21 District Health Boards

Mental Health Reportable Events

1 January 2007 to 30 December 2007

Northland District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	2	Accidental death of an outpatient	Functional smoke alarm might have prevented death. No issues with treatment.	Community staff and District Health Board (DHB) should promote installation and maintenance of functioning smoke alarms in patients' homes.	None required.
2.	4	Suicide of an outpatient	Long-term suicide risk, compounded by substance abuse; patient not engaging with treatment offered by Mental Health Services. Private counselling more acceptable to patient but curtailed because of cost. No liaison between private and public services.	Funding of private counselling to be encouraged nationally. Information sharing between private and public services. Increased staff training on treatment of substance use disorders.	WINZ, ACC and PHO funded counselling increasingly available. Clinician with expertise in both mental health and addiction problems employed.
3.	2	Death of an outpatient in fire	Previous history of arson, deliberate lighting of fire likely, motivation unknown, no obvious trigger. Psychiatric diagnosis unclear despite repeated assessments over many years. Planned follow-up admission to community treatment facility delayed.	Additional psychiatrist time in community clinic required. Clarification of referral processes between inpatient and community treatment teams required.	Psychiatrist recruited. Referral processes reviewed.
4.	2	Death of an outpatient from medical condition	No issues with psychiatric care.	None.	None required.

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
5.	4	Suicide of an outpatient	Suicide apparently triggered by escalation of financial problems, impending eviction from private rental accommodation. These problems had been identified and addressed during previous inpatient admission.	External agencies to be asked to seek permission from clients to notify mental health services of decisions adversely affecting them when external agencies are aware of mental health service involvement. Improved integration of inpatient and outpatient care.	Regular meetings between external agencies and mental health services. Some clinical teams working in both inpatient and outpatient setting.
6.	2	Accidental death of an outpatient	Long-term problems with multiple, severe disorders, including substance abuse, lifestyle and accommodation issues, poor compliance with treatment.	Powers of Alcohol and Drug Act noted to be limited. Legislation or regulation required to allow direct assignment of benefit payments to food and accommodation. Improved housing affordability.	Recommendations forwarded to Ministry of Health. Ongoing projects by DHB and Housing New Zealand to improve housing access and affordability for the mentally ill.

Waitemata District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	7	Physical assault by a patient	Assault in the context of deterioration in clients mental state Need for more staff training in incident management identified	Clinical Manager to ensure that a dedicated Registered Nurse is rostered on for each duty in the ward, including night shift. Debriefing and training provided for staff	Completed Completed & ongoing
2.	4	Suicide of outpatient	Despite multiple efforts to contact the client, medical assessment did not take place	No service recommendations were identified	N/A
3.	13	Attempted suicide of inpatient	Issues included timeliness of staff response, use of alarm, handover processes	Registered nurses reminded of duty to provide comprehensive hand-over and ensure alarm with health care assistant. Review appropriateness of clients requiring watch/special being allowed escorted leave, clinical governance group	Completed Completed & ongoing
4.	13	Attempted suicide of an inpatient	Divergent clinical opinions about diagnosis led to an extended length of stay	Where a difference in clinical opinion exists then a case review is held to clarify and reach an agreed management plan	Completed & ongoing
5.	12	Outpatient driving a car that struck and severely injured a pedestrian	Issues identified in relation to communication between teams, clarity of documentation, follow up arrangements when staff on leave	Review clinical review processes to ensure all relevant information is made available Clinicians are reminded of the need to maintain high standard of documentation	Completed Completed & ongoing

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
6.	4	Suicide of an outpatient	Issues included liaison and communication between multiple services involved, actioning of recommendation for complex case review of previous suicidal behaviour	The manager and service director meet with the family to discuss the findings from this review A complex case review be held following any serious suicidal behaviour	Completed Occurring and Ongoing
7.	4	Suicide of an outpatient	Issues identified with access to appropriate facilities where clients may undergo comprehensive assessment, need for face to face meeting of all stakeholders during stay in hospital	To clarify the reasons that limit access for Older Adults to appropriate assessment settings To agree a strategy for identifying complex cases and establishing complex client case reviews and to ensure all parties are involve in discharge planning	Ongoing Ongoing
8.	4	Suicide of an outpatient	Cover system for staff when on leave, quality of documentation and requirement fro cultural assessment	Review service system for cover when staff on leave All clinicians reminded of policy around clinical documentation & cultural assessment Roll out of key worker training	Completed & ongoing Completed & ongoing Initiated and ongoing
9.	13	Attempted suicide of an inpatient	Issue of communication and follow through on CT scan Length of time for ambulance to arrive Requirement for intubation equipment to be available	Review timelines for accessing CT scan, establish guidelines Memo to all staff access is via 111 not 777 Trolley to include intubation equipment	Completed Completed & regular checks ongoing Completed & monitored

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
			Requirement of new admissions to be seen for a psychiatric assessment by a medical practitioner Community key worker input during inpatient admission should be in line with best practice	Policy to be followed Review practice and protocols regarding arrangements for leave cover including community care coordinator cover for inpatient admissions	Completed & monitored
10.	4	Suicide of an outpatient	Old information in historical files was not brought forward into electronic file Mental health services did not know who GP was or what non-psychiatric medication was being prescribed. Early refills of prescriptions were regularly requested	Clinical teams to have accurate summaries of clients, identify service users active longer than 2 years, prioritize list and perform in-depth clinical reviews. Primary care sector should know if person is enrolled in Mental Health Services, develop a pathway to educate GPs and PHOs on how to check	Completed Initiated & Ongoing
11.	7	Alleged assault by an outpatient	Clinical staff were well engaged with Client Identified a need for improved information sharing across DHB's and involvement of services in the discharge planning of service users. Also identified the need for increased services for mental health and addiction patients	Improved interface between the ward and community team, a working group was set up to address the issues in relation to this Improved interface and information sharing across Northern Region DHBs, included discussion at recent inpatient forum for the Northern Region DHBs	Completed & ongoing Completed and ongoing

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
12.	7	Alleged assault by another resident	Client potentially vulnerable due to psychosis and impulsivity	Staff currently attempting to find female only housing Supportive therapy and counseling being provided Family meeting to occur	Completed Completed Completed
13.	4	Suicide of an outpatient	Care was fragmented Need for an improved system for maintaining an overall picture of what was occurring for the client	Develop a system that ensures a key worker is identified as holding overall responsibility and ensure relevant information is communicated Review risk documentation and management for clients	Change in system to ensure greater overview of chronic relapsing clients by manager and case manager Completed through in-service training and the roll out of an updated risk process
14.	3	Suicide of an inpatient	Documentation made in clinical hard copy file on general ward and not in electronic file for mental health Historical notes from Australia might have been accessed earlier following admission, and referral to mental health made sooner Issues of facilities planning such as ensuring no ligature points on the wards	The mental health team review the issues of documenting in both medical files and electronic files All staff reminded to refer to mental health team at the point when an acute psychiatric disorder is identified Recommended improvements to the buildings of risks associated with potential ligature points to enable future adaptation of facilities to minimise risk of hangings	Reviewed & decision made on safe/best practice & communicated to team Completed Completed
15.	13	Attempted suicide by an outpatient	Coordination between two service providers to ensure client's frequency of attendance at each provider known by each provider	Meeting to be held with the two services to discuss shared care arrangements	Completed & ongoing

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
				Service key worker to meet with the client & their family to discuss the incident and create a written plan for the future	Completed
16.	13	Attempted suicide by an outpatient	Issues identified in relation to discharge planning processes and coordination of inpatient and outpatient services	Discharge meetings are coordinated to include all relevant inpatient and community staff, overseen by senior nurse manager Ensure education for staff on risk factors for suicide, training team to teach the risk assessment toolkit	Ongoing Completed and ongoing
17.	4	Suicide of an outpatient	Risk was not always assessed at each appointment. One reason for this is that the client appeared to be forward thinking, had booked another appointment and was well engaged.	Review training offered in risk assessment and management Emphasize need for review of those with chronic risk and substance misuse, rather than focus on current and immediate risk factors	Risk training has been done through in-services and through roll out of up dated risk process Discussion through Supervisor and team leader meetings that they should carry an overview on chronic relapsing clients
18.	13	Attempted suicide of an outpatient	Communication between involved agencies was effective. There are significant complexities of the client's disorder and difficulties engaging with the client and their family. Intensive management is being recommended	The manager will ensure all overnight contacts made out of hours are reviewed at the risk handover in the morning to ensure information flow from overnight is picked up.	Actioned and ongoing
19.	2	Death of an outpatient – uncertain cause	A review of contact with the service identifies the client was able to effectively manage opiate dependency and attempts were being made to work on alcohol misuse	No specific service recommendations were identified and the overall care appears to have been managed to a high standard.	N/A

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
20.	2	Death of an outpatient – uncertain cause	Some clinical documentation was unclear about the clinician and their designation Communication between the involved services could have been improved The electronic systems that would identify when a person has made contact with a health service are not well integrated across the services	All staff to document in clinical file the name and designation of person they are liaising with Arrange access to electronic records for staff in all services Highlight risk on risk register	Completed and ongoing Electronic records now available to all Lead clinicians Completed
21.	13	Attempted suicide of an outpatient	The client's anaemia may have contributed to her collapse. Responsive and appropriate service was delivered	Following careful deliberation the panel was unable to identify any service recommendations	N/A
22.	13	Attempted suicide of an outpatient	There were regular reviews during which risk was assessed Patient received entire three month supply of medication as prescription was not endorsed 'close control'	Ensure a booklet about suicidal thinking and coping strategies is included in information pack for service users with information, provide medication information sheets and advice about what to do following overdose in service user information packs The case manager has developed a plan with the client and family about managing safety of medications Clarify and circulate prescription endorsements to medical staff	Completed and now included, ongoing Completed Completed by Service Clinical Director
23.	3	Suicide of an inpatient while on leave	The apparent suicide could not be predicted or prevented by clinical staff. No adverse comment could be made about the client's clinical care.	No service recommendations were identified	N/A

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
24.	9	Absent without leave (AWOL) - patient did not return from unescorted leave from the Unit	First absence without leave of a Special patient in a very long time. Leave to be reinstated, but escorted leave only Another DHB service did not communicate regarding the known whereabouts of the patient	Need to emphasise the importance of adherence to the leave policy. Improved communication and liaison with other DHB services in the case of an AWOL out of the DHB area centres, need to liaise with staff based in the region. Feedback to Special Patient Review Panel, to ensure the nature and structure of care and accountability is clear to Special Patients	Ongoing

Auckland District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	**5**	Outpatient charged with murder	Mental Health Act Status had inadvertently lapsed about 6 months prior	Review of Mental Health Act administration in the Community Mental Health Centres	Completed and new system implemented.
			General adult services were not resourced or configured to provide inpatient secure or intensive assertive community rehabilitation	Review and planning for high end rehabilitation including locked rehabilitation and intensive assertive community team.	In progress via Regional Service Planning Project - looking at high and complex needs. Auckland DHB has implemented an Assertive Community Outreach Service from Jan 2009
			Communication between general and forensic services was inadequate	Improve interface between general and forensic mental health services.	Additional forensic liaison support in place to ADHB from 2008
			Services for complex needs were not well integrated	Clarification of responsibility for actions of people with combined personality, addiction, and psychosis problems	Auckland DHB Coexisting Disorders Project is in progress Assertive Community Outreach Service from Jan 2009
			Significant drug abuse issues associated with psychosis were integral to this presentation Auckland DHB unable to access sufficient expertise for such cases	Development of better services for dual diagnosis of mental health and addiction disorders	Regular General Mental Health Service and Forensic Case Reviews and Liaison Meetings from Jan 2009 Joint planning between Auckland DHB Mental Health Services and the Regional Addiction Services is currently in progress with services for those with co existing disorder a major emphasis.

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
2.	**3**	Suicide of an inpatient	Ambulance was slow to attend emergency Hospital resuscitation team was not attending any mental health units on Auckland City Hospital site. Patient had easy access to illegal substances Risk Assessment not completed or updated Multiple electronic forms create duplication and limits access to information Difficulty in coordination of intersectoral services Patient was unwilling to have physical examination and blood tests	Work with ambulance service to improve response time to unit calls Work with general hospital to change policy and respond to emergency calls from acute inpatient unit. No current recommendation to routinely lock the open wards. This will be kept under review in the annual review of serious incidents. Risk assessments should be routinely done shortly after admission and recorded even when there is relatively little new information. Improve clarity of expectations of admission documentation and establish systems to integrate systems and provide cumulative assessment information between services. The interface between general mental health services, the courts, prisons and corrections will be kept under review. House Officers will receive more advice regarding physical examinations of clients who are unwilling to be examined.	Resolved - ambulance response time significantly improved. Resolved – now responding Wards have been frequently locked Decision made March 2009 to extend number of Intensive Care Unit beds from 8-12 Requirement formalised with introduction of Core Adult Documentation in October 2008. Implementation of Core Adult Service Documentation requirements in Oct 08 has enabled clear cumulative assessment and planning and a single shared risk process between services Auckland DHB has implemented an Assertive Community Outreach Service from Jan 2009 Additional forensic liaison support in place to Auckland DHB from 2008 Regular General Mental Health service and Forensic Case Reviews and Liaison Meetings from Jan 2009 Followed up by inpatient unit Clinical Director and now included in House Officer orientation

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
			Nursing observations were inhibited by disruption to sleeping patients	Towel rails were able to serve as a hanging point	Towel rails have been removed
				Options will be investigated for making the doors easier to open and close quietly and desirability of having windows for observation.	Locks have been removed from bedroom doors Minimum of hourly checks are completed and documented
3.	**3**	Apparent suicide of an inpatient psychiatric care (under consideration of the Coroner)	Psychiatric diagnosis uncertain	Improved collaboration between Alcohol & Drug Services and Mental Health	Project in progress
			Identified as high risk and placed in psychiatric Intensive Care Unit	Changes to nursing handover & observation protocols	Completed
				Single multi-disciplinary treatment plan	Completed
			Inadequate observation	Change leadership structure	Completed
				Review balance between client autonomy vs duty of care	In progress
			Unclear process and/or roles in emergencies	Protocol to clarify medical roles	Complete
				Modify emergency response system	Complete
				Formal risk assessment and management system	Implementation underway
4.	**1**	Death of inpatient from medical causes	Cause of death unclear	Review of nursing observation policy	Completed
				Clarification of response of mental heath doctors to medical emergencies	Completed
				Specialist physician for mental health ward	Part time position allocated but position unfilled currently

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
5.	**2**	Death of outpatient from natural causes			
6.	**2**	Death of outpatient from medical illness			
7.	**4**	Suicide of an outpatient with a terminal illness	All appropriate care was provided and well coordinated between providers	Nil	
8.	**2**	Death of an outpatient	No mental health issues		
9.	**13**	Attempted suicide of an outpatient	Patient had difficulty engaging with service provided despite a significant amount of input from both Community and previously inpatient Mental Health teams with good family support and liaison Patient had long term difficulties with mood disorder and sleeping problems. Stressors included, difficulties adapting to retirement and deterioration of vision.	There are no obvious recommendations that things could have been done differently to prevent this suicide attempt.	
10.	**4**	Suicide of an outpatient	Patient had repeatedly been offered the opportunity to attend at the community mental health centre to address issues but had not engaged.	No recommendations arose from the serious incident review but would probably now be considered for the services more recently made available.	Auckland DHB has implemented an Assertive Community Outreach Service from Jan 2009 Additional forensic liaison support in place to ADHB from 2008 Regular General Mental Health Service and Forensic Case Reviews and Liaison Meetings from Jan 2009

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
11.	**2**	Death of an outpatient from natural causes			
12.	**4**	Suicide of an outpatient	There was no documented Risk History or Safety Plan.	Community manager to audit clinical files and identify those without documented Risk Assessments and Safety Plans.	Completion of Risk Assessments and Safety Plans are electronically audited monthly. System also established to plan for anticipated leave by key workers to ensure Intra Muscular injections are not missed
			Patient was receiving as many hours of community help within Packages of Care as could be made available at that time but increased hours may have been of benefit.	Community Coordinator will review all recipients of Packages of Care to establish that people are getting the hours they need.	There is now more flexibility in provision of packages of care
			There was not a single plan that was being followed by both the Community team and the Community Support Worker but there was close communication between them.	Work to be done on developing a single care plan that can be developed collaboratively with the service user, community based staff and clinicians.	New collaborative planning process being trialled
			High caseload issues may have been a contributing factor.	Community team are reviewing their client caseloads to make them more equitable.	Caseloads and team composition are being reviewed

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
13.	**4**	Suicide of an outpatient	Patient had long standing problems of dual mental health and addiction disorders which complicated care.	The current proposal to increase staff with skills in both mental health and addiction disorders within acute inpatient unit is pursued.	Proposal submitted for specialist positions in adult mental health services was unsuccessful Currently Mental Health service wide project to enhance services for those with co existing mental illness and alcohol and drug problems is in progress.
			The clinical features changed to a level which was inconsistent with drug-induced psychosis.	Services for people with dual diagnosis and antisocial behaviour need to be expanded	An Assertive Community Outreach Service has been established Jan 09
			During the last few weeks of the patient's life the psychosis appeared to be under good control from antipsychotic medication and gaining insight into problems and situation caused depressed.	Alternatives to acute hospital admission continue to be progressed.	Acute Home Based Service is now fully functional.
			Patient faced a large number of significant social stresses and losses including liver disease.	No Recommendations	
			The significant suicide risk was well recognised by both community and in-patient teams. Social needs and safety concerns could have been better integrated in a single multi-disciplinary plan.	The multi-disciplinary planning documentation is to be reviewed to encourage integration of planning.	Integrated electronic core documentation for assessment and planning has been implemented October 2008
			Failure of Police to inform family abroad of suicide via local police	Mental Health Service use the police liaison meeting to bring to the police's attention the failure of communicating with the overseas police and ask that this be investigated	Tabled at Police Liaison meeting

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
			Family communication was inadequate	The specific family communication responsibilities are clarified in Acute Inpatient Unit	Family information pack is available for all family members Care coordinators role has been established as the primary point of family liaison

Counties Manukau District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	2	Death of outpatient from medical causes	Passed away from medical illness No issues with mental health care	Nil	N/A
2.	7	Physical assault by a patient on staff	Assault occurred during home visit to client and in the context of client's mental state. Police involved in containing situation.	Review Home visiting Policy Communication handover between community team and crisis staff re: assessment and management of risk	Completed Ongoing

Waikato District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	9	Absent without Leave of an inpatient	Inpatient unit allowed client to go to nearby shops unescorted despite being very unwell and requiring close observation.	To include updating client risk assessment in Mental Health education programme. To ensure formal planning is documented for Mental Health inpatients in ward over the Christmas period when multidisciplinary team meetings may not occur as scheduled.	In action In action
2.	3	Suicide of an inpatient	The client's risk level was not accurately assessed on admission, resulting in inappropriately low level of client observation. Levels of patient observation were not clearly defined. Team communication process following client review was not clearly defined regarding ongoing observation & management plan. Trees and bushes around perimeter fence obstruct clear view of areas. There was a lack of consistent psychiatrist overview of client's care, such that the pattern of client's mental health status over the previous months was not accurately reflected in the level of staff observation assigned to client's care.	Policy on client observation to be reviewed To ensure any changes to policy are communicated, implemented and monitored in a robust manner. To ensure learnings from this event are shared throughout the service through internal newsletter and appropriate education sessions. To review amount of trees and bushes in areas and determine if thinning/removal of shrubbery is required. To develop guideline for managing patients with complex/high/complicated needs, which require full psychiatric assessment, specifies required components of a management plan, and requires ongoing psychiatrist oversight of the patient's care.	Completed Completed Completed Completed Completed

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
			Clinical documentation needs to clearly identify who the key worker is. Client's property was logged and recorded as stored in the drawer however subsequent to incident, property could not be located. Discussions between client and clinical staff around medication took place but were not documented. Family and Health & Disability Commissioner (HDC) advised of outcome of this review.	All Mental Health teams to be notified of this required by memo. Audit of clinical record documentation to be undertaken. To review process of storage of patient property and valuables. To undertake education of staff around policy if required. Memo to all staff to remind them of the need to document in clinical records all discussions relating to client's care. Clinical Records Audit to be undertaken in 3 months' time To ensure family and Health & Disability Commissioner (HDC) advised of outcomes and learnings from this process.	Completed Completed Completed Completed Completed
3.	1	Self-inflicted death			Coroner's Report prohibits publication or release of information.
4.	4	Suicide of an outpatient	Query raised on appropriate completion of Whanau Ora Assessment forms. Notes from Multi-Disciplinary Team discussions should be detailed and form a picture of reviews and discussions. Files should contain a comprehensive personal history.	Education on Whanau Ora assessment. Completion of Multi-Disciplinary Team (MDT) plan memo sent by team leader in addition to baseline figure for completion of MDT treatment plans to be established from last 6 months documentation audits and follow up audits in 6 months to establish this has been improved.	Completed Completed

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
			Lack of detailed agreement between service providers in relation to discharge of clients from one service to another.	Discuss with Registrar group requirement for Clinical Assessment/ Admission form, detailing why any areas not completed and note in treatment planning to inform next steps for client. Develop process of engagement between service and other health provider.	Completed In action
5.	2	Death of an outpatient from medical conditions	As cause of death was medical, no internal review was necessary.	No recommendations.	No recommendations
6.	4	Apparent suicide of an outpatient	Internal review carried out. No clear precipitating factors identified.	No recommendations emerged from internal review.	No recommendations
7.	2	Accidental death of an outpatient	Internal review carried out. No clear precipitating factors identified.	Remind Responsible Clinicians to carry out family consultation as required by relevant legislation. Improve inter-agency communication to identify opportunities for improved support for the client.	Completed In action
8.	4	Suicide of an outpatient	Internal review carried out. No clear precipitating factors identified.	Random audit of 5 recently closed files to ensure discharge was successfully carried out.	In action
9.	4	Suicide of an outpatient	Internal review carried out. No clear precipitating factors identified.	No recommendations.	No recommendations
10.	4	Suicide of an outpatient	Internal review carried out. Identified the importance of flexibility on the part of the after hours triage phone line.	Feedback to be given to Funding and Planning regarding the future contracting arrangements for the emergency phone line.	Completed
11.	4	Suicide of an outpatient	Internal review carried out. No clear precipitating factors identified.	No recommendations.	No recommendations

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
12.	4	Suicide of an outpatient	Internal review carried out. No clear precipitating factors identified.	Other learning identified as part of review process: Review sharing of information in relation to partner/child abuse, in line with National Family Violence Intervention Strategy. Reminder to administration staff that all clinical files should be retrieved from off-site storage when client re-presents and clinicians can decide which are needed.	Completed In action
13.	4	Suicide of an outpatient	Internal review carried out. No clear precipitating factors identified.	No recommendations.	No recommendations
14.	4	Suicide of an outpatient	Internal review carried out. Other learning identified: Improve referral process to Community Alcohol and Drug Services (CADS).	Set guidelines for written internal referrals to CADS. CADS to write procedure to be distributed to other teams.	In action
15.	1	Death of an inpatient from medical conditions	As cause of death was medical, no internal review was necessary.	No recommendations.	No recommendations
16.	2	Death of an outpatient from medical conditions	As cause of death was medical, no internal review was necessary.	No recommendations.	No recommendations
17.	2	Accidental death of an outpatient	Internal review carried out. No clear precipitating factors identified.	No recommendations.	No recommendations
18.	7	Client physically assaulted staff	Internal review carried out. Client identified as having possible borderline intellectual functioning.	Testing to determine if there is a significant intellectual impairment and develop a behavioural management plan. Review current approaches to behavioural management of complex cases and strategies.	Completed Completed
19.	1	Death of an inpatient from medical conditions	As cause of death was medical, no internal review was necessary.	No recommendations.	No recommendations

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
20	2	Death of an outpatient	No internal review undertaken.	No recommendations.	No recommendations
21.	2	Death of an outpatient	No internal review undertaken.	No recommendations.	No recommendations
22.	1	Death of an inpatient due to medical condition	As cause of death was medical, no internal review was necessary.	No recommendations.	No recommendations
23.	2	Death of an outpatient due to medical condition	As cause of death was medical, no internal review was necessary.	No recommendations.	No recommendations
24.	1	Death of an inpatient due to medical condition	As cause of death was medical, no internal review was necessary.	No recommendations.	No recommendations
25.	7	Physical assault by an outpatient	Internal review carried out. Team did not recognise wider implications of protection orders in place. Issue of violence on family members had not been adequately addressed by the system.	Remind teams to consult with Child Protection Advisory & Support Service if there is a child involved in a family violence situation. Clinical records management policy reminder re dictated notes (ie handwritten entry in file that typed note to follow). Recommend Family Violence Coordinator training is specific to the Dual Diagnosis team which deals with mental health and addiction disorders. Need social work competencies to be highlighted.	Completed Completed NA (Subsequent to the recommendations, the Dual Diagnosis Service Delivery has been restructured and these recommendations were taken into consideration.)
26.	1	Death of an inpatient from a medical condition	As cause of death was medical, no internal review was necessary.	No recommendations.	NR

Bay of Plenty District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	4	Suicide of an outpatient	Concerns with interface between mental health services and community alcohol and drug services	The assessment and risk assessment policy be reviewed to include process for follow up assessment and risk assessments where the consumer has been intoxicated during the initial one.	Actioned
2.	4	Suicide of an outpatient	Current management plan in place.	Review identified no concerns with clinical management.	N/A
3.	13	Deliberate self harm of an outpatient	Consumer discharged from the mental health services inpatient unit earlier that day. Well resourced management plan in place which had been effective. Consumer was unhappy about discharge which should have resulted in a review of the management plan.	Continued education about borderline personality disorder and expansion of treatment options for people with personality disorders in the region.	Ongoing
4.	4	Suicide of an outpatient	Recent stressors resulted in increased support being provided to consumer.	No recommendations made.	N/A
5.	4	Suicide of an outpatient	Treatment plan adequate and appropriate. Risk assessment completed.	N/A	N/A
6.	13	Attempted suicide by an outpatient	Under care of youth services seen regularly with treatment plan in place.	No recommendations made.	N/A
7.	4	Death of an outpatient	Dependence on prescription medication, not engaging in treatment offered.	Acute admissions to a withdrawal facility should be available in the Bay of Plenty to support individuals to withdraw from drugs	In-patient and community Detox/ withdrawal services now operational
8.	4	Suicide of crisis line caller unknown to mental health service	Person phoned crisis team. Police requested to attend via 111 due to urgency. Found dead on arrival.	Actions by mental health services appropriate and urgency recognised.	N/A
9.	4	Suicide of an outpatient	Clinical documentation was inadequate	Need for all staff to comply with policies and procedures	N/A
10.	4	Suicide of an outpatient	Treatment and assessment was appropriate		N/A
11.	2	Death of an outpatient	Patient went absent without leave from an aged care facility and later found dead (natural causes). Treatment plan reflected ongoing risks including a special package of care.	No recommendations made.	N/A

Tairawhiti District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	**12**	Patient set fire to seclusion area of inpatient unit	Patient put into seclusion without being searched	Staff to have formal training on searching patients prior to seclusion	Training provided to staff at orientation and at three monthly intervals
2.	**1**	Death of an inpatient from medical condition	None carried out as patient died of medical condition.		

Lakes District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	**7**	Assault on an inpatient	Systemic improvements required: - accurate patient risk assessment - vigilance of patient observation - management of disruptive behaviour - reporting of adverse events	Review and audit risk assessment tool and audit use of this. All care plans reviewed regularly by multidisciplinary team. Education of staff re: sentinel event process. Enhancement of Continuous Quality Improvement Forum Develop guidelines to manage disruptive behaviour patterns	Regular auditing to ensure appropriate mental health patients have completed risk assessments and that they are regularly reviewed. Education completed. Implementation underway
2.	**7**	Physical assault by inpatient on staff member	Newly admitted patient to inpatient area in a distressed state Situation de-escalated and patient treated in appropriate environment	Correct action was taken during the incident Review patient risk assessment and alter treatment plan if appropriate	Review of risk assessment and adjustment completed.

Taranaki District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	1	Death of an inpatient from medical condition	The review process confirmed that although the care provided was unlikely to have impacted on the final patient outcome, three commendations for process improvement were identified.	Departmental education looking at the quality of notes in the Emergency Department. A review of the Discharge Against Medical Advice process. Explore the possible development of a guideline or pathway between Emergency Department and Mental Health Services for the acute assessment of patients where there is a concern that their apparent mental health disorder has an 'organic' cause.	Completed Ongoing Completed
2.	4	Suicide of an outpatient	The review process identified three recommendations. There were no other factors which would indicate there had been insufficient treatment provided by Taranaki DHB Mental Health Services.	Develops guidelines set for working with borderline personality clients. Progress the integration of Alcohol and Drugs Services and Mental Health Services. Community Mental Health Key Workers and Psychiatrists follow up closely any clients who miss outpatient appointments.	Completed Ongoing Completed
3.	4.	Suicide of an outpatient	The review process confirmed that no individual clinician or area of service directly contributed to or could have readily prevented this event. One recommendation for process improvement was identified.	Ensure the client's GP is kept up to date with summary reports every 1-2 months for ongoing clients. Keep a summary of contacts on the clients file if the client requests that information is not passed onto their GP.	Ongoing Ongoing

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
				Written communication with other health professionals should contain at least the client's working diagnosis and/or hypothesis and/or a problem list; a detailed treatment plan; communication evidence with other health care professionals eg GP when medications charted. Ensure a robust review before the decision to discharge is made. Ensure a single Clinician takes overall responsibility of a client's care Ensure all staff are trained in the Mental Health Act. Ensure all staff are alert to the possibility of client impaired intellectual function and tailor interventions accordingly.	Ongoing Ongoing Ongoing Ongoing Ongoing
4.	4	Suicide of an outpatient	The review process confirmed that the clinicians involved were not responsible through acts of commission or negligence. However, four recommendations for process improvement were identified	Clearly document who is present when assessments conducted, when there is more than one Clinician. Further training and knowledge about the risk of active substance abuse and completed suicide be delivered to Mental Health and Alcohol and Drug service staff. Inform administration staff about boundaries when communicating/ releasing information to the client's family/whanau. Ensure supervision for all staff is in compliance with service wide policy.	Completed Completed Completed Completed

Hawke's Bay District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	**2**	Death of an outpatient from a medical condition	Probable unintentional overdose in response to an acute on chronic medical condition.	Recovery plans and Assessment progress notes to include planning and interventions for physical health conditions. Remove duplication of notes within health records. Investigate feasibility of developing physical health clinics.	Education has been provided to ensure physical assessments documented. Electronic access to all health records now available on patient management system. 'Hassle free' physical health free clinics now available.
2.	**2**	Death of an outpatient from a medical condition	Independent Police enquiry conducted. Evidence to suggest death result of physical health event. No care issues identified.	No recommendations noted.	No further action required.
3.	**2**	Accidental death of outpatient	No care issues were identified	No recommendations noted	No further action required.
4.	**2**	Accidental death of an outpatient	No care issues were identified.	No recommendations noted	No further action required.
5.	**4**	Suicide of an outpatient	No care issues were identified. Case highlighted need for suicide risk to be raised in the community.	Mental health and addiction services clinician to provide education and advice to schools and other health agencies.	Discussion with mental health & addiction services teams to take a lead in raising suicide prevention through their networks with other health and social agencies.

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
6.	**2**	Death of an outpatient from a medical condition	Clinical documentation did not meet NZ Health Record Standard.	Clinical documentation to meet the NZ Health Record Standard NZS 8153:2002 and DHB policy.	Laminated posters reminding staff of the key requirements for documentation placed in all clinical areas. NZ Health Care standards regarding clinical documentation made available for staff.
7.	**2**	Accidental death of an outpatient	No care issues identified	No recommendations noted	No further action required
8.	**2**	Death of an outpatient from a medical condition.	No care issues identified	No recommendations noted	
9.	**4**	Suicide of an outpatient	No care issues identified.	No recommendations noted	No further action required
10.	**4**	Suicide of an outpatient .	No care issues identified.	No recommendations noted	No further action required**.**
11.	**9**	Client reported missing. Police investigation undertaken. Client listed as missing person and remains open to Police enquiries.	Police investigation undertaken. Client listed as missing person and remains open to police enquiries Increase staff awareness about the DHB's framework regarding the management of family violence.	Staff to be trained to have active response to victims of violence as per Partner Abuse Policy.	Staff are supported and encouraged to attend the organisational Family Violence training, available for all staff. Staff is aware of and adheres to DHB policy.
12.	**4**	Suicide of an outpatient	Client last seen by service 12 months earlier. No documentation to indicate that staff did consider the possibility of mental health issues and that additional resource had been made available. No documentation to evidence ongoing support offered or provided on completion of methadone programme. Crisis team log sheets were illegible	Staff to consider the possibility of mental health and addiction issues for unstable clients. Resources to be made available care of unstable clients. Staff to adhere to Recovery Co-ordination Policy. Crisis team to make comprehensive and legible notations on log sheets.	Case review outcomes completed. The upgraded Patient Management System will enable electronic capture of Crisis Team clinical notes. "Go Live" date expected May 2009.

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
			and incomprehensive.		
13.	**2**	Death of an outpatient with a medical condition	No care issues identified	No recommendations noted	No further action required
14.	**2**	Death of an outpatient from medical condition	Death referred to the Coroner. No inquest undertaken.	No care issues identified.	No further action required**.**
15.	**2**	Death of an outpatient from medical condition	No care issues were identified	No recommendations noted	No further action required
16.	**4**	Suicide of an outpatient	Care appeared to lack co-ordination and organization possibly due to intermittent and irregular contact by the client and a high number of service providers involved. Family/whanau involvement and support limited due to client's self destructive behavior. Clinical documentation did not meet NZ Health Record standard.	Staff to adhere to DHB's Recovery Co-ordination Policy and ensure families are included in the care and treatment planning and that roles and boundaries are clearly established. Clinical documentation to meet the NZ Health Record Standard NZS 8153:2002 and DHB policy.	Health record standard made available for all staff, access to electronic forms where possible to ensure legibility. National strategy for full electronic records still some time away. NZ Health Care standards re clinical documentation made available for staff
17.	**2**	Death of an outpatient of unknown cause	No care issues were identified	No recommendations noted	Final report to be obtained from Coroner.
18.	**4**	Suicide of an outpatient	No care issues were identified	No recommendations noted	No further action required.

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
19.	**6 – A,B,C**	Concern expressed by family regarding care and treatment	External review undertaken. Complexity of case acknowledged by review team, and the significant work by the service to improve care	Early engagement of Kaupapa Services Review of the current risk assessment and management strategies to ensure that these are kept up to date. Consider strategies for management of challenging or aggressive behaviors. Develop monthly documentation audits in acute inpatient unit Document multidisciplinary team meetings and forward copies to relevant community services Fully implement the primary nursing model and review its effectiveness Target training to manage complex case presentation and minimise risk i.e. personality disorders and aggressive behaviors Review nursing structure and leadership across all shifts to ensure appropriate access to skilled senior staff Review Managing Challenging Behaviors Policy Request Family Court to provide copies of the minutes of all Mental Health Act hearings. Develop clinical review processes for complex cases. Develop a forum for interagency discussions regarding the management of service users with aggressive or risky behaviors. Explore models of care used in other Mental Health and Addiction Services which provide quality communication between staff and family.	Recommendations monitored with three monthly reporting.

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
				Develop a system to document telephone or other contacts from family Address the current design of the Intensive Psychiatric Care Unit to best meet appropriate treatment options and facilities for de-escalation of potentially dangerous clinical situations.	
20.	**13**	Attempted suicide by outpatient	No care issues identified.	No recommendations noted	No further action required.
21.	**2**	Death of outpatient	No care issues identified	No recommendations noted	No further action required

Whanganui District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	1	Death of inpatient from medical causes	No review was necessary	No recommendations	N/A

MidCentral District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	1	Death of an inpatient	The patient had multiple co-morbidities. An ECG ordered on admission was not done. The assessment of the ongoing respiratory status was incomplete.	A Nurse Educator has been appointed to support staff education processes around competence in physical assessment, diagnosis, and managing acute respiratory states. A process be put in place to support junior doctors in ongoing medical physical examination. Improve handover of critical ward management information between the nurse in charge of shifts. A process to follow up on ordered medical investigations has been developed.	All of the recommendations have been implemented
2.	4	Suicide of an outpatient	No action was identified as being required.		Representatives from MidCentral Health's Mental Health team met with the family.

Wairarapa District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	2	Death of an outpatient	Reported to the coroner The external review found the care was satisfactory but made some quality improvement suggestions.	Awaiting results from Inquest No recommendations from the external review but the following suggestions that :- Consideration be given formal arrangement with local pharmacies to alert Mental health service if medication has not been picked up as expected. Mental health service reviews whether different DHB services that a patient is known to be using routinely copy each other in to receive clinic letters etc., patient consent permitting. Mental health service reviews the availability of psychological treatments for individuals with specific diagnosis and their families.	Coroner's findings no yet received. The suggestions were followed up and addressed through the Mental Health quality Group. Project groups have been established to work through these suggestions.

Hutt Valley District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	2	Death of an outpatient from a medical condition	No review required	No recommended actions	Nil required.

Capital & Coast District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommended Actions	Follow up
1.	4	Suicide of an outpatient	Care provided was appropriate	No further action recommended	
2.	4	Suicide of an outpatient	Appears to have occurred despite high level of appropriate care.	No further action recommended	
3.	2	Death of an outpatient from natural causes	No review required.		
4.	11	Client fall – sustained injury	Patient fell trying to climb out over wire barrier. Review found environmental, practice and staffing issues contributed to the event.	Table in courtyard to be removed pending environmental review Staff reminded that if courtyard cannot be supervised when clients are in the area it is to be vacated and locked All coordinators reminded of the need to adhere to the supervision process Monitor and review proposed activities programme for psychiatric intensive care Coordinators to regularly review staffing needs as acuity on the psychiatric intensive care increases	Clinical Nurse Specialist regularly checks that actions are now routine practice.
5.	12	Threats to harm another client	Special Patient. Both clients closely monitored until assessed by care team and responsible clinician.	Management Plan revised	Ongoing monitoring by clinical team
6.	2	Death of an outpatient from natural causes	No review required.		
7.	12	Threats to harm staff	Usual management processes implemented including close monitoring.	Management Plan revised	Ongoing monitoring by clinical team
8.	2	Death of an outpatient from natural causes	No review required.		
9.	7	Physical assault to staff	Usual management processes implemented including close monitoring and personal restraint.	Management Plan revised and debrief of restraint event conducted and support for staff provided.	Ongoing monitoring by clinical team

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommended Actions	Follow up
10.	2	Death of an outpatient from natural causes	No review required.		
11.	2	Death of an outpatient from natural causes	No review required.		
12.	7	Physical assault against other patients	Special Patient. Usual management processes implemented including transfer to more secure part of unit.	Management Plan revised.	Ongoing monitoring by clinical team
13.	2	Accidental death of an outpatient	No review required.		
14.	7	Physical assault against staff	Special Patient. Usual management processes implemented including transfer to more secure part of unit.	Multidisciplinary review instigated.	Ongoing monitoring by clinical team
15.	2	Death of an outpatient from natural causes	No review required.		
16.	4	Suicide of an outpatient	Care provided was appropriate.	No further action recommended	
17.	7	Physical assault by a patient on other patients	Usual management processes implemented including transfer to more secure part of unit.	Management Plan revised Leave revoked, resolution with other client initiated.	Ongoing monitoring by clinical team
18.	2	Death of an outpatient	Review identified the need for a checklist for respite clients.	Respite Checklist developed and implemented.	Audit and Evaluation
19.	9	Absent without leave of an inpatient	Client broke a window and exited through an unsecured fence from a secure unit. This occurred because standard security glass had not been fitted to the window, and work on the security fence was not complete.	Window replaced with standard safety glass, client observation processes reviewed and staff reminded of risks during renovation. Tighter security implemented during completion of renovation.	Work now complete.
20.	2	Accidental death of an outpatient	No review indicated.		
21.	2	Death of an outpatient	No review indicated.		
22.	2	Death of an outpatient of natural causes	No review required.		
23.	7	Physical assault by a special patient	This is normal escalation in aggression for this client. Usual management processes implemented including transfer to more secure part of unit.	CHANGE to : Management Plan revised	Ongoing monitoring by clinical team
24.	2	Death of an outpatient	No review. Death by natural causes.		
25.	4	Suicide of an outpatient	File review found no obvious significant deficits in care or follow-up.	No further action recommended	

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommended Actions	Follow up
26.	13	Deliberate self harm	This is normal escalation in aggression for this client. Usual management processes implemented including transfer to more secure part of unit.	Patient management plan revised	Ongoing monitoring by clinical team
27.	2	Death of an outpatient	Contact reviewed and found no recent cause for increased concern.	No recommendations from review	
28.	4	Suicide of an outpatient	Review find no obvious deficits in care or follow-up		
29.	4	Suicide of an outpatient	Review found that there had been careful review by the clinical team. The death came at a time of some stress, but was unexpected in the context of the current presentation.	Debrief conducted	
30.	4	Suicide of an outpatient	Review found no major concerns regarding discharge planning	Recommendations included communication with staff and family, handover improvements. Family Advisor positions are being appointed to the service. DHB Open Communication implementation includes increasing staff skills in talking with families in this type of situation	

Nelson Marlborough District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	4	Suicide of an outpatient	Appropriate provision of services.	Nil	Nil
2.	4	Suicide of an outpatient	Complex case with extensive history of recurrent suicide / self harm attempts. Intensive community care plan in place. Appropriate services provided.	Nil	Nil
3.	2	Death of an outpatient	Difficulty maintaining engagement with Marlborough adult mental health team. No indication of imminent risk or need for compulsory assessment prior to patient leaving the area.	Nil	Nil
4.	3	Suicide of inpatient on leave	Leave approved by experienced medical officer involved in patient's care. No indication of imminent risk to self. Uneventful prior periods of leave from the unit that past week. Historical risk factors not transferred to current risk assessment.	Review the content of the care plan and how historical risk information is transferred from existing file(s) to documentation for subsequent inpatient admission.	Completed
5.	4	Suicide of an outpatient	Appropriate and comprehensive mental health input in the community. No indication of imminent risk of suicide when seen by mental health staff three days prior to death.	Nil	Nil
6.	4	Suicide of an outpatient	Erratic attendance at scheduled appointments and compliance with prescribed medication. No indication of imminent risk of suicide at most recent contact. Alternative mental health treatment offered but declined.	Nil.	Nil
7.	4	Suicide of an outpatient	Intensive and appropriate treatment from mental health service.	Nil	Nil

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
8.	4	Suicide of an outpatient	No indication of imminent risk at time of last contact with mental health staff. Had missed follow-up appointment with psychiatrist on the inpatient unit following discharge. No system to record such appointments on the unit or to note and follow-up missed appointments. Unlikely to have affected outcome in this case as did have follow up by experienced case manager.	Recommended that a system for recording missed appointments be developed.	Systems developed.
9.	4	Suicide of an outpatient	Appropriate mental health input. Of note although unlikely to have affected the outcome the case manager had not been present at the discharge meeting on the inpatient unit and the patient was not seen as an outpatient within the recommended two week period following discharge.		Systems have been developed to involve case managers in discharge meetings as well as regular attendance at weekly meetings to discuss progress of their patients. Availability of outpatient appointments has improved with change in medical staff deployment.

West Coast District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	**1**	Death of an inpatient	Clinical care was appropriate and professional; process for determining levels of security confusing for staff	Review security processes	Review has been completed; changes made to decision making process and communicated to staff and patients

Canterbury District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations / Actions	Follow up
1.	4	Suicide of an outpatient	Risk assessment inaccurate. Psychiatric Emergency Service discontinued care and was unaware of delayed. Appointment for Alcohol and Drug service assessment.	Revise risk assessment processes with levels of risk clearly identified. Improve suicide risk assessment and management training. Triage and referral documentation to highlight assessed risk.	Processes reviewed and changes made and training ongoing. Complete
2.	2	Death of an outpatient due to medical condition	No further investigation	None	None
3.	1	Death of an inpatient due to medical condition	No further investigation	None	None
4.	2	Accidental death of an outpatient	No further investigation	None	None
5.	2	Death of an outpatient due to medical condition	No further investigation	None	None
6.	1	Death of an inpatient due to medical condition	No further investigation	None	None
7.	1	Death of inpatient due to medical condition			
8.	1	Death of a inpatient due to medical condition	No further investigation	None	None
9.	3	Suicide of an inpatient	Long standing history of mental illness and fluctuating suicidal thinking. Period between observations too long. Absence of adrenaline available in intravenous form in doses relevant to cardiac arrest on emergency trolley. Inadequate lighting in corridor area	Review frequency of nursing observations. Adrenaline is now available on Emergency trolley in the dose and form appropriate to the management of cardiac arrest. Additional lighting installed and torch on emergency trolley.	Observations policy reviewed. Complete. Environmental improvements complete.
10.	2	Accidental death of an outpatient	Inhalation of smoke & fumes from house fire. No further investigation	None	None
11.	4	Suicide of a mental health outpatient	Community follow-up delayed following discharge.	Proactive community follow-up following discharge.	Complete

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations / Actions	Follow up
			Outpatient team unaware of discharge.	Weekly verbal check of discharge patients between inpatient and outpatient teams.	Complete
12.	4	Suicide of an outpatient	Management of patient in relation to risk of suicide. Admission from courts to Specialist Mental Health Service requires review. Patient did not receive treatment from prison staff whilst in prison over weekend. No verbal handover of patient information and Psychiatric Emergency Service. Family not given opportunity to speak to clinician and provide information separately.	Improve suicide risk assessment and management training. Psychiatrist on-call roster for court liaison staff revised. Prison to ensure that prisoners receive reception health screen within 4 hours and initial health assessment within 24 hours Patient information is now documented at handovers at the Psychiatric Emergency Service. At every assessment family are given opportunity to speak to clinician and provide information separately.	Complete Complete Complete Complete Complete
13.	2	Death of an outpatient	Sudden death review indicated no further investigation	None	None
14.	4	Suicide of an outpatient	Patient discontinued l medications.	None	Complete
15.	4	Suicide of an outpatient	No further investigation	None	None
16.	2	Death of an outpatient due to natural causes			
17.	4	Suicide of an outpatient	Sudden death review indicated no further action	None	None
18.	1	Death of an inpatient due to medical condition	No further investigation	None	None
19.	4	Suicide of an outpatient	Sudden death review indicated no further action	None	None
20.	2	Death of an outpatient	Sudden death review indicated no further investigation	None	None
21.	2	Death of an outpatient	Sudden death review indicated no further investigation	None	None
22.	1	Death of an inpatient due to medical cause	Swallowing difficulties encountered though psychiatric illness be included in treatment and risk management planning	Swallowing difficulties are included in treatment and risk management planning	Complete

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
23.	2	Death of an outpatient	Discharged from the service a month prior. Ongoing life crises. Patient declined treatment. Sudden death review indicated no further investigation required.	None	None
24.	2	Death of an outpatient	No review required	None	None
25	2	Death of an outpatient due to medical condition	Sudden death review indicated no further investigation unless recommended by coroner.	None	None
26.	4	Suicide of an outpatient.	Consultation with other health professionals and family was indicated when establishing a treatment plan.	Treatment planning processes to include family involvement and consider the views of other health professionals.	Complete
27.	4	Suicide of an outpatient	Risk management acknowledged a moderate to high risk of suicide. Close follow-up until the time of suicide.	None	None
28.	2	Death of an outpatient	Condition possibly exacerbated by psychiatric treatment. Better integrated treatment plan may have provided significant health benefits.	Treatment plans to include physical illnesses and screening for metabolic syndrome. Frequency of follow-up of patients after discharge reviewed. Reviews copied to GPs include reference to physical conditions and medications not prescribed by the psychiatrist.	Complete
29.	2	Accidental death of an outpatient	No review required	None	None
30.	2	Death of an outpatient.	Engagement in treatment was limited. Sudden death review indicated no further investigation.	None	None
31.	2	Death of an outpatient	Numerous efforts made to engage in outpatient and opiate substitution treatment.	None	None
32	2	Death of an outpatient.	Sudden death review indicated no further investigation.	None	None
33.	2	Death of an outpatient due to medical condition	No further investigation required.		

South Canterbury District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	2	Death of an outpatient	A sudden death review confirmed that all clinical requirements had been met. Minor documentation issues related to strengths assessment but did not impact on the outcome.	Documentation compliance to be addressed.	Auditing shows compliance with completion of documentation**.**
2.	4	Suicide of an outpatient	Frequency of follow-up with client and family was appropriate. Some concerns regarding the quality of documentation noted but did not impact on the outcome. This included completion and communication of recovery documents.	Staff Training in recovery process and increased frequency of audit to assess compliance with completion of documentation.	Audit results indicate improvement in compliance with the completion of documentation.
3.	2	Death of a outpatient from a medical condition	No formal review required.	Nil recommendations	Nil follow-up required
4.	2	Death of an outpatient from a medical condition	Review confirmed that all clinical requirements had been met.	Nil recommendations	Nil follow-up required

Otago District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	2	Death of an outpatient from medical condition	Likely death would have occurred despite any medical intervention due to the severity of medical conditions.	No recommendations.	n/a
2	2	Death of an outpatient – cause of death uncertain	No specific learning points or corrective actions.		n/a
3.	4	Apparent suicide of an outpatient	No signs of suicidal intent.	Heighten awareness of the availability of the internal clinical review process which can assist in the management of complex cases.	Completed
4.	4	Suicide of an outpatient	Care and treatment was to a high standard. Some problems with documentation. The family suggested that they would have appreciated more education about the client's presentation and a referral to a community support organisation	Service to develop a file system similar to other Otago DHB mental health services. Service should consider the benefits of making referrals to family support organisations and consider the need to provide education to the wider family and involve the wider family.	Documentation Project Group set up in 2008 to standardize Psychiatric files. The service forwards referrals to family support organisations as appropriate.
5.	2	Accidental death of an outpatient	Care provided by mental health services thorough and supportive to client's health and social needs.	No recommendations	n/a
6.	4	Suicide of an outpatient	A good working relationship between client and case-manager. Whilst it is important to allow people the freedom to live where they choose, it is also important to acknowledge that isolated rural areas do not necessarily have the support systems that may be available in other areas. Mental Health staff were not aware of police intervention involving the client in the weeks prior to death.	When clients move to another areas support available to them in the new area should be evaluated and put in place. Ongoing networking and education with the Police.	Quality Auditor discussed this recommendation with the report writer and case manager and identified that the service does evaluate each client's need for support; however the issue is around the transferring of the relationship and the client's personal choice. Stronger relationships with the Police are evolving.

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
7.	4	Suicide of an outpatient	Clinical care appeared to be sound.	No recommendations.	n/a
8.	4	Suicide of an outpatient	Good communication with client and between clinical teams.	No recommendations.	n/a
9.	4	Suicide of an outpatient	Care provided was appropriate	No recommendations.	n/a
10.	4	Suicide of an outpatient	Care provided was appropriate	No recommendations.	n/a
11.	3	Suicide of an inpatient on leave	Plan to place client on overnight leave was appropriately cautious, well reasoned and clearly documented, with clear plans in place to follow client's progress while on leave.	No recommendations regarding clinical care.	n/a
12.	4	Suicide of an outpatient	Assessment and treatment received was appropriate.	No recommendations.	n/a
13.	4	Suicide of an outpatient	Care provided was appropriate	No recommendations.	n/a
14.	2	Death of an outpatient from natural causes	No review required	n/a	n/a
15.	12	Absent without leave inpatient – commits a serious criminal offence	Incident was neither preventable nor predictable and represented a significant increase in seriousness from previous offending.	No recommendations regarding clinical care.	n/a
16.	12	Person assessed and discharged by mental health service commits serious criminal offence.	Assessments, documentation and communication were all appropriate. The management at each stage of contact with the service appear to have been carefully considered and appropriate in the circumstances. There was an adequate clinical risk assessment carried out.	Otago DHB should at some stage liaise with the Police and the Corrections Department, to share findings from whatever reviews may be occurring within Police and Corrections Department.	Regular meetings held between Mental Health Service and Police Liaison
17.	2	Death of an outpatient from natural causes	Death deemed to be from natural causes. High level of care provided by community team.	No recommendations.	n/a

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
18.	3	Suicide of an inpatient on leave	Care provided was appropriate. Staff misunderstanding of a Section of the Mental Health Act (MHA). Lack of effective cover when some staff are on leave. Family did not feel they had adequate support over the years. Communication within the ward and with family could have been improved. Delay in ED notifying the emergency psychiatric service of client's presentation until client was medically cleared.	 Feedback and education for staff about the use of this Section of MHA Look at level of input into the ward during periods of leave Continue to work at support for families in distress. Develop better communication between nursing and medical staff. Review system for notifying staff of patient reviews and involving nurses. The rule of waiting for a patient to be medically cleared before reviewing them should be changed.	 Training on the MHA was carried out Reviewed. Ongoing. Medical review times are entered on a daily appointment sheet and this is left in the office for nursing staff to view. Weekly meetings with senior ward staff. In progress.
19.	12	Absent without leave inpatient returned to ward intoxicated and required urgent medical intervention.	Event misclassified as a sentinel event. No review required.	n/a	n/a

Southland District Health Board Summary

No.	Event code* (see codes below)	Description of Event	Review Findings	Recommendations/ Actions	Follow up
1.	3	Suicide of an inpatient on leave	No causal factors were able to be identified.	No recommendations on potentially preventable system gaps, but co-incidental reminder to staff to include the time of individual entries in documentation and to ensure their identity is clear. Regular auditing programme in place to monitor compliance.	completed
2.	4	Suicide of an outpatient	Crisis team were unable to contact patient and were unaware of recent change in mental state.	Process reviewed and improvements made to systems regarding sharing of information, assertive follow up of known patients with chronic suicide history, documentation of contacts, file summary for known patients, monitoring of clinical review. Regular auditing programme in place to monitor compliance.	completed
3.	2	Death of an outpatient	Death related to deterioration in physical health	No recommendations.	n/a
4.	2	Death of an outpatient	Sudden death review completed with three recommendations for improvement: staff reminded to document all contacts with service, to identify and document all risk issues, event when there is not change and three monthly reviews of patient to be completed.	Recommendations implemented. Regular auditing programme in place to monitor compliance. Coroner's inquiry identified that patient died of accidental butane overdose.	completed

Event Codes:

1 Death of an inpatient
2 Death of an outpatient
3 Suicide of an inpatient
4 Suicide of an outpatient
5 Homicide by an outpatient
6 Clinical management problem **- plus sub-code:**

- **A** Diagnosis (including delayed and misdiagnosis)
- **B** Treatment (including delayed and inadequate)
- **C** Monitoring/observations (not performed and/or actioned)
- **D** Procedure associated incident or complication
- **E** Investigation (delayed, not ordered or actioned)
- **F** Discharge and transfer
- **G** Other

7 Physical assault by or on patient
8 Delays in transfer
9 AWOL patient
10 Medication Error
11 Falls
12 Other
13 Deliberate self harm