AH. 6

31 January, 2005

The NSW Ombudsman
Level 24, 580 George St
Sydney 2000

Dear Mr Barbour,

re: The persistent and ongoing pattern of administrative maladministration and misconduct within NSW Health apparently aimed at concealing the massive increase in mortality involving actual and potential clients of mental health services since 1989

You have no doubt observed the increasing public and media concern over problems with mental health services in NSW. (Also in Australia generally, but with NSW invariably judged on a number of criteria to be the worst.) My particular concern is with the increase in mortality among clients of the services, which according to figures I have been collecting since 1993, has been of the order of 500% since 1989. My calculations suggest a total of some 2,000 preventable deaths in that period, continuing at the rate of 3-4 per week. This is predominantly from suicide, but as services have continued to deteriorate, homicide by people with mental illness, an extremely rare event before 1990, has also been contributing to the death toll. These are now running at around one per month, often with more than one victim, often children.

The response of NSW Health to what in any other field of medicine would be regarded as an emergency requiring immediate remedial action, has been inaction, obfuscation, and in my opinion what must be a deliberate cover-up. Late last year, at an Australian Institute of Criminology conference, a speaker gave the definition of crimes against humanity under international law, which struck me as almost certainly applying to what is happening to this most vulnerable group of people in our community. However, before taking the matter to an international forum, I need to establish whether all relevant arms of government in NSW are involved in condoning or allowing the crime, hence this letter. I trust that your office will be prepared to take action to remedy the maladministration and misconduct involved.

In the interests of brevity, I won't send you all my material on this in the first instance, but would be happy to expand on this letter and attachments if necessary.

I first wrote to NSW Health on this issue in 1993, on behalf of the Institute of Australasian Psychiatrists, since it was clear to me from anecdotal evidence that patient deaths from suicide had increased. The reply from the then Director-General, Dr Amos, (Attachment 1) confirmed this. That letter refers only to deaths of people who were hospital inpatients when they died, which makes comparisons with later years difficult, when a greater proportion of people with mental illness were not in hospital, as more and more beds were closed; and deaths 'in the community' became more frequent.

For convenience, and lacking specific data, I have taken the ratio of inpatient to outpatient deaths as being similar to that recorded in the 1995 paper (see below), i.e. of the order of 3 to 7.

NSW Health commences data collection:

Possibly stimulated by my enquiries, NSW Health started collecting data on the deaths from mid-1992. This is done on a 'Client death report form', which Area Health Service staff are expected to complete, and return to the Centre for Mental Health in NSW Health head office. (Attachment 2 is the Jan. 2000 version.) It is wildly unlikely that all such deaths would be reported - for example, if the patient had moved to another Area, or interstate; had walked out of an Accident and Emergency department when kept waiting to be seen, or died waiting for an outpatient appointment; if staff were not notified of the death, expecially of someone not in ongoing contact with the service; or simply failed to fill in the form. Figures collected by NSW Health must be assumed to significantly understate the problem.
Requests for information on the data collected were never answered; and in the light of what information has emerged or leaked over the years, it is difficult to avoid the conclusion that the figures have been deliberately suppressed by NSW Health from 1992 because they were so bad.

Manipulation of figures to hide the trend:

One of the earliest and most serious instances of malpractice that I'm aware of occurred in 1995, when a paper by officers of NSW Health was published very quietly in an in-house journal. (Attachment 3) Despite my regular requests for the mortality figures, I was not notified of this, and became aware of the paper only when I started making enquiries again some years later. One notable omission, although as mentioned in the paper, and can be seen from the 'client death report form', the information was collected, was the patients' age. Information supplied in the Sentinel Events Review Committee (SERC) report (see below) confirms what I had always suspected, that the dead are disturbingly young, suggesting that this information was omitted deliberately to reduce potentially negative fallout.
Far more serious, however, is what was done with the figures. Covering a 39-month period from 1992 - 1995, they were pooled, giving a mean of 6.35 deaths per month, or 76 per year. Bad enough, you might think, given the 1989-91 figures above - inpatient deaths in 1989 were 10, 1991 were 20; and the paper's pooled figures for inpatient deaths are 27 per year, i.e. nearly three times the 1989 figure; and nearly 50% more than 1991. The authors however failed to mention the earlier figures; and by pooling theirs, effectively hid the increase.
Attachment 4, page 13 of the SERC report, published also very quietly on 23rd December, 2003, shows what was hidden by pooling the figures in 1995: -
1993 deaths = 68; 1994 = 72; jumping to 100 in 1995. I have happened to meet one of the authors twice at conferences in the last couple of years, and asked her why they took the unusual step of pooling the figures. She refused, and has continued to refuse, to answer.
If you imagine such a process occurring with some kind of physical illness, such as asthma, or anaesthetic deaths, you can understand how serious the malpractice has

been. Normal process would have been, as the deaths started rising, to sound the alarm, and start immediate remedial action, with the death rate used as an ongoing indicator of whether the action was working.

Refusal to process or release the figures, even under FOI

Serious maladministration and malpractice over the figures have continued ever since, under various Director-Generals; but mostly under the same head of the Centre for Mental Health, Prof. Beverly Raphael.

Enquiries before 2001 brought the answer from various staff at the Centre for Mental Health, including Prof. Raphael, that although they were collecting the death report forms, they had not processed them, hence had no figures available, i.e. they had not even bothered to count the forms. Another excuse for not providing the figures was that the data had to be de-identified, as the figures could not be released for reasons of confidentiality. As you can see from the form, all that has to be done is a very cursory inspection to ensure that the form is genuine, and not a duplicate of a death that has already been reported. They then just have to be counted, a process that should take only a few minutes.

In 2001, the National Association of Practising Psychiatrists (of which I am now president) tried to access the figures under FOI. Attachment 5 shows the refusal. In 2002 we met Prof. Raphael to try to overcome this problem. At the meeting she agreed to supply the most recent figures to us, together with what information they had on the increasing number of homicides by clients of mental health services. The outcome, which occurred only after a number of telephone reminders, was the arrival of a publication on suicide in general in NSW, which was two years old, and contained no figures on suicides among mental health service clients. Our letter of protest about this (Attachment 6) to Prof. Raphael was never answered, and the figures never supplied.

Also in 2001, a journalist from the Sydney Morning Herald tried to obtain the figures under FOI. This request was also refused. (Attachment 7)

Unfortunately the figures, once forced to be released, could be manipulated, by further malpractice, in what I call the Soviet Solution. I was informed by a psychiatrist in the USSR in the early days of glasnost, that there was a 30-year period where there were no recorded suicides at all. This was because the authorities considered it unacceptable to have such things occurring in a perfect socialist society. I trust your office will be alert to the possibility of NSW's figures being similarly 'improved' by changing the definition.

Contempt of Parliament by an Acting Director-General, backed up by Area Health Service administration

Ongoing pressure from NAPP and others on the failings of the mental health services, including the deaths, led to the establishment of an inquiry in early 2002 by a committee of the NSW Legislative Council, chaired by Dr Brian Pezzutti. When Whistleblowers Australia heard late in 2001 that the inquiry had been set up, we wrote to the then Acting Director-General, Bob McGregor, to request that he notify staff of the inquiry, and of his support for staff who wished to give evidence to it. (Attachment 8)

That letter has never been answered. Instead of an answer, we had leaked to us a memo sent out by Mr McGregor, dated 9 Jan. 2002 (Attachment 9) which made it clear that staff were not to make independent submissions; that all submissions were to be "forwarded through the Department so the Minister can be informed, and in accordance with Premier's Memorandum No. 98-33 Agency Input to Statutory and Parliamentary committees, 'approve of the position being put.'"
This seemed to me a clear instance of contempt of Parliament, which unfortunately the Committee, although annoyed by it, did nothing about.
In a development directly related to that memo, two pathologists from the Glebe morgue, increasingly concerned about the number of bodies turning up for their attention where it was clear the death would not have occurred if services had been adequate, put in a submission (Attachment 10) direct to the Inquiry, as is of course their democratic right and professional responsibility. They were immediately victimised by the Central Sydney Area Health service (their employer), and harassed out of their jobs. One changed sub-specialties and is practising elsewhere in Sydney; the other moved interstate.

Continuing cover-up via the Sentinel Events Review Committee (SERC)
When the Parliamentary Inquiry had made its report, Prof. Raphael, at a wind-up function in January 2003, in response to ongoing pressure from NAPP for an independent psychiatric deaths committee analagous to those for maternal deaths and anaesthetic deaths, announced that one had already been set up, in May 2002. She had not seen fit to inform me, NAPP, or any other interested party of its existence; and in a number of respects the SERC did not and continues not to meet the need.
Firstly, its name, which conveys nothing to the average person who is unfamiliar with Newspeak. Part of the misconduct engaged in by NSW Health has been deliberate obfuscation by the misuse of language. Suicides by people who are or should be under the care of the mental health service are referred to as 'client incidents'; and homicides as 'critical incidents'. Potentially embarassing client and critical incidents are referred to as 'sentinel events'. None of these terms is understood for what it is by the general public. The SERC should have been clearly and plainly named as the Psychiatric Deaths Committee.
Secondly, its complete secrecy, while under the direct control of NSW Health. Instead of being independent, it meets in NSW Health head office, using Centre for Mental Health support and secretarial staff. Its members are sworn to secrecy about its deliberations, on pain of a $40,000 fine or 6 months' jail. Despite such threats, some information has become available, which indicates that NSW Health, in particular the Centre for Mental Health, has refused to provide complete figures to the SERC as well.
Thirdly, it reports, not to Parliament as we had requested, but to the Minister, who can choose whether to release its reports, and when. He chose to release the first one on 23rd December 2003, the optimum time to get little or no public attention through the media. I realise the Minister and his actions fall outside the Ombudsman's authority, but mention this for completeness. It is also clear that had NSW Health not been an active party in the continuing cover-up, it could have chosen to forward the report to him at a better time, when he would not have had the Christmas release option.

The report itself, despite the failings of the Committee, does contain one page of valuable information - page 13, already included as Attachment 4. This shows no figures before 1993, hence fails to indicate the magnitude of the tragedy. (The report is called "Tracking Tragedy".) It also understates the figures for 1999 and 2000 slightly, according to figures leaked to me in 2001. (Attachment 11) It also did not include the figure for 2002, although the report was completed in late 2003. But regardless of these (possibly instances of NSW Health failing to supply information to the committee) it still shows suicide deaths more than doubling between 1993 and 2001. It also shows that the percentage of all NSW suicide deaths which are of patients in care at the time has doubled over that period.
However, rather than mentioning this, the Minister in his media release concentrated on a figure given on the first page of the introduction to the report - "in 2002-3, there were 8 possible suicide deaths of patients who were in care as inpatients at the time of their death."
This figure would of course have been supplied to him, as well as to the SERC, by the Centre for Mental Health. It is not clear what period is meant by "2002-3", a most unusual usage in health statistics, where reference to calendar years is the norm; and from my limited and incomplete anecdotal knowledge, the figure of 8 is wildly inaccurate. (I know of 6 such cases occurring in only two units around that time.) I therefore tried, starting in January 2004, to find out from the Centre for Mental Health and/or the Minister (but as you well know, it's the bureaucracy of any minister's department who actually write the letters s/he sends out) exactly what is meant by a period given as e.g. '2002-3'; and where on earth the figure 8 came from, as it is grossly understated. (I've suggested that someone might have omitted a zero, but really think it's been understated by some 6-8 times rather than 10.)
Attachment 12 is some of the correspondence involved, which is still going on, including a letter to Cherie Burton, the Health Minister's Parliamentary Secretary, whose help I tried to enlist in a letter dated 13th October 2004. More than twelve months after my original enquiry to Health, I am however still waiting, either for her to extract a response from Health, or for them to respond themselves. Meanwhile preventable suicide deaths continue to occur, at a rate of 3-4 per week, and homicides at about one per month.

If all this does not represent a serious example of administrative maladministration and misconduct, I don't know what would. I suspect such serious and unpleasant issues have rarely if ever been brought to your notice - hopefully because they seldom happen, rather than because the bureaucracy is skilful at covering them up.
I look forward to hearing from you about what you can do to remedy this misconduct, and help to save at least some of the 180 or so young people with treatable mental illness who will otherwise die this year, and the twelve or more people, many of them children, who will be killed by people with mental illness who have been unable to get the treatment they need.

Given the length of time this has been going on, and the amount of information on it (and remember I am supplying only a fraction of it in this complaint), it is probably difficult for you to work out what can and should be done. I trust you will not be

suggesting that you are unable to take action until the complaint has been formally presented to the Director-General of Health, since it should be clear from the above information that the various people who have occupied that position since 1993 have been active participants in the problem. While the current Director-General is not as far as I know actively engaged in suppressing information, she is aware of the issue, and has done nothing to resolve it; while the Department for which she is responsible has failed for over 12 months to answer some very basic questions on the SERC report, with at least her tacit approval.

In summary: I suggest that what is required is an inquiry by your office into:
1. NSW Health's handling of the data it has been collecting since 1992 on mental health client deaths;
2. whether, as my evidence suggests, there is and has been a policy of cover-up; and if that is the case, who is, and has been responsible.
3. Once such an inquiry has been undertaken, and the results publicised, it would be essential to ensure that the data collection continues unchanged, and that the figures are made immediately publicly available, at least annually, by say February of the following year.

I understand your office is already charged with the responsibility for reviewing all deaths in care of people with intellectual disabilities, with a view to improving services to reduce early or preventable deaths. While the numbers of deaths now occurring in clients of mental health services might make a review of all of them difficult or impossible on your current staffing, as a first step would it be possible for the client death reports to go directly to your office, so the numbers could be reported direct to Parliament, and could no longer be covered up?

If you need more information, or clarification, please let me know. I can be best contacted on 9810 2511.

Yours sincerely,

Jean Lennane (Dr)

PS. A story in today's Sydney Morning Herald ("Hospitals riddled with fatal mistakes") refers to a report by yet another body, the Clinical Excellence Commission, which mentions suicides in hospital (4) and while in community care (128). If these are annual figures, they are greatly understated; and there is no indication where they come from. I hope you will not feel that the release makes it unnecessary to address my complaint. It certainly does not.