*Attachment 3*

# Prior Recommendations to a Sydney AMHS

In response to our daughter's absconding and subsequent suicide, the Mental Health Unit at which she was treated (MHU1) put in place an Action Plan based upon the recommendations of the External Review. In principle, this would certainly improve the operating systems at MHU1, and implicitly, it emphasizes the numerous dysfunctional systems that had been in place during our daughter's stay.

However, we are concerned that similar actions were supposed **already** to have been taken within the responsible Area Mental Health Service (AMHS) in response to previous suicides. These are illustrated below by reference to the suicides of patients "M", "J", "V" and "S". Hence our concern is that the AMHS's record of following through and auditing such actions is questionable, and hence those proposed in response to our daughter's case may also fall by the wayside.

**Had recommendations made by the Coroner, by Critical Incident Reviews and by coronial investigators following previous suicides indeed been carried out at the MHU1 prior to the time of our daughter's stay (December 2002 – February 2003), her life may well have been saved.**

We were given the documents quoted by the mothers of the patients (except for "S"), with permission to use them at our daughter's inquest.

## "M"

M committed suicide in January 2000 in the Sydney MHU2 that is part of the same AMHS as MHU1 where our daughter was treated.

After M's death, a Critical Incident Review (CIR) was carried out in March 2000 and amongst others, two relevant recommendations were made, one concerning **clinician documentation** and the other **risk assessment.**

Letters from the Deputy Director of Mental Health Services responsible for MHU2 in July 2000 to the Coronial Investigator at Westmead Coroners Court and from the Coronial Investigator (which includes a Report from the Deputy Director of Mental Health Services) in February 2001 to the Acting State Coroner at Glebe refer to the implementation of these recommendations at MHU2, and state that the Actions detailed below have been implemented by the Area Mental Health Service in all their MHU's, including MHU1 in which our daughter was treated. After the inquest into M's death, the Coroner issued a Report, and Recommendations to the Minister for Health, both in June 2002.

## Issue: Clinician Documentation

1. Critical Incident Review Recommendations

    **3. Review the importance of documentation with clinicians.**

(i) Documentation of observed or stated suicidality or self harm, must be followed by documentation of action taken by clinician (including any assessments).
**Action: Regular inservices (*training*) required for each team by Team Leader/Managers.**
(ii) Need for inservicing regarding what documentation standards are expected legally sound and foster continuity of care.
**Action: Responsibility Policy Development Manager. Timeframe: Research and information correlated to date. Inservices to be completed by end of June 2000 as well as policy and guidelines. Effectiveness reviewed at spot and annually via file audits.**
(iii) Review current draft policy regarding documentation and ratify.
**Action: Responsibility Director/Deputy Director via Program Managers for ratifying policies when consultation process complete June 2000.**

2. According to the letter from the Deputy Director of Mental Health Services, the following had been implemented:
**Review the importance of documentation with clinicians**. Appropriate and adequate documentation has been discussed with MHU2 staff.

- The MHU2 Mental Health Services Staff Orientation Review committee is currently incorporating "Clinical Documentation Guidelines" for staff entering the service. A checklist has been developed to ensure that this information (as well as other information) has been conveyed by the person responsible for the staff members' orientation.
- The input of MHU2 Mental Health staff into the development of the Area Mental Health Service Documentation Policy (ratified in March, 2000) distributed and implemented in MHU2 Mental Health clinical teams.

3. According to the Deputy Director of Mental Health Services' Report in the letter from the Coronial Investigator, the following had been implemented:
**Review the importance of documentation with clinicians** Improvement of clinical documentation and a checklist created to ensure information is passed to the appropriate persons.

4. The Coroner's Report states:
**97**. The Deputy Director of Mental Health Services in her statement makes reference to programmes implemented to stress the importance of documentation with clinicians.....

*It seems that these recommendations were not carried out at MHU1 where our daughter was treated, given the paucity of documentation by her clinicians and the lack of communication with staff, as commented on by the External Review (Issues 3,4 and 5; Recommendations 1,4 and 7). Why did the Director of the Area Mental Health Service not* ***make sure*** *these recommendations were implemented in all other Mental Health Units in the Area for which he was responsible?*

## Issue: Risk Assessment

1. Critical Incident Review Recommendations

    **7.Identifying when high risk factors are applicable.**
    Ensuring all staff have access to area suicide workshops to enhance existing suicide assessment and management skills.
    **Action: Responsibility of Team Managers/Managers ongoing**

2. According to the letter from the Deputy Director of Mental Health Services, the following had been implemented:

    **Identifying when high risk factors are applicable.**
    Increased attendance at the Area Mental Health Suicide Prevention Workshops. These workshops are compulsory for all clinicians of MHU2 Mental Health Services.

3. According to the letter from the Coronial Investigator, the following had been implemented:

    **Identifying when high risk factors are applicable.** Increased attendance at two-day AMH Suicide Prevention Workshops. The workshops are now compulsory for all clinicians in MHU2.
    In the conclusions in his letter, the Coronial Investigator stated:
    **A level of risk with certain protocols concerning frequency of observations should be recorded within the medical record.**

*The External Review (Issue 6) commented on the sparse documentation, lacking in detail, of Risk Assessment on which the care plan needs to be based, in our daughter's case. Why was this recommendation not implemented at MHU1? Were the Workshops set up?*

4. The Coroner's Report states:

    **94.** Also tendered was a document entitled "NSW Health – Clinicians Reference "Guide to NSW Mental Outcomes and Assessment Training". I was particularly impressed with the forms prepared by the AMHS with separate forms for

    a) Assessment of Current Presentation
    b) Physical Examination
    c) Family, Social & Developmental History
    d) Child Protection Issues
    e) Supplementary Assessment and Plan
    f) Individual Recovery Plan
    g) Individual Relapse Prevention Plan

*Having the forms is a good idea but they must also be filled in with a sufficient level of information. Only some of these forms were used at MHU1 for our daughter and as the External Review observed, the information given on them was sparse and not frequently updated.*

    **95.** Of particular importance is page 8 of the Assessment of Current Presentation where the clinician (*is*) required to complete a risk assessment of the patient, relating to self harm and harm of others and is required to rate the risk in relation to suicide, as low, medium or high.

*No such assessment is recorded in any of the forms used at our daughter's MHU1 that we have been given. It is apparent that Risk Assessment was still not being properly carried out or documented during the time that our daughter was in MHU1. The External Review commented adversely on MHU1 practices (Issue 6; Recommendation 2). Why had the not put in place throughout the AMHS the Coroner's recommendations following from M's suicide?*

> **97**. The Deputy Director of Mental Health Services in her statement....Importantly she sets out a requirement for compulsory attendance by all clinicians at a Mental Health Suicide Prevention Workshop which takes two days and which is aimed at assisting staff to identify when high risk factors are applicable.

*Did our daughter's consultant psychiatrist and the Registrars of MHU1 attend Workshops on Suicide Prevention? Why were they unable to adequately judge our daughter's level of suicidality?*

## General Observation

The Coroner observed as follows:

> LESSONS LEARNED (Clause **159**)
> There can be no doubt that M's death brought about immediate and significant changes in the procedures adopted at the hospital that will considerably lessen the risk of similar tragedies in the future. However as I indicated previously, there is no way to eliminate the risk. The task for all psychiatric hospitals is to continuously review their practices and procedures to ensure the risk of self-harm or harm to others is reduced to the absolute minimum. I hope that the comments and recommendations that I have made will add to the impetus for all hospitals to achieve the very best practice.

*Judging from the dysfunctional systems at our daughter's MHU1 that combined with clinician negligence to result in her absconding and committing suicide, it seems that the AMHS has **not** made all the significant changes claimed or taken this task on board. The "absolute minimum" has **not** been achieved.*

## Coroner's Recommendations

Among the recommendations the Coroner made was the following:

> I. To the Minister for Health:
> The Minister for Health should give consideration to the creation of a working party to examine and implement uniform guidelines in all hospitals in New South Wales where persons are detained under the Mental Health Act dealing particularly with;
> a) The assessment of risk of the patient to self-harm or suicide or to harm others
> b) The clear and precise documentation of the assessment of risk so that such assessment is clearly recorded and available to all other staff

c) The requirement to detail the minimum level of observation of such patients
d) The documentation of the requirement of level of observation and the documentation of the fact of observation

*We presume that the Director of the Area Mental Health Service would have been aware of this report and its recommendations.*
*Was the working party set up? When and where did it report?*
*Why did the Director of the AMHS not follow this recommendation, review the practices and procedures in AMHS, and bring about the necessary changes in the units under his direction, including our daughter's MHU1?* ***Why were none of a), b), c) and d) above properly carried out at MHU1 in our daughter's case, in particular at a critical time for her?***

Related to this, may be two documents tendered to the coroner, copies of which M's family received, "Your Guide to MH-OAT. Clinicians' Reference to NSW Mental Health Outcomes and Assessment Training" (Handbook, Nov 2001 – as mentioned in (4) above) and "AMHS Mental Health Outcomes and Assessment Training." We were sent Version 1.3 (August 2001) of the AMHS's "MH-OAT Training, Mental Health Clinical Assessment" by the Director of the Area Mental Health Service in December 2003. This has a long Appendix E specifically dedicated to "Suicide Risk, Self Harm and Harm to Others"

*Had the clinicians followed the protocols outlined in these documents, particularly those in Appendix E relating to suicide, our daughter's absconding from MHU1 and suicide might have been prevented.*

The events prior to M's inquest also demonstrate that the MHUs and AMHS cannot be trusted to implement and to monitor their own recommendations. When the Coronial Investigator completed his investigation into M's death, he initially believed that the recommendations from the CIR that the hospital said had been implemented were sufficient to correct the hospital's deficiencies and therefore an inquest was not necessary. However, a few days after coming to this conclusion, a patient at MHU2 nearly succeeded in committing suicide and some months later another patient there succeeded in hanging herself in a shower. And so the inquest did take place.

## "J"

J committed suicide in December 2002 while a patient at the same MHU1.

1. In the Critical Incident Review carried out in February 2002, it was recommended:
   **THAT relatives and persons responsible for taking clients on weekend leave are aware of service expectations and their responsibilities**
   **On return from leave – staff discuss leave with relatives and document same in file.**
   Action recommended (for Nurse Unit Manager at MHU1):

- Draft brochure/handout for relatives/persons responsible detailing service expectations and their responsibilities.
- Staff inquire how leave went and document same in file.

Status/Outcome: Brochure was created and available May 2002 and second recommendation implemented.

*No such brochure was ever provided to us while our daughter was at MHU1. After she had absconded we asked for and were given the Leave Responsibility Sheet. Why were we not given this before and why haven't we been given or even seen the brochure (or was the Sheet the so-called brochure)?*
*Staff sometimes discussed leave with us and sometimes wrote minimal comments in the Patient File.*

**THAT indicators be developed to identify clients who have high level/intensive needs and are at high repeat harm (repeat admissions, repeat self harm, minimal treatment response.)**
Action recommended:

- Devise a check list to identify high level/intensive needs clients
- Create Intensive Care Plan
- Trial this system over a period of time with one or more clients

Status/Outcome: Liaise with AMHS

*No such check list or Intensive Care Plan was given to us with our daughter's hospital records, even though she had committed repeated self harm in making three suicide attempts in November/December 2002.*

2. In the Statement by one of her nurses, he states:

   Following the incident, measures have now been adopted to the Category check list highlighting what time a patient leaves and approximately time of return and if a delay occurs action is undertaken to establish whereabouts. Information (in written form) is now provided to the patient's relatives outlining conditions of leave and detailing procedures re notification of patients return.

   In his July 2002 Statement, another nurse says essentially the same.

*As mentioned previously, we were **not** given a leave leaflet during our daughter's stay at MHU1 that began 5 months after these Statements were given.*
*On the day she absconded, no one could find where it was written that she had left and what time she had left. It may have been on a white board. The Category Observation Sheet for that day does not mention her. **There is no existing record of what happened.** We were not notified that she was missing until 6 hours after she had left and 2 hours after she had supposedly said she was returning.*

3. A meeting was held in December 2001 between J's mother and the Directors of MHU1 and the AMHS following a letter from her to an HCCC Patient Support Officer (sent only a few days before our daughter was admitted to the MHU1), requesting proof that the hospital had indeed carried out the recommendations from the CIR. This meeting was held while our daughter was an inpatient.

J's mother was most disappointed to find that the recommendations had either been only partially implemented or not implemented at all. The Director of MHU1 admitted that there were "gaps in procedure". She records:

- No clear risk assessments had been done on the files they audited at random.
- No clear policy was established about how soon a nurse should contact the family when the patient did not return from leave.
- The leave sheet was being provided to patients but **not** to their carers.
- There was still no standardised leave policy. Still haphazard. Time frequently not written. Still on a whiteboard so not a permanent record.
- J's mother told them that the nurses were rarely at the desk when she took her son on leave. or returned him from leave. This was denied (but it was nearly always the case during our daughter's stay also.)

At that meeting she told the Directors of MHU1 and the AMHS something similar to the following: "I don't want another family to lose a child because the hospital has not implemented and monitored the recommendations that were promised on paper." **They obviously did not take her words seriously.**

4. From the letter from J's mother to Coroner A, from the draft Submissions to the Coroner by her lawyers, from the Statements from two nurses and from our conversations with J's mother, it is clear that there were many failings in J's case which were similar to those in our daughter's case.

- No clear risk assessment was done
- No regular management plans were made
- There was sloppiness of record keeping.
- No leave information was given to J's mother.
- Nurses were frequently not at front desk.
- Not enough communication with family.
- Staff seemed not to take J's suicidality seriously (even though he was scheduled 5 days before because of his suicide risk).
- J was allowed to take unescorted walks despite the fact that his mother expressed her concerns and requested that he not be permitted to do so.
- On the day he absconded, J missed a meal and medications and there was confusion at change of shift. Information about leave not handed over to afternoon and night shifts. Nurses did not read whiteboard.
- Nurses seemed to have been deceived/fooled by the "bright and reactive" behaviour of J before he absconded.
- Security was so low that J could easily abscond.
- There was delay of 7 hours in notifying J's mother that her son had absconded.

***All** the above failures were true or similar with respect to our daughter. Why had no improvements been introduced in response to his suicide, by either the Director of MHU1 or the Director of the AMHS? Why have management and staff at MHU1 and the AMHS not learned from adverse experiences?*

Unlike Coroner L who finally did decide to hold an inquest into the death of M, Coroner A refused to hold an inquest into J's death, despite his mother's strong request (less than a year before our daughter absconded). Unfortunately, Coroner A believed that the changes the hospital said they had adopted would suffice to prevent such events happening again. However, as the above demonstrates, this was not the case and *many* of the *same* mistakes (both those addressed in the CIR and others included in the dot-points above that were not identified in the CIR but that had been brought to the attention of the hospital) were repeated, with disastrous consequences for our daughter.

## "V"

V committed suicide in June 2000, after MHU1 first failed to admit her to the hospital and then failed to send a crisis team to her home the next day as promised.

In his letter of July 2001 to the HCCC, the CEO of the Area Health Service mentions two initiatives that the AMHS was planning to take in the future to help deal with similar problems.

1. The implementation in July 2001of MH-OAT Clinical Assessment Protocols to strengthen the mental health assessment skills of mental health clinicians and to introduce uniform protocols throughout NSW.
2. The development of new protocols and guidelines on suicide risk assessment and management and implementation of NSW Health Department Circular 98/31. This Circular includes the component: "Protocols will cover the concept of risk being dynamic and changeable requiring re-assessments at appropriate intervals"

He further states that a review of the current Area Suicide Assessment and Management Training Program will be carried out to coincide with the implementation of Circular 98/31 and that: "the Area Health Service is currently taking very significant steps to improve the standard of assessment across all mental health services".

Training in MH-OAT was completed in this AHS in 2002.

*This review and training made no difference in our daughter's situation, since the recommended protocols* ***were not followed by the clinicians.***

The CEO of the Area Health Service also states that recommendations coming from the Critical Incident Reviews are implemented throughout the Area, and that the AHS is committed to continual improvement in service delivery.

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*As shown in the cases of M, J and the S (below), recommendations from Critical Incident Reviews elsewhere in the Area were, in fact,* ***not*** *always implemented at MHU1. Commitment to continual improvement is questionable and while recommendations may appear on paper, they are* ***not*** *always followed in the Mental Health Units.*

## "S"

A Sentinel Event Review was held by MHU1 in July 2002 into the death in May 2002 of a patient who committed suicide while on day leave.

## Issue: Risk Assessment prior to Leave

Recommendation: that prior to going on leave, all formal patients should have a risk assessment complete and documented (including supports available on leave).

**Actions:**

- **All patients going on leave to be reviewed by clinical team**
- **Risk assessment to include risks to self, others, and the type of supports available to the patient while on leave**
- **The risk assessment to be documented in medical file**

**Person Responsible: Clinical Teams**

**Target Date: Immediate**

*The Actions above were either not followed at all or inconsistently followed in our daughter's case. In particular, no risk assessment was carried out before she* ***supposedly*** *was going on leave in February 2003, when in fact she absconded. Had this been done, and more questions asked, her "leave" and absconding might have been prevented, because it was clear that she was too suicidal to be allowed leave and her proposed "leave with a friend" was only a pretence.*

## In summary:

**Despite the recommendations of the Critical Incident Reviews and the Coroner arising from these suicides, which took place between three and one years before our daughter absconded, and the supposed actions taken by the AMHS on the issues reported above, these same issues were still major problems in our daughter's case. Why did the Director of the AMHS not ensure that the recommendations and actions were indeed carried out and continued to be carried out in all parts of the AMHS, including MHU1?**