Terms of Reference: for a review of MHAIDS 3DHB incidents – five events involving of alleged homicides.

Casefile review and meta analysis of the care and treatment provided to five clients by Mental Health, Addictions and Intellectual Disability Service 3DHB (MHAIDS 3DHB) who were involved in incidents of alleged homicide.

To the reviewers:

- Dr Graham Mellsop, Professor of Psychiatry, Waikato Clinical School, University of Auckland. (**to undertake five casefile reviews and meta review of the five events**);
- Dr Helen Hamer, Registered Comprehensive Nurse, Director, Helen Hamer and Associates Limited (**to undertake meta review of the five events**).

Purpose of Review:
This review is part of MHAIDS 3DHB on-going commitment to improve and protect the health and safety of patients and the public and to ensure the effective conduct of MHAIDS 3DHB's affairs by:

- ascertaining as far as practicable the factual circumstances surrounding each event providing individual analysis;
- identifying any systemic or shared issues that may have contributed to the four incidents;
- recommending any further action MHAIDS 3DHB should take as a result of these events.

This review is simply to find out and record what happened and to make recommendations as to any further action required. The purpose of the review is not to enquire into individual responsibility or to attribute blame. It is not a disciplinary inquiry. Wherever possible, the review and recommendations should be focused on systems rather than individuals. In the event that any issues concerning individuals' conduct are identified, a separate review may be carried out. A decision will be made on what, if any, further action or review is warranted after the review report has been received and considered.

Background to Review:
Nigel Fairley General Manager MHAIDS 3DHB has asked for an external review of five cases with a view to considering these cases, the recommendations from the separate reviews, into the circumstances of the care provided to:

- **undertake a casefile review, include in meta review;**
- **undertake a casefile review, include in meta review;**
- **review complete, include in meta review;**
- **undertake a casefile review, include in meta review;**
- **undertake a casefile review, include in meta review.**

Please enquire, as below, and report to Nigel Fairley.

Overview:
The review team are asked to undertake an independent review of the five cases with a view to considering these cases, the recommendations from the reviews, comments on any similarity in the clinical care or omissions, the management and recommendations. Then to provide recommendations of actions to improve the provision of our MHAIDS 3DHB services.

The reviewers will investigate and report on the factual circumstances surrounding the clinical care and treatment of The focus will be on whether there were factors shared by all or a number of the cases that may have contributed to the adverse outcomes. The reviewers will make recommendations on any further actions that MHAIDS 3DHB should take as a result of these incidents.

Terms of reference:

1. Ascertain as far as practicable the circumstances surrounding the adverse events including:
   (a) Providing a brief chronological overview of the care provided to the five clients relevant to the incidents;
   (b) Reviewing the clinical files and associated documentation (hardcopy and electronic) with regard to identifying any systemic or shared issues that may have contributed to the four incidents;
   (c) Recommend any further actions MHAIDS 3DHB should take as a result of this review.

Steering group:
The steering group who overview the review process and receive the final report comprises of:

- Nigel Fairley (General Manager MHAIDS 3DHB)
- (Operations Director MHAIDS 3DHB)
- (Medical Director MHAIDS 3DHB)
- (Executive Director Quality and Risk HVDHB and WDHB)

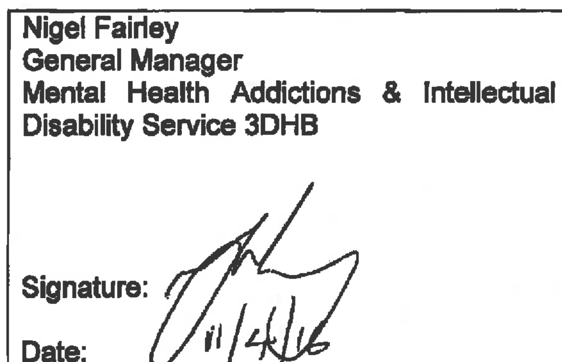
Legal advice:

- Legal advice will be provided by Claro Law.

Steering group and review team support:
The persons supporting this review is Quality Manger MHAIDS 3DHB and Personal Assistant to the Medical Director MHAIDS 3DHB.

Signed:

Nigel Fairley
General Manager
Mental Health Addictions & Intellectual Disability Service 3DHB



Signature:

Date:

Background
This review follows five incidents involving alleged homicides perpetrated by clients under the care of MHAIDS 3DHB at the time of the events.

Methodology
The inquiry into what happened will be based on the London protocol methodology[1] and be at the discretion of the review team and include:

- Undertaking clinical casefile reviews of the five clients;
- Referencing all relevant documents, including medical records (both hardcopy and electronic) and subsequent reports;

Process

- Development of a draft reports for each of the five incidents and a draft meta review report of the five incidents;
- Provide final reports to Steering Committee.

Conduct of Review
The review will be conducted in a fair and reasonable manner. Identifiers (not the names of any individuals) are used in the body of the report. The client's names and names of the reviewer are only provided on the cover of the report.

The review is to be conducted strictly in accordance with the terms of reference. Any deviation from the terms of reference must only occur with the consent of Nigel Fairley General Manager MHAIDS 3DHB.

External Release of Review Report by C&C DHB
MHAIDS 3DHB will only release the review report in accordance with legal requirements (e.g. Privacy Act, Health Information Privacy Code, Official Information Act, and Health and Disability Commissioner Act).

Usual process includes release of the terms of reference and report to (as relevant):

- The Coroner, the Health and Disability Commissioner and/or Ombudsman, District Inspector in accordance with the law;

Actions Subsequent to Review Completion
Nigel Fairley General Manager MHAIDS 3DHB will make a decision on what, if any, further action or review may be warranted after considering the final report.

Timetable
The casefile reviews and meta review are to be completed and draft reports available by 1 September 2016.

- **undertake a casefile review - 24 hours total;**
- **undertake a casefile review – 24 hours total:**
- read through review report and clinical file **(review complete) 4 hours total;**
- **undertake a casefile review – 24 hours;**
- **undertake a casefile review – 24 hours total;**
- **Meta review of the five cases – 24 hours total.**

<u>Total allocated time – 124 hours (15.5 days)</u>

In the event that the review cannot be completed by this date, the investigators will report to the Steering Group to request an extension of time.

[1] Taylor-Adams, S. Vincent, C. Systems Analysis of Critical Incidents, London Protocol. Clinical Safety Research Unit, Imperial College London.
http://www1.imperial.ac.uk/medicine/about/institutes/patientsafetyservicequality/cpssq_publications/resources_tools/the_london_protocol/