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REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to sections 46A and 46B of the *Coroners Act 1993*

In the matter of the Territory Coroner's Findings and recommendations regarding the death of Mr Daniel Alexander Bleaney

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Pursuant to section 46A and 46B of the *Coroners Act 1993*, I provide this Report on the findings and recommendations of Local Court Judge Greg Cavanagh, the Territory Coroner, dated 13 September 2019, regarding the death of Mr Daniel Alexander Bleaney (the Deceased). A copy of the Coronial Findings is attached (Attachment A refers).

The Report includes the response to the recommendations from the Chief Executive Officer (CEO) of the Department of Health (Attachment B refers).

The Deceased, a 37 year old man, died at 2.50 pm on 19 October 2017, at the rear carpark of the Menzies School of Health Research Building (the Menzies Building) on the campus of the Royal Darwin Hospital. The cause of death was blunt force injuries to the head and chest.

The Deceased had been admitted as an involuntary patient to the Cowdy Ward at the Royal Darwin Hospital, under the *Mental Health and Related Services Act 1998*, after an earlier suicide attempt. Consequently, he was a person in care at the time of his death. The Deceased absconded from the Cowdy Ward by jumping over a courtyard wall that was a known escape point. The Deceased then committed suicide by jumping off the top of the Menzies Building.

Recommendations of the Territory Coroner

Pursuant to section 35 of the *Coroners Act 1993*, the Territory Coroner made the following recommendations in regards to the death of the Deceased:

> '93. **I recommend** that Top End Health Service ensure such alternations are made to the courtyard in Cowdy Ward so as to prevent absconding over the fence.
>
> 94. **I recommend** that induction and training of all staff include an appropriate description of the security status of Cowdy Ward and appropriate mitigation strategies to mitigate the known risks.

95. **I recommend** that Top End Health Service implement the recommendations made by the family, agreed to by the Top End Health Service and set out above at paragraph 89.'

The recommendations made by the family of the Deceased, as set out at paragraph 89 of the Coronial Findings, are as follows:

(a) that the Top End Mental Health Service (TEMHS) take all appropriate steps to ensure that Cowdy Ward is a physically secure ward, including the construction of a courtyard fence that is fit for purpose while not detracting from the therapeutic environment;

(b) that TEMHS review the way that it assesses patients, including the risk of suicide, and educates staff (both in the inpatient units and the Emergency Department (ED)) on risk assessment and on what steps to take once a risk has been assessed (including on the appropriate and timely use of the powers under the *Mental Health and Related Services Act 1998*);

(c) that TEMHS review its guidelines on the use of 'specials' or one-to-one observation for patients in Cowdy Ward and educated staff (both in the inpatient units and the ED) around the availability, need for and the requirements of one-to-one 'specials' in Cowdy Ward;

(d) that TEMHS implement a policy in relation to the conduct of 15 minute observations, including an outline of the information expected to be noted during such observations, the relationship of observations to risk assessment, and the process to hold accountable staff who fail to properly conduct observations;

(e) that the psychiatric consultant and/or the registrars responsible for patient care each day perform a ward round before leaving for outpatients, or at least attend the morning handover meeting;

(f) that TEMHS cease using the term 'take own leave' in relation to involuntary patients and replace it with the term 'abscond' or 'AWOL' or some other appropriate term;

(g) that TEMHS conduct a review and further training for all staff in relation to the taking of appropriate, responsive and timely steps in the event of a patient absconding, including rapid search protocols and notifications;

(h) that TEMHS implement a policy or protocol around meeting with the family of a deceased patient, including the necessary information that should be obtained before a meeting is offered to ensure that any meeting is useful and beneficial and minimises further distress;

(i) that the above policies, procedures and protocols are regularly reviewed, updated and kept contemporaneous and available to all staff, and are available during the orientation of staff; and

(j) TEMHS audit and monitor the progress of the key findings and the recommendations in a meaningful way to make sure that these gaps in improvements are not lost.

Response to Territory Coroner's recommendations

A copy of the Coronial Findings was provided to the CEO of the Department of Health on 10 October 2019 in accordance with section 46A(1) of the *Coroners Act 1993*.

A written response was received from the CEO of the Department of Health dated 11 December 2019, as required by section 46B(1) of the *Coroners Act 1993*, advising as follows:

- In response to the recommendation at paragraph 93 of the Coronial findings:

  An external security consultant has reviewed all the courtyards in the inpatient Mental Health Unit and recommendations are pending consideration by the Clinical Risk Committee in January 2020.

- In response to the recommendation at paragraph 94 of the Coronial findings:

  The intent of the Cowdy Ward is to provide a safe therapeutic space for the lower acuity mental health patient. Staff will have the knowledge and skills to assess a patient's risk of absconding and understand the relevance to safe care of providing a risk assessment and communicating this effectively.

  Thirty clinicians attended risk assessment training in November 2019 over a three day period which covered the following areas:

  1. Critical Components of Risk Assessment Management.
  2. Engage, Assess, Respond to, and Support Suicidal People.
  3. Youth, Engage, Assess, Respond to, and Support Suicidal People.

  The next session will be scheduled for January 2020 to provide a knowledge update.

  Orientation packages for new staff will be updated to ensure new staff are aware of their responsibility for risk assessments.

- In response to the recommendation at paragraph 95 of the Coronial findings, including the response to the recommendations made by Deceased's family at paragraph 89 of the Coroner's Findings:

  a) Refer to response to recommendation 93.

  b) Risk assessment training occurred in November 2019 with the next session to be scheduled for January 2020 to update staff knowledge.

     In addition, a culture of staff ownership for risk assessment and management is to be promoted to mitigate potential risk. Regular in-house training will be provided for staff which articulates the responsibility for risk assessment, the development of plans to mitigate risk and the purpose of visual observations.

Training is provided and completed by all Authorised Psychiatric Practitioners and Designated Mental Health Practitioners to ensure compliance with the *Mental Health and Related Services Act 1998.*

c) The current TEMHS Category of Observations Policy clearly defines responsibilities and requirements for Category S (Specials) and states: "Risk assessment gives reason to believe that there is immediate high risk of danger to self or others through act or neglect. Consumer has one-to-one, 'arm's length' contact with assigned nurse/patient care assistant at all times. The nurse/patient care assistant has no other duties". Categories' can be varied and the process for doing this is clearly defined in the policy.

d) The current TEMHS Category of Observations Policy clearly defines responsibilities and requirements for carrying out 15 minute and states that 'If there is an alteration in level of risk, frequency of observation must be increased to reflect that risk and if indicated, observation category must be changed to category 'S' (Special)'. The visual observation chart has been updated to include prompts for the management of absconding.

The current process of recording visual observations is task orientated, a process change to ensure congruence with a culture of patient centred care and will be assessed by the service leaders. The purpose and responsibility for recording visual observation will be included in risk management training updates to align with promoting a culture of staff ownership of risk management.

e) Ward rounds occur daily and outcomes/decisions are documented in the patient record.

f) As part of a wider NT Health review of the Riskman Incident Database, the Top End Health Service and TEMHS are reviewing the classification of incidents within Riskman, and the nature of Riskman reporting across all of NT Health. The Top End Health Service is unable to commit to replacing the term 'take own leave' due to the wider NT Health system implications but it can commit to ensuring there is a distinction made in the reporting of voluntary or involuntary patients who 'take own leave'.

g) The Client Absent without Notice TEMHS Policy provides a procedure for staff to follow if a consumer goes missing. To ensure staff are aware of this information, further education can be scheduled as part of the planned in-house education to promote a culture of staff ownership for risk assessment and management to mitigate potential risk.

h) TEMHS, as part of the wider Top End Health Service, in reviewing its open disclosure system, has identified the following actions:

- develop Top End Health Service Open Disclosure Guideline;
- development of reporting process and measures of Open Disclosure for Incident Severity Rating 1 and Incident Severity Rating 2 incidents; and
- with NT Health, implement open disclosure training across the Top End Health Service.

i) All policies are monitored and reviewed prior to their due date at weekly and monthly meetings which are part of the TEMHS Clinical Governance process. This process is managed by the Director of Nursing for Top End Mental Health, Alcohol and Other Drug Services.

j) The monitoring of recommendations and subsequent process changes will be audited as part of National Safety and Quality Health Service Standard 5 (Comprehensive Care) and Standard 1 (Clinical Governance).

I am satisfied that the Department of Health has considered the recommendations of the Territory Coroner and is taking the necessary steps with respect to those recommendations.

DATE: 21 JAN 2020

Natasha

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NATASHA FYLES

ATTACHMENT A

CITATION: *Inquest into the death of Daniel Alexander Bleaney* [2019] NTLC 025

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D185/2017
DELIVERED ON:	13 September 2019
DELIVERED AT:	Darwin
HEARING DATE(s):	30, 31 July 2019
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Death in care, high risk suicidal patient, involuntary admission to ward (not secure), failure to improve security after previous death, poor communication with family**
REPRESENTATION:	
Counsel Assisting:	Kelvin Currie
Counsel for Top End Mental Health Service:	Stephanie Williams
Counsel for wife: Instructed by Maurice Blackburn Lawyers	Matthew Littlejohn
Counsel for mother and sister:	Paul Maher
Judgment category classification:	A
Judgement ID number:	[2019] NTLC 025
Number of paragraphs:	95
Number of pages:	27

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D185/2017

In the matter of an Inquest into the death of

DANIEL ALEXANDER BLEANEY

ON 19 OCTOBER 2017
AT ROYAL DARWIN HOSPITAL

FINDINGS

Judge Greg Cavanagh

Introduction

1. Daniel Bleaney (the deceased) was born in the Falkland Islands on 30 January 1980. His parents were working on the Islands at the time. His father was Works Manager for the Falkland Island Company. His mother was a General Medical Practitioner.

2. His younger sister Emma was born the following year. The family were still in the Falklands when hostilities broke out between Great Britain and Argentina in April 1982. Daniel remembered being boarded up in the hospital, sleeping under beds, friends of his parents being killed and insurgents with machine guns storming the hospital.[1]

3. The family remained in the Falklands until 1984. They then moved to Australia and eventually settled in St Helens in Tasmania.

4. Daniel finished his schooling at Scotch Oakburn College in Launceston. He completed year 12 in 1997. He went on to complete a three year cadetship with ASP Ship Management. In 2001 he obtained his Officer of the Watch licence and worked on an oil tanker for two years. He then

[1] Notes of Cichello p.10

quit his employment and with a friend from his school days travelled the world for four years.[2]

5. He moved to Melbourne and there met his wife, Sarah, who was undertaking a medical degree. They married in January 2014. By that time Daniel had joined Farstad Shipping where he had been promoted in 2013 to Chief Mate.

6. In November 2016 Daniel and Sarah began planning to work and live in NSW. On 2 October 2017 Daniel left his home in Warrnambool for his last swing before they moved. He was due to return on 7 November 2017. Most of their possessions were already packed and were being moved to their new home.

7. His swing was as Chief Mate of the *Far Sword*, a 78 metre offshore supply vessel. Things seemed normal until two weeks into the swing. On 16 October 2017, the Captain and some of the crew started to notice a change in Daniel's demeanour. He had often seemed thoughtful and distracted but from 16 October 2017 he seemed more distracted than usual. He repeatedly asked the same questions. He seemed not to absorb the answers. He also seemed rather too affectionate and was hugging other crew members and saying "We need more love".

8. The Captain thought he might have family issues on his mind and at 11.30am on 18 October 2017 suggested that it might be best for Daniel to go home at the next port. That was Darwin. He told Daniel to think about it and get back to him in 20 minutes. He surmised that Daniel probably needed that time to discuss the suggestion with his wife.

9. Daniel did not however return. At midday the Captain went for lunch expecting that Daniel might also be having his lunch. But he wasn't there. The Captain went to his cabin, he wasn't there. He then looked in

[2] Notes of Cechello p.8

the gym. He wasn't there. He walked around the living quarters, the decks and then back to the bridge. He asked the officer on the bridge to look for Daniel.

10. However at 12.25pm, even before the officer returned, the Captain turned the ship around and made an announcement over the PA asking Daniel to come to the bridge. When there was no response the Captain sounded the alarm and asked everyone to muster on the bridge to start a complete search of the vessel.

11. Daniel could not be found. However at about 12.50pm he was sighted, naked, in the water. A life buoy was thrown out to him along with an orange flare and the rescue craft was sent to collect him. He was picked up at 12.52pm.

12. Family were contacted by the shipping company and Daniel was kept in the sick bay with one-on-one constant observation. Daniel was given an iPad and had a Facetime conversation with his wife. He repeated over and over: "babe, I lost my mind, I completely lost my fucking mind. I jumped from the ship, god told me to do it and I jumped from the ship." Daniel also said:

> "I felt all the pain inside of me and it was like I was feeling the whole world's pain, all at once. And then I saw things Sarah, it was like I was seeing the world's pain in front of my eyes. I saw terrible things ... it was like I was trapped into the collective consciousness and I saw it all."

13. The Captain increased the speed to cut nine hours off the trip to Darwin with the expectation they would get there at about 9.00pm that night. The shipping company's HR department contacted the Royal Darwin Hospital to let them know what had happened and that they would be bringing Daniel to the Emergency Department late in the evening. Arrangements were made for Daniels sister, Emma, who lived and worked in Darwin, to meet him at the wharf. His mother booked the

flight from Melbourne to Darwin that arrived just after midnight. His wife organised to arrive the next day with their daughter.

14. Daniel was escorted to the Royal Darwin Hospital Emergency Department by his sister and two members of the crew at 10.07pm. He was seen by the psychiatric nurse shortly after. He told her that he was wanting to end his life because the voices were telling him that he had sinned and that he needed to kill himself to keep his daughter safe.

15. He said to his sister:

> "Everyone who is mentally unwell is enlightened, that's why they have seen the light ... How do you know if they are psychotic or enlightened? ... There is so much pain in here, I can feel it ... I have taken on my father's sins, and his father's sins, and all the pain and the trauma in the world, and that's why I jumped, to end all the suffering. The trauma ends here with me."

16. At about 1.00am he became agitated and was saying that he was going to leave. His family managed to de-escalate the situation and asked that he be given something to calm him. At 1.40am he was given 10mg of the sedative diazepam. About 20 minutes later he was able to settle and said: "At last, oh the relief, the relief".

17. Daniel was seen by the psychiatric Registrar and sectioned (pursuant to sections 34, 38 and 39 of the *Mental Health and Related Services Act*[3]) at 2.30am. He was admitted to Cowdy Ward at 4.30am as an involuntary

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[3] Section 38 (3) of the *Mental Health and Related Services Act* states that the authorised psychiatric practitioner cannot both recommend a person for assessment (section 34) and make the assessment (section 38). In this case the doctor in ED or the psychiatric nurse could and should have made the recommendation. Among other things such a recommendation authorises the detention of the person at the facility for up to 24 hours.
However, the *Approved Procedures (No.6)* for involuntary admission, requires that where an authorised psychiatric practitioner makes the recommendation they must also undertake the assessment. As such the procedure is not consistent with section 38(3) of the Act.

patient on 15 minute observations. He was given 10mg of Olanzapine orally at 4.35am.

18. At 8.00am Daniel appeared to be having further hallucinations. He seemed in considerable distress. He was crying out, "*no I can't stand it, I can't do it, it's too much, it's too much ...the pressure, I just can't do it anymore.*" He was given 10mg Olanzapine and 10mg diazepam at 8.15am.

19. His family arrived at Cowdy Ward before 10.00am. At about 11.00am Daniel saw another Psychiatric Registrar. He was in the company of his mother. Daniel seemed to be more disorganised in his thoughts than previously. However he remained calm and articulate and seemingly appreciated that he needed psychiatric assistance.

20. By 2.22pm Daniel appeared tired. His family asked if he wished to sleep. He said he did and his mother, wife and sister left the ward at 2.27pm and went to a nearby coffee shop.

21. At 2.32pm Daniel returned to his room. At 2.39pm he was seen testing the handle of a locked door leading from the ward. CCTV recording captured him entering the courtyard at Cowdy Ward at 2.41pm. He was last seen on the CCTV briefly while in the courtyard at 2.45pm. He was not seen on any CCTV recording inside the ward thereafter.

22. At 2.49pm he was captured on CCTV running along Paracelsus Road (one of the Royal Darwin Hospital Campus roads). As a car approached he threw himself into the path the vehicle. However the car was going relatively slowly and the driver was able to brake and come to a stop without hitting him. Daniel got up and ran past the vehicle.

23. He climbed the rear stairs of the Menzies School of Health Research building at 2.49pm and then took the fire stairs to the roof (to a height of

8.65 metres). At 2.50pm he dived head-first off the roof and impacted the concrete below. He died instantly. He was just 37 years of age.

The aftermath

24. The 15 minute observations at 2.45pm were not undertaken. They were however conducted at 3.00pm. During that process Daniel could not be found. The nurse conducting the observations continued to look for him.

25. It was at 3.04pm that a medical practitioner exiting the Menzies building found Daniel on the pavement in the rear carpark. He found no signs of life and rang "000" and asked for an ambulance. The ambulance arrived at 3.12pm. Police arrived and set up a crime scene at 3.27pm.

26. At about 3.30pm the senior nurse at Cowdy Ward still unaware as to Daniel's whereabouts telephoned the mother of the deceased. The family were at that stage still at the café. The nurse asked if Daniel was with them. They hurried back to Cowdy Ward. His sister, Emma asked how he could have escaped. The nurse pointed to the courtyard and said, "Well, they usually get out over the fence".

27. Emma enquired whether the police had been notified and when she was told they had not, she called police at 3.59pm to report her brother missing. The senior nurse also contacted police shortly thereafter at 4.01pm.

28. During the call to police Emma was informed that they might try looking for Daniel down Lee Point Road or at the Buffalo Creek boat ramp. The family drove toward the beach in two vehicles and commenced to search. It was only shortly after they left (at 4.15pm) police advised Cowdy Ward that Daniel had been found deceased.

29. It was not until about 5.15pm that concern was expressed by some staff members that the family were still out searching. At about that same

time Emma rang Cowdy Ward seeking an update and was mistaken for a nurse. She was told that Daniel had been found deceased.

30. The family returned to Cowdy Ward in one vehicle. They met the Director of Psychiatry, Dr Rob Parker. He would not confirm that Daniel was dead or provide any details of Daniel's passing. He said that was a matter for police. He did however offer to assist in getting the other vehicle from the beach and to put the family up for two nights at a City hotel so they could be together. He organised to see them again the next day at midday along with the General Manager of Top End Mental Health.

31. At the meeting the following day Dr Parker explained that patients occasionally go over the fence and that Cowdy Ward was not a secure ward. Among other things, the family asked how high risk patients could be managed in such a ward. Dr Parker told them the ward tried to have the least oppressive environment. The family were not impressed with the meeting and less so when Dr Parker excused himself for another meeting at 12.30pm. He said he needed to make the other meeting because his staff were traumatised by the death of Daniel.

32. On leaving the meeting the family once more met the nurse that had been in charge of the ward the previous day. He told them that patients escaped over the fence "all the time". He said they normally didn't kill themselves. He said the patients usually came back by themselves or were brought back by police.

EXPERT REVIEWS AND OPINION

Professor Matthew Large

33. The Top End Mental Health Service (TEMHS) obtained a review from Professor Matthew Large at the Prince of Wales Hospital in Randwick.

34. Professor Large visited Cowdy Ward and interviewed staff. For the purpose of the review Professor Large also had available to him the coronial investigation material. He provided his report to the Top End Mental Health Service on 15 January 2018. He provided an additional report on 11 June 2019 responding to the opinions of Dr Guiffrida.

35. In his report he made the following comments:

> TEMHS provides timely and comprehensive care within a contemporary framework of mental health policy and law. The medical and nursing staff I interviewed were caring, dedicated and thoughtful. It is evident to me Daniel's death had impacted on all staff I interviewed, they were all reflecting on the events and what might be learned from it.
>
> Many of the staff told me that TEMHS is a very busy service that manages patients with severe disorders. This is borne out by the number of episodes of inpatient and outpatient care, the high proportion of involuntary patients, and the high rate of bed occupancy in the last year.
>
> The TEMH inpatient services cannot be considered to have an elevated rate of inpatient suicide. This is remarkable given that the Northern Territory has the highest rate of suicide among Australian States and Territories.
>
> Suicides in direct response to psychotic symptoms are rare, but are more common in first episode psychosis than later in the course of psychotic illness. Those involved in Daniel's care were generally apprised of this risk, and were further informed by the earlier suicide attempt made by Daniel.

36. In the opinion of Professor Large the following TEMHS procedures were "entirely within acceptable practice in Australia":

- Procedures for assessing and admitting people;
- Procedures for assessing and managing risk to inpatients;
- Procedures for preventing involuntary patients from taking their own leave.

- The procedures for responding when an involuntary patient takes their own leave.

37. He went on to say:

> "The physical environment of Cowdy Ward, particularly with regard to the safety and security is comparable to facilities in other jurisdictions ... few similar wards have higher fences than those at Cowdy Ward although there are units that have fully enclosed balconies rather than courtyard areas. Some units, but not all, have fully air locked doors."

38. Professor Large made a number of recommendations:[4]

a. "That the TEMHS carefully consider the impact of any further enhancement of the security barriers on the therapeutic milieu of Cowdy Ward;

b. That the practice of admitting mentally ill patients and prisoners with attendant security staff to JRU should be reconsidered; and

c. That the TEMHS should explore the possibility of increasing its bed base at RDH campus by building an observation and assessment ward for mentally ill people who are potentially suicidal and/or at risk of absconding".

39. Although not stating it in so many words, it seems that Dr Large thought it would have been desirable if the Top End Mental Health Service had an option for Daniel additional to either putting him in JRU with convicted prisoners or in the unsecure environment of Cowdy Ward.

Dr Michael Giuffrida

40. Dr Giuffrida provided an expert report to the lawyers for Daniel's wife on 9 October 2018. In his opinion the staff appropriately assessed Daniel and categorised him as high risk of self-harm. However in his opinion Daniel should have been admitted to the secure JRU ward or had a one-

[4] At page 48 of his review

to-one nursing special observing him for the first 24 hours at least. He provided a second report on 24 July 2019 having by that time received the information in the coronial brief and the opinions of Dr Large and Dr Ryan.

41. In his view the care fell below an acceptable standard with regard to "Daniel's containment, level of supervision, observation and monitoring".[5]

42. Dr Giuffrida also provided evidence during the course of the inquest. One of the issues I asked him about was whether clever people are more likely to be able to complete suicide despite the efforts of those who wish to prevent that outcome. In my experience as a Coroner that has been the case. The basis of the question was that the repeated reference to Daniel as a fisherman may have disguised the extent of the risk he posed to himself despite his seeming compliance.

43. Dr Giuffrida said:

> "Yes ... unfortunately the more highly educated and intelligent you are, the more likely you are to act upon psychotic symptoms." [6]

Associate Professor Christopher Ryan

44. My Office obtained an expert opinion from Dr Ryan on 23 April 2019. His opinion was generally similar to that of Professor Large. He also provided a supplementary report on 5 June 2019 responding to the opinions of Dr Guiffrida.

45. He indicated that there were three aspects involved in the treatment of acute psychosis (particularly if drug induced). They were:

- "Containment in a safe environment until it is judged that the person can be safely managed in a less restrictive manner;

[5] Page 9 of report dated 24 July 2019.
[6] Transcript p 85

- Consideration of medication aimed at the person's psychosis and distress; and
- Attention to the underlying substance use issue."[7]

46. Associate Professor Ryan was of the opinion that the first aspect was met by Daniel's involuntary admission. However, in my view containment has a practical aspect. Indeed, the primary issue seems to be that he was not contained. The difference of opinion between the experts relates in large part to whether the failure to contain should be attributed to substandard care and treatment or not.

Professor Patrick McGorry

47. Professor McGorry provided a report on 19 July 2019. In his opinion once the decision was made to admit Daniel to Cowdy Ward rather than the Joan Ridley Unit, the highest level of nursing supervision, known as "Category S" [one-to-one] should have been provided:

> "... it does appear that a conscious decision was made not to allocate to Daniel the highest level of nursing supervision otherwise known as Category S ... These doctors decided instead to allocate Daniel to 15 minutely observations, which is probably the default level of supervision for most patients around Australia. The question arises given Daniel's very serious level of suicide attempt and floridly psychotic state, whether this was the right decision. Once again with the benefit of hindsight, one can clearly say that it was not, however even at the time I would have thought that given he was not in a high security environment and he had just survived a serious suicide attempt, that Category S was clearly the most appropriate level of nursing supervision. In Dr Large's report it stated that allocation to Category S would not have posed major logistical problems, and could have been achieved, so one cannot blame staff shortages it seems for the thinking behind the decision. Hence it is difficult to understand why it was not enabled."

48. As to the argument that the ward is similar to those found elsewhere in Australia, Professor McGorry said:

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[7] Page 24 of report dated 23 April 2019

"One final aspect that needs to be considered is that many of the reports assume that the current level of design and resource allocation in inpatient units in Australia is of an optimal or even acceptable level. This is what I call "the soft bigotry of low expectations"."

49. In the opinion of Professor McGorry the death of Daniel was preventable.

50. I note that none of the experts found any significant issue with the assessment and treatment that Daniel received either while in the Emergency Department or Cowdy Ward. The issues related, as Professor McGorry stated, "*much more to the physical environment of the ward in which he was admitted and the level of nursing supervision and care that he received during his brief stay on the ward*".[8]

Previous Inquest

51. On 14 January 2015 another male, Mr Jigili, died after absconding from Cowdy Ward. Like Daniel he had been suffering command hallucinations, although the commands were not telling him to kill himself, rather, they were telling him to hit his wife.

52. He was involuntarily admitted and spent the first 24 hours in the Joan Ridley Unit (JRU), the secure ward. The next day he was transferred to Cowdy Ward just before midday. He absconded over the fence before 6.00pm. He went to the house of a relative and not long after hung himself.

53. In the findings into the death of Mr Jigili, in speaking of the balance between security and a therapeutic environment, I said:

"[The] efforts to find the right [therapeutic] balance commenced after the death of Dale Vincent in October 2004 and have continued to date. The efforts have not been insignificant. In 2004 the Ward had multiple entry and exit points and no security. The very fact that to

[8] Page 2 report dated 19 July 2019

leave Kwementyaye did so over a four metre fence provides some appreciation of how different the balance had become a decade later.

It might be thought the balance should have been even more toward security. Hindsight makes such calculations easier, but I accept that most clinicians would have believed that to do so would be at a cost to the therapeutic environment.

After the death of Kwementyaye the balance was reassessed and further changes made. Mental Health provided a solution, putting mesh on part of the fence so as to negate holding points, rather than making the fence higher or covering the outdoor court yard.

...

3. ... Those alterations were only completed in April 2016. It was reported that no one had absconded over the fence in the short period between then and the hearing.

It is clear that the Top End Mental Health Service took the circumstances of Kwementyaye's absconding and death seriously. The effort put into the self-reflection and necessary improvements is commendable. I therefore make no recommendations."

54. However the evidence is that soon after the inquest those works were demonstrated to be ineffective in stopping patients from leaving by scaling the fence. One of the senior nurses gave the following evidence:

Q. You were there, were you, when Mr Jigili went over the wall and killed himself?
A. Yes, I was there.
Q. Can you remember what happened in response to that death?
A. They put a new fence which was a bit taller than the one that was there before he jumped, yes.

Q. Did athletic people continue to go over the fence?
A. Yes, they did.
Q. Was there any response to them continuing to go over the fence?
A. Yes. They - they put a stainless steel mesh over the fence.
Q. Did athletic young people continue to go over the fence after that?
A. Yes.

Q. Was there any response to that?
A. Not that I know of.[9]

55. The institutional response provided by the Director of Psychiatry noted that after Daniel's death further alterations were made. However they were also ineffective in stopping patients scaling the fence. From January 2018 until July 2019 there were eight persons said to have left the ward in that manner.

56. The institutional response to this inquest provided the following information:

> "The TEMHS Clinical Risk Committee that is composed of senior TEMHS Management and Clinicians meets monthly. Any issues of TOL |Take own Leave or absconding| from the Cowdy Ward courtyard are reviewed by the Committee to assess the issues of absconding and whether any further improvements are required for the security of the courtyard."

57. The Committee has not seen fit to make further improvements to the fence despite those eight persons absconding over the last 18 months and there is no indication that continued absconding over the fence is seen to be a significant issue.

Cowdy Ward – not secure

58. Cowdy Ward is not a secure ward. There may be a range of factors that contribute to that status. One of those factors is the fence in the courtyard. It is able to be scaled by athletic patients.

59. If suicidal patients are to be admitted to Cowdy Ward the lack of security becomes a risk that requires mitigation. The reasons for the failure to mitigate the risk appear to have been partially to do with a misapprehension of the security status of Cowdy Ward and a misunderstanding of the likelihood of Daniel wishing to abscond.

[9] Transcript pp 91, 92

60. Many of the persons making decisions around the care of Daniel were of the view that Cowdy Ward was secure. Both the psychiatric registrar and the consultant involved in sectioning and admitting Daniel to Cowdy Ward were not aware that it was not secure.[10]

61. When giving evidence Dr Parker described Cowdy as a secure ward.[11] In 2016 he described it as a "controlled and closed ward environment but is not operated as a secure ward environment" [12] He was asked whether that remained consistent with his views now. He said:

> "I suppose that depends again on your version of secure. I would argue that for the vast majority of individuals, it is a secure environment. It's not a prison. And again it depends on the individual." [13]

62. The lack of appreciation as to the security status of Cowdy Ward was also responsible for communication to the family that Daniel would be placed in a secure ward. That led the family into believing he was safe when in reality he was not.

63. On Dr Parker's version, he was likely to be one of the individuals for whom Cowdy Ward was not secure. The representation that he was to be in a secure environment was misleading. It comforted his family and seemingly removed from them any requirement to independently assess the risks and what they might do to better protect or advocate for him.

Safety essential to a therapeutic environment

64. In the materials tendered there were many documents that made mention of the need for a "therapeutic environment". That is without doubt most

[10] Transcript page 73. Statement of Dr Weerasundera para 23
[11] Transcript page 25
[12] Transcript pages 26,27
[13] Transcript page 26

beneficial to the recovery of patients. One of the many aspects of a therapeutic environment is the "built" environment.

65. However, the very first responsibility of a mental health service is to keep patients safe. That is also a necessary ingredient of a therapeutic environment. If people are not kept safe the objects of the *Mental Health and Related Services Act* mean nothing.

66. The priority of safety as an essential ingredient of a therapeutic environment seems not to have been accepted by the Top End Mental Health Service. Indeed the Service seemed more determined to ensure each point in its service delivery would not be criticised than to address its failure to keep Daniel safe.

67. At the time of Daniel's death the Director of Psychiatry believed he had insufficient information to determine if an apology should be made.[14] Even eighteen months later, when submitting the institutional response from the Top End Mental Health Service, most paragraphs were a defence of the treatment of Daniel. There was no paragraph devoted to the failure to keep Daniel safe.

68. The only apology proffered was for the miscommunication that led to the family being told he was dead over the phone. Attached to the institutional response was a letter of apology dated 18 July 2019 (12 days before the start of the inquest), that related only to that miscommunication.

69. In my view, given the evidence of Dr Parker, it is unfortunately necessary to state the obvious, that is, a therapeutic environment is of no use to a dead patient. A safe environment comes before a therapeutic environment. In my view an environment that allows suicidal and

[14] Statement of Robert Parker dated 22 July 2019 para 75

psychotic patients the freedom to kill themselves cannot be considered either safe or therapeutic.

Lack of induction and training as to risks

70. The staff who worked for the Mental Health Service at the time that Mr Jigili died knew and understood that a patient had previously absconded over the fence and taken his own life. The staff who were not with the Service at that time were unaware of those events.

71. It is troubling that the death of Mr Jigili had such little impact. If a risk register were appropriately kept it would note the risk of absconding over the fence and taking one's life was a high risk. After all, it was not only foreseeable, it happened. That high risk required mitigation if suicidal and athletic patients were going to be admitted to the ward.

He flew under the radar

72. Daniel was bright, intelligent and charming. When staff spoke to him he presented as articulate, compliant and understanding of his need for treatment.

73. At the same time he was clearly psychotic and his risk of self-harm was considered to be at the highest level. That was because he had recently tried to end his life in a very forthright manner and he seemed to be unable to articulate his protective factors.

74. The latter may well have been because the usual protective factor of his family was also the centre of his command hallucinations. That is, he was trying to end his life to save his daughter.

75. He successfully masked the seriousness of his ongoing intent to end his life. The psychiatric registrar who saw him after he was admitted to Cowdy Ward said:

> "There's a number of reasons why I may have been misled by Daniel in the interview. The fact that he cooperated so well and that from a

personal interaction, he was a client that's unusual to Darwin; was articulate, affluent, of high education, professional. I maybe had too much positive counter transference from that interaction to acknowledge how severely unwell he was." [15]

Communication

76. Effective communication with grieving families is often difficult. Some seem to do it well, others less so. I have had occasion over the years to comment on issues that have arisen at the Royal Darwin Hospital, primarily due to poor communication. That has been an issue in the majority of the inquests into deaths at the Hospital over the last few years.

77. It is however, not difficult to understand that having needlessly lost a loved one, a family will seek assurance that the institution and staff are mortified by what has occurred, take the death seriously, strenuously reviews its processes and procedures, and makes any necessary changes to ensure that others do not die through the same failures that caused or permitted the death.

78. That is in part a vindication of the life of their loved one and in part to ensure that another family does not have to go through the agony they are experiencing.

79. After the death of Daniel the Mental Health Service left the family searching for him well after the time when he was known to have died. When the family rang in to seek an update his death was mistakenly confirmed over the phone. Mistakes happen but then when the family came back to Cowdy Ward the Director would not confirm that Daniel had died or the circumstances of his death. That is not supportive or useful to a family desperate for information. If the essential information

[15] Transcript page 99

was not known the helpful thing to do would have been to acquire the information or the person who could provide it.

80. Telling a family that staff are traumatised may not be seen as helpful information to a traumatised family. Demonstrating that staff are a priority over family by cutting short time for explanations and debriefing with family to meet with staff is likely to be seen as insensitive and insulting.

81. Refusing or omitting to apologise for obvious shortfalls ensures that the institution is seen as lacking empathy, insight and appreciation of their own role in the demise of the loved one. It is likely to sever any lingering trust in the relationship and often breeds anger and resentment.

82. The following evidence was provided:

> Q. And as you've read, one of the concerns seems to be that you couldn't bring yourself to give an apology?
> A. That was obviously a mistake, in hindsight, yes. I wasn't the only one at the meeting. Richard Campion was there as the manager.
> Q. Do you accept at this point in time that it was an appropriate time to give an apology?
> A. Yes, we should have given an apology.
> Q. What was your reticence at the time?
> A. Again, I wasn't still certain of what had happened. You know, we didn't have the – I didn't have the full information; and again, I felt it was difficult to give an apology again, lacking the full information about the situation.
> Q. Well, you at least had the information that someone who should have been safe in your care had killed themselves, didn't you?
> A. Yes.
> Q. Surely, that deserves an apology all by itself, without knowing anything more?
> A. I accept that.
> Q. So, there was some time thereafter to think about it. Did you think about it?
> A. As I said, again, I know people are not very happy with me, but things move on and unfortunately just the life,

> looking after patients, doing things, unfortunately, to be frank, I didn't think about it a lot ... So, until the inquest started to appear in the timeline, other things were happening.

Comment

83. The Top End Mental Health Service knew that the fence in the courtyard of Cowdy Ward was not sufficient to contain athletic patients. In 2015 one of their patients absconded over the fence and later took his own life.

84. The fence had modifications made just before the inquest into that death. However, athletic patients continued to abscond over the fence. The Top End Mental Health Service did not see fit to make further improvements to contain those wishing to scale the fence and abscond.

85. It happened again. Daniel, a fit man, died after absconding over the fence. He was in a psychotic state and suffering command hallucinations. He was assessed as the highest risk and yet put into Cowdy Ward without any special measures to dissuade him from scaling the fence.

86. Those doctors involved in admitting him to the Ward were of the belief that it was secure. That was mistaken belief. It should not have been held given that patients continued to leave over the fence.

87. The Top End Mental Health Service did not keep alive the story of the death of Mr Jigili, did not properly label the Ward as a non-secure ward and did not have a practice of using one-on-one observations for high risk patients on the ward. The Top End Mental Health Service did not mitigate the obvious and demonstrated risks. His death was entirely preventable.

88. After the event Top End Mental Health Service pursued a version that they were blameless and refused to engage in any real way with the

family. It is understandable that the family members were critical of the Service. Each made a statement during the course of the inquest:

Alison (mother)

> "Dan is our much loved brother and son. He was 37 years old when he died while an involuntary patient at Cowdy Ward, RDH. He was the ship's captain. He like his father had a great love of the sea. He was a gifted musician and a writer. He was highly intelligent and perfectly fit. He was charismatic and he had a huge heart and a love for life.
>
> He was a traveller, both in the spiritual realm and around the world. His life and efforts to support his family were unbounded and he was deeply loved by many. His sudden death during an acute psychotic episode ten hours after an involuntary admission immediately after a near fatal suicide attempt has left us struggling for answers, struggling to understand how the system could have let him down so badly.
>
> It remains unfathomable to us that he was kept safer at sea with his crew and his shipmates than he was as an inpatient in a psychiatric ward. That this lack of appropriate care could happen in a hospital seems incomprehensible as Dan was not kept physically safe, or properly supervised or cared for when he was still acutely and seriously unwell.
>
> Under the *Mental Health Act* Dan had a right to be kept safe and the hospital had a duty of care to do so. His death was entirely preventable, in our eyes, particularly in view of the recommendations of the previous inquest into the death of Dean Jigili who escaped from Cowdy Ward in 2015.
>
> We thank the Coroner and all those involved at this inquest for their time and professionalism in investigating the events leading up to Dan's death, and hope that the recommendations will assist in ensuring that no more patients die from the same lack of safe and proper care while an inpatient in Top End Mental Health at Royal Darwin Hospital."[16]

Emma (sister):

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[16] Transcript pp 114, 115

"As Dan's sister I just wanted to say a few words and pose some questions and make some statements. So it is evident that there is a catastrophic gap in service delivery for patients who present to RDH ED acutely unwell and high risk and who are also well mannered, polite and cooperative.

They are in no man's land, unsuitable for both the nasty JRU Ward and the therapeutic less restrictive Cowdy Ward. These patients appear to be left loose in a facility, unbeknown to both patient and family that is non secure, where the locked doors merely act as a facade for safety and security. Apparently Dan's fate was determined not by his acutely psychotic and suicidal state but by his amenable character.

His fate was sealed not by his mental state and recent fully determined suicide attempt but by being too articulate, too polite, intelligent and well mannered. As Dan's family we had a right to know that Cowdy Ward was non secure and therefore unsafe for him. We had a right to help in the decision-making process about where Dan was to be admitted and how to keep him safe. We had a right to know that there was an imminent risk of him absconding over the courtyard fence.

If we had all been made aware of this risk, we would have supervised him ourselves one to one in rotating shifts during the day. How is it possible that staff and management are not clear on whether the facility in which they work is secure or non-secure? How is this possible when you have both low and high risk patients mixed on ward; where ultra-high risk, acutely unwell patients are not being supervised in a non-secure courtyard; a courtyard that is a well-known escape route with some escapees suiciding.

It is nothing short of a tragedy that Dean Jigili's death and others before him did not motivate TEMS to secure the courtyard in which he and many others have escaped and some have died. If they did, Dan would not have died during his brief stay at RDH. By definition a therapeutic space must be both non oppressive and safe. If the physical space does not keep safe our most at risk and vulnerable patients how can it be therapeutic.

Bottom line, you cannot provide a therapeutic space or continued therapy for someone who is dead. Thank you."[17]

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[17] Transcript pp 115, 116

Sarah (wife):

> "My name is Sarah Bleaney and I was Dan's wife for three and a half years. And I'm also an obstetrician who works in a small rural hospital at the moment in New South Wales.
>
> As an obstetrician I'm no stranger to the concept of risk and specifically managing risk and what a fluid, dynamic, at times protean beast that can be. Perhaps an important difference of my job is that almost in all cases my patients have the capacity to understand that risk, as best they can, and it's my job as their doctor to engage them in a therapeutic relationship whereby I try to help them understand that risk, as best they can; and participate with me in making clinical decisions about their care.
>
> Dan, when he was at Darwin Hospital, didn't have that capacity. He was relying solely, as were we, upon the staff of the Cowdy Ward to keep Dan safe. Obstetrics is a tricky business. When it goes wrong, it goes wrong badly. And we are always dealing as you guys often are, with people who are fit and otherwise quite healthy and often have, you know, their whole lives ahead of them.
>
> It's an everyday challenge of my job that I relish as I endeavour to strike the right emotional distance, and by that I mean a balance whereby I can make objective clinical decisions about my patients based on best practice to keep them safe and minimise risk, yet also bring my emotion and integrity to the table.
>
> I care deeply about my patients and I wouldn't be any good at my job if I didn't. I'm sorry, just give me a second. I think everybody can agree in this courtroom today, you know, that Top End Mental Health Service failed in its duty to keep Dan safe. But in addition to that I'd say to you, Mr Parker, that if you really are too busy and too cold and too, dare I say it, mind blowingly numb, to fail to acknowledge the distress that you're causing to our family, and dare I say other families., I don't know however long it is since you burnt out, I don't know, but I would say – I would ask you to consider whether or not you're fit to continue the job. Particularly given your job, quite poignantly, is to take responsibility for the emotional and mental wellbeing of an entire unit of patients."[18]

89. The family set out recommendations for improvement of the service:[19]

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[18] Transcript p 116
[19] Transcript pp 119, 120

a. That TEMHS take all appropriate steps to ensure that Cowdy Ward is a physically secure ward, including the construction of a courtyard fence that is fit for purpose while not detracting from the therapeutic environment;

b. That TEMHS review the way that it assesses patients, including their risk of suicide, and educates staff (both in the inpatient units and the ED) on risk assessment and on what steps to take once a risk has been assessed (including on the appropriate and timely use of the powers under the *Mental Health and Related Services Act*);

c. That TEMHS review its guidelines around the use of 'specials' or one-to-one observation for patients in Cowdy Ward and educate staff (both in the inpatient units and the ED) around the availability, need for and the requirements of one-to-one 'specials' in Cowdy Ward;

d. That TEMHS implement a policy in relation to the conduct of 15 minute observations, including an outline of the information expected to be noted during such observations, the relationship of observations to risk assessment, and the process to hold accountable staff who fail to properly conduct observations;

e. That the psychiatric consultant and/or the registrars responsible for patient care each day perform a ward round before leaving for outpatients, or at least attend the morning handover meeting;

f. That TEMHS cease using the term 'take own leave' in relation to involuntary patients and replace it with the term 'abscond' or 'AWOL' or some other appropriate term;

g. That TEMHS conduct a review and further training for all staff in relation to the taking of appropriate, responsive and timely steps in

the event of a patient absconding, including rapid search protocols and notifications;

h. That TEMHS implement a policy or protocol around meeting with the family of a deceased patient, including the necessary information that should be obtained before a meeting is offered to ensure that any meeting is useful and beneficial and minimises further distress;

i. That the above policies, procedures and protocols are regularly reviewed, updated and kept contemporaneous and available to all staff, and are available during the orientation of staff;

j. TEMHS audit and monitor the progress of the key findings and the recommendations in a meaningful way to make sure that these gaps in improvements are not lost.

90. The Top End Health Service indicated during the inquest that the Top End Mental Health Service accepted those recommendations in full.

91. It is unfortunate that it took 18 months for the Top End Mental Health Service to accept its shortcomings and listen.

Formal Findings

92. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased is Daniel Alexander Bleaney, born on 30 January 1980 in the Falkland Islands.

(ii) The time of death was 2.50pm on 19 October 2017. The place of death the rear carpark of the Menzies School of Health Research Building on the campus of the Royal Darwin Hospital.

(iii) The cause of death was blunt force injuries to the head and chest.

(iv) The particulars required to register the death:

1. The deceased was Daniel Alexander Bleaney.

2. The deceased was of Caucasian decent.

3. The deceased was the Chief Mate of the *Far Sword* employed by Farstad Shipping.

4. The death was reported to the Coroner by Police.

5. The cause of death was confirmed by Forensic Pathologist, Dr John Rutherford.

6. The deceased's mother is Alison Ann Bleaney and his father was Michael Bernard Bleaney.

Recommendations

93. I **recommend** that Top End Health Service ensure such alterations are made to the courtyard in Cowdy Ward so as to prevent absconding over the fence.

94. I **recommend** that induction and training of all staff include an appropriate description of the security status of Cowdy Ward and appropriate mitigation strategies to mitigate the known risks.

95. I **recommend** that Top End Health Service implement the recommendations made by the family, agreed to by the Top End Health Service and set out above at paragraph 89.

Dated this 13th day of September 2019.

GREG CAVANAGH
TERRITORY CORONER

NORTHERN TERRITORY GOVERNMENT | Department of HEALTH

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The Hon Natasha Fyles MLA
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Minister for Justice
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Our ref: EDOC2019/418569
EFILE2019/46788

Dear Attorney-General

Re: Coronial Findings – Daniel Alexander Bleaney [2019] NTLC 025

Section 46B (3) of the *Coroner's Act* requires the Department of Health to provide a written response to the Coroner's recommendations to enable the Attorney-General to table a report in the Legislative Assembly of the NT.

I provide you with the following statement of action taken by NT Health in relation to the findings in this matter.

Recommendation 93: *I recommend that Top End Health Service ensure such alterations are made to the courtyard in Cowdy Ward so as to prevent absconding over the fence.*

An external security consultant has reviewed all the courtyards in the Inpatient Mental Health Unit and recommendations are pending consideration by the Clinical Risk Committee in January 2020.

Recommendation 94: *I recommend that induction and training of all staff include an appropriate description of the security status of Cowdy Ward and appropriate mitigation strategies to mitigate the known risks.*

The intent of Cowdy Ward is to provide a safe therapeutic space for the lower acuity mental health patient. Staff will have the knowledge and skills to assess patient's risk of absconding and understand the relevance to safe care of providing a risk assessment and communicating this effectively.

Thirty clinicians attended risk assessment training in November 2019 over a three day period which covered the areas:

1. Critical Components of Risk Assessment and Management
2. Engage, Asses, Respond to, and Support Suicidal People
3. Youth, Engage, Asses, Respond to, and Support Suicidal People

The next session will be scheduled for January 2020 to provide a knowledge update.

Orientation packages for new staff will be updated to ensure new staff are aware of their responsibility for risk assessments.

Recommendation 95: *I recommend that Top End Health Service implement the recommendations made by the family, agreed to by the Top End Health Service and set out above at paragraph 89.*

a) ***That TEMHS take all appropriate steps to ensure that Cowdy Ward is a physically secure ward, including the construction of a courtyard fence that is fit for purpose while not detracting from the therapeutic environment.***

Refer to recommendation 93.

b) *That TEMHS review the way that it assesses patients, including their risk of suicide, and educates staff (both in the inpatient units and the ED) on risk assessment and on what steps to take once a risk has been assessed (including on the appropriate and timely use of the powers under the Mental Health and Related Services Act).*

- Risk assessment training occurred in November 2019 with the next session to be scheduled for January 2020 to update staff knowledge.
- In addition, a culture of staff ownership for risk assessment and management is to be promoted to mitigate potential risk. Regular in-house training will be provided for staff which articulates the responsibility for risk assessment, the development of plans to mitigate risk and the purpose of visual observations.
- Training is provided and completed by all APPs and DMHPs to ensure compliance with the Act.

c) *That TEMHS review its guidelines around the use of 'specials' or one-to-one observation for patients in Cowdy Ward and educate staff (both in the inpatient units and the ED) around the availability, need for and the requirements of one-to-one 'specials' in Cowdy Ward.*

The current TEMHS Category of Observations Policy clearly defines responsibilities and requirements for Category S (Specials) and states "Risk assessment gives reason to believe that there is immediate high risk of danger to self or others through act or neglect. Consumer has one-to-one, 'arm's length' contact with assigned nurse/patient care assistant at all times. The nurse/patient care assistant has no other duties". Categories' can be varied and the process for doing this is clearly defined in the policy.

d) *That TEMHS implement a policy in relation to the conduct of 15 minute observations, including an outline of the information expected to be noted during such observations, the relationship of observations to risk assessment, and the process to hold accountable staff who fail to properly conduct observations.*

- The current "TEMHS Category of Observations Policy" clearly defines responsibilities and requirements for carrying out 15 minute observations and states that "If there is an alteration in level of risk, frequency of observation must be increased to reflect that risk, and if indicated, observation category must be changed to category 'S' (Special)". The visual observation chart has been updated to include prompts for the management of absconding.
- The current process of recording visual observations is task orientated, a process change to ensure congruence with a culture of patient centred care will be assessed by the service leaders. The purpose and responsibility for recording visual observation will included in risk management training updates as per 95(b) to align with promoting a culture of staff ownership of risk management.

e) *That the psychiatric consultant and/or the registrars responsible for patient care each day perform a ward round before leaving for outpatients, or at least attend the morning handover meeting.*

Ward rounds occur daily are outcomes/decisions are documented in the patient record.

f) *That TEMHS cease using the term 'take own leave' in relation to involuntary patients and replace it with the term 'abscond' or 'AWOL' or some other appropriate term.*

As part of a wider NT Health review of the Riskman Incident Database, TEHS and TEMHS are reviewing the classification of incidents within Riskman, and the nature of Riskman reporting across all of NT Health. TEHS is unable to commit to replacing the term "take own leave" due to the wider NT Health system implications but it can commit to ensuring there is a distinction made in the reporting of voluntary or involuntary patients who "take own leave".

g) ***That TEMHS conduct a review and further training for all staff in relation to the taking of appropriate, responsive and timely steps in the event of a patient absconding, including rapid search protocols and notifications.***

The Client Absent without Notice TEMHS Policy provides a procedure for staff to follow if a consumer goes missing. To ensure staff are aware of this information further education can be scheduled as part of the planned in-house education (95b) to promote a culture of staff ownership for risk assessment and management is required to mitigate potential risk.

h) ***That TEMHS implement a policy or protocol around meeting with the family of a deceased patient, including the necessary information that should be obtained before a meeting is offered to ensure that any meeting is useful and beneficial and minimizes further distress.***

- TEMHS as part of the wider TEHS in reviewing it's open disclosure system has identified the following actions:
  - Develop TEHS Open Disclosure Guideline
  - Development of reporting process and measures of Open Disclosure for ISR 1 and ISR 2 incidents.
- With NT Health implement open disclosure training across TEHS

i) ***That the above policies, procedures and protocols are regularly reviewed, updated and kept contemporaneous and available to all staff, and are available during the orientation of staff.***

All policies are monitored and reviewed prior to their due date at weekly and monthly meetings which are part of the TEMHS Clinical Governance process. This process is managed by the Director of Nursing for TEHMHAOD Services.

j) ***TEMHS audit and monitor the progress of the key findings and the recommendations in a meaningful way to make sure that these gaps in improvements are not lost.***

The monitoring of recommendations and subsequent process changes will be audited as part of National Safety and Quality Health Service Standard 5 (Comprehensive Care) and Standard 1 (Clinical Governance).

If further information is required, the contact officer is Andrew Modra, Director Safety and Quality Top End Health Service on telephone 8944 8040.

Yours sincerely

Professor Catherine Stoddart
11 December 2019