Submission No 27

INQUIRY INTO THE MANAGEMENT OF HEALTH CARE DELIVERY IN NSW

Name: Mr Michael Raftery

Date Received: 26 July 2017

Dear Public Accounts Committee representatives

On the 19th of March, 2015, my daughter, Ahlia Raftery, took her own life in the intensive care mental health ward of the Calvary Mater Newcastle hospital. She was 18 years old. The hospital was meant to be a place to protect her, but an available assessment is that things got worse for her in the hospital, and that negligence led to Ahlia's death.

An inquest was held in May of this year, and I have attached the findings. The HCCC have concluded one investigation, and I invite the Inquiry to obtain a copy of that report directly from the HCCC.

She was everything to me. I am now a broken man with a horrible life and not much to look forward to. What may assist me, is if everything that can be done, is done, to mean that her death brings about change.

Summarised, your terms of reference (ToR) go to: data collection, monitoring and reporting; performance information; and, how the current framework drives improvement.

These ToR are not ideal for my submission. I would much prefer ToR that allow me to highlight:

- what, as I see it, is going wrong in the mental health care system; and
- improvements I might suggest to the mental health care system.
- I believe Ahlia's death had various causations which include:
- a lack of adolescent mental health services (people are either a child or an adult under the current system);
- poor hospital policy and procedures;
- complacency in wards;
- nurses not performing to the requisite standards of care.

Rather than explaining the above points here, it is requested that the inquest findings and HCCC investigation report is duly considered.

The circumstances of Ahlia's death, while novel, should be no surprise. I am aware of other mental health patients either dying whilst in hospital, or after being discharged / turned away. I wish I knew how prevalent these deaths are, but I am not aware of a source to learn the statistics of these deaths. I ask the committee to investigate this matter in order that the Inquiry may inform itself of how big this problem is.

The issues I request the Inquiry to consider / address are:

- a consideration of the recommendations made by the Assistant Coroner in the findings of inquest into Ahlia's death, and what recommendations the Inquiry may make in light of the Coroner's recommendation;
- that the inquiry considers the need for and recommends to government that a separate inquiry be convened at the earliest opportunity to look into the failings of the mental health care system in NSW, and that the ToRs are tailored to allow such an inquiry to learn all it can from tragedies such as Ahlia's;
- a consideration of the lack of adolescent mental health services in NSW, what is happening in other jurisdictions, and that a recommendation is made that stand-alone adolescent mental health care services are established to bridge the services between those for children and adults;

- that if it doesn't already exist, that Inquiry recommends that a body is established in NSW to promote the introduction of best practices across all NSW mental health services, so that lessons learned in one place, are pollinated to other places and services in NSW;
- that the matter of mental health practitioners continuing to work after a fatality, despite their being under investigation, is considered and that the Inquiry recommends for the introduction of policy that would suspend mental health practitioners (nurses and doctors) who are under investigation in relation to a death which occurs in a mental health facility; and
- that the Inquiry considers how technological innovation may improve the safety of patients in mental health facilities as much as technology is so used in medical wards. Eg, the introduction of back-to-base pulse oximetry wrist bands for mental health patients on wards.

I request and will be pleased to appear before and have a dialogue with the Inquiry at a later date if possible. I am similarly keen to meet with the ministers for health and mental health at the earliest opportunity.

Regards, Michael Raftery.