

health

Chief Psychiatrist's investigation of inpatient deaths 2008–2010

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Executive summary

The unexpected death of a person that occurs during a hospital inpatient admission is a tragic event that causes immense distress to families, carers and staff. This is especially so where the person commits suicide.

In September 2011, there were a number of media reports directed to the issue of deaths in Victorian mental health inpatient units. These reports focussed on three individual patients and the impact of their deaths on their families and carers. In the context of the concerns raised by reporters, writers of opinion pieces and letters to editor, the Premier of Victoria, the Hon Ted Baillieu MP and the Minister for Mental Health, the Hon Mary Wooldridge MP, sought a formal investigation into how services responded in the event of an unnatural/unexpected or violent inpatient death. This was to include processes for internal reviews, and whether the services learnt from critical incidents and instituted changes to practices or amenities that would lessen the risk of future deaths.

The scope of the investigation was limited to those deaths that occurred from January 2008 to December 2010. Forty-one people came within scope of the investigation relating to 13 health services (19 inpatient units). Two of the deaths occurred in aged persons mental health services, one was in a secure extended care unit, two occurred in a low security forensic unit, one in a youth unit, and the remainder related to adult inpatient units. Of the 41 deaths in scope, eight deaths were by suicide on an inpatient unit, eight deaths where the cause or intent was uncertain on an inpatient unit, 13 deaths occurred after a person had absconded from an inpatient unit (most of these were likely suicides, but at least two were accidental or intentional overdose of opiates), eight deaths while on approved or planned leave, two homicides and two deaths related to emergency department presentations. It should be noted that in only thirteen cases had the Coronial process concluded, such that the cause of death in the remainder had not been formally ascertained.

A number of mental illnesses are associated with suicidal ideation and behaviour. There is an increased risk of suicide in those with mental illness. The rate of suicide in Victoria was 9.3 per 100,000 in 2009, which equates to approximately 500 deaths per year. The act of suicide is a decision made by the individual. In most cases we cannot know what made a person move from having thoughts of suicide to actually committing suicide. This makes consideration of the 'cause' very difficult, and means we can only look at the events leading up to the suicide, and consider whether there were clinical, personal or environmental factors that may have influenced or enabled that final decision. Our preliminary view is that of the 41 deaths, 29 most likely occurred as a result of suicide.

A limited review of the national and international literature suggests that risk assessment is a notoriously difficult and imprecise process. Even though inpatient suicide is a relatively rare occurrence that is difficult to predict and prevent, continuing to refine and improve our efforts remains important and relevant. Recommendations suggested in the literature may be difficult and costly to health services. Decisions must be made about how to balance patients' rights and quality treatment with more restrictive interventions stemming from a desire to prevent inpatient suicides.

There is a common perception that any suicide by a person who is receiving treatment from a mental health service, particularly when treatment involves an admission to hospital, represents a failure on the part of the service. This is not always the case and in many instances mental health services provide effective treatment and care and are likely to have played a role in preventing many incidents of self-harm and suicide. This needs to be kept in mind in any investigative process which has as its purpose the identification of systemic issues and opportunities for improvements in service delivery.

The investigation method involved collation of service level incident reviews, policies and protocols, statutory paperwork and where available, coronial reports. These were considered by individual service and by types of deaths. The investigation panel (including two interstate mental health experts) conducted site visits to consider relevant deaths and systems issues in greater detail. Five sites were visited. This knowledge was supplemented by the findings of three recent in-depth clinical reviews, two

service visits following the death, and the separate inquiry following the homicides at Thomas Embling Hospital, meaning that in total eleven different services had been inspected, covering 31 of the 41 deaths. The site visits were followed by comprehensive discussions by the panel regarding the findings and recommendations.

The panel concluded that the reporting requirements had been fulfilled in all cases, and that services had in place formal review mechanisms. Key themes that emerged included the adequacy or otherwise of the processes followed by services in the immediate period following the death; subsequent incident reviews; the variable practices regarding whether or not an inpatient unit is locked and how this is managed; the management of co-morbid substance use; staffing issues including nursing observation practice; and decision making processes regarding risk assessment and leave.

Services reported that the current funding model for inpatient units limits the capacity of management to better respond to the increased throughput and acuity with the appropriate levels of staffing and skill mix needed to manage complex patients and situations. The panel recognised that inpatient services are provided within a budget determined by the department and health services. The panel believes this warrants review.

A particular coronial inquiry or service review generally occurs in response to a single event. This investigation provided an opportunity to consider all 41 deaths over a three year period and therefore to identify systemic or practice issues. The panel concluded that review of deaths over a period such as three years allowed better consideration of system-wide issues, especially given the low base rate of such tragic occurrences.

Recommendations

The panel made the following recommendations:

1. That health services review existing policies and implement procedures to provide clarity about the immediate response required following a death. At a minimum this should include who would be most appropriate to communicate with families and other relevant people immediately and in an ongoing way. Procedures should include providing support to other patients and staff who witnessed or were impacted by the event. Policies and procedures need to be accompanied by training and education of staff to ensure the needs of families during a time of bereavement are respectfully considered.
2. That the Chief Psychiatrist consult with the Department's sentinel event program to identify how root cause analysis and risk reduction action plans can be improved to provide better targeted interventions including those directed to treatment and care. Services should ensure that senior clinicians and quality and safety managers external to the mental health program are involved in critical incident review and root cause analysis to support greater objectivity, external scrutiny and improved governance.
3. That the Chief Psychiatrist develop a guideline to assist services in relation to patient searches, especially in relation to searches for illicit substances and the equipment required to administer such substances.
4. That the Department of Health and health services review the design of planned and current inpatient units with particular reference to the security of the unit including the provision of air locks to reduce opportunities for absconding. The removal of ligature points, wherever possible, including in en suite bathrooms, should be undertaken. Safety and security of the unit needs to be balanced with patient rights and privacy within a therapeutic environment. The review should also consider for future planning the most appropriate size, configuration and location of inpatient units to balance local accessibility with sufficient capacity to support appropriate gender segregation and amenity.
5. That the Department of Health and health services review the staffing skill mix in acute inpatient units to reflect the 24 hour, 7 day a week need for input from multidisciplinary staff. There should be access to timely consultant psychiatrist review including after hours, weekends and public holidays. There should be access to appropriate staff for discharge planning, including social workers and

other allied health staff. There should be budget capacity and clear protocols to guide staff in when to 'flex up' staffing levels in response to patient need and acuity.

6. That the Department of Health and health services review the design and model of care in high dependency units (HDU) to ensure the provision of a therapeutic environment with appropriate staffing levels and skill mix to safely manage the vulnerability and disturbed behaviours likely in patients placed in the HDU.
7. That the Department of Health and health services ensure there is a clear and consistent process and documentation for nursing observations, and that any change in required observation level is made after suitable discussion and consideration. The frequency of observations over the night shift should be congruent with daytime observations unless otherwise decided and documented.
8. That dual diagnosis training for multidisciplinary staff in inpatient services include the recognition and management of alcohol and other drug withdrawal during an admission episode. Treatment planning should reflect this and may involve referral to addiction medicine specialists. The Department of Health and health services should review the availability and accessibility of specialists for expert consultation and advice.
9. That health services develop policies and provide training to guide staff in the recognition and management of the physically deteriorating patient as required by the National Safety and Quality Standards, including when and how to access specialist medical services when this is required.
10. That the Department of Health and health services review the training requirements of all inpatient clinical staff in regard to areas including mental state examination, risk assessment, and the recognition, treatment and management of acute arousal.
11. That health services develop clearly documented policies with the relevant emergency departments regarding which service component has primary responsibility for providing care to mental health patients, and who has the responsibility for communication including notification and support of families in case of an adverse event.
12. That health services establish a process to review circumstances in which an inpatient unit may require to be locked. This should include decision-making by senior clinical staff, regular review and monitoring of times the unit is locked. Any changes should be communicated to staff, other patients and visitors, including information on how to access or exit the unit when it is locked.
13. That health services ensure the mental health program implements full engagement with appropriate family members and carers wherever possible from the commencement of admission. This should include areas such as obtaining collateral information, providing education about what items can be brought onto the unit, and discussions regarding leave, including carer's capacity to provide supervision, when and how to access support and discuss the progress of leave and education about access to illicit substances or alcohol during leave.
14. That health services ensure that relevant policies including death procedures are appropriate to specific work areas such as mental health and that implementation and monitoring practices are applicable to the program area.
15. That the Chief Psychiatrist convene a panel every three years to inquire into inpatient deaths over that time to consider overall practice improvements and issues relevant to the mental health system.

Introduction

Background to the investigation

The unexpected death of a person that occurs during a hospital inpatient admission is a tragic event that causes immense distress to families, carers and staff. This is especially so where the person commits suicide.

In September 2011, there were a number of media reports directed to the issue of deaths in Victorian mental health inpatient units. These reports focussed on three individual patients and the impact of their deaths on their families and carers. In the context of the concerns raised by reporters, writers of opinion pieces and letters to editor, the Premier of Victoria, The Hon Ted Baillieu MP and the Minister for Mental Health, the Hon Mary Wooldridge MP sought a formal investigation into how services responded in the event of an unnatural/unexpected or violent inpatient death including processes for internal reviews, and whether the services learnt from critical incidents and instituted changes to practices or amenities that would lessen the risk of future deaths.

Terms of reference were developed for the investigation. The investigation considered unexpected, unnatural and violent deaths of inpatients from 1 January 2008–31 December 2010 (appendix 1).

Legal mandate

The investigation was convened under the provisions of section 106 of the *Mental Health Act 1986* (the Act). Under these provisions the Chief Psychiatrist and authorised officers have powers to visit a psychiatric service and carry out investigations if the Chief Psychiatrist forms the view that such action is necessary. This may include inspecting premises and records held by the service, making enquiries about a person's treatment and interviewing staff. The Chief Psychiatrist also has powers to formally direct a service to cease or implement a particular treatment or clinical action where deemed appropriate and necessary.

Purpose

The purpose of the investigation was to assess the adequacy and appropriateness of the service response following the unexpected death of an inpatient. The objectives included but were not limited to:

- the immediate actions taken including notification of family and staff support
- fulfilment of reporting requirements to the Chief Psychiatrist and Coroner
- systematic incident review and response
- completion of a root cause analysis as required by the sentinel events program
- development and implementation of recommendations, including in relation to comments or recommendations made by the Coroner.

The investigation panel was to report the findings of the above by the end of 2011 to the Minister for Mental Health and make recommendations to the Department of Health and health services in relation to improving service performance.

Scope of the investigation

Over the period 2008–2010 over 1,200 deaths were reported to the Chief Psychiatrist. The majority of these deaths occurred in the community, with 395 reportable deaths occurring during an inpatient stay or on the day of discharge. Most of these deaths related to the death of persons receiving treatment and care in aged persons mental health services, and were from natural causes. These were outside the scope of this investigation.

Where the cause of death is uncertain, or where the death appears to be unnatural, unexpected or violent, it is the role of the Coroner to determine cause of death. The Coroner may also decide to hold an inquest into the death. There is often a considerable period between the notification of death and the conclusion of the coronial process. As the cause of death had not been formally ascertained in most cases, this investigation excluded those deaths which were likely to be the consequence of underlying physical illness, or to have occurred in the context of natural aging on the basis of material included in the reportable death notices to the Chief Psychiatrist. After excluding those deaths where the cause was most likely to be due to natural causes, 41 deaths were found to be within the scope of the investigation which was approximately 10 per cent of the reported deaths during that period. The total number of people who received a public mental health service in 2010–11 was 61,645.¹ There were 19,726 inpatient unit admissions in 2010–11.² Over the three–year period under investigation there were 53,244 hospital admissions to public mental health services of 36,797 consumers. The 41 deaths considered in this investigation equate to a rate of 0.08 per cent of all hospital admissions.

For the 41 deaths the coronial process had concluded in thirteen cases. In some instances the cause of death can be reliably extrapolated from the manner of death. For example, death by hanging is assumed to be the result of a suicide. The investigation chose a low threshold for deciding which deaths would be in scope for the investigation under the category of unexpected, unnatural or violent deaths and included two deaths that occurred during the course of an emergency department presentation where the major reason for the presentation related to mental illness.

¹ CMI/ODS data extract, 15-09-2011.

² CMI/ODS data extract, 15-09-2011.

Context

The provision of specialist mental health services in Victoria

Mental health service provision is complex. The Australian Government funds primary care and private specialist care through Medicare. The State Government funds health services to provide a range of community and bed based services, and the non-government or community managed sector provides bed based and community based support and rehabilitation services. State funded services are referred to as public specialist mental health services and are targeted to those who experience the most severe mental illness for whom care in the primary or private sector is not appropriate.

Victoria has over two thousand public mental health beds in a mainstreamed system. In this context 'mainstream' refers to the provision of mental health services within the general health system. Victoria operates an area based mental health service system with each area providing a range of bed based and community based services. In most areas, the adult acute inpatient unit comprises 25 beds, of which four or five beds are within a locked area of the inpatient unit variously known as high dependency units, extra care units or similar. The majority of inpatient units now have single rooms with en suite bathroom facilities, and separate wings or corridors to allow for gender segregation.

In general, admission to an inpatient unit is only considered if treatment and care cannot be safely provided in the community. Most inpatient units in Victoria run at very high occupancy levels often of 90–95 per cent occupancy. However, because the volume of emergency admissions is unpredictable, it is generally accepted that 85 per cent occupancy provides the flexibility for facilitating admissions from emergency departments and ensuring better discharge planning and throughput from acute units. Acute inpatient units are busy and pressured environments with an average length of stay of 11 days. The proportion of patients who are admitted involuntarily under the Act varies, but is generally greater than 50 per cent.

Under the Act there is a general principle that care should be provided in the 'least possible restrictive environment and least possible intrusive manner consistent with the effective giving of that care and treatment'.³ The Act also requires that 'any restriction upon the liberty of patients and '... any interference with their rights, privacy, dignity and self respect are kept to the minimum necessary in the circumstances.'⁴

These contextual, policy and legislative requirements have been interpreted as requiring mental health inpatient units to be managed as unlocked units whenever possible. This emphasis on the least restrictive environment is further supported by the requirements of the *Charter of Human Rights and Responsibilities Act 2006*.

Legal framework

Coroners Act 2008

The *Coroners Act 2008* requires the reporting of certain deaths, and establishes the Coroners Court of Victoria as a specialist court. The Coroner is required to investigate a particular category of death called 'reportable deaths'. The court must be advised of a reportable death in order for a coroner to investigate. The Coroners Act stipulates clear objectives which includes the acknowledgement of the distress of families and the need for support following a death.

³ Mental Health Act 1986, section 4(2)(a).

⁴ Mental Health Act 1986, section 4(2)(b).

In addition to the reporting of 'reportable deaths' to the Coroner, health services are required to also report these deaths to the Chief Psychiatrist. A death is considered to be a 'reportable death' to the Coroner if it meets certain criteria. The basis on which inpatient deaths are reportable to the Coroner is that the Coroner investigates those deaths where:

- the death appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury
- the death concerns a person, who immediately before their death was a person placed in 'custody or care' (which includes a patient in an approved mental health service)
- the death of a person who immediately before death was a patient within the meaning of the Mental Health Act.

The immediate family of a deceased person may also report a death to the Coroner, if the person was discharged from an approved mental health service within three months immediately before the person's death. 'Discharged from an approved mental health service' has been interpreted broadly to cover both inpatients and those receiving services in the community.

Mental Health Act

Under the Act (section 106A), mental health services are required to report to the Chief Psychiatrist the death of any person receiving treatment or care for a mental disorder which is a 'reportable death' within the meaning of the Coroners Act. This includes the death of a person who immediately before death was a patient within the meaning of the Act, and any death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury. Guidelines developed by the Chief Psychiatrist also require that the death of a person within six months of being treated by the mental health service is reported if the service becomes aware of the death.

Current mechanisms for review of inpatient deaths

Health service reviews

All unexpected mental health inpatient deaths are routinely reviewed by health services under internal critical incident review mechanisms. Documents from these reviews were made available to the investigation team for all 41 deaths within the scope of the investigation.

Health services also report sentinel events to the Department of Health under the sentinel event program (see page 8). There are eight nationally defined sentinel events, one of which is 'suicide in an inpatient unit'. Victoria is unique in having added an additional 'other catastrophic' category in its sentinel events program. This category covers near misses, as well as deaths of psychiatric patients who have absconded from the inpatient unit with adverse outcome, or where the cause of death may not be suicide.

Sentinel events are reviewed by the health service where the event occurred using a process analysis method called root cause analysis (RCA). The RCA process is used to identify factors that contributed to an adverse patient outcome or near miss event. The root cause is the earliest point at which action could have been taken to reduce the chance of the incident happening. The RCA investigations use recognised analytical methods and focus on systems and processes, not individual performance, and problem solving rather than assignment of blame. The RCA report includes a risk reduction action plan (RRAP), which contains recommendations that are rated using a scale of effectiveness regarding its ability to eliminate or minimise risk. The Department of Health provides training to health services staff on how to conduct RCAs.

Additionally, all Victorian publicly funded health services and agencies that provide health services on behalf of the Department of Health are subject to the Victorian health incident management policy. The purpose of the policy is to provide governance that clearly outlines the responsibilities of individuals, services and the Department of Health in relation to incident management, to ensure consistency in incident management and ensure organisational learning from incidents to mitigate future risk. The majority of services have a critical incident review committee with stated membership and terms of reference. The committees are required to report through senior management to their Board on a regular basis.

Department of Health

Sentinel event program

The Victorian sentinel event program commenced during 2001–2002 as part of the department's clinical risk management strategy. The definition of a sentinel event is 'a relatively infrequent, clear-cut event that occurs independently of a patient's condition; it commonly reflects hospital system and process deficiencies, and results in an adverse or unintended outcome for the patient'. The definition of an adverse event is 'an unintended injury or complication that results in disability, death or prolongation of hospital stay and is caused by health care management rather than the patient's disease'. The aim of a risk management program is to implement strategies to reduce the possibility of human error or organisational failings and to improve patient safety and quality of care, particularly in relation to events deemed to be sentinel.

While it is crucial to analyse inpatient deaths in order to identify potential systemic failures and opportunities for improvements in service provision, it should be noted that inpatient suicides differ from other sentinel events in that these events do not occur independently of the patient's condition, rather, they are intrinsically connected to the mental state and mental illness of the patient. This area warrants further consideration and research given its complexity and the inherent tension between internal and external factors which influence the likelihood of suicide.

Victorian health information management system (VHIMS)

In February 2010 the department began a phased 12-month rollout of the Victorian health incident management system (VHIMS), which is designed to manage clinical incidents, consumer feedback and occupational health and safety data relating to the public health system, including all Victorian public hospitals. Data related to clinical incidents are accessible to the department in de-identified electronic format. This is intended to allow the department to provide advice on issues arising from the analysis of statewide aggregate clinical incident data.

Chief Psychiatrist reviews

Reportable deaths

The Chief Psychiatrist is responsible for the medical care and welfare of people receiving treatment or care for a mental disorder in Victoria. There are a number of ways in which the Chief Psychiatrist reviews the deaths of mental health consumers, including those who were inpatients at the time of their death.

The Act stipulates a requirement for approved mental health services⁵ to forward notification of reportable deaths within the meaning of the Coroners Act to the Chief Psychiatrist. The Chief

⁵ An 'approved mental health service' is any premise or service that is proclaimed by the Governor in Council to be an approved mental health service under section 94 of the Act. Approved mental health services are places where involuntary inpatient treatment may be provided to persons with a mental illness.

Psychiatrist's guideline on reportable deaths provides guidance to services about their reporting obligations. Services are required to report all deaths which are unexpected, unnatural or violent, including suspected suicides, and of the death of people who have been in contact with or were provided treatment by mental health services. These deaths need to be reported to the Chief Psychiatrist within three days using a 'MHA33—Notice of Death' form. The forms are reviewed by the Chief Psychiatrist or delegated Deputy Chief Psychiatrist. The death of a person under treatment as an inpatient requires notification within 24 hours by telephone, followed by the MHA33—Notice of Death form. All deaths involving inpatients or persons being treated under the Act or under the *Crimes (Mental Impairment and Unfitness to be Tried) Act* also require a detailed clinical report from the authorised psychiatrist, to be forwarded to the Chief Psychiatrist within 14 days of knowledge of the death. In a number of instances the Chief Psychiatrist seeks further information from the authorised psychiatrist about the patient's treatment and care to enable the Chief Psychiatrist to undertake a more considered judgement on the appropriateness of the treatment and care provided. The Chief Psychiatrist also registers interest in coronial findings of deaths involving mental health consumers. Coroners' reports are reviewed by the Chief Psychiatrist and a thematic summary of issues identified in recommendations made by the Coroner is published on the Chief Psychiatrist's website periodically and sent to health services.

Sentinel event review committee (CPSERC)

The Chief Psychiatrist convenes the Chief Psychiatrist's Sentinel Event Review Committee (CPSERC), which meets quarterly and includes nominated senior psychiatrists and mental health clinicians to review all RCAs and RRAPs involving mental health related events submitted to the department's sentinel event program. These RCA reports and action plans are received in de-identified form. The role of the CPSERC is to review the circumstances of the sentinel event and to provide written comment on the appropriateness and quality of the RCAs and RRAPs to the sentinel event program which in turn provides this feedback to the submitting service.

The clinical review program

The Chief Psychiatrist conducts a clinical review program, which involves an audit of individual patient records and a review of clinical practices at mental health services using a peer review methodology. This is in exercise of the Chief Psychiatrist's role and responsibilities in monitoring treatment and care. Each clinical review is carried out by a team of senior clinicians visiting the service over several days. Reportable deaths that have occurred in the service under review are within the scope of clinical reviews. The clinical review program involves a report back to the service with recommendations. The service is required to respond to this with an action plan which is monitored by the Chief Psychiatrist's Quality Assurance Committee (QAC) constituted under section 106AC of the Act. A review under the auspices of the QAC may also be instigated to consider a particular service component in the context of a service request. Three metropolitan and one rural service have been reviewed through this process over the past two years.

Chief Psychiatrist investigations under section 106 of the Act

In specific circumstances the Chief Psychiatrist will convene a panel and conduct an investigation of a reportable death. During the period covered by this investigation, two patients died in a low security unit at Thomas Embling Hospital. The Chief Psychiatrist conducted an investigation into these deaths in November 2009 with the assistance of a panel which included senior psychiatrists and a senior clinician from interstate.

Coronial inquests

Upon notification of a reportable death, the Coroner's Court will arrange for the deceased person to be conveyed to a mortuary. An investigation into the death is commenced. Not all investigations will result in an inquest. An inquest is a court hearing into a death that is heard by the Coroner and is generally open to the public.

Once the coronial investigation has been completed, the Coroner must make written findings about the identity of the deceased, what caused the death and in certain cases, the circumstances in which the death occurred. The Coroner may also make recommendations about matters connected with the death. These recommendations are aimed at preventing similar deaths from occurring in the future. In conducting investigations and developing recommendations, coroners may be assisted by specialist units within the court, such as the Coroner's Prevention Unit (CPU). The CPU comprises several distinct investigation teams who gather and provide expert information on particular types of deaths, and was created for coroners to strengthen their prevention role and provide them with expert assistance. The intentional death investigation team assists in the investigation and development of recommendations surrounding intentionally caused deaths, such as suicides.

The Coroner in the course of an investigation is often provided with information about improvements undertaken as a result of a service review of the death. In some coronial investigations these recommendations are sometimes commented on or endorsed by the Coroner.

Methodology

Literature review

While an exhaustive literature review was not within the scope of this investigation, an effort was made to review recent national and international papers and research on inpatient deaths and in particular inpatient suicides. While psychiatric inpatients are known to be at particular risk for suicide, these deaths are an infrequent occurrence and consequently the literature base is relatively small. The purpose of examining the literature was to enable comparison with the reported incidence of inpatient suicides internationally, to identify patient risk factors, to examine the effectiveness of risk assessment in identifying those at risk and preventing deaths, recommendations in the literature relating to the inpatient unit environment and clinical practice, and findings on the impact of inpatient deaths on families, staff and other patients.

Most studies relating to inpatient deaths focus on suicide and emphasise that predicting and preventing inpatient suicides is extremely difficult. The reported rate of inpatient suicide varies widely between locations and over time. A systematic review of several studies found that an inpatient suicide rate could be calculated per 100,000 head of population per year and ranged from 0.28 to 2.8.⁶ The rate of inpatient suicide as a proportion of all suicides yielded figures ranging from 0.01 to 0.15. Another literature review calculated the rate of inpatient suicide across all admissions and established that inpatient suicides constituted between 0.1 and 0.4 percent of all psychiatric admissions.⁷

It is difficult to generalise from these figures given the variability of services provided; inpatient facilities provided care to very different patient populations and the length of stay in the studies varied considerably also. However, it can be concluded that schizophrenia and affective disorders (as well as depressive symptoms) are most frequently associated with inpatient suicide. These are the most common diagnoses of inpatient psychiatric patients. Certain life stressors and relationship difficulties have also been found to be salient for certain diagnostic, gender and age groups. Acute risk factors include severe anxiety and agitation.⁸

Several studies suggest that having at least one prior admission to hospital is associated with greater risk of inpatient suicide. There is also support for the finding that suicides are more likely to occur early in an admission, often before treatment can take effect. Between three to 28 per cent of inpatient suicides have been found to occur within the first week of hospitalisation, while 17 to 71 per cent occur within the first month.⁷ Some studies have also found an association between suicide and longer length of stay, suggesting that these suicides may be associated with despair and loss of hope.

Generally most of the inpatient suicides occur while patients are off the psychiatric unit, with seven to 65 per cent of patients out of the unit without permission at the time of death and 19 to 81 per cent of patients on approved leave when they killed themselves.⁷ Off-ward suicides are often violent and involve hanging, jumping from a height or in front of a moving vehicle. In terms of method, timing and location of suicides on the inpatient units, these reflect available means. Suicides on the inpatient unit are usually accomplished by hanging, as this is the most accessible means, usually occur in isolated areas (such as bedrooms and bathrooms) and often at times of reduced staff supervision, such as nights or at handovers.⁶

Several researchers have tried to predict inpatient suicides on the basis of identified risk factors. However, the evidence suggests that these factors are not specific or sensitive enough to have significant clinical utility. In one study five predictive risk factors were identified. However, on review

⁶ Bowers, L., Banda, T. & Nijman, H. (2010). Suicide Inside: A systematic review of inpatient suicides. *The Journal of Nervous and Mental Disease*, 198, 5, 315-328.

⁷ Combs, H & Romm, S. (2007). Psychiatric inpatient suicide: A literature review. *Primary Psychiatry*, 14(12), 67-74.

⁸ Tishler, C.L. & Reiss, N.S. (2009). Inpatient suicide: preventing a common sentinel event. *General Hospital Psychiatry*, 31, 103-109.

these risk factors only identified two out of 97 patients who suicided as having a predicted risk of suicide greater than five per cent.⁹ Another study which identified five significant predictors failed to identify any of the patients who committed suicide.¹⁰ The authors of several studies noted the difficulty of predicting suicide. Large and colleagues (2011) found that more than 98 out of 100 patients classified as being at high risk of inpatient suicide would not commit suicide, while one in three patients who do complete suicide were classified as low risk at the time of their death.¹¹ Often when deaths by suicide are reviewed multiple risk factors are identified retrospectively and questions are raised about why these deaths were not foreseeable. The research indicates that hindsight bias is strong with retrospective death reviews; current scientific evidence does not support the ability to predict inpatient suicide.

While capacity to predict which patients are at risk of inpatient suicide is poor, the literature does suggest precautions that can be taken by inpatient facilities to reduce the risk of inpatient suicide. There is an ongoing tension between creating an environment that is therapeutic and comforting to patients and one that is 'suicide proofed' but stark and prison-like. A number of articles recommend eliminating or reducing structural hazards in the physical environment of units as an important strategy to protect the safety of patients.^{3 12} Removing ligature points is recommended as well as reducing access to items that may be used to self-harm including, but not limited to, razors, electrical items, plastic bags, belts, and cords. This results in the need not only for regular audits or rounds of the unit using a checklist of potential environmental hazards, but also checking of patients and the unit for potentially harmful belongings and educating visitors and monitoring of items brought by them which are potentially harmful.^{13 14}

The question of whether to lock inpatient units to prevent patients leaving without permission has also been examined. Bowers and colleagues (2010) indicated that the evidence suggests that locking the ward door does not seem to have an effect on inpatient suicide rates. This may be because the locked door is an imperfect barrier and patients still manage to abscond, or because it increases the rates of suicide on the unit due to increased feelings of stigmatisation and depression. In New South Wales the *Tracking Tragedy* report included a recommendation that all psychiatric inpatient facilities be locked.¹⁵

The death of a family member by suicide, particularly suicide on an inpatient unit, can be extremely difficult, devastating and overwhelming for families. Each family member will respond uniquely to the death. It is suggested that the next of kin or designated person should be contacted as soon as possible, provided information and support, a contact point at the service and possible referral or advice about other support services.¹⁶

Inpatient suicide is an extremely significant event, not only for families but also for the staff who have been involved in the care of the patient and for other patients on the ward. The literature notes the negative impact of an unexpected death on staff and other patients. Combs and Romm (2007) reviewed the research and found that staff experienced a range of symptoms following a patient suicide, including feeling shocked, stressed and sad. Approaches to supporting staff varied, but it was suggested that informal peer contact was considered to be helpful and participation in debriefing should be voluntary.

⁹ Powell, J., Geddes, J., Deeks, J., Goldacre, M., Hawton, K. (2000). Suicide in psychiatric hospital inpatients: Risk factors and their predictive power. *British Journal of Psychiatry*, 176, 266-272.

¹⁰ Spiessl, H., Hubner-Liebermann, B., & Cording, S. (2002). Suicidal behaviour of psychiatric inpatients. *Acta Psychiatrica Scandinavica*, 106(2), 134-138.

¹¹ Large, M., Smith, G., Shamra, S., Nielssen, O., & Singh, S.P. (2011). Systemic review and meta-analysis of the clinical factors associated with the suicide of psychiatric in-patients. *Acta Psychiatrica Scandinavica*, 124, 18-29.

¹² Lieberman, D.Z., Resnik, H.L.P., & Holder-Perkins, V. (2004). *Environmental risk factors in hospital suicide. Suicide and life-threatening behaviour*, 34(4), 448-453.

¹³ Cardell, R., Bratcher, K.S., Quinnett, P. (2009). Revisiting "suicide proofing" an inpatient unit through environmental safeguards: A review. *Perspectives in Psychiatric Care*, 45(1), 36-44.

¹⁴ Mills, P.D., DeRosier, J.M., Ballot, B.A., Shepherd, M., & Bagian, J.P. (2008). Inpatient suicide and suicide attempts in veterans affairs hospitals. *The Joint Commission Journal on Quality and Patient Safety*, 34(8), 482-488.

¹⁵ *Tracking Tragedy 2008—Fourth Report of the NSW Mental Health Sentinel Events Review Committee*; see <http://www.health.nsw.gov.au/pubs/2008/mental_health_fr.html>.

¹⁶ Kaye, N.S. & Soreff, S.M. (1991). The psychiatrist's role, responses, and responsibilities when a patient commits suicide. *American Journal of Psychiatry*, 148, 739-743.

Patients on the inpatient unit at the time of an incident need special attention. A range of interventions are suggested in the literature, with patients who have a history of suicidal behaviour being particularly affected. Overall the literature found that staff reactions were emphasised more than patient reactions and that it may be important to bring outside support for staff to deal with their emotions, so that they can better care for other patients.¹⁷

The importance and value of a formalised reporting system and approach to reviewing adverse events was strongly emphasised in the literature. Important features of a sentinel event reporting system were thought to be keeping the information confidential (to increase likelihood of reporting) and increase utility of the RCA and the recommendations, ensuring reports are analysed in a timely fashion and focussing on systems and processes rather than how to punish institutions and clinicians.

In conclusion, the literature suggests that risk assessment is a notoriously difficult and imprecise process. Even though inpatient suicide is a relatively rare occurrence that is difficult to predict and prevent, continuing to refine and improve our efforts remains worthwhile and relevant. Recommendations suggested in the literature may be difficult and costly to health services. Decisions must be made about how to balance patients' rights and quality treatment with more restrictive interventions stemming from a desire to prevent inpatient suicides.

Data sources

Defining the cohort for the investigation

In defining the cohort for this investigation, the following data sources were checked, compared and reconciled:

- all public mental health services were asked to provide material relating to any unnatural, unexpected or violent (UUV) deaths of inpatients that occurred between 01–01–2008 and 31–12–2010
- the Chief Psychiatrist's database for deaths of inpatients that occurred between those dates, identifying deaths classified as possibly 'unexpected, unnatural, or violent' (UUV) was interrogated
- reports of coronial findings pertaining to the deaths of inpatients between those dates were also obtained.

As noted on page 5 these queries yielded a list of 41 deaths after the exclusion of those deaths most likely to be due to natural causes.

Inpatient deaths and recommendations made by the health service

On 16 September 2011, the Chief Psychiatrist wrote to all public mental health services in Victoria requesting the following information regarding any unexpected, unnatural or violent inpatient deaths that had occurred in the period under review:

- immediate actions taken, including notification of next of kin
- fulfilment of reporting requirements to the Chief Psychiatrist, the Department of Health's sentinel event program and the Coroner
- evidence of systematic service review and response to each death
- recommendations resulting from internal review processes
- status of implementation of recommendations, including any comment or recommendations made by the Coroner.

The Chief Psychiatrist received confirmation from the 13 health services covering the 41 deaths that were in scope.

¹⁷ Bowers, L., Simpson, A., Eyres, S., Nijman, H., Hall, C., Grange, A., & Phillips, L. (2006). Serious untoward incidents and their aftermath in acute inpatient psychiatry: The Tompkins acute ward study. *International Journal of Mental Health Nursing*, 15, 226-234.

The Chief Psychiatrist also requested a copy of the following service policies and procedures from those mental health services where an inpatient death had occurred:

- policies and procedures following an inpatient death
- patients absent without leave from the inpatient unit
- accompanied leave with carers or others
- risk assessment and nursing observation policies and procedures.

Recommendations made by the Coroner

As noted above, the coronial investigation had concluded in 13 of the 41 deaths. The remaining cases were still open with the Coroner.

Observations made by the sentinel event program

While the sentinel event program had not been used as a data source for this investigation because of the de-identified nature of its' reporting, several health services also provided the Chief Psychiatrist with copies of Root Cause Analyses and risk reduction action plans provided to the sentinel event program.

Investigation panel process

Appointment of panel members

The investigation panel included two interstate mental health experts who agreed to participate in the investigation (see page 41 for panel membership list). These panel members were appointed as authorised officers of the Quality Assurance Committee under section 106AC of the Act for the duration of the investigation. This provided the necessary powers for all panel members to be able to view patient records and make inquiries of staff.

Panel activities

In addition to teleconferences and review of collated materials, the full panel met over two days to review in detail the service responses to all the inpatient deaths that were in scope and to undertake a number of site visits. The sites visited were selected to expand the coverage of services or incidents that had been undertaken in the past two years. The Chief Psychiatrist had conducted separate site visits following the suicide of a patient at the Northern Hospital in 2010, and following the homicides at Thomas Embling Hospital in 2009. The Chief Psychiatrist had also undertaken detailed clinical reviews over the past two years at Austin Health, Mercy Mental Health, Ballarat Health Services and Central East Area Mental Health Service (Eastern Health) and had visited the inpatient unit at South West Healthcare (Warrnambool) to review the patient documentation and to discuss implementation of the recommendations following an inpatient suicide. At each clinical review, reportable deaths were also audited as well as audits of clinical practice and site visits of the inpatient units.

The panel visited the following sites as part of the investigation into inpatient deaths, meeting with key staff, inspecting the facilities and reviewing patient records pertaining to the deaths under investigation:

- Inner West Area Mental Health Service, Melbourne Health
- Mid West Area Mental Health Service, Melbourne Health
- Alfred Psychiatry, Alfred Health
- Monash Medical Centre, Southern Health
- Peter James Centre, Eastern Health

Through the site visits, clinical reviews, separate visits or inquiry, 31 of the 41 deaths had been reviewed at the relevant service sites. The remaining 10 deaths were reviewed through information provided to the Chief Psychiatrist by services and from coronial findings where these were available.

Findings

Profile of inpatient deaths under review

Deaths during the inpatient admission episode occurred under a number of different circumstances. In 13 instances coronial processes had concluded and these findings and recommendations were available to the investigation panel. While only the Coroner can make a finding about the cause of death, for the purposes of this report the deaths were categorised and a distinction was made between the deaths of people on the inpatient unit where suicide was considered a likely cause (due to death by hanging, which is strongly suggestive of suicide) and deaths on the inpatient unit from other causes. A number of inpatients died in the community. In some instances this involved a patient who had left the unit without permission or discussion with staff, and in other cases it involved a person who was granted leave from the unit as part of their discharge planning. Periods of leave to ascertain a person's readiness for discharge, where appropriate, is considered good discharge planning practice. Conditions may be imposed on leave and may specify various aspects of leave such as the amount of leave granted (for example 30 minutes or weekend leave), whether or not the patient needs accompanied leave (with a carer or staff member) and where the patient may go (hospital grounds only or leave in the community).

Given these variations in the circumstances of the deaths, the 41 deaths were categorised as shown in Table 1. Fifteen patients were female and 26 were male. Many of the patients had multiple diagnoses, with substance misuse a common co-occurring problem. Nineteen inpatient units (17 adult, one youth and one aged) covering 13 area mental health services were within scope for the investigation.

Categories of deaths

1. **Suicide on the inpatient unit:** eight deaths (three women and five men) were of patients who suicided while on the inpatient unit. Five of these patients had been admitted on a voluntary basis. The ages in this category ranged from 18 to 65 years. In each of these cases the means of suicide was by hanging—most often from a bathroom en suite door and in six of the eight cases during the night. The principal and most common diagnosis was major depression.
2. **Death on an inpatient unit, but not by suicide:** eight of the deaths occurred on the inpatient unit but were associated with a range of other factors such as physical co-morbidity or substance use. Two of the deaths occurred in high dependency units. There were four men and four women with an age range of 28 to 69 years. Six of the eight people were involuntary patients at the time of the death. The principal and most common diagnosis was schizophrenia or schizo-affective disorder.
3. **Death while absent from the inpatient unit without leave (AWOL / absconders):** thirteen deaths occurred following the person leaving the inpatient unit without informing staff and without having leave approved. In most instances the death resulted from major injury secondary to a jump from a height, being hit by a train or motor vehicle accident. Two deaths were the result of an intentional or accidental overdose. The time of death after absconding varied from hours to days of absconding. This supports the observation in the literature that while some patients who abscond may do so with intent to suicide, others are ambivalent and have died due to impulsive acts that may have been triggered by what occurred outside of hospital. Most patients left the inpatient unit through the entrance to the unit, but in five of the 13 cases reviewed it was not clear how the person had absconded. Two patients were reported to have absconded from the unit when it was locked.
4. **Death while on approved leave from the inpatient unit:** eight deaths occurred while on planned leave, usually as part of discharge planning. This included both accompanied and unaccompanied leave and in several deaths there had been a previous episode of leave. One patient died on leave granted on day three of the admission, the timing of leave granted for the other deaths ranged from day 10 to three months. It is likely that all were suicides. Six of the patients were male and four of the eight patients were of involuntary status at the time of death. Ages ranged from 28 to 62 years. Major depression and schizophrenia were the most frequent diagnoses.

5. **Other:** there were four deaths in this category. Two deaths were the result of homicide at a low security forensic unit at Thomas Embling Hospital. Another two deaths occurred while undergoing assessment in an emergency department. While strictly speaking these two deaths did not occur in a mental health inpatient unit, in both cases mental health issues were prominent and it was felt appropriate that consideration of this aspect of care be included in the investigation. The ages of the deceased ranged from 33 to 54 years and all of these patients were male. The patients at Thomas Embling Hospital were forensic patients; one of the other deaths was a person who was involuntary at the time of his death. It should be noted that both of the emergency department deaths raised issues of dual diagnosis (mental illness and drug and alcohol misuse).

Table 1: Deaths by category, legal status, year and mode¹⁸

No	Status: voluntary or involuntary	Year of death	Mode of death
Inpatient suicides			
12	V	2010	Hanging
15	I	2010	Hanging
17	V	2009	Hanging
28*	I	2010	Hanging
29	V	2009	Hanging
36	V	2010	Hanging
40	I	2009	Hanging
31*	V	2009	Hanging
Other inpatient deaths			
6	I	2008	Not ascertained
8	I	2008	Not ascertained
13	I	2010	Not ascertained
16	I	2008	Not ascertained
30	V	2008	Drowned
34	I	2009	Overdose
35*	I	2010	Not ascertained
39	V	2008	Not ascertained
Absent without leave			
3	I	2010	Overdose
4*	V	2010	Hit by train
5	I	2010	Hit by train
7	I	2008	Hit by car
10	I	2009	Hit by car
11	V	2010	Hit by train
18*	I	2009	Fell from height
21	I	2008	Fell from height
22	I	2010	Fell from height
25*	I	2009	Hit by car
26	I	2010	Drowned
32*	I	2008	Overdose
33*	V	2009	Self-inflicted laceration
On leave from the inpatient unit			
1*	V	2008	Overdose
2*	V	2010	Hanging
9	I	2008	Hit by train
14*	I	2008	Hit by train
19	I	2010	Hanging
20*	V	2010	Fell from height
24*	V	2008	Fell from height
41	I	2009	Hanging
Other			
23	V	2010	Hanging
27	I	2010	Not ascertained
37	I	2009	Homicide
38	I	2009	Homicide

¹⁸ An asterisk indicates a death where the coronial process had concluded.

The service response

The objectives of the investigation were to assess the adequacy and appropriateness of the service response following the death of an inpatient including but not limited to:

- immediate actions taken, notification of family, staff support
- fulfilment of reporting requirements to the Chief Psychiatrist and Coroner
- systematic service review and response
- completion of a root cause analysis
- development of recommendations
- implementation of recommendations, including any comment or recommendations made by the Coroner.

Findings in relation to the above objectives are provided below.

Immediate actions taken including notification of family and staff support

Findings

Notification of family/next of kin: In 38 instances families were contacted by the service; in one instance the family could not be contacted; in two instances documentation did not indicate whether family contact had occurred.

Family support offered or provided: In 34 deaths this was noted to have occurred; in seven instances contact was not noted.

The panel reviewed the individual death related information and policies and procedures relating to inpatient deaths submitted by mental health services within the scope of the investigation. While relevant policies existed, often these were of a general nature and intended to be relevant to the entire health service. The panel felt there were special issues raised by the unexpected death of a mental health inpatient, and that staff needed particular guidance in the response to these deaths. There were several examples of regular communication with family members or carers and a record of support and information offered. However, the panel considered that policies and procedures need to provide clear direction to staff to ensure there is consistency and clarity in how or which staff communicate with family, other patients and staff in the event of a death on or off the inpatient unit. These guidelines should specify the manner in which patients' clothing and personal items are stored and returned to the family. The panel recognised that initial communication is a sensitive and complex issue. In the immediate aftermath of a tragedy, there may be uncertainty about what has happened; the circumstances may not yet be clear and there may be understandable anger and perplexity that a death has occurred in the place of anticipated greatest supervision and support. Nonetheless, each service must have clear systems in place to guide communication after such tragic events.

Each service must have clear policies and procedures to guide who will contact families, carers and other affected people, what information should be provided (including the practice of open disclosure) and how support will be provided over the period following the death or disappearance of a patient. A staff member with appropriate seniority such as the clinical director or a senior consultant, and where appropriate other staff with whom the family are comfortable with should undertake this contact as soon as possible after the death. The panel concluded that support and information should be offered as soon as possible, and again once further information is available. Support and information about other services such as that provided through the Coroner's Court and agencies including the Australian Centre for Grief and Bereavement (ACGB) should also be provided in the weeks to months following the death.

Procedurally, when a death occurs, the patient's record has to be forwarded to the Coroner. This record is removed from the inpatient unit for photocopying and the original record provided to the Coroner.

Some staff interviewed indicated that they were not clear where their actions, including communications with families and carers, should be documented in the absence of the original record. Services need to provide appropriate guidance about where documentation can be recorded in the interim period so as not to lose continuity in documentation. All communication should be evident in the patient's clinical record or contained in relevant incident reporting documentation. Communication that occurs during the period that the clinical record has been removed should be incorporated into the record.

Debriefing/support for other patients: This was noted to have occurred in eight instances. It is not clear if this was provided in all other instances from the documentation provided.

Staff debriefing/support: This is noted to have occurred in 31 instances. In 10 instances documentation did not note if this had occurred.

Recommendation

- That health services review existing policies and implement procedures to provide clarity about the immediate response required following a death. At a minimum this should include who would be most appropriate to communicate with families and other relevant people immediately and in an ongoing way. Procedures should include providing support to other patients and staff who witnessed or were impacted by the event. Policies and procedures need to be accompanied by training and education of staff to ensure the needs of families during a time of bereavement are respectfully considered.

Fulfilment of reporting requirements to the Chief Psychiatrist and Coroner

Findings

In all 41 instances this requirement was met. These responses indicate high compliance from mental health services with the requirement that inpatient deaths are reported to both the Chief Psychiatrist and the Coroner.

Systematic service review and response

Findings

In all 41 instances an internal review was conducted by health services and in most instances using the RCA process (see section on *Completion of a root cause analysis* below).

Completion of a root cause analysis

Findings

Each of the 41 deaths had received an internal review within the health service's serious incident reporting and review processes. In the majority of cases (36 of 41) this internal review process consisted of the systematic use of a Root Cause Analysis process as required by the department's sentinel event program.

The panel noted a number of issues regarding the RCA methodology that resulted in some areas being poorly considered. For example, the RCA focuses on systems and processes and explicitly excludes a review of patient and treatment factors. This is due to the definition of adverse events and the theoretical basis of the program. However, these factors are very important in mental health, where the risk of the adverse event (suicide) is directly impacted by the adequacy and effectiveness of treatment. The panel concluded that these issues meant that services should not be constrained by the RCA methodology and needed to look at all aspects of the treatment and care provided during the incident review process.

Of the six deaths which were not reviewed with an RCA process, there were two instances which were not reported to the sentinel event program as these involved homicide and as such do not meet criteria for the sentinel event program. The sentinel event program does not require reporting of deaths due to homicide as it is more appropriate for these matters to be investigated by Victoria Police and the

Coroner's Court. Deaths due to homicide (usually where the alleged perpetrator is also a mental health patient) may be the subject of an internal service review where it is thought that there may be systems and processes that contributed to the outcome and require recommendations for action and improvement.

The two homicide deaths that occurred at Thomas Embling Hospital were the subject of a formal investigation by the Chief Psychiatrist in November 2009. The Chief Psychiatrist was assisted by two senior psychiatrists and a senior nurse from interstate. These deaths are not considered further in this report.

There were a further four deaths (patients 7, 16, 23 and 35), from four separate services, for which the service conducted an internal review but did not conduct an RCA as part of the sentinel event program. These services had conducted RCA reviews for other deaths which occurred in the service.

Patient 7 involved the death of a person who had absconded from the inpatient unit. A retrospective health record review was conducted and this included a clinical incident review and a risk reduction action plan. The review made four recommendations which the service reported had all been completed. The panel expressed the view that this death should have been reported to the sentinel event program and an RCA conducted.

Patient 16 involved the death of a patient on the inpatient unit. An RCA was not commissioned as the person was considered to have died from natural causes recorded as cardio-respiratory failure. An internal review was undertaken by the service and this critical incident review yielded four recommendations, all of which were implemented.

Patient 23 involved the death of a person who was not admitted to a psychiatric inpatient facility at the time of death, but was in the process of being assessed in the emergency department when the person absconded. The service indicated that as the patient had not been admitted, this death did not meet criteria for a sentinel event. A mental health team based review was undertaken and two recommendations were made and implemented.

Patient 35 died on the inpatient unit. The service conducted a preliminary investigation and internal review panel report, rather than an RCA. The internal review made two recommendations, both of which were reported to have been implemented. The Coroner had completed an investigation into this death and concluded that a cause of death could not be ascertained. The Coroner made no recommendations.

Development of recommendations by the service

Findings

The number of recommendations made in service reviews ranged from 0–11, with three service reviews concluding that there were no recommendations to be made and most reviews yielding between three and five recommendations. In a number of instances recommendations related to the same issue (one service made 11 recommendations where the Coroner made five). In these instances, recommendations tended to be comprehensive and could have been better targeted to the issues identified. Training in RCA methodology and the development of risk reduction action plans for all staff participating in this process would likely improve the formulation of consistently appropriate recommendations and actions.

The various recommendations in RCAs may be summarised or categorised to enable an overview of the issues typically identified and how services propose to address these. These are shown in table 2. Many recommendations relate to the review of policies and procedures. In most instances these reflect review and/or changes in practice, with the policy and procedure being an important vehicle for ensuring that all staff, including agency staff, are aware of the unit's practice in relation to the provision of care.

Table 2: Service recommendations in relation to inpatient deaths

Inpatient suicides
<ul style="list-style-type: none"> • Review of admission procedures; need for treatment plan to be developed from point of admission (including after hours), criteria for use of HDU, consideration of room allocation for high risk patients
<ul style="list-style-type: none"> • Need for access to consultant psychiatrist review after hours for high risk or deteriorating patients
<ul style="list-style-type: none"> • Recommendations related to nursing observations, including ensuring observations are conducted as prescribed, procedures around downgrading frequency of observations, systems for conducting and recording observations
<ul style="list-style-type: none"> • Review policy and procedures on patient searches
<ul style="list-style-type: none"> • Review of practices, policies and procedures related to clinical practice on the unit, including escalation processes available to staff for times of high acuity, undesirable staffing skill mix or unavailability of areas on the unit, handover procedures, model of care provided on night shift
<ul style="list-style-type: none"> • Staff training in relation to new practices and procedures, including risk assessment and risk management, alcohol and other drugs (AOD) issues
<ul style="list-style-type: none"> • Recommendations related to the physical amenity of the unit such as modification of beds, bathroom doors, bedroom doors, collapsible hooks on doors, testing of equipment such as the duress alarm system
<ul style="list-style-type: none"> • Implement a schedule of audits of ligature points on the unit and compliance with recommended changes in practice in relation to treatment plans, nursing observations, documentation
<ul style="list-style-type: none"> • Other review activities such as benchmarking with other services regarding design and management of ligature points, conducting a cluster review of inpatient suicides
Inpatient deaths
<ul style="list-style-type: none"> • Development or review of treatment guidelines in relation to medication and sedation, identification and management of deteriorating patients, management of physical co-morbidities, when to take vital signs, risk assessment and review procedures
<ul style="list-style-type: none"> • Recommendations related to nursing observations (as above)
<ul style="list-style-type: none"> • Review of escalation processes (as above)
<ul style="list-style-type: none"> • Improve transfer of information between community based services and the inpatient unit, at shift handovers (nursing and medical) and in documentation
<ul style="list-style-type: none"> • Recommendations related to the amenity of the unit such as access to call bells in patient bathrooms, access to a resuscitation trolley, management of potential hazards on the unit such as plastic bin liners
<ul style="list-style-type: none"> • Staff training in relation to new practices and procedures
<ul style="list-style-type: none"> • Review of practices, policies and procedures in relation to AOD
Absent without leave
<ul style="list-style-type: none"> • Review of admission procedures (as above), particularly in relation to HDU and need for treatment plan on admission
<ul style="list-style-type: none"> • Need for early engagement of families and carers to obtain collateral history
<ul style="list-style-type: none"> • Recommendations related to improving the security of the unit, including improved ability to control and/or monitor points of egress and also processes during maintenance work and repairs
<ul style="list-style-type: none"> • Recommendations related to nursing observations (as above)
<ul style="list-style-type: none"> • Review of practices, policies and procedures related to clinical practice on the unit including clarification of staff roles and responsibilities
<ul style="list-style-type: none"> • Improve transfer of information (as above)
<ul style="list-style-type: none"> • Review of escalation processes (as above)
<ul style="list-style-type: none"> • Review of practices, policies and procedures in relation to risk assessment, granting of leave, AOD, support of bereaved families
<ul style="list-style-type: none"> • Recommendations in relation to the needs of Koori patients
<ul style="list-style-type: none"> • Staff training in relation to new practices and procedures, including risk assessment and risk management, alcohol and other drugs issues
<ul style="list-style-type: none"> • Conduct audits of absconding incidents, clinical documentation
Planned leave
<ul style="list-style-type: none"> • Review of leave policy and procedures, development of materials to support and inform families and carers in relation to patient leave
<ul style="list-style-type: none"> • Staff training and education in relation to leave policy and procedures
<ul style="list-style-type: none"> • Review risk assessment documentation and processes
<ul style="list-style-type: none"> • Review frequency of medical review
Other
<ul style="list-style-type: none"> • Need for early engagement of families and carers to obtain collateral history (as above)
<ul style="list-style-type: none"> • Recommendations regarding amenity in the ED for disturbed patients
<ul style="list-style-type: none"> • Development/review of practice guidelines in relation to patient restraint
<ul style="list-style-type: none"> • Clarification of governance, roles and responsibilities of clinical and non clinical staff within the ED

As can be seen from table 2, there was some overlap between the categories in the types of recommendations proposed in the service reviews. The panel noted that there were examples of some good practice improvements achieved as a result of the service's review of the death. For example, in relation to leave procedures, one service developed guidelines for staff and specific materials for families and carers to use with the aim of ensuring that discussions occurred regarding the impending leave, that those supervising patients on leave were informed about their responsibilities, when and how to provide feedback or access support and advice from the unit and how to manage identified issues of concern that may arise for the patient.

Recommendation

- That the Chief Psychiatrist consult with the department's sentinel event program to identify how root cause analysis and risk reduction action plans can be improved to provide better targeted interventions, including those directed to treatment and care. Services should ensure that senior clinicians, and quality and safety managers external to the mental health program are involved in critical incident review and root cause analysis to support greater objectivity, external scrutiny and improved governance.

Implementation of recommendations, including any comment or recommendations made by the Coroner

Findings

All services reported on the progress of the implementation of the recommendations made in either the RCA or internal reviews. As indicated above, there were three reviews which did not generate a recommendation and for which there was no implementation plan required. Of the remaining 36 death reviews, services reported that all recommendations had been completed in 25 cases (69.4 per cent). There were 11 cases (30.5 per cent) in which the service reported that some aspect of the risk reduction action plan remained outstanding. In four of these the wording of the service report was ambiguous and it was unclear whether or not all of the recommendations had been completed. In the remaining cases there was usually one item only which was still in progress. Examples of this include an audit of compliance with a new process or practice which was outstanding, or delay in the structural modification of an aspect of the unit which was contingent on funding resources and/or engineering expertise. Some of the recommendations made in one RCA had not yet been implemented due to complex governance arrangements of the mental health service, which was auspiced by Melbourne Health but located at Northern Hospital.

Health services provided evidence of completion of recommendations in a variety of ways, including

- submission of revised or newly created policies and procedures in response to specific recommendations
- minutes of the quality improvement committee, including documentation of actions and dates by which these were completed
- viewing of documents and staff interviews during site visits
- training dates and calendars provided in relation to recommendations involving staff education.

The investigation panel considered issues relating to staff training and education, engagement with families following an adverse event, consideration of when inpatient units may be locked, leave practices, risk assessment, nursing observations and policies and procedures. These issues are elaborated on under relevant sections in this report.

Findings and recommendations made by the Coroner

The Coroners Act 2008 allows a coroner to make recommendations as part of their finding following an investigation into a death. Recommendations can be made to 'any Minister, public statutory authority or entity' that may help prevent similar deaths. The Coroners Act requires that all inquest findings with recommendations be published on the internet, unless otherwise ordered by a coroner. Anyone who receives a recommendation from a coroner must respond, in writing, within three months stating what action, if any, has or will be taken. This response is published on the internet and provided to certain persons with interest, unless otherwise ordered by a coroner.

Of the 41 deaths within the scope of this investigation, 13 deaths (32 per cent) had been investigated and closed by the Coroner's Court. Completion of coronial investigations can involve significant time. The time from death to closure of the investigation for these cases ranged from eight to 28 months. The 13 coronial investigations closed at the time of this inquiry covered three deaths that occurred on an inpatient facility, five deaths of patients who were absent from the inpatient unit without leave, and five patients who had been granted leave from the inpatient unit and died while in the community.

In 11 cases the Coroner found that the person had committed suicide. There was one finding of an unintended overdose and one instance in which the cause of death was unascertained.

Investigations concluded with no coronial recommendations

In making findings and recommendations, the Coroner can comment on any factors which in their opinion may have contributed to the death or make suggestions about factors which may make it more difficult for patients to take their own lives. In nine of the 13 investigations the Coroner concluded that the treatment and care provided by mental health services had been appropriate, that the death could not have been foreseen or that sufficient steps had been taken to try to ensure the patient's safety. These investigations accordingly did not make any recommendations in relation to the deaths.

Death 1 involved the death of a patient who was on approved leave from the inpatient facility. An inquest was held and the Coroner concluded that the cause of death was heroin toxicity in circumstances in which the patient committed suicide. In reviewing the treatment provided to this patient and the decision making in relation to approval of leave, the Coroner stated that the treatment plan was 'both reasonable and sensible' and that 'the clinical judgements exercised by the treating team (...) were appropriate and reasonable'. There were no recommendations made by the Coroner in this case.

Death 2 was of a voluntary patient who hanged himself at home while on approved weekend leave from the inpatient facility. The Coroner did not comment on the mental health treatment that had been provided to the patient. He noted that toxicological analysis suggested that he had 'not been taking his prescription medication for some time before his death'. The Coroner reported that police found no suicide note and no evidence of suspicious circumstances and concluded that the patient 'intentionally took his own life'. No recommendations were made.

Death 4 was of a voluntary patient who left the inpatient facility unnoticed and without approval of staff and who died due to multiple injuries after she was hit by a train. Toxicological analysis of post mortem bodily fluid was positive for prescribed medications, all within therapeutic concentrations. The Coroner did not offer any comments about the treatment provided to this patient, nor any recommendations. He found that the patient had intentionally taken her own life by stepping into the path of an oncoming train.

Death 14 involved the death of a patient who was on approved leave from the inpatient facility when he was struck by a train. The Coroner concluded that the actions of the patient in placing himself on the railway tracks led him to conclude that the patient took his own life. In relation to the treatment provided and decision making by clinicians concerned the Coroner stated that 'there is nothing in the material contained in the brief to suggest that [the patient] presented as a risk of suicide to Mental Health Staff. It appears that all appropriate and necessary systems and protocols were adhered to in relation to his

treatment, and to the decision to extend him unsupervised leave'. The Coroner further stated that 'there was in my view nothing that his mother nor staff from [the mental health service] could have done to prevent his death that day'. No recommendations were made.

Death 20 was of a voluntary patient who died while on approved leave from the inpatient facility. After indicating in the patient logbook that he was going out for a coffee and would return in an hour, the patient departed to the rooftop of the building. He was found by the Coroner to have died of multiple injuries sustained when he fell from a height. The Coroner did not comment on the care provided to this patient and no recommendations were offered.

Death 24 was of a patient who died while on overnight leave from the inpatient unit. The Coroner found the cause of death was 'multiple injuries and fall from a height'. In his report, the Coroner indicated that he was concerned to investigate the clinical decisions made in this case, in particular the decision to grant overnight leave the day after the client's admission. He engaged an independent expert to provide an opinion in respect to the treatment and clinical decision making. The psychiatrist providing the expert opinion indicated that there were two factors of concern in relation to the patient's leave, namely his expressed intent to consume alcohol while on leave and his wife's statement that their marriage was in difficulty and reconciliation unlikely. According to the expert opinion, the patient's clinical record did not indicate whether these factors were taken into consideration. However, he stated that 'even if they had been taken into account, it is my opinion that in these circumstances the majority of psychiatrists in Victoria would have still made the decision to allow [the patient] to go on leave'.

The Coroner found that 'in all the circumstances, the mental state management of [the patient] whilst an inpatient at both the Royal Melbourne Hospital and the Sunshine Psychiatric Service was not inappropriate' and that 'further, the decision to grant Mr S overnight leave was not unreasonable'. He concluded that 'as a result of my investigation, I am satisfied that the treatment received by [the patient] at the RMH and the Sunshine Psychiatric Unit was not unreasonable'. He made no recommendations.

Death 32 was of a patient who was found by the Coroner to have died from a hypoxic brain injury and toxicity to heroin (presumed) while away from the inpatient unit. The patient left the hospital without approval while on leave in the hospital grounds with a staff member and was attended by ambulance paramedics after collapsing with a syringe in his hand. Toxicological analysis of serum specimens taken the day after the patient's collapse and admission to hospital showed only the presence of therapeutic medications. However, the forensic pathologist reported that illicit drugs may well have been cleared from the deceased's bloodstream prior to this blood sample being taken. Anatomical findings were consistent with hypoxic brain injury being the cause of death and this was presumed to have been caused by toxicity to heroin.

The investigation into this death found 'no evidence that anyone else contributed to his death'. The Coroner did identify a number of issues requiring further exploration in relation to security for psychiatric patients, the policies and procedures in place at the hospital in relation to the authorising/granting of escorted and unescorted leave to psychiatric patients and specifically whether a risk assessment was performed before allowing the patient to have escorted leave including his suitability to have escorted leave with one carer.

The Coroner stated that there was no evidence to link the patient's management to his reason(s) for absconding, nor any evidence to suggest that he was suicidal at the time he absconded. There is no evidence that he accessed illicit drugs with the intention of taking his own life and his death was found to have been the unintentional consequence of his illicit drug taking. The Coroner stated that he accepted that 'the granting of leave of absence for inpatients is a balancing and potentially problematic process' and that in this case 'the evidence supports a conclusion that [the patient] was appropriately managed'. He further stated that 'appropriate risk assessments were performed before the granting of leave to [the patient] and that the escorted leave granted to him by [the nurse] on the afternoon of 5 January 2008, was reasonable and appropriate in the circumstances. I also accept that once [the patient] absconded (...) all reasonable steps were taken to locate him and to notify his mother and police'. He concluded that 'there is no relationship between the cause of death and the fact that immediately before his death he was a person placed in care'. He made no recommendations.

Death 33 was of a man who failed to return to the inpatient unit as planned after having been granted brief escorted leave with a family member in the hospital grounds. The Coroner made her findings without an inquest. In her report the Coroner concluded that the patient 'intentionally took his own life by means of the self-infliction of incised injuries to his neck and forearm'. She stated 'I further find that the management of [the patient] at the adult psychiatric unit at MMC was reasonable and appropriate in the circumstances. [The patient's] voluntary admission was an appropriate response to his deteriorating mental health. His condition appeared to be improving and there appeared to be no basis or grounds to deny him leave to attend the kiosk with his mother. I am satisfied that he gave no prior indication to staff or his mother that he intended to abscond from the hospital or take his own life'. No recommendations were made in this report. The panel noted that this death raised questions about the provision of information to carers or others who accompany patients on leave. There should be clear information about how to return the patient to the unit, and the necessity of feedback from the accompanying carer to staff on how the leave had progressed.

Death 35 was of a person who was found to have died in his bed on the inpatient facility. A post mortem examination was performed but a cause of death was not able to be determined and the death was recorded as 'unascertained'. In relation to this death the Coroner indicated that he had investigated concerns raised by family members of the deceased about the amount of medication he had been administered whilst in the care of the hospital. He concluded that 'the evidence in this case satisfies me that the treatment and care [the patient] received at the Monash Medical Centre was within the parameters of reasonable health care management'. The Coroner made no recommendations.

Investigations concluded with recommendations to the mental health service

Four coronial reports offered comments or recommendations about aspects of service delivery. In one of these the Coroner indicated satisfaction with the response provided by the service in reviewing the death and was satisfied that the recommendations had been sufficiently implemented and therefore the Coroner offered no further recommendations. In two cases the Coroner concluded that the service had provided appropriate treatment and care but offered recommendations that may be helpful in the prevention of similar deaths. One coronial report found that service delivery had not been consistent with reasonable health care and one recommendation was made. These cases are detailed below.

1. Death 18 was of an involuntary patient who absconded from the inpatient facility through a rear access door to the unit which was faulty and failed to lock following access by ancillary staff. The Coroner found that this patient 'intentionally took her own life and that the cause of death was injuries sustained in a fall from height'. She stated that the patient's absconding from the unit 'was facilitated by a combination of possible human error in leaving the rear door open, the lack of any protocol or policy to regulate access to the [unit] by non-psychiatric staff and a door that was inadequate for the purpose of securing access to and from the Unit'. She found that 'whilst [the patient] was a determined and resourceful young woman, the existence of such security measures in place prior to her escape from the [unit] would undoubtedly have been much more difficult and ultimately may have prevented her untimely death'. She acknowledged that 'the hospital has now made significant changes to the security arrangements to and from the Unit'. In light of these arrangements the Coroner made no recommendations.
2. Death 25 was of an involuntary patient who was admitted to the inpatient unit via the emergency department. He was admitted to the low dependency unit (LDU) from the emergency department but on admission was assessed by his doctor as requiring care in the high dependency unit (HDU) of the facility. While arrangements for this were being made the patient absconded from the unit and shortly thereafter died due to a head injury he sustained when he was hit by a motor vehicle. The Coroner in this case examined a range of issues related to the clinical assessment and management provided by the service. In his report he stated that the inquest hearing highlighted a conflict in the evidence of witnesses regarding clinical practice in relation to management of HDU patients and that it had been suggested to him that the admitting nurse

would stay with the patient until an HDU bed became available. He concluded that due to the inconsistencies in evidence provided, he was 'not satisfied that there was a policy within the unit requiring [the nurse], being the admissions nurse, to remain with [the patient] at all times prior to his admission into the HDU'. The Coroner further disagreed with the service's submission that there was insufficient evidence to form a view as to how the patient had absconded. He stated that 'on the balance of probability I am satisfied that the [patient] left the unit by going over the courtyard fence, using a chair to provide sufficient elevation to enable him to do so'. The Coroner outlined a series of changes and improvements undertaken by the service following the death of this patient. These included an increase in acute services beds, the development of an online daily access and bed co-ordination system, protocols for the local area and local area access to acute beds, local and network wide escalation plans, review of clinical documentation, improvement in clinical documentation, improvement in clinical observations with an enhanced clinical risk assessment and management improvement project (CRAAM), new risk assessment forms, new observations guidelines and improved guidelines for admission to the unit.

The Coroner offered comment in relation to this death and found that the CAT team, who visited the patient on the evening prior to his deterioration and presentation to the Emergency Department, had failed to verify the veracity of the patient's statement that he had already taken his medication and that their explanation about the reason for not doing so was not reasonable. The Coroner flagged anomalies in the documentation and verbal direction for the level of observation required and the nurse's understanding of the nature of the risk for which the observations were required. He concluded that 'these anomalies are indicative of suboptimal care, as they fall outside the parameters of reasonable health care management'.

The Coroner made one recommendation in this case, which was that 'the wall be modified in such a way as to prevent climbing over it and/or secure any courtyard furniture so that it cannot be used as a climbing aid'.

3. Death 28 was the hanging death of a patient from the en suite door of a bedroom on an inpatient unit. In his report the Coroner offered a number of comments in connection with the death. He stated that 'this tragedy highlights dilemmas facing health professionals who manage and treat individuals with mental illness and their difficulty predicting when a patient is at risk of crossing the suicide threshold'. He went on to discuss the importance of prior attempts and risk factors but these can rapidly go out of date and may not be predictive of future behaviour. He emphasised the importance of staff remaining alert to the significance of the impact of external stressors and the importance of obtaining collateral information from sources such as family, medical records and other health professionals. The Coroner stated further that he concurred with observations made by the Chief Psychiatrist in relation to ongoing staff training and supervision and observation practices and placement of patients within the unit, given the design of inpatient units, which currently are primarily comprised of single person rooms with attached en suite bathrooms.

The Coroner in his report made specific comments about the appropriateness of the patient's 'low' risk assessment and management on the low dependency area of the unit. He stated that 'I accept the evidence that there was no basis for high dependency placement, as there was no clear evidence of her being at risk of immediate self harm'. The patient sought support when distressed and was cooperative with treatment. She did not express any plan or intent to self harm during risk assessment interviews and had not engaged in self harming behaviour when home. He concluded that 'in the circumstances, I am satisfied that there is no evidence in this case that [the patient's] medication regime, or treatment plan was other than appropriate'.

In his further comments the Coroner acknowledged that all en suite bathroom doors on the unit were modified and that monthly risk assessment in-service sessions had been implemented with staff. He also commented on the access the patient had to a ligature (a scarf given to her by the visitor of another patient) and that this issue needed to be addressed as he perceived that 'there

is a duty of care to ensure patient safety, and this requires effective monitoring of what is taken in, and for whom’.

Three recommendations were made by the Coroner in this case. These were:

- I. That the Northern Hospital examine the level of observation (with a view to harm minimization) that is possible within the Northern Psychiatry Unit, when the patients have full access to their single occupant bedrooms.
- II. That staff remain vigilant in obtaining collateral information from sources such as family, medical records and other health professionals, and that consideration be given to introducing an electronic case note system, to facilitate dissemination of the information.
- III. That the Northern Hospital develop and implement protocols aimed at monitoring and or restricting potentially harmful items being taken into the psychiatry unit.

The investigation panel concurred with these recommendations and made further observations and recommendations in this report to guide systems improvement.

4. Death 31 involved the death by asphyxia of a person on the inpatient facility due to hanging himself with a belt from the ensuite bathroom door, in the context of his earlier self administration of Oxycodone, a semi-synthetic opiate narcotic analgesic related to morphine. The Coroner made a finding without inquest that this death was a suicide.

In relation to the patient’s access to Oxycodone the Coroner commented that ‘it is reasonable to speculate that the deceased had either brought the drug Oxycodone, and the paraphernalia to allow him to inject it, with him on admission to the ward, or that he had somehow obtained it whilst in the ward, and had injected himself, probably sometime early on the 28th of October. Whilst this lapse of hospital security is of course concerning, from the material before me I am satisfied that the only consequence of this behaviour by the deceased may have been to compromise the resuscitation efforts made by the staff after he was found in his room’.

The Coroner found that ‘tragically in this case a number of compounding events, together with weaknesses in the procedures in place at Ward 9 meant that the available supports were unable to prevent the death of [this patient]’. He acknowledged that the service had identified a number of areas where patient management can be improved to try and guard against the occurrence of such events in the future. The Coroner highlighted those recommendations which he considered to be most significant. In closing the report he stated ‘it should be stressed however that even if these modified procedures and protocols had been in place in October 2009 they would not have been able to prevent a determined person from acting as [this patient] did, and taking their own life’.

Service responses to coronial recommendations

In relation to Death 31 the Coroner noted that the service had made 11 recommendations in its sentinel event report and that almost all of these recommendations had been implemented. The Coroner highlighted five recommendations which he considered to be the most significant of those made by the service. There were therefore no outstanding coronial recommendations requiring action or response from the service.

At the time of writing of this report, the Coroner’s recommendations regarding Death 25 and Death 28 were only just published and the mental health service was not required to respond to the recommendations until March and January 2012 respectively. However, for Death 28 discussions had already commenced within the service’s Clinical Risk Management Committee regarding the recommendations and whether policies and procedures across the organisation required modification and whether a quality and safety bulletin needed to be issued. The panel noted that the ensuite bathroom doors had now been modified in a number of units in an effort to limit their utility as a ligature point. All new units since 2008 include modified ensuite bathroom doors.

The panel noted that the issues raised by the coronial hearings led to consideration of both the security of the units, and the safety of persons receiving care and treatment. They felt that security was related to structural issues such as locked doors, having an air lock, and the height of external fences. Safety of the person is related to the vigilance of staff, eliminating hazards such as ligature points, instituting searches of persons and possessions according to clear guidelines, and educating families and visitors about expectations while on leave or what is able to be brought on the unit.

Recommendations

- That the Chief Psychiatrist develop a guideline to assist services in relation to patient searches, especially in relation to searches for illicit substances and the equipment required to administer such substances.
- That the Department of Health and health services review the design of planned and current inpatient units with particular reference to the security of the unit including provision of air locks to reduce opportunities for absconding. The removal of ligature points wherever possible including in en suite bathrooms should be undertaken. Safety and security of the unit needs to be balanced with patient rights and privacy within a therapeutic environment. The review should also consider for future planning the most appropriate size, configuration and location of inpatient units to balance local accessibility with sufficient capacity to support appropriate gender segregation and amenity.

Systems and clinical practice improvements

There were many examples of individual health services responding to deaths in an appropriate and significant way, for example by instituting new regimes and training in risk assessment and by demonstrating rigorous processes around critical incident reviews. However, the focus of the Chief Psychiatrist's investigation of inpatient deaths was also to consider what could be learnt from these tragic incidents. Following examination of documents pertaining to the investigation and interviews with health services staff, the panel formed the view that a number of themes emerged that identified opportunities to further improve clinical practices and processes to provide safer treatment and care.

Assessment including risk assessment and nursing observations

The panel recognised that working in a mental health inpatient unit is often challenging. There are many reasons for this. As noted, admission is only contemplated when treatment in the community cannot be safely provided. People who need inpatient care are generally acutely unwell, and often have a severe mental illness complicated by other factors such as alcohol or other substance misuse, co-existing physical illness, complex social or family issues. A significant number of people will be admitted under the provisions of the Act and so may be resistant to engaging with staff. As part of their illness, or because of the circumstances of admission, they may be verbally or physically aggressive, especially if intoxicated or if withdrawing from alcohol and other drugs. There is consistently a high demand for beds. Discharge planning begins on admission to give the patient and family maximum benefit from the admission. Having a number of new or unknown patients is associated with a need for greater vigilance and observation and increased demands on staff.

In this context, having an adequate, skilled, multidisciplinary staff complement is vital. Many services commented that the impact of functioning as a seven-day-a-week service with a high number of after-hours' admissions placed increased pressure on their staffing capacity. The need particularly for consultant psychiatrist and medical input at weekends and after hours (as occurs in specialist general health services) was not congruent with current staffing models. In a number of services the majority of admissions occurred after hours. The increased acuity and likelihood of admissions after hours requires further consideration of the staff complement over the 24 hour day. As admissions and discharges are also likely to occur on weekends and public holidays, there needs to be consideration of staffing requirements over the seven day week, including medical and allied health.

Some services commented that the inpatient unit was the hardest area to staff, and that staff of all disciplines generally preferred to work in the community, with the result that staff in the inpatient unit may be less experienced, and that agency staff are required relatively frequently. There have also been pressures to make more efficient use of a limited workforce through greater reliance on Division 2 nurses or more junior nurse graduate staff. While accepting that it is important for junior staff to gain experience by working under supervision, the panel noted the need for an adequate number of skilled and experienced staff to provide active assessment, review and engagement of patients at high risk of suicide or other adverse event. This is especially the case in the high dependency unit where patients may be placed because of extreme vulnerability or because they are at high risk of intrusive, inappropriate or aggressive behaviour. The panel noted that while considerable effort had been directed to having gender separate areas on inpatient units, gender segregation was difficult to implement in smaller areas such as high dependency units.

The panel formed the view that in this context consideration should be given to an appropriate funding model to staff inpatient units, including that needed to 'flex up' staffing levels during periods of increased acuity or when a large number of patients on the unit are new or unknown to staff. The panel was aware of the budget constraints under which inpatient units operate. The panel understands that mental health is included in the pricing review currently being undertaken by the department, and that mental health is included in the preparation for a move to activity-based funding in the next one to two years. These

processes may provide an opportunity to more realistically determine the cost of provision of inpatient care in the current environment.

Risk assessment, mental state examination

Risk assessment is a core component of clinical practice. The panel noted that all services had in place documented risk assessment processes. Risk assessment is expected to occur at key times, such as upon admission, movement from locked high dependency to low dependency areas, or when leave or discharge is contemplated. It requires early and full involvement of families, carers and other services involved in the patient's care. Patient confidentiality should not be seen as an impediment to a comprehensive assessment that includes the views of families and carers. As 34 per cent of the deaths related to voluntary patients, the legal status of a patient does not diminish the need for a full assessment when determining risk. This is particularly so where patients present from out of area, or are admitted as inpatients for the first time and not known to the inpatient service. This should flag the need for increased observation that includes an interim management plan at the point of admission as well as collateral history from families and other service providers to guide staff interventions.

Recommendations

- That the Department of Health and health services review the staffing skill mix in acute inpatient units to reflect the 24 hour, 7 day a week need for input from multidisciplinary staff. There should be access to timely consultant psychiatrist review including after hours, weekends and public holidays. There should be access to appropriate staff for discharge planning, including social workers and other allied health staff. There should be budget capacity and clear protocols to guide staff in when to 'flex up' staffing levels in response to patient need and acuity.
- That the Department of Health and health services review the design and model of care in high dependency units (HDU) to ensure the provision of a therapeutic environment with appropriate staffing levels and skill mix to safely manage the vulnerability and disturbed behaviours likely in patients placed in the HDU.

Nursing observations

The panel is aware that there is ongoing discussion about the advantages of functional (dynamic) as opposed to checklist nursing observations. Practices in regard to nursing observations varied between services. Of concern, it was apparent in the review that in some instances observation practice was not in accordance with that expected or documented. For example, in one service night time observations reverted to a lower level than in place during the day without this being a considered or documented decision. Similarly, in some cases where the person had absconded, there were not documented observations in accordance with the level of risk identified. In two cases, the level had been reduced during a period of increased unit activity including a new admission with a high level of disturbance or a distraction such as nursing handover. In a dynamic and highly pressured environment, it is most important that there is clear communication, documented decision-making and regular review and monitoring of the level and type of nursing observations required.

Equally, reliance on risk assessment and nursing observation levels alone does not negate the need for therapeutic engagement with patients in order to get a better understanding of their mental state, and the impact of the admission on their wellbeing. Again, this underscores the need for well trained and experienced specialist mental health nursing staff.

In some of the cases, concern had been raised that the person had access to licit or illicit substances brought in by others. This is one example of the need for observations to be more than whether the person is physically on the unit, but also needs to include assessment of physical and mental state.

The panel accepts that mental health patients, like other patients in the general health system should have access to privacy and be safe from intrusive or unwanted approaches by others. The current practice of providing single room with en suite bathroom accommodation is congruent with the expected

standard and amenity regarding privacy. However, this model of accommodation comes at the cost of a reduction in the capacity of staff (and others on the unit) to observe and report changes in behaviour. This makes the need to engage therapeutically with patients even more important. The panel noted that services had made a number of practice improvements regarding nursing observations. Implementation of recommendations had resulted in changes such as clarification of responsibility for continuing visual observations during admissions or handover.

The panel discussed the use of other forms of monitoring such as closed-circuit television (CCTV), use of electronic bracelets and so forth. While it is considered appropriate to use CCTV in monitoring the external entrances, the panel did not support more invasive means of tracking or observing a person's whereabouts.

Recommendation

- That the Department of Health and health services ensure there is a clear and consistent process and documentation for nursing observations, and that any change in required observation level is made after suitable discussion and consideration. The frequency of observations over the night shift should be congruent with daytime observations unless otherwise decided and documented.

Alcohol and other drugs

Mental illness is often associated with a propensity to use or misuse alcohol and other drugs. Concurrent use of alcohol and other drugs (AOD) complicates the assessment and management of mental illness. This has been recognised for some time and increased access to training and specialist services has been supported through the Dual Diagnosis Initiative. A number of the deaths investigated had prominent dual diagnosis issues. The panel felt that in spite of increased awareness and documentation of the problem, there was still a lack of consideration of the impact of AOD on the presentation or management of people with severe mental illness during an inpatient episode. It was noted that even when significant alcohol dependence was documented at assessment, the need to recognise and plan interventions accordingly including the use of a withdrawal risk scale was not always evident in treatment planning. It was also not evident that staff had discussed withdrawal symptoms and their management with the patient as part of the treatment plan. The panel noted that patients who were experiencing withdrawal may argue for leave early in the course of an admission or may abscond in order to access substances. This appeared to be a factor in at least three of the deaths. Staff need to be alert to drug seeking as a motivation for leaving the unit.

It was not clear in documentation related to approved leave that a propensity to consume alcohol while on leave had been considered. Four of the deaths reviewed involved probable opiate overdose, and while the use of opiates was recognised, it was not clear that there was a management plan in place regarding use of opiates or education of the person regarding risk of lowered tolerance after a period of abstinence. The involvement of AOD services including addiction medicine specialists should be considered where appropriate. The panel recognised that access to addiction medicine specialists is limited. This may be considered in the current development of an alcohol and other drugs strategy.

Recommendation

- That dual diagnosis training for multidisciplinary staff in inpatient services include the recognition and management of alcohol and other drug withdrawal during an admission episode. Treatment planning should reflect this and may involve referral to addiction medicine specialists. The Department of Health and health services should review the availability and accessibility of specialists for expert consultation and advice.

Treatment and treatment planning

Pharmacological management

The panel did not find any instances of inappropriate pharmacological treatment, but did note the challenges of reducing risk of aggressive behaviour through pharmacological treatment. Most often, those who are being prescribed high doses of psychotropic medication in the context of very disturbed behaviour are managed in the high dependency area. This emphasises the need for staff to be skilled and vigilant in their observation and assessment of those under their care and for staff in those areas to have relevant skills and experience.

Physical co-morbidities

Physical co-morbidity is common in severe mental illness, especially in older people. Although the panel noted that death in the inpatient unit due to causes other than suicide tended to be from a number of different causes, in some cases underlying respiratory or cardiovascular illness contributed to the death. Awareness of physical health needs, recognising the deteriorating patient, appropriate examination and investigation, including access to medical specialists, should be a routine part of management and documented in the clinical record. The importance of this is acknowledged by its inclusion in the *National Safety and Quality Health Service Standards*, that services will be required to meet by January 2013. Standard 9: recognising and responding to clinical deterioration in acute health care¹⁹ requires health service organisations to establish and maintain systems for recognising and responding to clinical deterioration. Clinicians and other members of the workforce are expected to use the recognition and response systems. Mental health services will need to develop policies and procedures to comply with this standard.

Given the level of patient acuity, it should also be a requirement that all units have a functioning resuscitation trolley and that staff are regularly trained in its use.

Relationship with emergency departments

In two of the deaths under investigation, the patient had not been admitted to the inpatient unit but had received mental health assessments or treatment in the emergency department (ED). Another case related to a person who had spent a prolonged period in the ED, and had absconded shortly after being transferred to the inpatient unit. The care provided in the ED to a person who is acutely disturbed is complex. While the ED staff retain primary responsibility, it is usual for care to be determined based on shared decision making and close collaboration with mental health clinicians. This may be more difficult when the health service responsible for the ED is different from that responsible for the inpatient unit. However, auspicing arrangements should not impede good patient care. Information exchange is especially critical when transferring a person at high risk of suicide from one service area to another.

Recommendations

- That health services develop policies and provide training to guide staff in the recognition and management of the physically deteriorating patient as required by the National Safety and Quality Standards, including when and how to access specialist medical services when this is required.
- That the Department of Health and health services review the training requirements of all inpatient clinical staff in regard to areas including mental state examination, risk assessment, and the recognition, treatment and management of acute arousal.
- That health services develop clearly documented policies with the relevant emergency departments regarding which service component has primary responsibility for providing care to mental health patients and who has the responsibility for communication including notification and support of families in case of an adverse event.

¹⁹ Australian Commission on Safety and Quality in Health Care (ACSQHC) (2011): *National Safety and Quality Health Service Standards*, page 64.

Amenity, equipment and environment

Physical environment

The design and layout of an inpatient unit is closely related to the level of nursing observation and monitoring required in delivering safe inpatient care. As noted previously, under current policy, it is expected that most general adult acute units will function as unlocked units, other than the beds in the high dependency area. Secure extended care units (SECUs) are locked, although many patients will be able to access leave from the unit.

However, the design of some inpatient units means that there is not a clear line of sight to the main exit. It is more likely that these units will be locked. The high dependency areas are intended to provide a low stimulus environment for short periods where a person is acutely unwell and needs very close supervision. These areas often appear stark, with little opportunity for activities or distraction other than a television screen. They are not pleasant or inviting spaces. The panel was of the view that the high dependency area should not be used solely as a means of detention for those who are high risk because of their mental illness or an absconding risk.

In an environment where the majority of patients are very unwell, or are under the provisions of the Act for involuntary treatment, the panel believed the policy of having unlocked units requires further discussion. The panel noted that one of many recommendations made by the *Tracking the Tragedy* reports in New South Wales²⁰ was that all acute units should be locked. The panel noted during the investigation that some services had a clear process in place to guide decisions about whether and for how long a unit should be locked. The panel were of the opinion that all acute units needed to have such processes in place.

This investigation considered 13 deaths that had occurred while a person was absent without leave. Not all of these could or would have been prevented had the unit been locked. Some of the examples related to a person leaving by scaling the outdoor courtyard wall, or by accessing a back door that was normally locked. However, where there is a high risk of absconding, a large number of new or unknown patients, and high levels of acuity, the panel were of the view that consideration should be given to locking the unit and/or increasing staffing levels for appropriate periods in preference to overcrowding in locked high dependency areas. It is important that any practice relating to locking a unit is well communicated to staff, patients and visitors. Patients need to know how they can exit the unit and a request to exit or enter should be responded to without delay.

The panel noted that at least one service had implemented a clear process regarding a decision to lock the unit, including signage to assist patients and visitors. This system should be extended to other units where a decision is made to lock a unit in order to provide safer care. It is noted that some inpatient units are regularly locked. This should not reduce the need for clear signage and explanation to patients, visitors and staff. Equally it should be remembered that when the front door of the inpatient unit is locked, egress may be made through other means such as over a courtyard wall. Services should in these situations consider the overall security in an inpatient unit.

The panel also noted that even when a unit is locked, there will still be considerable coming and going. In some units an air lock means that there is added deterrence to a rapid opportunistic exit, but in general, units do not appear to have an air lock at the entrance. The panel suggests that this element of design be considered by the department.

Current design guidelines stipulate single room with en suite bathroom facility. It is appropriate that mental health services are of an equal standard to those in other areas of health. However, this has presented an added risk given the difficulties in providing accessible observation and the degree of ingenuity sometimes shown by a person intent on suicide. There will always be a balance between the

²⁰ See, for example, http://www.health.nsw.gov.au/pubs/2009/pdf/tracking_tragedy_2008_final_response.PDF

physical environment and amenity, and potential for self harm. Four of the inpatient suicides used the en suite bathroom door as a hanging point; the remaining four used some other point in the bedroom as a ligature point—the bed, bedroom door or window winder. In a number of units, the en suite bathroom door has been modified to reduce this risk; at least one service had bolted all beds to the floor; most had removed the doors from cupboards.

The panel supports the alteration of en suite bathroom doors but cautions against progressively limiting the amenity of bedrooms in response to single events.

In considering the physical design of inpatient units and the need to provide appropriate observation, staff must be particularly vigilant to the safety of women and other vulnerable patients in mixed gender units and particularly in high dependency areas. While the investigation did not note this to be a factor in any of the 41 deaths, it is nevertheless an important issue which must be in the forefront in treatment planning and in providing safe treatment and care. Services must have policies and procedures in place to ensure gender safety issues are considered and addressed at all times.

As noted above it is not practicable to have gender separate areas in small units such as high dependency areas. To some extent these issues reflect the tension between providing smaller locally accessible inpatient units, and larger but more regional centres that would allow greater consideration of placement according to vulnerability or treatment needs.

Recommendations

- That health services establish a process to review circumstances in which an inpatient unit may require to be locked. This should include decision-making by senior clinical staff, regular review and monitoring of times the unit is locked. Any changes should be communicated to staff, other patients and visitors, including information on how to access or exit the unit when it is locked.
- That the Department of Health and health services review the design of planned and current inpatient units with particular reference to the security of the unit including the provision of air locks to reduce opportunities for absconding. The elimination of ligature points, wherever possible, including in en suite bathrooms, should be undertaken. Safety and security of the unit needs to be balanced with patient rights and privacy within a therapeutic environment. The review should also consider for future planning the most appropriate size, configuration and location of inpatient units to balance local accessibility with sufficient capacity to support appropriate gender segregation and amenity.

Family and carer engagement

Communication with families

While the investigation found that families had been contacted following the death or disappearance of an inpatient, this practice varied between services. The panel noted that the response of the family will sometimes include anger and rejection of the offer of support. Nonetheless, all services should have clear guidelines to inform staff when contacting family or carers in the event of a patient death. These should include information about the adverse event, an opportunity to attend and discuss with senior staff, clear information on the process of what is going to happen including moving the body, returning personal items, and referral to the Coroner. Particular attention must be paid to the manner in which the patient's personal belongings are returned to the family, including respectful packaging and return of personal items.

The panel noted that some services had in place a system for checking in with the family in the weeks or months following a death. Where the family reject any contact with the service, it is appropriate that information about other sources of support such as that provided through the Australian Grief and Bereavement Service or the support provided by the Coroner's office. The panel noted that one service was considering developing a 'bereavement team' with input from senior social work staff so that a consistent response was provided that was seen as separate from the treating team. It was intended that this team provide oversight and contact in the longer term, complementing the immediate response by senior staff and the treating team.

The panel noted the importance of contact with families and other carers early on in an admission to obtain collateral history and to provide information and support. There also needs to be clear information about what can or cannot be brought onto the unit, how leave is planned and how families can communicate with the service during episodes of leave if concerns or questions arise.

Recommendations

- That health services review existing policies and implement procedures to provide clarity about the immediate response required following a death. At a minimum this should include who would be most appropriate to communicate with families and other relevant people immediately and in an ongoing way. Procedures should include providing support to other patients and staff who witnessed or were impacted by the event. Policies and procedures need to be accompanied by training and education of staff to ensure the needs of families during a time of bereavement are respectfully considered.
- That health services ensure the mental health program implements full engagement with appropriate family members and carers wherever possible from the commencement of admission. This should include areas such as obtaining collateral information, providing education about what items can be brought onto the unit, and discussions regarding leave, including carer's capacity to provide supervision, when and how to access support and discuss the progress of leave and education about access to illicit substances or alcohol during leave.

Policies and procedures

A clinical governance framework establishes accountability for continually improving the quality of services and provides safeguards for high standards of care. It is the responsibility of the Board and health service executive to ensure that such a framework is in place. Policies and procedures guide staff in expected standards of practice in key areas of treatment and care. However, policies and procedures need to be effectively translated into practice by clinicians working in busy inpatient environments. The critical elements of staff training and education and clinical audits must accompany policies and procedures to ensure effective implementation and monitoring of standards of practice.

As part of the investigation, the Chief Psychiatrist sought copies of the following policies and procedures from services within scope:

- inpatient deaths procedures
- patients absent without leave from the inpatient unit
- accompanied leave with carers or others
- risk assessment and functional nursing observation policies and procedures.

These were reviewed by the panel. While all services had policies and procedures in place to guide staff practices in the relevant areas, there was great variability in the structure and content of these. Services would benefit from reviewing the relevant policies and procedures to ensure these comply with the Chief Psychiatrist's guidelines as a minimum standard.

Some policies and procedures submitted on inpatient deaths were developed in the context of general hospital presentations. Its applicability to mental health services was not always relevant particularly where a death is unexpected. This may particularly be so in areas where there are qualitative differences in the type of adverse event or expected management of clinical presentations. Death by suicide raises very different issues to death in the context of a terminal illness. The clinical response to potential or actual aggressive behaviour in mental health generally has different elements in mental health than in other parts of the health service. Services need to review the mental health content to ensure appropriate consideration is given to procedures following an inpatient death particularly in relation to notification, care and support of families.

It is not uncommon for reviews and inquiries to result in the development or redevelopment of policies and procedures. It is far more difficult to ensure awareness of relevant policies and to monitor their implementation and consequent changes in practice. The practical application of relevant policies should be part of regular staff training.

Recommendation

- That health services ensure that relevant policies including death procedures are appropriate to specific work areas such as mental health and that implementation and monitoring practices are applicable to the program area.

Staff training and education

Clinical leaders and managers are critical to achieving cultural change in a dynamic and changing environment. They are at the forefront of delivering good outcomes through effective implementation of policy reforms and supervision of direct practice. They need to be able to guide and support their staff while responding to the changing needs of consumers and carers. To facilitate this effectively, each health service will need to have structures in place to identify and address core skills, capabilities and attributes required of clinical staff to practice confidently and competently. Clinical leaders and managers need to be supported in their roles so that they can in turn, support direct care staff.

Consumers and carers have consistently called for increased therapeutic engagement from clinicians. Therapeutic engagement is a core skill that is particularly important in inpatient treatment and care and matters greatly as patients in this environment are often seriously ill and at their most vulnerable. Clinicians report that the increased number of policy and legislative compliance requirements detracts from time for therapeutic engagement with patients. Workforce issues in inpatient environments need to be identified and addressed. While the panel was aware that the department is currently developing a new workforce strategy, health services nevertheless need to demonstrate that current resources directed specifically to staff training and education are prioritised to meet identified core skills and capabilities required to deliver good patient outcomes. There needs to be a sustained focus on underlying principles of best practice. Training needs to be accessible to all staff and has to be presented in a number of ways that are appropriate to the varying skill and experience level of staff. Services should ensure that they are making the most effective use of funded positions, such as nurse educators, in the provision of appropriate training.

The introduction of new or revised policies and procedures should always be accompanied by training and education to ensure that staff are aware of changes to practices as well as competent in providing new models of practice. The panel was of the view that risk assessments and assessments, nursing observation practices and the impact of alcohol and drug withdrawal on a patient during an admission could be strengthened by regular staff training and education for all staff involved in providing inpatient treatment and care. While the panel is aware of the difficulty at times of freeing staff up to attend training or of providing backfill, mental health services need to ensure that inpatient staff in particular have access to training and education. Agency and new staff need to have access to orientation, including awareness of policies and procedures.

Some of the recommendations made in internal service reviews or RCA and risk reduction action plans required the introduction of new practices. Examples include changes to models of risk assessment, nursing observations and leave practices. In some services, there were a number of excellent examples of considered work to introduce new risk assessment protocols, such as clinical risk assessment and management frameworks (CRAAM) at Melbourne Health, Southern Health and Eastern Health. However, the accessibility to inpatient staff of training opportunities was less clear.

Recommendation

- That the Department of Health and health services review the training requirements of all inpatient clinical staff in regard to areas including mental state examination, risk assessment, and the recognition, treatment and management of acute arousal.

Conclusions

This investigation considered the service response to 41 cases of the unnatural, unexpected or violent death of a person while an inpatient in a mental health unit. The period under investigation was from 1 January 2008 to the 31 December 2010. In only 13 instances had the coronial process concluded, meaning that the cause of death had not been formally determined in most instances. One death remains under investigation by both police and the Coroner. While every effort was made on the basis of the material available to exclude only those where the death resulted from natural causes, it is possible that not all relevant deaths were included, and it is likely that some of those included will be found to be from natural causes. The majority of deaths reported during the period under investigation were of elderly patients and likely to be due to known related physical conditions. As noted in the report, the number of deaths that fell within the scope of the investigation represents 0.08 per cent of the 53,244 hospital admissions during this period and approximately 10 per cent of the inpatient deaths reported. Thus at an individual service level, these represent rare events.

The investigation relied on in-depth clinical reviews, individual case reviews, site visits and review of documentation provided by services and by the Coroner's office. A panel was convened and authorised under the Act to carry out the investigation.

The panel concluded that each of the services involved did have systems in place to review the circumstances of the death and to consider whether changes in the inpatient unit environment, policies and procedures, operational issues and staff training and education could lessen the risk of a similar critical incident. The recommendations made were appropriate to the case under investigation and in the majority of instances had been implemented by the time of the investigation. The panel concluded that the critical incident review process and the root cause analyses were appropriate, and noted that in many of the services these had been consistently strengthened and were subject to internal review and audit. The panel supported inpatient suicide being part of the sentinel event program, but noted that unlike most adverse clinical events considered by that program, the intent to suicide was not 'caused' by clinical error. The panel questioned whether there could be further consideration by the sentinel event program to further refine the RCA process to take into account this fundamental difference without lessening the examination of systems and processes or scrutiny of the events leading up to the death.

The panel noted that a number of significant improvements in practice and design had resulted from existing inquiry and review processes.

The panel considered the findings across six broad themes of assessment and nursing observations; treatment and treatment planning; amenity, equipment and environment; family and carer engagement; policies and procedures; and staff training and education.

An area that the panel felt was not routinely well managed was the contact with family, carers, staff and other patients at the time of the critical incident and in the weeks or months following. While practice in this area was variable, the panel was of the view that every service should give consideration to this aspect of practice and develop more instructive documentation to guide who has the most appropriate responsibility to make contact, what should be conveyed in the context of open disclosure policies and what supports and follow up is indicated. There needs to be clear documentation of how staff and other patients are supported, especially when the death occurs on the inpatient unit, and in sight or knowledge of other patients.

The panel recognises that changes to the coronial process following the enactment of the Coroners Act 2008 have increased the public availability of both the findings and recommendations made by the Coroner, and the service or departmental response. However, the conclusion of the coronial process is often delayed by two or more years, and each finding most often relates only to one case. Given the rarity and often the singularity of unnatural inpatient deaths, the panel felt that the opportunity for the system as a whole to learn from such events is limited. For some years, the Chief Psychiatrist has been providing an overview of relevant coronial findings to the clinical mental health sector. While this has

some utility, it is limited by being a summary of individual cases, rather than being able to group by theme and to highlight where commonality exists.

By considering deaths over a three year period, even though the number is still small, this investigation has raised a number of issues that the panel believes needs further debate and consideration at the service level, and by the Department of Health. In the panel's view, there should be a more categorical expectation of the standard of nursing observations, how the frequency of these is determined, and by what process any change is made. This is especially relevant to consideration of changes between daytime and night-time observation. The panel does not support intrusive means of observation such as CCTV, but recognises that in some areas such as the high dependency unit, the level of observation needs to be very high. While the design of inpatient units is continually improving, consideration needs to be given in generic planning standards of how to improve the overall observation of patients, and how to reduce the risk of doors, and other furniture being used as ligature points.

There is inevitably a tension between allowing privacy, autonomy and freedom of movement with the expectation of close observation and maintenance of patient safety. The panel did not conclude that all inpatient units should be routinely locked, but formed the view that every unit should have a process in place to consider whether and for what period the unit should be locked to provide greater security and safety when required. Such circumstances may include when there are a number of new, unknown and acutely unwell persons on the unit. If a unit is locked, there needs to be clear explanation and signage to assist all staff, patients and visitors to be aware of how to gain entry and egress. The panel noted that a number of inpatient units do not have an air lock, such that even when the doors are locked, an observant person will easily be able to take the opportunity to exit when the door is opened. Of relevance to this issue is the high occupancy and relatively short length of stay in many units. One of the most potent ways to minimise risk is engagement with the person and awareness of their physical and emotional vulnerabilities. This is more difficult if the person was previously unknown to the unit, or if the staff change frequently. Consideration of the needs for support and training by the multi-disciplinary staff who work in these environments to be able to engage with their patients, will in the panel's view both lessen the risk of adverse events and also lead to general improvement in the outcome of inpatient care.

A further area related to the issue of staff experience and training is the need to improve staff capability in considering the management as well as the assessment of patients with alcohol and other drug issues as well as greater awareness of physical co-morbidities and the risk of physical deterioration.

Finally, the panel would like to thank the services that so readily provided documentation and supported the site visits. The panel recognises the challenges in providing therapeutic and safe inpatient care, but is of the view that improvement can be made through greater attention to the skill mix on the unit including seniority of staff, better training and improved amenity. This will require review of the current funding model of inpatient units. The panel also recognises the extensive literature which documents the difficulty in accurate prediction of an adverse event, particularly suicide with a very low base rate. While the panel agrees that every effort should be made to reduce the likelihood of such events, it is also the panel's view that there is much that can be done to support families and staff affected by these events through improved communication and support.

Appendices

Terms of reference

Purpose

To determine whether health services are responding appropriately to reviews and recommendations arising from unexpected, unnatural or violent deaths of mental health inpatients over the period 1 January 2008 – 31 December 2010; and what, if any, additional responses may be required.

Scope

The Chief Psychiatrist will investigate:

- Each health service that experienced an unexpected, unnatural or violent death of a mental health inpatient between January 2008 and December 2010, including consideration of:
 - a. what the health service's internal review and/or inquiry found
 - b. what recommendations were made
 - c. whether these recommendations have been implemented by the health service.
- In respect of any unexpected, unnatural or violent deaths of mental health inpatients that occurred between January 2008 and December 2010 for which the Coroner has completed an investigation, whether the Coroner's recommendations have been properly implemented.

The Chief Psychiatrist will report back the findings of these investigations to the Minister for Mental Health by the end of 2011.

Objectives

To assess the adequacy and appropriateness of the service response following the death of an inpatient. This will include but not be limited to:

- immediate actions taken, notification of family, staff support
- fulfilment of reporting requirements to the Chief Psychiatrist and Coroner
- systematic service review and response
- completion of a root cause analysis
- development of recommendations
- implementation of recommendations, including any comment or recommendations made by the Coroner.

Process

1. Obtain records of reportable deaths from OCP database and coronial database.
2. Reconcile and classify the data about inpatient deaths (suspected suicide, treatment-related adverse event, probable natural cause, other).
3. Request from each relevant service a full report of the response to the client death, including immediate actions taken and recommendations made both in the relevant health service's internal review and the relevant coronial review.
4. Conduct visits and/or inspections of selected services to determine whether recommendations and practice improvements have been implemented.
5. Compile a report providing key themes and findings, and actions directed to further improvements at the individual health service concerned as well as across health services more generally.

Legislative authority

The investigation will be conducted under the authority of the Chief Psychiatrist as prescribed under s106 of the *Mental Health Act 1986*.

Panel membership

The investigation was led by the Chief Psychiatrist and supported by clinical, project and administrative staff of the Office of the Chief Psychiatrist. The Chief Psychiatrist also convened a panel comprising interstate clinicians to assist in the investigation. These panel members were appointed, for the duration of the investigation, as authorised officers under the Act. They received no remuneration.

Membership of the project team is shown below:

Clinical panel

- Dr Ruth Vine, Chief Psychiatrist, Victoria (Chair)
- Dr John Allan, Chief Psychiatrist, New South Wales
- Ms Barbara Wieland, General Manager, Community and Rehabilitation, Glenside Hospital, South Australia
- Ms Bee Mitchell-Dawson, Senior Clinical Adviser, OCP

Project support team

- Dr Kuruvilla George, Deputy Chief Psychiatrist
- Dr Rick Yeatman, Deputy Chief Psychiatrist
- Ms Claudia Mulder, Clinical Adviser, OCP
- Mr Gilbert Van Hoeydonck, Project Manager, OCP
- Mr Andy Brewer, Project Support Officer, OCP

List of abbreviations

ACGB	Australian Centre for Grief and Bereavement
AOD	Alcohol and Other Drugs
CCTV	Closed Circuit Television
CMI	Client Management Interface—a component of the statewide database for mental health services
CPG	Chief Psychiatrist guideline
CPSERC	Chief Psychiatrist's Sentinel Event Review Committee
CPU	Coroner's Prevention Unit
CRAAM	Clinical Risk Assessment and Management
DH	The Victorian Department of Health
ED	Emergency Department
HDU	High-Dependency Unit
NSQHS	National Safety and Quality Health Service Standards
OCP	Office of the Chief Psychiatrist
ODS	Operational Data Store—a component of the statewide database for mental health services
QAC	Quality Assurance Committee
RCA	Root Cause Analysis
RRAP	Risk Reduction Action Plan
SECU	Secure Extended Care Unit
VHIMS	Victorian Health Incident Management System