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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

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 Coroner's 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 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; 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



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NATASHA FYLES