

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	<p>Management of patient in relation to risk of suicide.</p> <p>Admission from courts to Specialist Mental Health Service requires review.</p> <p>Patient did not receive treatment from prison staff whilst in prison over weekend.</p> <p>No verbal handover of patient information and Psychiatric Emergency Service.</p> <p>Family not given opportunity to speak to clinician and provide information separately.</p>	<p>Improve suicide risk assessment and management training.</p> <p>Psychiatrist on-call roster for court liaison staff revised.</p> <p>Prison to ensure that prisoners receive reception health screen within 4 hours and initial health assessment within 24 hours</p> <p>Patient information is now documented at handovers at the Psychiatric Emergency Service.</p> <p>At every assessment family are given opportunity to speak to clinician and provide information separately.</p>	<p>Complete</p> <p>Complete</p> <p>Complete</p> <p>Complete</p> <p>Complete</p>
13.	2	Death of an outpatient	Sudden death review indicated no further investigation	None	None
14.	4	Suicide of an outpatient	Patient discontinued I 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	<p>Care provided was appropriate.</p> <p>Staff misunderstanding of a Section of the Mental Health Act (MHA).</p> <p>Lack of effective cover when some staff are on leave.</p> <p>Family did not feel they had adequate support over the years.</p> <p>Communication within the ward and with family could have been improved.</p> <p>Delay in ED notifying the emergency psychiatric service of client's presentation until client was medically cleared.</p>	<p>Feedback and education for staff about the use of this Section of MHA</p> <p>Look at level of input into the ward during periods of leave</p> <p>Continue to work at support for families in distress.</p> <p>Develop better communication between nursing and medical staff. Review system for notifying staff of patient reviews and involving nurses.</p> <p>The rule of waiting for a patient to be medically cleared before reviewing them should be changed.</p>	<p>Training on the MHA was carried out</p> <p>Reviewed.</p> <p>Ongoing.</p> <p>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.</p> <p>In progress.</p>
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-incident 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