropriate in some situations but should be the result of considered and documented review rather than an automatic service response.

Accordingly the Committee recommends that:

NSW Health develop mandatory procedures for response to loss of contact or non-attendance at planned follow-up for people who may be at risk of suicide or risk of harm to others. If loss of contact occurs within 28 days of discharge for any patient, or at any time if a person remains at significant risk, then

- immediate consultation should occur with a senior mental health clinician, and
- a considered action plan should be documented by the service.

Recommendation 19

Implementation timeframe: 12 months

Additional Issues and Recommendations

1. The review of suicide deaths in Drug and Alcohol Services

All suicide deaths of people in mental health care are coded as serious events and require notification of NSW Health through its incident monitoring system. All suicide deaths of inpatients or suicides occurring within 28 days of mental health contact require detailed review. All deaths of mental health clients, of any cause, are reported to the Centre for Mental Health, NSW Health.

In NSW, Drug and Alcohol Services operate within a separate administrative and legal framework to that of Mental Health Services. However, mental health and alcohol and drug problems frequently go hand in hand. Substance abuse is common in those experiencing mental illness. Depression, suicidal ideas and suicide death are common in those with serious drug and alcohol problems. In many jurisdictions clinical services for these two groups are integrated.

A small number of cases included in this review involved people recently discharged from Drug and Alcohol Inpatient Services. The Committee was advised that their inclusion was fortuitous, and that there is currently no requirement by NSW Health for routine reporting or review of suspected inpatient or community suicide deaths by clients of Drug and Alcohol Services.

The Terms of Reference of this Committee include a brief to review suicide deaths occurring in the context of all NSW Health Services and not just specialist Mental Health Services. Currently it appears that NSW Health has no system for monitoring or reviewing suicide deaths which may be occurring in the high risk patient group served by Drug and Alcohol Services. The Committee

believes that Drug and Alcohol Services should be included in such a system, and some specific recommendations to that effect appear below.

Case examples

1. A man in his 30s with a diagnosis of heroin and cannabis dependency was admitted to a specialist detoxification unit. During his 11 day stay there was no documentation of medical assessment or review, and no documentation of any assessment of psychiatric state or suicide risk. He was disruptive and non-cooperative during admission. He apparently died by suicide on the night following discharge.
2. A man in his 20s with poly-drug use and depression was admitted to a metropolitan psychiatric unit with suicidal ideas. After 6 days he was referred to an inpatient detoxification facility run by a specialist Alcohol and Drug Service. One week later he was asked to leave the detoxification unit, and was taken by drug and alcohol staff to a train station. He apparently died by suicide while accompanied by staff.

Accordingly the Committee recommends that:

NSW Health examine the effectiveness of current reporting and review processes for suspected suicide deaths of patients of Alcohol and Drug Services.

Recommendation 1

Implementation timeframe: 6 months

NSW Health ensure the development of policies and training for suicide risk assessment in Alcohol and Drug Services.

Recommendation 21

Implementation timeframe 24 months

2: Reporting and review systems

As has been stated above (p. 26):

“Detection of post-discharge suicide death in NSW occurs through a network of local systems, including links between mental health services, families, police, emergency departments and local Coroners’ courts. ... In NSW, privacy legislation does not permit a centralised mental health case register, or linkage of health records directly with coronial records as is possible in some jurisdictions. Therefore the rate of suspected suicide death known to mental health services will inevitably be an underestimate; some patients may have lost contact with a mental health service prior to their suicide, and the service may therefore not be notified of their death.”

Currently it appears that NSW Health has not put in place systems which allow the comprehensive and accurate monitoring of suicide death in people in contact with health services as has occurred in some other jurisdictions. The Committee understands that individual clinicians, Area Health Services and the Centre for Mental Health have worked to develop systems which detect many such suicide deaths, however these efforts cannot be entirely effective while substantial structural barriers remain. The Committee considers it unsatisfactory that a relevant record from (say) Ballina might take three days or more to reach (say) Newcastle.

An effective state-wide system of detection of suicide death of patients of health services would require:

- Routine links between NSW Health and the NSW Coroner, so that health services are promptly notified of any apparent suicide death occurring within the area of their population responsibilities or by a person who has had contact with their services.
- Development of data linkage strategies such as a Unique Patient Identifier system which allows reliable identification of the services which have been responsible for the care of an individual at different times or in different locations. The Committee understands that such a system is in development by NSW Health.

Detection of possible suicide deaths should be followed by effective review. Such reviews are complex; they must work to find a balance between independence, involvement of the clinicians and managers with responsibility for local care, the need for both openness and accountability, and the need to support both families and staff after a client death by suicide.

The Committee is aware that NSW Health has introduced a Root Cause Analysis (RCA) process for the review of serious incidents including suicide death. The period covered by this review predates the introduction of RCA reviews. The Committee believes that the RCA is likely to provide a useful and consistent framework, and the Committee will review with interest the results of RCAs into suicide deaths. Given the importance of suicide deaths, NSW Health should ensure that the needs of mental health services are given high priority in the development of state-wide incident monitoring and review systems. The effectiveness of RCAs in the review of suicide deaths should not be automatically assumed, but should be reviewed by NSW Health after an adequate period of implementation.

Accordingly, the Committee recommends that:

NSW Health work with the NSW Coroner to develop systems for communication between the Coroner and local mental health services to ensure that services receive prompt and comprehensive notification of suspected suicide deaths.

Recommendation 3

Implementation timeframe: 12 months

NSW Health ensure the development of

- a unique identifier, and
- electronic record systems

to ensure the constant availability and prompt transfer of relevant clinical information between services and between service providers.

Recommendation 4

Implementation timeframe: 24 months

NSW Health evaluate the effectiveness of the current system of reporting and review of suspected suicide deaths. This evaluation should consider whether RCA methodology facilitates meaningful involvement of local clinicians, and consider additional methods for such involvement if necessary.

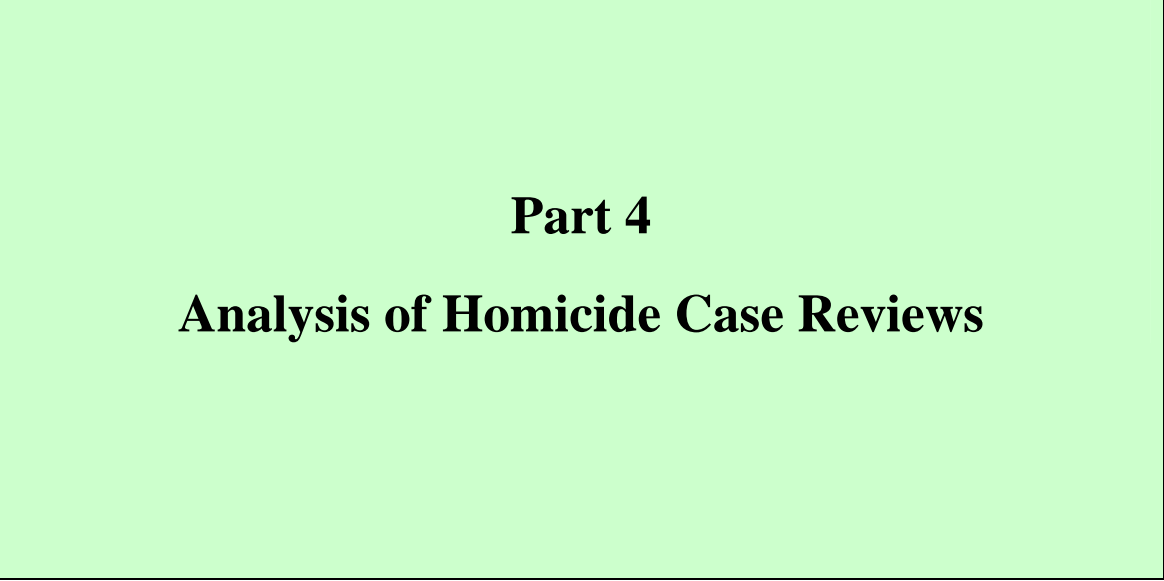
Recommendation 5

Implementation timeframe: 24 months

The Committee also notes that even the most effective possible system for detection and review of suicide deaths will not, by itself, translate into a reduction in preventable suicides. This will only occur through addressing the resource, system and clinical practice issues identified through such reviews.

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Part 4
Analysis of Homicide Case Reviews

Analysis of Homicide Case Reviews

Summary

-
- 11 cases were reported between January 2002 and January 2004, five involving the death of a child.
- Reviews were available for only 6 of the 11 cases.
- The absence of external reviews for all cases of homicide by a mental health patient, and the poor standard of some of those available for analysis are of concern.
- The Committee noted lack of engagement with the mental health service in 3 cases.
- 5 patients had approached health services for help prior to the incident.
- The medical record was often not utilised as the central instrument for documentation and communication of ongoing assessment, evolving management plans and inter-professional, inter-team communication.
- The quality of communication between services and service providers was poor.
- There was a lack of corroborative history in formulation of risk assessments.
- In relation to parents:
 - assessment, monitoring and support of parenting capacity was inadequate;
 - response to missed appointments was inadequate.
- There was over-reliance on phone assessments.
- A procedure is required for flagging and reviewing patients who are failing to improve.
- Response to loss of contact or non-attendance at planned follow-up was lacking.
- A register of forensic patients in the community should be developed.
- Risk assessment and management for both harm to others and self harm should be a core clinical skill.
- External reviews of homicide cases involving mental health patients are needed to provide for more detailed case analysis by the Committee and for improving any responses by NSW Health to media and public enquiries.

Introduction

In total, 11 cases were identified by the Centre for Mental Health database for analysis by the Homicide Sub-Committee in 2004: 4 cases from 2002, 6 cases from 2003 and one case from January 2004. One case was a murder/suicide death. Child deaths were involved in 5 of the 2003 cases but none of the other cases. Of the 11 cases identified, reviews were available for only 6 cases, 3 of which involved child deaths. No Root Cause Analyses (RCAs) were available. The Committee would expect that in future, reviews will always be available.

The small sample size means that analysis of these cases is generally limited to descriptive methods. Nonetheless, even in this sample there are emergent themes and salient issues that suggest directions for improved clinical effectiveness and greater safety. The Committee's approach is to consider the cases firstly in terms of whether they tell us something about improving the assessment of risk. Secondly, the Committee asks whether they provide information in relation to our ability to prevent fatalities through the improvement of systems of care.

The absence of external reviews for all cases of homicide by a mental health patient and the poor standard of some of those available for analysis is of concern. This finding is the basis for a recommendation requiring standardised procedures to guide the review of such an incident. The Committee believes that the development of standardised review procedures will assist the thorough assessment of systemic issues that contribute to or fail to prevent homicide deaths. Such procedures will be an important and explicit signal to the clinician body and the general public about the expected standards of care and the performance of the systems that deliver that care.

Accordingly the Committee recommends that:

NSW Health develop and trial a standardised terms of reference and documentation format for the external review of a homicide by a patient of a mental health service.

Recommendation 2

Implementation timeframe: 12 months

In summary, the findings of this analysis of homicide cases conclude with recommendations around three key areas:

- The need to develop a framework for assessment and management in relation to risk of harm to others;
- Assessment and management of parents with a mental illness;
- The need to strengthen systems of clinical governance.

Demographics and Risk Factors

The demographic characteristics and salient risk factors of the 6 cases analysed for the January 2002 - January 2004 period are provided in Table 13. The diagnostic spread of these cases is consistent with those previously reported by the Committee for 1999 - 2001. All patients suffered from major psychoses or mood disorders complicated by psychosis.

This group also includes three patients who killed children, two of them women who killed their own children. The ages of the patients in the group range from 23 - 33 years.

Three had clear histories of violent behaviour. In these cases the history of violence had been elicited by the clinical team and was extensive and/or serious. In a further case a history of violence towards the patient's children seems likely. Substance abuse was evident in only two cases.

Two patients were recent immigrants from a non-English speaking background, both with tertiary level education. Language does not appear to have been a barrier to accurate assessment in either case. However, the Committee's analysis was unable to determine whether language and cultural background contributed to either management difficulties or problems with engagement of family.

Table 13 Demographic factors, diagnosis and other factors

Gender	Age range (yrs)	Diagnosis	History of violence	Other factors
Male	20-24	Schizophrenia	Yes	Substance abuse
Male	20-24	Schizophrenia Childhood ADHD	Yes	Substance abuse
Male	45-49	Major Depression with melancholia	Yes	Family breakdown
Female	30-34	Schizoaffective disorder	Equivocal	Previous Dept. of Community Services notifications
Female	30-34	Major Depression with psychotic features	No	non English-speaking background
Male	30-34	First presentation psychosis	No	non English-speaking background

Other Risk Factors Noted

There are insufficient numbers of cases in this sample to draw conclusions about risk factors, however, the Committee noted some issues.

Lack of engagement with the mental health service was noted in 3 cases. In one of these the external reviewer seems to be hinting at the breakdown of the relationship with the case manager as a barrier to continuity of care. Non-compliance with medication was clearly identified in 4 cases. Lack of stable accommodation was a factor in one case. Family breakdown was a precipitating factor in one case.

Presentation Prior to the Incident

Five of these patients had approached health services for help prior to the incident. In one of these cases Housing Department staff had made a referral. In another case the patient's relative phoned the mental health service expressing concerns about deterioration in the patient's mental state on the day prior to the fatal incident. While most approaches for help were directly to the mental health service, there were also presentations to general practitioners, emergency departments, and a call to Lifeline.

The number of days between the last face-to-face contact with the mental health service and the incident ranges from 1 - 26. In the case where the patient had not been seen for 26 days the patient's relative had contacted the mental health service one day prior to the incident.

Table 14 Days between last contact and incident

Number of days between last face-to-face contact and incident					
1	3	3	5	11	26

The concern of every clinician assessing a person who is unwell and distressed is that of type II error, i.e. that the clinician's assessment rules out serious risk of harm in a patient who goes on to self-harm or harm someone else in the immediate term. The degree of difficulty in making such decisions is further confounded by the need to rely on clinical assessment because actuarial assessments using risk factors known to be predictive in cohorts over longer periods of time will produce an unmanageable level of type I error in clinical situations. Moreover, the unnecessary incarceration of a large number of people who are actually 'false positives' for suicide or homicide and the potential for unintended harm to their psychological well being preclude an actuarial approach to suicide or homicide risk prediction. These patient statistics are therefore provided not to direct blame at mental health services but to raise the question as to whether important windows of opportunity to alter the trajectory towards a fatal incident are being missed.

In particular attention is drawn to the probable **clinical utility of self-presentation in an agitated or perturbed state as an indicator of elevated risk**. The Committee draws attention to the fact that this advice is also supported by the 2004 review of suicide deaths by this Committee. While the Committee does not know how many such presentations to health services do not go on to a fatal outcome it seems reasonable that clinicians be alerted to this finding. More empirical data on this issue are required.

The Committee takes the position that presenting an analysis of these cases will be informative to clinical practice, clinical policy and procedural development. These findings support a recommendation that repeatedly arose in the Committee's discussions, and is further discussed in Risk Assessment and Management, below.

Systemic Issues

Analysis of systemic issues was more difficult than expected for a number of reasons. These include the Committee's lack of access to incident reports or reportable incident briefs, the poor quality of reports of incident reviews, and the exclusion of a clear account of events and timeline even in some of the more thorough review reports. Often the latter deficiency was because the review report assumed the reader had knowledge of other documents such as file audits or comprehensive case summaries that were not included in or appended to the review report. Finally, some external reviews provided findings and recommendations in relation to gaps in performance, policy or procedures in local services that were not necessarily generalisable to other mental health services.

Of particular note is the finding that the medical record is often not being utilised as the central instrument for documentation and communication of ongoing assessment, evolving management plans and inter-professional, inter-team communication. The introduction of an electronic health record will significantly strengthen the ability of clinicians to have all the necessary information for complex assessments and clinical decision support across the range of treatment settings.

Accordingly the Committee recommends that:

NSW Health ensure the development of

- a unique identifier, and
- electronic record systems

to ensure the constant availability and prompt transfer of relevant clinical information between services and between service providers.

Recommendation 4
Implementation timeframe: 24 months

The Committee noted the following systemic issues:

Information/Communication

- Poor quality of information provided in interagency referral (Department of Housing to NSW Health).
- Three different patient records kept in different teams of the same mental health service.
- Poor communication between hospital and community teams (e.g. discharge summaries should routinely be copied to the community teams involved in the patient's care).
- Poor communication resulting in ineffective hand-overs between teams, between mental health services and between mental health service and general practitioner.
- Risk assessments documented in non-permanent recording systems such as whiteboards, or methods of documentation not accessible to all mental health professionals such as team diaries. These practices should be discouraged, and all such information documented in the medical record.

- Patient's risk status changed but no rationale for that change recorded in the medical record.
- The issue of patient confidentiality as a putative barrier to effective communication between treating clinicians operating (e.g. general practitioner and mental health worker). The Committee suggests that NSW Health Legal Branch should provide advice on whether and under what circumstances duty of care and/or the public interest in these situations overrides the patient's right to privacy and confidentiality.

Accordingly the Committee recommends that:

NSW Health ensure that risk assessments and risk management plans are routinely documented in the medical record, and that changes to the level of risk are documented and are accompanied by a specific and appropriate management plan.

Recommendation 16

Implementation timeframe: 24 months

NSW Health ensure that where multiple health providers (eg general practitioner, private psychiatrist, psychologist, non-government organisation) are involved in a shared management plan that there is effective flow of appropriate information between them. Where the patient refuses consent for the exchange of information there is review by the senior clinician.

Recommendation 20

Implementation timeframe: 12 months

Clinical practice

There are limitations to the Committee's analysis of clinical practice with the information available. Much of the clinical practice that was reviewed was of a high standard. Some of the events reviewed were not predictable, even with the benefit of more information than the assessing or treating clinician had access to at the time. However, the nature of the analysis of incidents is to focus on deficiencies and gaps in performance because the intention is to identify what could have been done differently to prevent or mitigate the incident. Following the analyses of these and other cases it is the view of the Committee that clinical practice guidelines, clinical pathways or protocols may provide explicit standards of care that will assist clinicians, consumers and reviewers of incidents.

Issues of clinical practice identified in the analysis of these cases include:

- Inadequate assessment of developmental history in relation to parenting capacity.

- Over-reliance on phone assessments.

Face-to-face assessment is preferred when the patient presents an unknown level of risk (though supported by face-to-face assessments, phone contacts will continue to have a place in monitoring, supporting and keeping a patient engaged). Reliance on telephone contact in high risk situations should be discouraged.

- Lack of assertive follow-up.
First episode psychosis patients and those with the first episode of a major mood disorder require assertive follow up for at least the first 12 months.
- Lack of engagement of family and social supports for a patient who is a parent.
- Lack of assertive treatment and symptom control with no period of clinical stabilisation.
- Lack of corroborative history in formulation of risk assessments.
Corroborative and collateral histories are essential in making risk assessments.
- Decision not to use a Community Treatment Order when this was indicated.
- Delay in use of depot medication when indicated.
- Inadequate response to missed appointments in the case of parents with a mental illness.
Even a medium or low risk of harm to self or others when present in a parent should trigger 'immediate action' in the case of a missed follow up appointment

Accordingly the Committee recommends that:

NSW Health develop standards for the use and documentation of telephone contact in initial and ongoing assessment, treatment and post-discharge follow-up by mental health services. Reliance on telephone contact in high risk situations should be discouraged.

Recommendation 14

Implementation timeframe: 12 months

NSW Health ensure that people with a first episode of psychosis or major mood disorder receive active follow-up by the senior attending mental health clinician for at least 12 months following first service contact, in keeping with the National Psychosis Guidelines. Where this is impossible or unnecessary, the case should be reviewed and adequately documented.

Recommendation 18

Implementation timeframe: 12 months

NSW Health commence immediately the development of a clinical guideline for the management of risk to children of a parent with a major psychiatric disorder, for implementation within 24 months.

Recommendation 6

Implementation timeframe: 6 months

Clinical Governance

Issues of clinical governance were raised in every case to some extent giving the impression that this is an area requiring significant development and strengthening in mental health services. Many clinical governance issues arising from these cases turn around the role of the psychiatrist or the leader of the clinical team or unit.

Issues that were specifically raised in the analysis of these cases include:

- A procedure is required for flagging and reviewing patients who are failing to improve. It is noted that the MH-OAT consumer outcome measures may be an under-utilised data set in this respect. There needs to be clear criteria for treatment resistance that indicate the application of evidence-based treatment algorithms.

Accordingly the Committee recommends that:

NSW Health implement a procedure for flagging and reviewing patients who are failing to improve.

Recommendation 15

Implementation timeframe: 24 months

- The importance of achieving remission of symptoms and restoration of social function, and the assessment, monitoring and support of parenting capacity in parents with major psychoses or mood disorders. This is highlighted in two of these cases. This may require input from a range of mental health professions and teams including child and adolescent mental health, drug and alcohol services, other government agencies such as the NSW Departments of Community Services and Housing and community agencies such as Non-Government Organisations. The coordination of care by a senior clinician is required in such cases. Even a medium or low risk of harm to self or others when present in a parent should trigger 'immediate action' in the case of a missed follow up appointment.
- As a component of a clinical practice guideline, parents with mental illness should receive a comprehensive assessment including a detailed developmental history in relation to parenting capacity and assessment and engagement of family and social supports.

Accordingly the Committee recommends that:

NSW Health commence immediately the development of a clinical guideline for the management of risk to children of a parent with a major psychiatric disorder, for implementation within 24 months.

Recommendation 6

Implementation timeframe: 6 months

- There is a need to define an industry standard in relation to the review of decisions made by members of the multidisciplinary team at critical points including:

- all new presentations
- acute exacerbations/ relapses of illness
- discharge of patients from the mental health service.

The role of a psychiatrist or most senior clinician in the overview of these review processes is essential.

- There is a need to define a clear standard of psychiatrist (or most senior clinician) consultation and/or overview of every patient assessed to be of risk of harm to self or others.
- A procedure is required for mental health follow up of inpatients who were under the Mental Health Act and who following discharge fail to attend follow up appointments within 4 weeks of discharge. The Committee has requested that NSW Health includes in the Review of the NSW Mental Health Act the requirement for a procedure for mental health follow up of inpatients who were under the Mental Health Act and who following discharge fail to attend follow up appointments within 4 weeks of discharge.
- There is a need for clear lines of responsibility to a psychiatrist (or most senior clinician) for all patients admitted to a community team and input to regular team case reviews.

Accordingly the Committee recommends that:

NSW Health develop mandatory procedures for response to loss of contact or non-attendance at planned follow-up for people who may be at risk of suicide or risk of harm to others. If loss of contact occurs within 28 days of discharge for any patient, or at any time if a person remains at significant risk, then

- immediate consultation should occur with a senior mental health clinician, and
- a considered action plan should be documented by the service.

Recommendation 19

Implementation timeframe: 12 months

NSW Health define standards in relation to the timely review by a senior mental health clinician, of decisions made by members of the multidisciplinary team at critical points in the patient's care, including

- new presentations
- acute exacerbations or relapses of illness
- changes in the level of risk of harm to self or others
- discharge from the mental health service.

These standards should specify the involvement of a treating psychiatrist or most senior attending mental health clinician.

Recommendation 12

Implementation timeframe: 12 months

Forensic Patients

The Committee considers that a register of forensic patients in the community should be developed. A Forensic Patient in this case is a patient who is either an *insanity acquitee* or a person found unfit to stand trial, who remains under the care of the Mental Health Review Tribunal. The purpose of this register would be to ensure that NSW Health and Area Mental Health Services are aware of which Area Mental Health Services are responsible for these patients. Area Mental Health Services (with the assistance of Justice Health) should report regularly to NSW Health on the progress of these patients.

Accordingly the Committee recommends that:

NSW Health develop a register of forensic patients in community care.

Recommendation 10

Implementation timeframe: 6 months

NSW Health develop guidelines for the minimum level of care that should be provided to forensic patients in community care.

Recommendation 11

Implementation timeframe: 12 months

Risk Assessment and Management

There is no clinical activity that is of greater concern to the Committee than risk assessment and management. A properly conducted assessment is essential for the development of an effective management plan. “Risk assessment” is not a separate, discrete procedure, but rather is an intrinsic component of a comprehensive mental health assessment. In other words, a mental health clinician does not “conduct a risk assessment”, rather they should conduct a comprehensive mental health assessment of which risk a vital dimension.

Assessing and managing risk is one of the critical tasks of a mental health service. Evidence from service effectiveness research and from individual cases and coronial enquiries suggests that – just as in other branches of health care – these tasks are often not systematically performed and have a component of preventable error. Empirically validated risk assessment tools may provide a valuable support to clinical decision-making.

Accordingly the Committee recommends that:

NSW Health develop an empirically based risk assessment and management framework of risk of harm to others.

Recommendation 8

Implementation timeframe: 24 months

Given the relatively high risk nature of the patients that are managed by general mental health services, the increasing public interest in mental health patients and the increased focus on quality and safety in the last twelve months, there is a need to up-skill mental health

practitioners in risk assessment. Risk assessment and management for both violence and suicide should be a core clinical skill.

Accordingly the Committee recommends that:

NSW Health liaise with mental health professional bodies to include in professional development programs defined minimum risk assessment skills.

Recommendation 9

Implementation timeframe: 24 months

There seems to be an expectation that "risk assessment" can be undertaken using a tick box approach. The Committee does not consider that this is an adequate method of assessing risk. It is likely to be invalid and unreliable and may thus put individuals and services at risk. If risk assessment is to be a formalised process and made policy by NSW Health, it has to be done in a manner that is ethically, professionally and scientifically defensible. This could be supported by the risk assessment tools that are available, have international recognition and that have a strong empirical basis.

The stumbling point for many practitioners is that a reliable risk assessment and management plan can take time to develop. In the Committee's view, poorly completed risk assessments have such negative consequences for patients, practitioners and services, that sufficient time should be allowed for the development of a comprehensive risk assessment. This requires a change of practice and culture.

External Review of Homicide Incidents

In its First Report to the Minister, the Committee suggested that an appropriate instrument was needed for mandatory reporting of homicide cases to capture quality information and to immediately identify weaknesses in processes and systems. The development of such a tool was crucial for the future collection and analysis of data relating to homicide deaths.

In 2003, the Committee considered that tools developed in the UK for the **National Confidential Inquiry into Suicide and Homicide by People with Mental Illness** were useful models upon which to base the development of such instruments for application in NSW mental health facilities. The Homicide Sub-Committee reviewed the Homicide tool, seeking expert psychiatrist opinion on its applicability in the NSW context and modifications needed for application in NSW. It was considered suitable for retrospective analysis, but its adequacy for prospective reviews may be limited and a forensic psychiatric case review in questionnaire form may be needed for a more comprehensive view of the assailant at the time of the event.

In 2004 the Committee developed a draft proposal for a framework for incident reporting and external review of homicide cases involving mental health patients to assist Area Health Services in the public scrutiny of their response to such incidents and allow for more detailed and timely case analysis by the Committee. The proposal is currently before NSW Health for consideration and consultation with Area Health Services.

Currently the Committee is frequently obliged to analyse information on cases two or more years after the event, then to commission a review because the information was not reported in a way useful to the Committee in the first place. The Committee needs information at a suitable level of detail well within 12 months of the event.

The RCA would remain at the heart of the review process. In the field the RCA is seen as valuable for driving improvements and capturing issues of safety risk, and as an investigation and system improvement tool the RCA is of value to the Coroner. An external review would be broader, more immediate and would provide more detail to facilitate the work of the Committee. In further development of the proposal, a number of issues would need to be addressed. These would include, but not be limited to the relationship of the external review to the RCA process, privilege and the requirement for Ministerial approval.

The Committee proposed that to ensure consistency, external reviews would comply with agreed terms of reference and a standardised format and content. The Committee noted that in practice, Services would need to resolve issues of availability of appropriate senior personnel and skills required in some health services to conduct preliminary reviews. The utilisation of external personnel in the management of public perceptions of the process was considered advantageous. The Committee thought it desirable that the majority of an external review team would be external to the Area Health Service, although the new administrative arrangements in Area Health Services could make this difficult, at least for a time. Control over the quality of the review and decisions about membership of the review team would largely depend on who commissions the review. If it is commissioned by the Chief Executive, then the Centre for Mental Health should provide advice if asked.

At present any external review is at the discretion of Area Mental Health Directors, and there is a clear and established convention that an external review is done in the case of a homicide. However, if Area Health Services are not required to undertake external reviews the Committee is limited in its capacity to analyse cases. The database assembled for the Committee by the Centre for Mental Health illustrated a change in culture and policy, as reviews were available for all cases since 2002. Earlier cases were less likely to have been reviewed.

Accordingly, the Committee recommends that:

NSW Health develop and trial a standardised terms of reference and documentation format for the external review of a homicide by a patient of a mental health service.

Recommendation 2

Implementation timeframe: 12 months

Over time, if the proposed process of external review were implemented, and as the Committee analyses a number of cases using this process, the results may be aggregated and a group of contributing factors may emerge to assist in further refinement of the process.

Attention could be given to the use of a similar procedure for inpatient suicide deaths, as is currently the practice in some Area Health Services.

The Committee understands that the Centre for Mental Health will continue to maintain a database and inform the Committee of cases as they arise, and will do the same with cases of suicide death. The Committee also understands that the Centre for Mental Health will continue to manage the overall process of external reviews.

Appendix 1

**NSW Mental Health Sentinel Events Review
Committee**

Members

Privilege

Meetings

Appendix 1

Members

Professor Peter Baume AO (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 of the Foundation for Development Cooperation; Patron of the Voluntary Euthanasia Society of New South Wales; Member of the Editorial Board, Australian Health Review; Chair, Family Drug Support; Official Visitor to four psychiatric hospitals and two community psychiatric facilities.

Dr Stephen Allnutt (July 2004 onwards)

Stephen Allnutt is a senior clinician representing Area Health Services and specialist forensic psychiatrists. Stephen has 12 years full time experience in Forensic Psychiatry. He is currently Clinical Director of the NSW Community Forensic Psychiatry Service.

Mr Terry Clout (May 2002 onwards)

Chair of the Homicide Sub-Committee

Terry Clout was appointed Administrator of the Hunter New England Area Health Service in July 2004, and Chief Executive from January 2005. He was previously 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 Group 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. His 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.

Ms Clair Edwards (July 2004 onwards)

Clair Edwards is a registered nurse with 20 years experience in the provision of mental health services, initially as a clinician and more recently in senior management positions. She is currently Acting Director of Mental Health Nursing for the Eastern Zone of the newly amalgamated Sydney South West Area Health Service.

Mr Brett Holmes (May 2002 to November 2004)

Brett Holmes is General Secretary, New South Wales Nurses' Association.

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. She is a member of the Restorative Justice Unit Committee and the Coronial Review Committee. Martha is a community member of the Serious Offenders Review Council. Her interests are to further promote victims' rights and needs, with 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 is currently Local Area Commander, Liverpool Local Area Command, New South Wales Police Service. Terry was formerly Corporate Spokesperson for issues involving mental health since August 2002.

Mrs Jennifer Mackellin (May 2002 onwards)

Jennifer Mackellin is the Committee's Carer and 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 to December 2004)

Leonie Manns is a mental health care consumer representative

Dr Nick O'Connor (July 2004 onwards)

Nick O'Connor is a member of the NSW Branch Committee of the Royal Australian and New Zealand College of Psychiatrists, a Board member of the NSW Institute of Psychiatry and the NSW Mental Health Association. He is Director, Area Mental Health in the Northern Sydney Area Health Service.

Mr Stephen Olischlager (July 2004 to November 2004)

Stephen Olischlager was Manager Coronial Services New South Wales and Executive Officer to the State Coroner until November 2004.

Dr Susan Page-Mitchell (May 2002 onwards)

Chair of the Suicide Sub-Committee

Sue Page-Mitchell is a Rural GP in Lennox Head, a Visiting Medical Officer at St Vincent's Hospital Lismore and at Ballina District Hospital, and is senior lecturer and Director of Education at the Northern Rivers University Department of Rural Health. Sue currently holds positions as national President of the Rural Doctors' Association of Australia, Committee member of AMWAC, RACGP/ACRRM Examiner and Registrar Supervisor. She is on the ACRRM Panel of Censors, is NSW Ministerial appointee to the Rural Health Taskforce and the Expert Advisory Group on Drugs and Alcohol. She is the ANSWD Rural Chapter Representative for North Coast, RDA Representative for Ballina Region, Board member of Northern Rivers Division of General Practice and Board member of the NSW Clinical Excellence Commission.

Mr Kieran Pehm (August 2004 onwards)

Kieran Pehm is Deputy Commissioner, Health Care Complaints Commission. His previous positions include Deputy Commissioner - Independent Commission Against Corruption, Assistant Commissioner (Legal) - Office of the Legal Services Commissioner, Operational Lawyer - Police Integrity Commission, Assistant Secretary (Complaints) - Human Rights and Equal Opportunity Commission, Assistant Ombudsman (Police) - NSW Office of the Ombudsman, and Senior Investigations Officer - NSW Office of the Ombudsman.

Dr Grant Sara (July 2004 onwards)

Grant is a psychiatrist with experience as a clinician and manager in acute hospital and community psychiatry services. He is currently Acting Director of "InforMH", establishing a service for collecting and analysing mental health service information for NSW Health. He has a clinical role in the Acute Inpatient Unit at Macquarie Hospital, Ryde, NSW.

Professor Trevor Waring AM (May 2002 to November 2004)

Chair of the Implementation and Outcomes Monitoring Sub-Committee

Trevor Waring is Chancellor, University of Newcastle. He also currently holds the positions of President of the New South Wales Psychologists' Registration Board, Director of the Hunter Institute of Mental Health, Member of the New South Wales Victims Services Professional Advisory Panel, Member of the New South Wales Children's Court Clinic Professional Advisory Panel and Member of the New South Wales Institute of Psychiatry Academic Advisory Committee.

Executive Support

Executive support to the Committee is provided by Marlyn Sciberras, Executive Officer, Centre for Mental Health.

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 is deemed to be competent or compellable to produce or give evidence in respect of matters placed before the Committee.

Meetings

The Committee ordinarily meets 6 times a year for 3 hours on dates agreed by its members. The Committee met on 9 occasions in 2004, on the following dates:

19 February	5 August
16 April (RCA Training)	21 October
17 April (Planning Workshop)	25 November
22 April	9 December
24 June	

Homicide Sub-Committee

Membership

Mr Terry Clout (Chair)
Dr Stephen Allnutt
Professor Peter Baume AO
Ms Martha Jabour
Superintendent Terry Jacobson
Dr Nick O'Connor
Mr Stephen Olischlager
Mr Kieran Pehm

The Sub-Committee met on 5 occasions in 2004:

19 February
22 April
24 June
5 August
21 October

Suicide Sub-Committee

Membership

Dr Susan Page Mitchell (Chair)
Professor Peter Baume AO
Ms Clair Edwards
Mr Brett Holmes
Ms Jennifer Mackellin
Mr Stephen Olischlager
Mr Kieran Pehm
Dr Grant Sara

The membership of the Case Review Working Party was:

Dr Susan Page Mitchell (Chair)	Ms Jennifer Mackellin
Professor Peter Baume AO	Dr Grant Sara
Ms Clair Edwards	

The Sub-Committee met on 5 occasions in 2004:

19 February
22 April
24 June
5 August
21 October

The Case Review Working Party met on 4 occasions in 2004:

5 May
3 June
17 August
7 September

Implementation and Outcomes Monitoring Sub-Committee

Membership

Professor Trevor Waring AM (Chair)	Ms Leonie Manns
Professor Peter Baume AO	Mr Stephen Olischlager
Ms Clair Edwards	Dr Nick O'Connor
Ms Martha Jabour	Dr Susan Page Mitchell
Superintendent Terry Jacobsen	Mr Kieran Pehm
	Dr Grant Sara

In 2004 the Implementation and Outcomes Monitoring Sub-Committee met on four occasions:

24 June
5 August
21 October
8 November

Appendix 2
References

Appendix 2

References

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Glossary

Glossary

CRDF Client Death Report Form	The form to be completed by the Health Service in the case of an incident involving the death of a mental health patient. Unlike the RIB, identification is required on this form and it should therefore be sent directly to the NSW Centre for Mental Health.
CTO Community Treatment Order,	A CTO is a legal order made either by the Mental Health Review Tribunal or a magistrate under section 131 of the Mental Health Act 1990. A CCO is a legal order made either by the Mental Health Review Tribunal or a magistrate under section 118 of the NSW Mental Health Act 1990.
CCO Community Counselling Order	These orders allow a person to live in the community. They must receive treatment or counselling from hospital or community health centre staff. The conditions of treatment or counselling are specified in the treatment plan. Community orders may last for up to 6 months. If the treating team feel that a renewal of the order is required, they may apply to a Magistrate or to the Mental Health Tribunal. If the person refuses the treatment or counselling set out in the treatment plan then he or she may be in breach of the order.
Forensic Patients	Patients with a mental illness who have also been the subject of serious criminal charges. Some are convicted offenders with a mental illness, while others have been found not guilty of their crimes by reason of their mental illness. Others are found unfit to stand trial because of mental illness. Forensic patients remain under the care of the Mental Health Review Tribunal.
Homicide	A killing of one human being by another. The use of the word "homicide" in this Report is simply to specify an incident where a person or persons has died as the result of the actions of another, and does not reference the elements of a crime, such as murder, manslaughter or other offences under criminal codes or statutes.
IIMS Incident Information Management System	<p>A key quality assurance tool for public health organisations. Incidents to be entered into IIMS include any unplanned event resulting in, or having the potential for, injury, ill health, damage or other loss. The system also captures near misses ie any event that could have had adverse consequences but did not, and is indistinguishable from actual adverse events in all but outcome.</p> <p>Adverse events recorded in IIMS include unintended patient injury or complications from treatment that result in disability, death or prolonged hospital stay and are caused by health care management. Hazards recorded in IIMS relate to a source or situation with a potential for harm in terms of human injury or ill health, damage to property, damage to the environment or a combination of these.</p> <p>Notification of RIBs to the Department of Health occur in the electronic environment via the IIMS.</p>

**MH-CCP
Mental Health –
Clinical Care and
Prevention**

A model for establishing population mental health bed targets. It predicts acute mental health bed requirements based on population size and age distribution. It predicts a population-based requirement for acute adult mental health beds of between 30 and 32 beds per 100,000 population, depending on the age-mix within that population.

**MH-OAT
Mental Health –
Outcomes and
Assessment Tools**

Standardised clinical modules developed to support comprehensive clinical assessments and accurate documentation for all mental health consumers. Area Health Services are responsible for ensuring that clinicians maintain an adequate health record for each consumer. All public Mental Health Services are required to adopt the standardised MH-OAT clinical assessment protocols and modules from the date of Circular 2004/30.

Mental Health Assessment protocols and standard clinical documentation were revised to form the basis for the MH-OAT clinical modules which were designed to cover most circumstances requiring clinical documentation in mental health services including inpatient, ambulatory and community residential services. The mandatory implementation of the standardised clinical modules will provide for the documentation of clinical practice at different points in the cycle of care (assessment, care planning, review and discharge), along with standard measures of outcomes and case complexity.

**Mental Health Review
Tribunal**

An independent body established by the NSW Mental Health Act 1990 which reviews case management plans proposed by psychiatric case managers and hospital staff. It conducts hearings and collects evidence from consumers, mental health workers and other interested people. After considering this information, the Tribunal members decide whether or not the treatment and care suggested by the hospital or community health centre staff is appropriate and in accordance with the Mental Health Act.

**Multidisciplinary
Review/
Multidisciplinary
Team**

Multidisciplinary team is a term widely used. However, the critical conceptualisation is that the different health disciplines each have expertise relevant to their discipline's skills, competencies and knowledge that should be available to contribute to the relevant aspects of the patient's assessment and management.

In mental health such disciplines would include psychiatrists, mental health nurses, clinical psychologists, social workers and occupational therapists and possibly others. The contribution of some or all may be required and should be appropriately coordinated or brokered for optimal outcomes, through the team or clinician responsible for the person's clinical care.

Patient

The use of the term "patient" in this report includes any inpatient, client or consumer of mental health inpatient or community mental health services.

Privilege

The Committee is accorded privilege under Section 23 of the Health Administration Act 1982. Any information supplied to or reports commissioned for the Committee have the protection of confidentiality under s23 of the Act. With the approval of the Minister, and in accordance with section 23(3) of the Act, the Committee may share limited information with other Ministerial Committees on cases which are common to these Committees.

RCA Root Cause Analysis	A process used to review and analyse an incident, to identify the root causes of the incident and the factors that contributed to the incident. A report of the results of any Root Cause Analysis must be sent to the NSW Department of Health within 50 days of an incident occurring, as specified in NSW Quality and Safety Circular 2003/88.
Suicide, suspected	An unconfirmed reported suicide death. Until confirmed by Coroner's investigation, a reported suspected suicide death remains unconfirmed. NSW Mental Health Client Death Reports notify cases of suspected suicide death that must be confirmed by coronial investigation.
RIB Reportable Incident Brief	The method for reporting defined health care incidents to the Department of Health. RIBs must be de-identified and treated as confidential, particularly when such notifications involve staff, patients or clients.
SAC Severity Assessment Code	A risk matrix that is used to stratify the consequence and likelihood of an incident so that a numerical rating is allocated to every incident. This is designed to ensure that appropriate management of the incident takes place.
SIP Safety Improvement Program	A statewide program designed to make health care safer in NSW. The program has a number of components, including training for health care providers in incident management, the RIB system and the IIMS. The key objective of this program is to ensure a coordinated approach to the management of all incidents that occur in the NSW health system.
Type 1, Type 11 errors	<p>Type 1 error, or "false positive" i.e. a clinician's assessment (incorrectly) finds serious risk of harm in a patient.</p> <p>Type II error, or "false negative" i.e. a clinician's assessment (incorrectly) rules out serious risk of harm in a patient who goes on to self-harm or harm someone else in the immediate term.</p>