REPORTING AND REVIEWING ADVERSE EVENTS INVOLVING USERS OF MENTAL HEALTH SERVICES

Introduction and Background

The annual District Health Board serious and sentinel event (SSE) report released from 2006/07 to 2009/10 included cases of suspected suicide by users of outpatients mental health services within seven days of contact with the service. The mental health sector advised the Commission in late 2011 that the inclusion of these cases in the SSE report was inappropriate. In addition, the sector advised the Commission that use of root cause analysis (RCA) methodology to review the cases was also inappropriate.

The Commission agreed with the sector representatives, and charged a working group with recommending alternatives to RCA and public reporting for serious incidents involving users of mental health services.

In July 2012, the Commission Board accepted the recommendations that are set out in this document as the process to follow for local review of adverse incidents involving users of mental health services.

Serious Incident Review

1. A family/whānau centred approach should be emphasised. The process applies the concepts of open disclosure, transparency and willingness for clinicians to work with consumers and families/whānau throughout the investigation.

2. The approach for review of serious incidents involving mental health service users is called Serious Incident Review (SIR). SIR is consistent with the national policy but provides discretion for agencies[1] to investigate incidents based on an initial triage process.

3. In summary, SIR consists of the following elements:

    1. **Reporting** – all SAC 1 and SAC 2 incidents must be reported to HQSC as per the national reportable events policy (and any other regulatory authorities)

    2. **Triage** by SIR Triage Team

    3. **Review recommendation** is made by SIR Triage Team

    4. **Review (or not)** as per recommendation

    5. **National Reporting** including specific recommendations about contributory factors, systems improvements that will be made (if any) and what clinical improvements will be made (if any).

4. **The SIR Triage Team** will comprise:

    - Consumer and Family input – specific advisors where DHBs employ or contract them for this purpose
    - Senior clinical staff, preferably medical, nursing and allied health practitioners
    - Quality manager/officer

[1] The term 'agencies' refers to public, private and non-government organisations who provide mental health services

- Service manager[2]

5. **Triage process:** The SIR Triage Team will assess all incidents that meet the entry criteria to decide which ones require further investigation. This decision on further investigation will be based on concern about aspects of one or more of the following factors:
    1. How recent the last contact was with secondary and/or tertiary mental health services
    2. How adequate the person's mental health care plan was, having regard to their mental health needs
    3. Risk assessment and risk management processes
    4. Distinguishing features of the case
    5. Family/whānau issues
    6. Service issues.

6. **Review process**: After consideration of these factors, the SIR Triage Team will make written recommendations that may involve one or more of the four options below:
    1. No additional review unless new information comes to light.
    2. File review with no interviews, based on a more detailed consideration and elaboration of the initial triage criteria. Reasons for not investigating more fully are to be included on the file and on the Reportable Events Brief (REB) which is sent to the Commission in line with all SAC 1 and SAC 2 incidents.
    3. File review with interviews of relevant staff/team, based on a more detailed consideration and elaboration of the initial triage criteria. Reasons for not investigating more fully are to be included on the file and on the REB which is sent to the Commission in line with all SAC 1 and SAC 2 incidents.
    4. Systematic review using the London Protocol[3] (or a comparable structured process of systematic analysis) as the framework for analysis. Contributory factors, systems improvements and clinical improvements must be included in the REB which is sent to the Commission in line with all SAC 1 and SAC 2 incidents.

7. Option 2 or 3 (above) will be carried out by a senior person from another service, selected by the SIR Triage Team. If option 4 is directed, a Serious Incident Review Team (SIR Team) will be formed. The SIR Triage Team will decide the appropriate membership of the SIR Team.

8. A typical SIR Team appointed by the SIR Triage Team should involve three members with an appropriate mix of professional roles relevant to the incident under review. At least one member must be independent to the service involved with the incident. There must be consumer and family advisory input and, if an NGO has been involved with the consumer, representation on the SIR Team from that NGO should be considered. The SIR Triage Team has the discretion to appoint the number of team members it decides is appropriate under the circumstances.

[2] At least one person must be independent of the service involved with the incident.

[3] http://www1.imperial.ac.uk/resources/C85B6574-7E28-4BE6-BE61-E94C3F6243CE/londonprotocol_e.pdf

Questions and Answers for Serious and Sentinel Mental Health Incidents
(These will be added to over time and uploaded onto the Commission Website)

How do I report and review suicides?

Inpatient suicides are those cases where a current inpatient commits suicide. Included in this group are those patients of mental health services who commit suicide while on approved leave from an inpatient unit, or who commit suicide having absconded from an inpatient unit.

These cases require reporting as a SAC 1 to the Commission, and the highest level of local service review using the London Protocol, or a comparable structured process of systemic analysis that reflects the seriousness of the event.

Outpatient suicides are those cases where an outpatient of mental health services has committed suicide with **28 days** of contact with that service. These cases are to be reported to the Commission as a SAC 2 event (although may be SAC 1 depending on specific circumstances), and require a local service review that reflects the circumstances (see below).

A service may choose to review and subsequently report to the Commission cases of outpatient suicide that occur outside the 28 day period.

What local review should I use for cases of suicide?

All inpatient suicides and other SAC 1 events involving clients of mental health services should be reviewed using the London Protocol, or a comparable structured process of systemic analysis.

Outpatient suicides are to be reviewed in a two-stage process, involving an initial local service review to determine the level of severity of the event, and the type of review required. The local service review will subsequently recommend what level of review is appropriate for the specific case. Depending on the circumstances of each event, the review may vary from no further review unless new information comes to light, a file review, a review involving staff interviews, or a systematic review involving independent expert advice.