
**A summary analysis of the
reportable events in the Office of
the Director of Mental Health
Annual Report 2007**

Preface

In 2007 between 85,000 and 95,000 people accessed mental health services in New Zealand. These services range from regional forensic psychiatric facilities and acute inpatient care, to accessing outpatient service and attending community mental health centres.

The number of people accessing mental health services increases annually, as does the number of people presenting to mental health services with co-existing drug and alcohol disorders.

The purpose of recording and investigating reportable events (also referred to as 'serious and sentinel events') is to understand why these events occurred and to take action to try to prevent similar events from happening in the future.

Our aim is to encourage open and frank discussion of how these events may have happened and to develop even safer services and improve the health outcomes for all people accessing mental health services.

We have great health professionals, managers and support staff and we must support them to continue to deliver safe and effective care.

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Reportable events in mental health services

This report contains the summaries of the audited action plans relating to the 183 reportable events, reported in the *Office of the Director of Mental Health Annual Report 2007*.

Reportable events in mental health services are collected from two different sources:

1. Section 132 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act) requires that any death of a 'patient' (a person being assessed and treated under the provisions of the Act) must be reported to the Director of Mental Health within 14 days.
2. In addition to this legislative requirement, the Director of Mental Health has requested notification of all reportable events involving people under the care of mental health services. The definition of reportable events is taken from section 31 of the Health and Disability Services (Safety) Act 2001 and has been extended by the Ministry of Health to include:
 - any incident or situation (eg, fire, flood, or failure of equipment or facility);
 - any police investigation into any aspect of a service or premises;
 - any death of a person receiving services, that is required to be reported to the Coroner under the Coroners Act 1988.

For mental health services the Ministry of Health has extended the definition of reportable events to include the following:

- serious incidents involving special patients; and
- incidents with potential for significant public interest.

The investigation of events

District Health Boards may initiate an inquiry into any death or reportable event. The Director of Mental Health can also initiate an investigation under section 95 of the Act, and the Minister or Director-General of Health can initiate an inquiry under section 72 of the New Zealand Public Health and Disability Act 2000.

Some events are also investigated by the Health and Disability Commissioner. Even if the Health and Disability Commissioner is not involved in an investigation there is often a good deal of communication between the Ministry and the Commissioner's office. The Director of Mental Health is also involved to ensure that recommendations arising out of inquiry processes are implemented, and to follow up on these issues with the Directors of Area Mental Health Services (DAMHS).

If an inquiry is of national significance, the recommendations are disseminated through the Office of the Director of Mental Health to District Health Boards.

The Annual Report of the Office of the Director of Mental Health

The first Office of the Director of Mental Health Annual Report was published in 2006, and it reported on the events of the 2005 calendar year. It was published to reflect the increasing importance placed on transparency, accountability and trust, and to reflect that mental health care, and compulsory care in particular, is often the subject of public interest.

The figures in the first annual report indicated to the Ministry that there was considerable variation in the reliability of reporting about reportable deaths. As a result the Office of the Director of Mental Health worked with mental health services, and distributed reporting guidelines that clarified the services' reporting obligations to enhance compliance and improve the reliability of the data collected.

The annual report for 2005 stated that there were 100 reportable deaths (65 percent male, 35 percent female) reported by mental health services during 2005. Of the 100 individuals, 23 were people who were receiving care under the Act. Included in the reported deaths were 66 suspected suicides. Of the 66 suspected suicides, 6 people were receiving care under the Act.

The second annual report was published in 2007 and reported on the events of the 2006 calendar year. The annual report for 2006 stated that there were 107 reportable deaths (68 percent male, 32 percent female) reported by mental health services. Of the 107 deaths, 29 were people who were receiving care under the Act. Included in the reported deaths were 70 suspected suicides. Of the 70 suspected suicides, 11 people were receiving care under the Act.

The third annual report was published in 2009 and reported on the events of the 2007 calendar year. The annual report for 2007 was the first annual report to include information about all reportable events. Reportable events include all serious and sentinel events, and all reportable deaths.

The annual report for 2007 stated that 183 reportable events were reported by mental health services. Of the 183 reportable events, 152 were deaths. Of the 152 deaths, 46 were people under the care of the Act.

Following the collation of data for the 2007 annual report, the Office of the Director of Mental Health has recorded an additional 29 events for the 2007 calendar year. The total number of events for the 2007 calendar year is now 216. The additional events have been included in this report along with summaries of the action plans associated with the events.

The national incident management system

Since 2006 when the Office of the Director of Mental Health began publishing an annual report, the Quality Improvement Committee has begun a nationally coordinated programme for reporting and releasing information about the reporting of serious and sentinel events in District Health Boards (DHBs).¹

One aim of the programme is to standardise reporting practices and definitions throughout the health sector. Within the next two years mental health reportable events will become part of the national incident management system. This will provide a better structure for classification and reporting, thus ensuring consistent reporting. The Office of the Director of Mental Health will continue recording information regarding reportable deaths in accordance with its statutory requirements.

Reporting on all other serious and sentinel events in mental health will be collected as part of the DHBs' nationally coordinated incident management system.

¹ For more information about the nationally coordinated programme see <http://www.qic.health.govt.nz/>

Understanding this report

It is important to understand the following points to properly interpret the data in this report.

- The annual report for the 2007 year records reportable events – a classification that is broader than previous reports and therefore cannot be readily compared.
- Reportable events include reportable deaths, and also serious and sentinel events.
- Reporting events in the annual report helps to provide transparency, accountability and trust in government and its agencies, rather than providing data for analysis.
- Variability in the numbers of events among DHBs reflects the DHBs differ in the range and complexity of services provided.
- Each DHB interprets the definition of reportable events, specifically serious and sentinel events differently.
- Events include reports from regional forensic psychiatric units, and only a few DHBs have a regional forensic unit.
- Events involving ‘special patients’² require different reporting and review processes.
- The term suicide is used advisedly given that not all deaths recorded as suicides have been confirmed as suicides by a Coroner.
- An increasing number of patients are presenting to services with increasingly complex problems. This includes an increasing number of people with a drug or alcohol problem and mental illness.
- There is nothing in the sector to suggest there has been an increase in the rate of suicide; the increase is more likely to reflect better understanding and use of the reporting process.
- The aim of investigating serious events in greater detail and sharing the results is to identify weaknesses in systems and understand what went wrong so that they can be improved.

² Special patients are people found to be unfit to stand trial, or not guilty by reason of insanity by the courts, and detained in a regional forensic unit in accordance with the Criminal Procedure (Mentally Impaired Persons) Act 2003.

Analysis of Events

For the 2007 calendar year 216 events were reported to the Director of Mental Health. Included in those events were 176 deaths. Of the 176 deaths, 85 were reported as suicides. The number of deaths by suicide of people receiving inpatient mental health services was 11. The number of deaths by suicide of people who had had contact with mental health services in the previous 12 months was 74.

Of the 91 remaining deaths, 18 were deaths of inpatients, including 16 deaths due to medical causes. The causes of the remaining three deaths are not available, either because they are still undergoing investigation, or details of the death have been embargoed by the coroner.

The remaining 73 deaths all involved outpatients. Of these, 23 deaths were from medical causes, 16 were accidental (including falls, motor vehicle accidents or fires), and 14 deaths were the result of natural causes, primarily old age.

Conclusion

Those employed in mental health services work very hard to provide care for approximately 95,000 people who need mental health care each year. The great majority of people receive mental health care without incident. However, despite good care and the best efforts by carers', things may go wrong. Although relatively rare, these events are regrettable and of great concern.

The fact that people die while in the care of mental health services does not necessarily mean the service is deficient or that someone is at fault. It has been established that mental illness is a risk factor for suicide. This risk is increased further by the increasing frequency of mental health problems going hand-in-hand with drug or alcohol addictions, and other social problems.

The process of collecting data is still being refined – recording mental health reportable events as part of the national incident management system will provide a better structure for classification and improve consistency of reporting.

Reporting serious and sentinel events is not about apportioning blame. There are other systems for measuring and assessing professional competency. Reporting and investigating these events is about finding out if something went wrong, whether it could have been prevented, and if something needs to change.

This is about improving the quality of patient services and patient safety.

Appendix one

Mental Health Reportable Events for the year 1 Jan 2007 – 31 Dec 2007

DHB	Number of reported events
Northland	6
Waitemata	24
Auckland	13
Counties Manukau	2
Waikato	26
Bay of Plenty	11
Lakes	2
Tairāwhiti	2
Taranaki	4
Wanganui	1
Hawkes Bay	21
MidCentral	2
Hutt Valley	1
Wairarapa	1
Capital and Coast	30
Nelson Marlborough	9
West Coast	1
Canterbury	33
South Canterbury	4
Otago	19
Southland	4
Total	216

Table 1: Reported events by District Health Boards, 1 January 2007 to 30 December 2007

Appendix two

Summary of event types

	Category	Number of events	% of events
1	Death of an inpatient	18	8%
2	Death of an outpatient	73	34%
3	Suicide of an inpatient	11	5%
4	Suicide of an outpatient	74	34%
5	Homicide by an outpatient	1	0.5%
6	Clinical management problems, made up of: <ul style="list-style-type: none"> • 6a – Diagnosis • 6b – Treatment • 6c – Monitoring • 6d – Procedure • 6e – Investigation • 6f – Discharge • 6g – Other 	3	1.4%
7	Physical assault by or on patient	13	6%
8	Delays in transfer	0	0%
9	AWOL patient	4	2%
10	Medication error	0	0%
11	Falls	1	0.5%
12	Other	7	3%
13	Deliberate self harm	13	6%
	Total	216	100%

Table 2: Summary of event types from 21 District Health Boards

Appendix three

Event types

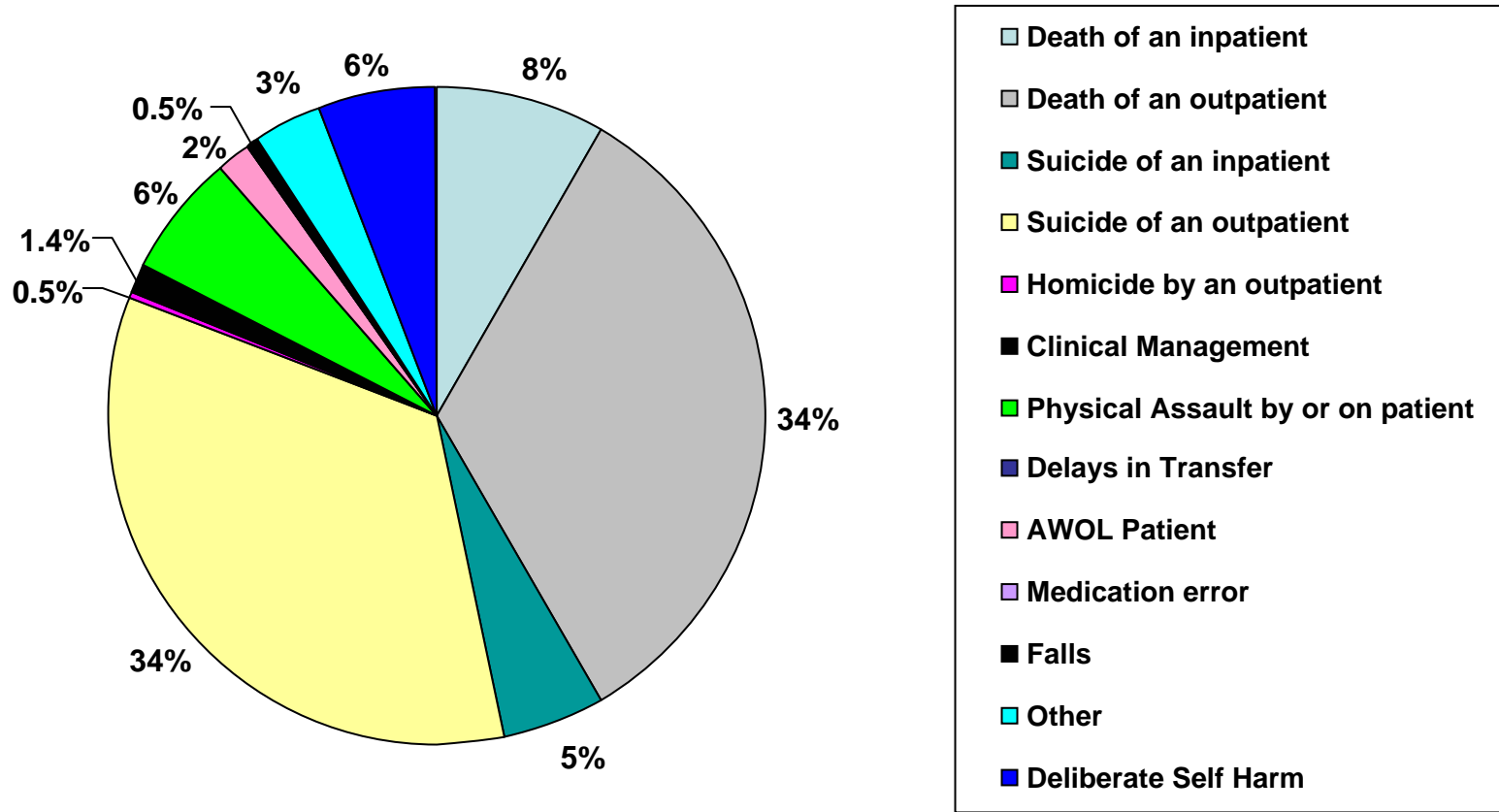


Chart 1: Events from the 21 DHBs

Appendix four

Cause of death from 21 DHBs

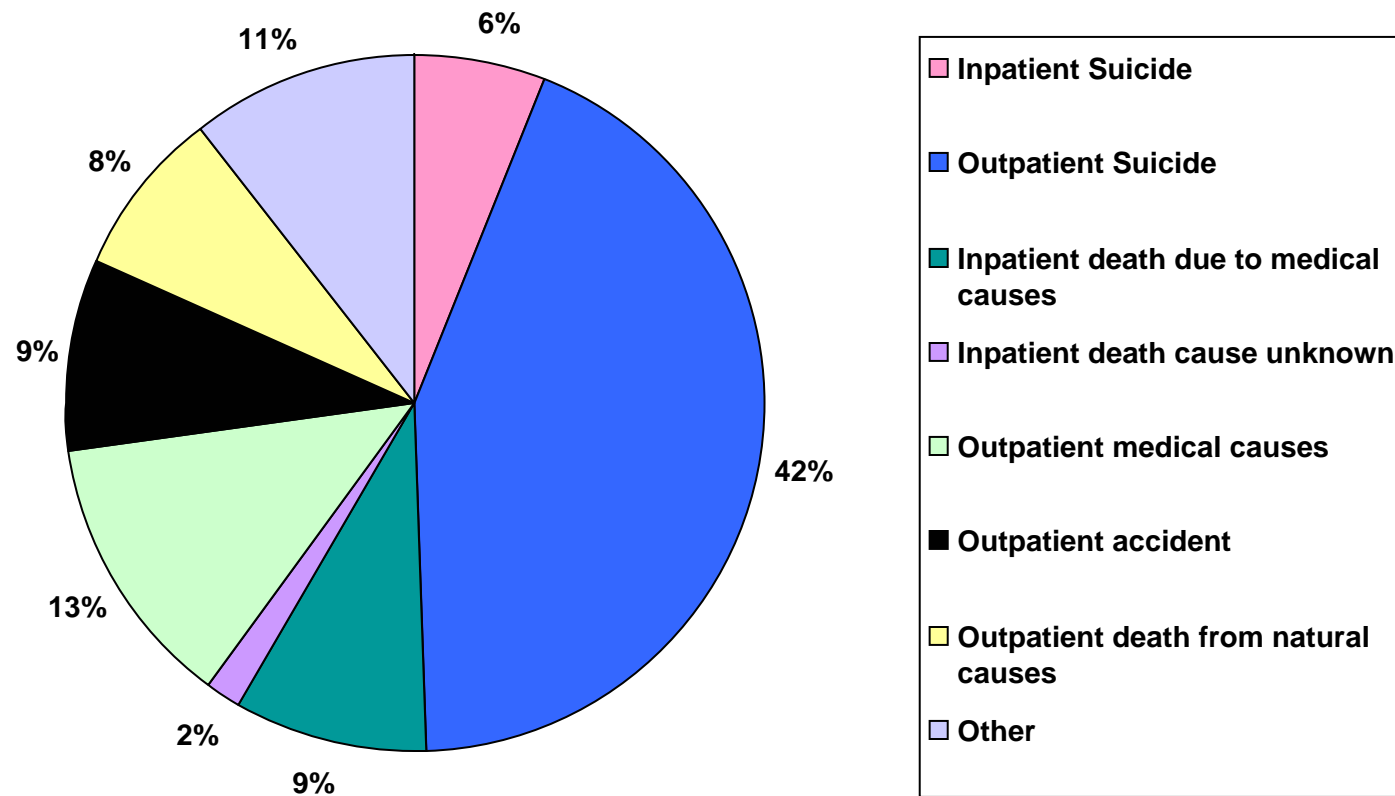


Chart 2: Nature and types of events associated with a patient death