Counties Manukau District Health Board
(now Te Whatu Ora Counties Manukau)

DHB2 (now Te Whatu Ora 2)

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC02053)

HDC
Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary 1
Complaint and investigation 2
Information gathered during investigation 3
Opinion: Introduction 14
Opinion: CMDHB — breach 15
Opinion: Dr C — adverse comment 20
Opinion: DHB2 22
Opinion: RN D — adverse comment 25
Changes since events 28
Recommendations 29
Follow-up actions 29
Appendix A: Independent clinical advice to Commissioner 30
Appendix B: Counties Manukau DHB Review 54
Appendix C: The Transfer of Patient Care Across DHB Boundaries Mental Health Services March 2018 55
Appendix D: The assessment and management of people at risk of suicide. Best practice evidence-based guideline. Ministry of Health 2003 (reviewed 2008) 57

Executive summary

1. This report considers the care provided to a man by Counties Manukau District Health Board (CMDHB) (now Te Whatu Ora Counties Manukau), and a second district health board (DHB2) (now Te Whatu Ora 2) in 2018.

2. In particular, the report emphasises the importance of adequate systems for the co-ordination of the transfer of a patient's care from one region to another, and of ensuring that the handover is clear, and that the receiving region has accepted responsibility for the patient's care. The report also highlights the importance of providing timely and responsive services.

Findings

3. The Deputy Commissioner had several concerns about CMDHB's patient discharge and transfer process: on the day of the discharge, there was no adequate engagement with the man's main support person; staff permitted the man to travel to the DHB2 region without a confirmed person picking him up; no adequate post-discharge aftercare plan was issued to the man and his whānau; no communication was initiated by CMDHB with receiving services at DHB2 at the time of discharge and transfer; limited information was sent to DHB2 comprising only a partially completed discharge form; and there was no follow-up by CMDHB after the man's discharge.

4. The Deputy Commissioner found CMDHB in breach of Rights 4(1) and 4(5) of the Code.

5. The Deputy Commissioner did not find DHB2 in breach of the Code, but was concerned that DHB2 missed an opportunity to establish a timely and critically important therapeutic relationship with the man once it became known to it that he was back in its catchment area.

Recommendations

6. The Deputy Commissioner recommended that Te Whatu Ora provide HDC with an update on the changes implemented in response to these events, and any further changes that occurred following their implementation; consider developing a guideline about transport and supervision when a patient is to be transferred within the Te Whatu Ora districts; consider the independent advisor's recommendation for a review of the work pressures on staff in in-patient units, including staffing issues, demand for in-patient beds, and volume of admissions and discharges; and provide a written apology to the man's family for the inadequate care provided to the man.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint via the Coroner from Mrs A about the services provided to her late husband, Mr A, by Counties Manukau District Health Board (CMDHB) (now Te Whatu Ora Counties Manukau) and DHB2 (now Te Whatu Ora 2).[1]

8. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr A by Counties Manukau District Health Board in Month1[2] 2018.*
- *The appropriateness of the care provided to Mr A by DHB2 from Month1 to Month2 2018 (inclusive).*

9. This report is the opinion of Deputy Commissioner Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner.

10. The parties directly involved in the investigation were:

Mrs A	Consumer's ex-wife/complainant
Ms B	Support worker for Mrs A/complainant
CMDHB	Provider
DHB2	Provider

11. Further information was received from:

Dr C	Consultant psychiatrist CMDHB
RN D	Registered nurse DHB2

12. Also mentioned in this report:

Ms E	Social worker
Dr F	Psychiatrist
Dr G	Psychiatrist
Dr H	Consultant psychiatrist
Ms I	Occupational therapist

13. Independent advice was obtained from a psychiatrist, Dr Jubilee Rajiah (Appendix A).

14. A review undertaken by CMDHB is included as Appendix B; the Transfer of Patient Care Across DHB Boundaries Mental Health Services Guidelines is included as Appendix C; and

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to CMDHB now refer to Te Whatu Ora Counties Manukau, and all references to DHB2 now refer to Te Whatu Ora 2.
[2] Relevant months are referred to as Months 1–2 to protect privacy.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

the Best Practice Evidence-based Guideline from the Ministry of Health 2003 (reviewed 2008) is included as Appendix D.

Information gathered during investigation

15. This report concerns the mental health services provided by CMDHB to Mr A, aged in his thirties at the time of events, and the subsequent care provided by DHB2 in 2018. He was found after having died by suspected suicide.

Background

16. Mr A had a history of paranoid schizophrenia, substance-induced psychotic disorder, and polysubstance drug abuse, and had been prescribed risperidone[3] and promethazine.[4] He had made previous attempts to end his life. At the time of his death, Mr A was subject to a Community Treatment Order[5] under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act). The Community Treatment Order had been made when he was discharged from Hospital 2.

17. Mr A had lived in the DHB2 area and had received services from DHB2's Community Mental Health. He moved to Auckland for work on 4 Month1, and his care was transferred to CMDHB's Community Mental Health Centre (CMHC).

CMDHB

18. On 13 Month1, Mr A's ex-wife telephoned CMHC and reported that two days previously Mr A had harmed himself. During this telephone call, Mrs A said that Mr A "down plays" his symptoms to mental health services, and that he required admission to hospital. The registered nurse to whom Mrs A spoke[6] advised Mrs A to contact an ambulance for Mr A.

19. On 14 Month1, Mr A was admitted to the Emergency Department at Middlemore Hospital and assessed by the on-duty psychiatry registrar. Mr A told the registrar: "[Two days ago] it was my time to go or my number was up." Mr A said that he had harmed himself. He told the registrar that he had not slept or eaten in days, was feeling low in his mood, and had feelings of paranoia. The registrar considered that Mr A's thought form was disorganised, and his insight and judgement were poor, and assessed Mr A as a moderate to high risk for suicide. The registrar documented: "[R]elapse of psychosis in context of non compliance."

[3] A medication to treat schizophrenia and bipolar disorder.

[4] An antihistamine used to treat allergies, insomnia, and nausea.

[5] A community compulsory treatment order under section 29 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

[6] CMHC's clinical notes state that a registered nurse spoke with Mrs A.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Mr A was admitted to the closed ward[7] in the residential unit,[8] and he was commenced on an antipsychotic medication.[9]

Admission to residential unit

Initial assessment

20. At 10.53am on 14 Month1, Mr A was reviewed by a consultant psychiatrist, Dr C (accompanied by other staff[10]). It was documented that Mr A had a history of drug-induced psychosis and previous suicide attempts, and had presented following a suicide attempt on 11 Month1. Mr A reported that over the previous few months he had felt low, and that four years ago he had attempted suicide following an affair. Mr A said that he wanted to be discharged from hospital to see his child, but was agreeable to the admission to hospital for treatment. The risk assessment revealed no current suicidal thoughts, but noted a risk of self-neglect due to "poor oral intake", a history of alcohol and drug abuse, and a suicide attempt. Under the section, "mental status examination", Dr C documented, "low mood, severely depressed" and "limited insight and poor judgement", as Mr A was unsure about the reasons for his admission to hospital. Dr C recorded that Mr A's diagnosis on this occasion was likely alcohol-induced mood disorder. The treatment plan was to commence the Alcohol Withdrawal Syndrome (AWS) Protocol,[11] to prescribe diazepam (to alleviate alcohol withdrawal symptoms), and for 15-minute observations on the closed ward. This was implemented.

21. Dr C told HDC that Mr A's previous suicide attempts had occurred while he was using or withdrawing from drugs and/or alcohol. She said that Mr A was displaying signs of significant alcohol withdrawal, and that without treatment there was a risk of seizures or death. Dr C said that her plan for Mr A was in accordance with the Ministry of Health guideline for the assessment and treatment of suicidal persons (Appendix D).

22. On the same day, a house officer reviewed Mr A and assessed that he was medically stable, but also noted that he was not registered with a GP, and that this needed to be raised at a "family meeting (if one occurs) & included in discharge planning if he really is not enrolled anywhere".

23. On 15 Month1, Mr A's AWS score was 3[12] (mild alcohol withdrawal) and he was administered 10mg of diazepam. The nursing notes record that Mrs A telephoned the ward and asked whether Mr A could be transferred to a hospital in the DHB2 region so that she could provide him with support. The nurse told Mrs A to discuss a transfer to Hospital 2 with

---

[7] A person who is under a community treatment order under section 29 of the Mental Health Act can be treated as an inpatient under section 29(3)(a).

[8] The residential unit provides 24-hour mental health services for patients with serious or complicated mental health concerns.

[9] Risperidone.

[10] Two medical students and a nurse were present.

[11] The Alcohol Withdrawal Syndrome Protocol provides for the management of alcohol withdrawal and recommendations for monitoring of patient progress in the acute inpatient setting.

[12] The alcohol withdrawal scale (AWS) is a 7-item rating scale. Each item is scored from 0–4 according to severity. An AWS score of 1–4 indicates mild alcohol withdrawal, 5–9 moderate withdrawal, and above 10 severe alcohol withdrawal.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Mr A, and that if he agreed, the clinical team would then discuss this on Monday. Later that day, a nurse recorded: "Informed [Mrs A] that writer has discussed with [Mr A] about his TOC[13] to [DHB2] and he stated that he will think about this." The nurse also recorded that Mrs A was unable to attend a family meeting because of work commitments.

24. On 16 Month1, a nurse recorded that Mr A reported feeling better and denied thoughts of self-harm and harm to others, and did not understand why he was in hospital. His AWS score was 1 and he was given 10mg of diazepam. The nursing notes indicate that Mrs A telephoned the ward and again requested that Mr A's care be transferred to DHB2. The nurse told Mrs A that her request would be discussed at the team meeting the following day. The nurse recorded: "[P]lease call [Mrs A] to discuss [Mr A's] progress and transfer of care to [Hospital 2]."

Consultant review 17 Month1

25. Dr C reviewed Mr A again on 17 Month1. Mr A reported not thinking clearly but doing better, and that his sleep had improved with medication. Dr C noted that Mr A denied suicidal ideation and homicidal ideation and that his insight and judgement was improving.

26. Dr C told HDC that although Mr A had said that he was not feeling suicidal, he tended to down play his suicide history. Dr C said that as Mr A was thinking more clearly, she had a long discussion with him about the effects of alcohol on mental health, the connection between excessive alcohol use and suicidal ideation, and the need for professional treatment of his alcohol use.

27. The plan was to continue with Mr A's current medications as he appeared to be improving, and to transfer him to an open ward as a step towards eventual discharge.

28. On 18 Month1, a social worker, Ms E, telephoned Mrs A and told her that a transfer to DHB2 could not be facilitated because Mr A resided in South Auckland. Ms E told Mrs A that she could contact DHB2 and request a transfer for Mr A, and let CMDHB know the outcome of the request.

29. Mrs A told Ms E that Mr A could stay with her once discharged, but she expressed concerns that he had attempted suicide on two occasions and that his job was a contributing factor, and he might return to work before he was ready. Ms E documented that initially Mr A was unsure about whether to move, but later he accepted Mrs A's offer.

30. On 19 Month1, Mr A's care was discussed at the multidisciplinary team (MDT) meeting. It was documented that the plan was for discharge in the near future and a transfer of care to DHB2 if Mr A moved.

20 Month1

Ms B

31. Ms B (a family support worker for Mrs A) told HDC that on 20 Month1, she telephoned the open ward to convey her concerns that Mr A was unwell, and that his suicide attempts were

[13] Transfer of care.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

serious. Mrs A asked that Mr A remain under a Community Treatment Order. Ms B said that she was told that a psychiatrist would call Mrs A. However, there is no record in Mr A's clinical notes of this discussion with Ms B.

32. Dr C reviewed Mr A at 11.20am on 20 Month1 (day six since his admission). She noted that Mr A was "feeling much better and anxious to be getting on with his life", and that although he was unsure about where to live, he wanted to go to the DHB2 region. Dr C documented that Mr A denied suicidal ideation, homicidal ideation, paranoia, grandeur, auditory hallucinations or visual hallucinations. She noted that Mr A's mood and affect were appropriate, he was alert and orientated, his thought process was oriented, and his grooming and hygiene were also appropriate. Dr C documented her plan to discharge Mr A to Mrs A's address and transfer his care to DHB2.

33. Dr C told HDC that she told Mr A that he was not at risk at that time, and that continued abstinence from alcohol was crucial to maintain his mood and safety. Dr C said that she told Mr A that there was a connection between his suicidal ideation/psychosis and his use of alcohol, and of the "absolute necessity" of his seeking treatment for his substance use disorder. Dr C said that Mr A was dismissive about seeking treatment, but said that he would give this further thought.

Discharge process and transfer of care

34. The national agreement for the Transfer of Patient Care Across DHB Boundaries Mental Health Services,[14] which applied to all DHBs at the time, provided the agreed principles and procedures for DHBs to adhere to when transferring service users between DHBs for mental health care (see Appendix C). The agreement states the following:

> "It is the responsibility of any previous DHB from which the service user has relocated to provide whatever expertise or record as would be required to promptly and fully allow the receiving service to assume both clinical and legal responsibility."

35. CMDHB told HDC that at 12.11pm on 20 Month1, its staff sent an email to RN D, Mr A's key worker at DHB2, informing her that Mr A was being discharged to Mrs A's address, and that a transfer of care to DHB2 was being completed. CMDHB clinical notes do not contain a response or an acknowledgement from RN D.

36. Mr A's clinical records document that at 12.14pm, Dr C confirmed that Mr A was going to be discharged and requested CMDHB staff to contact Mrs A. Ms E telephoned Mrs A twice, but there was no response, and a message was left informing Mrs A of Mr A's discharge, and asking her to return the call. Mrs A told HDC that she received a voicemail message from CMDHB, but it did not contain any information about when Mr A would be leaving Auckland or when he was due to arrive in the DHB2 region. CMDHB told HDC that Mr A also telephoned Mrs A, but there was no answer.

[14] March 2018.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

37. At 1.15pm, Ms E documented that she assisted Mr A to book a bus ticket, via a telephone booking, to travel at 4pm that day, and that she advised him to inform Mrs A and he agreed.

38. At 1.34pm, a nurse documented that the following documents were completed: the Mental Health Smart In-Patient Discharge, the discharge checklist, and the discharge summary for Mr A. The records state that the plan was for no further follow-up care from CMHC.

39. Dr C signed a section 127 transfer of care form under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA), to formally transfer Mr A's care to another responsible clinician[15] at DHB2 Mental Health and Addictions under the MHA. Dr C filled and signed the section "Referring Team to Complete", as the responsible clinician referring Mr A's care. The section "Team being asked to accept transfer to care" records "[DHB2] Mental Health and Addictions". The form also provided space for the name and signature of the responsible clinician accepting the care of the patient under the Mental Health Act, but this section of the form was left blank. The form did not contain any further details about when the transfer of care was to happen, or specify Mr A's travel arrangements. In addition, Mr A's records, completed by Dr C, did not contain any notes suggesting that a telephone call or any other type of communication was attempted with a responsible clinician at DHB2 at the time of discharge and transfer.

40. Dr C completed a discharge summary that advised Mr A to abstain from alcohol and other substances, and engage in substance abuse treatment. CMDHB acknowledged that the discharge summary did not include any emergency contact numbers.

41. Dr C told HDC that in terms of the discharge process, she was involved in the signing of the section 127 transfer of care form, but it was the auxiliary staff[16] at CMDHB who coordinated the sharing of pertinent clinical information such as the discharge summary with DHB2. Dr C stated:

> "My understanding was that information would be sent to [DHB2] and I am aware there was a verbal confirmation between staff [from CMDHB and DHB2]. As [Mr A] had only been in the care of CMDHB for 14 days, he would be known to [DHB2] and that any information, outside of the discharge summary, was therefore not necessary."

42. At 1.46pm, a CMDHB nurse documented that Mr A was agreeable to discharge. Under the section "follow-up care plan", it stated: "[Associate Clinical Nurse Manager] emailed [Mr A's] key worker in [the DHB2 region], scribe was advised that they are aware of him returning to their catchment area."

43. At 2.35pm, Mr A was discharged from hospital and a staff member assisted him with transport to the bus depot. DHB2 told HDC:

---

[15] In section 2 of the Mental Health Act, a "responsible clinician" is defined as the clinician in charge of the treatment.

[16] Registered nurses, social workers, and mental health and addictions personnel.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

"[DHB2] received mental health paperwork through the [Director Area Mental Health Services (DAMHS)] Office but this was not accompanied by any clinical reports or discharge summaries. [DHB2] did not receive a notice advising that [Mr A] had been discharged from Counties Manukau DHB mental health services."

44. CMDHB told HDC that it reviewed its systems and spoke with the staff members involved, and it believes that Mr A's clinical information, which was required to transfer Mr A's care to DHB2 successfully, was faxed to DHB2 on 20 Month1. CMDHB said that it believes that a nurse faxed the "clinical information for [Mr A]" to DHB2, because it was noted in Mr A's clinical record. However, CMDHB said that it was not able to retrieve the fax records to confirm the specific information that was faxed to DHB2.

45. HDC has not been provided with a copy of any outbound correspondence from DHB2 to CMDHB on 20 Month1. As discussed further below, DHB2 contests any suggestion that it was aware of Mr A's return on 20 Month1.

Further comment: CMDHB

46. CMDHB apologised to Mrs A for the distress that this situation caused her.

47. CMDHB told HDC that all new Mental Health Services clinical staff attend training on "Safety Planning and Management of Risk". In addition, its induction and orientation process includes training related to care planning, discharge planning, and transfers.

48. In respect of Dr C's diagnosis of Mr A, CMDHB stated:

"It is well recognised that during an acute presentation, the symptoms of drug-induced delirium or withdrawal are often indistinguishable from those of functional psychiatric disorders."

49. CMDHB told HDC that Mr A's presentation was an example of diagnostic dilemmas, and in light of his complex personal history it was "entirely appropriate for [Dr C] to query the extent to which [Mr A] had a functional mental disorder, versus substance-induced change in mental state".

Dr C

50. Dr C told HDC that staff obtained collateral information from Mrs A, and that Mrs A's concerns about Mr A's mental health were addressed by staff and documented.

51. Dr C said that she emphasised to Mr A that he would relapse and possibly experience another suicidal episode if he did not seek treatment. She considered that if Mr A remained abstinent from alcohol or drugs his risk was low, but without substance use treatment, his long-term risk was high. Dr C stated that Mr A appeared to have little intention to engage with treatment, and that because he was not an acute risk, he could not remain in the hospital to continue his sobriety.

52. In response to the provisional opinion, Dr C acknowledged the importance of communication of up-to-date information between the districts. She said that her

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

expectation was that sending the discharge summary alone, without any further information, would convey the relevant information regarding Mr A's care at CMDHB.

Transfer of care to DHB2

53. Ms B told HDC that Mr A arrived by bus on 20 Month1, and was picked up by Mrs A and taken to her apartment.

54. DHB2 told HDC: "[I]n this case there was a lack of clarity about precisely when [Mr A] came under our care." DHB2 said that a DAMHS transfer was received from CMDHB, but this was not accompanied by any clinical reports or discharge summaries, and it did not receive any clinical handover from CMDHB. DHB2 stated that as a result, it was unaware that Mr A had returned to the DHB2 region. DHB2 told HDC that this was not consistent with the Transfer of Patient Care Guidelines (see Appendix C). DHB2 said that prior to transfer, a responsible clinician to responsible clinician discussion would ordinarily take place as required by these guidelines, but this did not occur.

Contact with Mr A

55. Ms B stated that on 25 Month1, she contacted RN D, the key worker for Mr A, to request an appointment for Mr A with a psychologist,[17] but was told that there was an eight-month wait for an appointment. Ms B documented that Mr A had an appointment with a psychiatrist on 17 Month2, and that RN D said that she would try to arrange an earlier appointment for Mr A.

56. There is no record of this discussion between RN D and Ms B. RN D told HDC that she was on leave when Mr A initially returned. She stated:

> "I recall the conversation with [Ms B] and a number of attempts made upon my return from leave to get [Mr A] up the psychology list. I was informed that there was an 8 month waiting list which was relayed to [Ms B]."

57. On 28 Month1, Mr A was prescribed zopiclone by a psychiatrist, Dr F.[18] DHB2 said that at that time, Mr A's usual psychiatrist, Dr G, was on unexpected leave, and in his absence it was not unusual for another psychiatrist to write an emergency prescription.

58. On 8 Month2, Ms B documented in her notes that she contacted RN D and reported that Mr A was at risk of suicide, and that he needed to see a psychiatrist. An appointment with a psychiatrist was made for 12 Month2. HDC has not been provided with a record documenting these discussions.

---

[17] In relation to childhood trauma.

[18] It is not clear from the notes provided by DHB2 whether Mr A was seen face to face prior to the provision of this prescription.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

59. On 10 Month2, RN D documented retrospectively[19] that she telephoned Mr A to advise that his usual psychiatrist, Dr G, was on unexpected leave and that an appointment had been scheduled for 17 Month2.

Assessment 11 Month2

60. On 11 Month2, Mrs A contacted DHB2 Mental Health and Addictions Service (MHAS) and reported that Mr A could be suicidal. The duty clinician arranged for a nurse and a support worker to visit Mr A, since his key worker, RN D, was not available. Mr A was seen at home and he agreed to attend the MHAS clinic that day for an urgent review by a consultant psychiatrist, Dr H. DHB2 told HDC that Dr H had been redeployed from another service to provide emergency cover for the community team, because of the absence of a number of psychiatrists at that time.

61. Dr H reviewed Mr A and documented that he was low, anxious, and had reduced motivation, but was well presented. Mr A expressed suicidal thoughts. Dr H documented: "[N]ot sure if he would kill himself — has things prepared — has identified …" However, Dr H noted that Mr A had no clear intent, and that he had hope of finding employment. The plan was to commence an antidepressant medication,[20] and for Mr A to attend a recovery workshop, have a review by his key worker the following day, and receive follow-up with his usual psychiatrist (Dr G) in four months' time.

12 Month2

62. On 12 Month2, a support worker saw Mr A at the MHAS clinic and assisted him with transport to deliver a work referral form. The support worker noted that Mr A did not express any risk of self-harm or harm to others. It was documented that Mr A was also seen by a nurse at the clinic.

63. Despite Dr H's plan for Mr A's key worker to review him on 12 Month2, RN D did not see Mr A. She told HDC that Mr A's appointment on 12 Month2 was for a review by a doctor.

64. DHB2 told HDC that it was RN D's responsibility to review Mr A on 12 Month2, and that there is no record of the reason why this review did not occur. DHB2 said that ongoing follow-up should have occurred for Mr A, and his case should have been escalated in a peer setting and to the psychiatrist involved. DHB2 stated that this was not acceptable practice.

14 Month2

65. On 14 Month2, Mrs A telephoned the Crisis Assessment and Home Team (CAHT)[21] and told the duly authorised officer (DAO) that she had received an email[22] from Mr A stating that on the previous day he had attempted to harm himself.

[19] Recorded in the electronic notes on 15 Month2.
[20] Paroxetine.
[21] A service that provides crisis mental health assessment for individuals who require an urgent response and are likely to require the support of community or inpatient mental health services.
[22] The email had been written the previous day, and the delivery had been delayed for sending on 14 Month2.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

66. Mr A was contacted by occupational therapist Ms I from the MHAS crisis team. Mr A said that he was safe at home for the night, and that he had a job interview on Thursday and was looking forward to "getting his life sorted". Mr A told Ms I that he would not attempt to harm himself again, as it "hurt too much". Ms I advised Mr A to attend the Emergency Department for a medical examination, but Mr A refused, and he denied any pain. A plan was made for Mr A to be reviewed by the community treating team the following day.

67. Ms I told HDC that a face-to-face appointment and medical support was offered to Mr A, but he declined. She said that there was nothing in Mr A's presentation that she could use to compel him to be seen, other than using the Police, which would have been a substantial coercive action, given that Mr A said that he felt safe. DHB2 told HDC that Mrs A was distressed, and Ms I offered her support.

68. RN D told HDC that she had discussed Mr A's care in the MDT meeting, and it was agreed that she would review Mr A and arrange an urgent review by a doctor if there were any concerns. However, there is no documentation of an MDT meeting at the time of these events.

15 Month2 — assessment by RN D

69. On 15 Month2, Mr A was seen by RN D at the MHAS clinic. RN D recorded that Mr A disclosed that he had attempted to commit suicide on 13 Month2 following an argument with Mrs A, which had been brought about by a relationship conflict. RN D documented: "[Mr A] reiterated that he will not harm himself or others." The plan was for a review of the compulsory treatment order with Dr G on 24 Month2.

70. RN D told HDC that she made a request for an urgent doctor's appointment on 15 Month2, but a doctor was not available, and Mr A's usual doctor, Dr G, did not return to work for a number of weeks. RN D said that Mr A did not want daily contact. However, she said that he was "inadvertently seen every other day" as he was attending group sessions at the MHAS clinic, and RN D recalled catching up with him afterwards.

71. DHB2 told HDC that because Dr G was on unplanned leave, the appointment with Mr A was rescheduled for 24 Month2. DHB2 said that RN D's plan for Mr A was insufficient, and did not consider the immediate and long-term risk adequately. DHB2 stated that RN D should have discussed Mr A's care with either a psychiatrist, the MDT, or a peer, but acknowledged that this was made more difficult because Dr G was on sick leave. As stated above, there is no documentation of any MDT meetings at the time of these events.

72. On 23 Month2, RN D telephoned Mr A and told him that Dr G was still on unexpected leave, and that an appointment with Dr H had been scheduled for 25 Month2.

Review of compulsory treatment order

73. On 25 Month2, Mr A was seen by Dr H and RN D for a review of the compulsory treatment order. Dr H documented Mr A's suicide attempt 10 days earlier, and that Mr A had stated that his suicide attempt had been stupid, but he wished that it had worked. In this review, Mr A indicated that he was managing at home and talking to Mrs A, but he was anxious and

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

struggling to be calm. Mr A also reported that the paroxetine he was taking was having some effect on his anxiety and depression. Dr H documented under "mental state examination" that Mr A was slightly unkempt, his responses were "cursory", his mood was low, and he had suicidal ideas but no current intent and no psychotic features.

74. The plan was to continue the compulsory treatment order, to continue regular medication, to attend the Recovery Group, to see RN D weekly, and to follow up with a psychiatrist before the end of the compulsory treatment order. Dr H advised Mr A to contact the Crisis Team for support.

75. Dr H contacted Mrs A and documented that she was agreeable to the compulsory treatment order remaining in place.

76. Subsequent to these events, Dr H told the Coroner that he discussed with Mr A the option of admission to a psychiatric hospital for intensive support and monitoring, but Mr A declined this and said that it would be a step backward for him. Dr H said that he did not arrange to see Mr A again, and recommended follow-up with Mr A's team.

77. The next contact with MHAS was on 29 Month2, when Mrs A reported that Mr A was missing, and that the Police had been notified.

78. A few days later, Mr A was found deceased.

Subsequent events

DHB2

79. DHB2 completed an initial service incident review report,[23] which identified three issues that may have affected DHB2's service delivery. The reviewers noted that the community team, who had valuable information as to Mr A's possible location, were not notified by CAHT that it had received information about Mr A having gone missing on 29 Month2. The report noted that "[Mr A's] [e]ngagement with [RN D] was inconsistent", but there was no elaboration on precisely how this had affected the services DHB2 provided to Mr A. Lastly, the reviewers raised concern about DHB2's transfer of care process, and specifically noted that there was no indication that DHB2 had followed up its transfer to CMDHB in Month1.

Meeting 6 June 2019

80. Some months after Mr A had died, representatives from DHB2 met with Mrs A and Ms B at Mrs A's request. DHB2 said that at this meeting an offer of information about counselling and support was made to Mrs A. Ms B stated that during this meeting, Mrs A said that Mr A should have been seen weekly following his return to the DHB2 region, and that he should have been offered appointments at home rather than at the clinic.

[23] DHB2 noted that the primary focus of the review was to understand how the incident occurred, and what could be done to reduce the likelihood of such an incident occurring again.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

81. Ms B stated in her 25 June 2019 complaint, initially sent to the Coroner, that Mrs A believed that "[h]ad [Mr A] received appropriate intervention from Mental Health Services his [death] could have been prevented".

CMDHB

82. In December 2020, CMDHB conducted a review into the care provided to Mr A. In summary, the review found that the care provided to Mr A was clinically appropriate and of an acceptable standard. However, the review identified areas of improvement for the existing discharge process and made a number of recommendations (summarised in Appendix B).

Further comment

DHB2

83. DHB2 conveyed its sincere condolences to Mrs A for the death of Mr A.

84. DHB2 told HDC that it did not depart from the standard of care when Mr A's care was not transferred appropriately, because at the relevant time DHB2 was not aware that Mr A was in its region. DHB2 stated:

> "Each of the clinicians involved in [Mr A's] care were responsible for the services they provided, within their specific clinical scope of practice … Given that, it would therefore be reasonable to assume at the point [Mr A] was given a prescription from us, we would assume responsibility, even though the relevant transfer of care and Responsible Clinician documentation had not been completed, and, the clinician that knew him had gone on unexpected sick leave and was being covered by [Dr H], who saw [Mr A] in person, on two occasions."

85. DHB2 said that while every effort was made to deliver safe and effective services, it operated within resource constraints and was limited by demand and capacity issues. DHB2 noted that at the time Mr A was receiving care and treatment from DHB2, there were pressures on its services in terms of demand and capacity. DHB2 said that at the time of Mr A's death, the community mental health team responsible for his care had psychiatry vacancies of 2.69 full-time equivalents (FTE), and the nursing and allied health staff had vacancies of 4–7 FTE.

86. DHB2 stated that the community mental health service was unable to seek cover within its own teams, and sought support from the forensic service to facilitate Dr H's urgent secondment. DHB2 said that staffing vacancies affect the ability to cross cover and to staff existing caseloads adequately when staff are on planned or unplanned leave of any kind, and raises questions about the capacity to manage existing caseloads.

87. DHB2 told HDC:

> "[DHB2] crisis services provide services across [the whole DHB2 region], and do not have the capacity to provide face-to-face assessments for all contacts with the team. Their work practices are consistent with other DHBs, where many after-hours calls across the country are often managed by the Mental Health Line, who are unable to provide any face-to-face contacts."

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

88. DHB2 said that had greater resources and capacity been available, it would have been less challenging to deliver consistent best practice in mental health and addictions services.

RN D

89. RN D told HDC that she is unsure why Mr A was not seen by DHB2 on his return to the region during her absence.

90. RN D said that although a rapport with Mr A had developed, he could mask his feelings. She stated that Mr A was reluctant for staff to contact Mrs A, but when he did agree, contact could not be made with Mrs A.

Responses to provisional opinion

CMDHB (Te Whatu Ora)

91. CMDHB was given an opportunity to comment on the provisional opinion. CMDHB accepted the findings and recommendations. CMDHB had no further comments to make.

Dr C

92. Dr C was given an opportunity to comment on the relevant parts of the provisional opinion. Dr C told HDC that she accepts HDC's proposed recommendations. She stated:

> "I always try to involve whānau as much as possible in assessments and treatment planning, but this is a reminder of the importance of that, even with the difficulties of geographical distance."

DHB2 (Te Whatu Ora 2)

93. DHB2 was given an opportunity to comment on the provisional opinion. DHB2 accepted the provisional findings and had no further comments. DHB2 again expressed its deepest condolences to Mr A's family and particularly Mrs A.

94. In addition, DHB2 extended an open invitation to meet with Mrs A and discuss some of the changes made as a result of Mr A's death.

RN D

95. RN D was also given the opportunity to respond to the relevant sections of the provisional opinion and she agreed with the report and made no further comments.

Opinion: Introduction

96. This report emphasises the importance of adequate systems for the co-ordination of the transfer of a patient's care from one region to another, and of ensuring that the handover is clear, and that the receiving region has accepted responsibility for the patient's care. The report also highlights the importance of providing timely and responsive services.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

97. Clearly there were communication issues between CMDHB and DHB2, evidenced by the lack of consensus about the handover information received by DHB2, which led to a delay in Mr A being seen by the appropriate services.

98. In order to assist my assessment of Mr A's care, I obtained independent clinical advice from a psychiatrist, Dr Jubilee Rajiah.

Opinion: CMDHB — breach

Introduction

99. Mr A was admitted to the closed ward of the residential unit at CMDHB on 14 Month1 following a serious suicide attempt. Mr A was treated for alcohol withdrawal symptoms, and his treatment plan identified that his alcohol intake was a risk for suicide. Mr A improved clinically, and on 20 Month1 he was discharged to Mrs A's address.

100. I have a number of concerns about the care provided to Mr A by CMDHB, including the transfer of Mr A's care to DHB2 following Mr A's discharge. I discuss this in detail below.

Discharge and handover

Communication with Mrs A

101. It is documented in the clinical notes that several days prior to Mr A's discharge, various staff spoke with Mrs A and noted that she supported the plan for Mr A to be discharged to her address. However, on the day of discharge, staff made several unsuccessful attempts to contact Mrs A. A CMDHB staff member left one voice message on Mrs A's answerphone with limited information, and the message did not include information about either Mr A's travel arrangements, or his follow-up arrangements.

102. Ms B, Mrs A's support worker, told HDC that on the day of discharge she contacted CMDHB to report that Mrs A had concerns about the plan to discharge Mr A. Specifically, Ms B reported that Mr A was unwell and his suicide attempts were serious, and that he remained under a compulsory treatment order. Ms B said that she was told by CMDHB that a psychiatrist would call Mrs A. However, there is no record in Mr A's clinical notes of this discussion with Ms B.

103. There is no evidence that CMDHB staff took any action in response to Mrs A's concerns about CMDHB's decision to discharge Mr A.

104. My independent advisor, psychiatrist Dr Jubilee Rajiah, was critical of CMDHB's lack of engagement with Mrs A. Dr Rajiah stated that it was accepted practice for the discharge plan to be discussed with the patient's main support person, which in this case was Mrs A. Dr Rajiah advised:

> "The family member or friend nominated as the main support should be informed of the person's risk, about the follow-up arrangements and provided with emergency

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

contact details. This would include the discharge date and discharge arrangements and written information regarding medication, treatment plan and follow-up arrangements whenever possible."

105. It is evident that Mrs A had expressed her concerns about Mr A's discharge on numerous occasions. Although Ms B's contact with CMDHB on 20 Month1 was not documented, I find it more likely than not, considering Ms B's detailed recall of the discussion, that she did make a call to CMDHB in order to raise Mrs A's concerns about Mr A's discharge. However, despite Mrs A and Ms B's concerns, CMDHB proceeded with the discharge without establishing meaningful contact with Mrs A on 20 Month1.

106. I consider that it would have been appropriate for staff to contact Mrs A prior to discharging Mr A, in order to understand her concerns better. This was also an opportunity for CMDHB staff to clarify Mr A's discharge arrangements, treatment plan, and follow-up. In addition, CMDHB could have used this opportunity to inform Mrs A about Mr A's travel arrangements. Mrs A told HDC that she was not aware of when Mr A would be arriving in the region, and she picked up Mr A from the bus station only after receiving a text directly from him.

107. In my view, the level of engagement with Mrs A on the day of discharge was poor, particularly when considered alongside the lack of response to her concerns about discharge, and the lack of communication about Mr A's arrival time.

Travel arrangement to the DHB2 region

108. On the day of discharge, staff supported Mr A to purchase a bus ticket to travel from Auckland, although Mr A travelled alone.

109. Dr Rajiah advised that CMDHB's process regarding transport and supervision when a patient was to transfer to another city is unclear, and the expected practice was for a patient to be provided with transport and to be escorted by staff or family. Dr Rajiah said that her peers would query the decision to ask Mr A to return to the region by bus on his own. I acknowledge Dr Rajiah's comment, but I also accept that in some circumstances, escorting patients could prove difficult for the provider from a resourcing perspective. I consider that the most practical arrangement, and the expectation in Mr A's scenario, would have been to make sure that Mrs A or another appropriate person was able to meet and escort Mr A on his arrival. I am critical that CMDHB did not implement this arrangement. I note that there was a lack of procedure to guide CMDHB staff on this aspect of Mr A's care, and I make recommendations on this matter below.

Information given at discharge

110. On discharge from CMDHB, Mr A was provided with a discharge summary. However, the discharge summary did not include emergency contact numbers or the contact details for the services involved, and because Mr A did not have a GP, a copy of the discharge summary was posted only to the regional medical record.

111. Dr Rajiah raised concerns about the information provided to Mr A on discharge. Specifically, Dr Rajiah stated that an overview of the whole treatment plan, including emergency contacts and details of the follow-up services, should be provided to patients and their

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

nominated support person on discharge. I agree. In my view, the details of emergency contacts and follow-up services is important safety-netting information for patients on discharge. I am critical that Mr A and Mrs A were not provided with a post-discharge aftercare plan that included emergency contact numbers or contact details for the follow-up mental health team at DHB2. Mr A's prior knowledge of the service at DHB2 is irrelevant, as I would expect any consumer being discharged from an intensive care service to be provided with safety-netting advice and crisis contact numbers, irrespective of the person's previous engagement with the service.

112. I note that the fact that Mr A did not have a GP was recorded by a CMDHB house officer on 14 Month1. The house officer noted that this issue should be discussed in the family meeting, and addressed in discharge planning. However, this did not occur. I acknowledge that there were difficulties in arranging a family meeting (with Mrs A being based in a different region), but in my view, this issue should have been explored further with Mr A or Mrs A.

113. CMDHB advised HDC of steps it was taking to improve the discharge summary information (as outlined below at paragraph 190), and I consider this to be appropriate.

Communication with DHB2 about transfer of care

114. CMDHB maintains that it transferred Mr A's care to DHB2 successfully on 20 Month1 by sending DHB2 all the requisite information it required about Mr A's care and discharge. CMDHB told HDC that it contacted DHB2 staff to advise them of Mr A's imminent arrival, and received an acknowledgement affirming its advice.

115. Principle 8 of the National Transfer of Care Guidelines (Appendix C) states that where a patient relocates to another area but has not presented at the new location, the departing service, in this case CMDHB, continues to hold clinical and legal responsibility to arrange transfer of care, and should coordinate outreach in the new location to engage the patient.

116. DHB2 told HDC that Mr A's transfer of care was not consistent with the Transfer of Patient Care Guidelines (see Appendix C). DHB2 said that prior to transfer, ordinarily a responsible clinician to responsible clinician discussion would take place as required by the Guidelines, but this did not occur in Mr A's case.

117. Dr Rajiah advised that the transfer of care is an important aspect of all health care and treatment, and it is a vitally important process in mental health care, particularly with regard to issues of patient safety. Dr Rajiah stated that the week following discharge is known to be a very high-risk time for those who have been suicidal, and therefore discharge planning and communication between relevant parties is crucial.

118. Dr Rajiah said that prior to discharge, verbal and written reports should be provided to the team to whom care is being handed over, and particular attention should be paid to the verification and confirmation process to ensure that the referral information, transfer of care, and discharge summary has been received.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

119. I consider that the evidence does not support that CMDHB successfully advised DHB2 that it was transferring Mr A's care back to DHB2.

120. CMDHB told HDC that Dr C, the consultant psychiatrist responsible for Mr A, completed a statutory transfer of care form, which was faxed to DHB2 on 20 Month1 via the DAMHS Office. I acknowledge that DHB2 accepted that it did receive this form on 20 Month1.

121. However, I note that the transfer of care form faxed to DHB2 was only partially completed by Dr C, as it did not contain the name or signature of the responsible clinician who would be receiving Mr A's care at DHB2. CMDHB has provided no evidence that Dr C took any action to engage with a responsible clinician at DHB2 to accept the transfer of care, as would be expected.

122. CMDHB also told HDC that a registered nurse emailed Mr A's key worker, RN D, about Mr A's imminent discharge. CMDHB provided HDC with a copy of the email, and I accept that this was sent to RN D, but I am unable to determine conclusively whether the email was read by RN D on 20 Month1, as RN D was on annual leave that day. I discuss this matter further below. Regardless, it is not the responsibility of the key worker to accept the transfer of care for someone under a compulsory treatment order, so this action alone is insufficient to establish that the transfer of care occurred.

123. DHB2 told HDC that the only document it received on 20 Month1 was the statutory transfer of care form signed by Dr C through the DAMHS office transferring a statutory role in Mr A's care. DHB2 advised that the form was only partially completed, and there was no clinical handover, discharge summary, or any type of notice advising its staff that Mr A had been discharged from CMDHB on 20 Month1.

124. In the absence of any evidence to the contrary, I find that the only information regarding discharge or transfer sent to DHB2 was the partially completed transfer of care form and the email to RN D.

125. Dr Rajiah emphasised that the transfer of statutory care document alone does not convey information that is necessary for transfer of clinical care; instead, it is an administrative document to transfer the patient's care to another responsible clinician under the Mental Health Act. I accept this advice.

126. I also accept DHB2's submission that Mr A's transfer of care that occurred on 20 Month1 was not consistent with the National Transfer of Care Guidelines. In particular, I refer to Principle 6, which states that transferring patients under the Mental Health Act should involve responsible clinician to responsible clinician communication at the time of discharge and transfer (by telephone, in person, or by video conference). As noted above, I find that such contact did not occur in Mr A's case.

127. Dr Rajiah considered that the discharge and handover of care process in this case represented a moderate to severe departure from the accepted standard of care. I accept this advice.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

128. I note that Dr Rajiah advised that all other aspects of Mr A's inpatient care at the residential unit was of a good standard and within accepted practice.

Conclusion

129. As detailed above, I have a number of concerns about the discharge process initiated by CMDHB. In particular, I consider that CMDHB:

- Did not engage with Mrs A adequately on the day of Mr A's discharge.
- Permitted Mr A to travel without a confirmed support person picking him up.
- Did not provide Mr A and Mrs A with a post-discharge aftercare plan that included emergency contact numbers or contact for the follow-up mental health team at DHB2.
- Did not discuss Mr A's discharge planning with the responsible clinician or receiving care team at DHB2.
- Did not ensure communication occurred with the responsible clinician at DHB2 at the time of discharge and transfer, either by telephone, in person, or by video conference.
- Did not provide the receiving team at DHB2 with a verbal or written report about Mr A's care, clinical information, or discharge summary, other than the partially completed transfer form.
- Did not confirm or follow up with DHB2 about Mr A's transfer of care after his discharge.

130. Furthermore, as discussed by Dr Rajiah, I note that the week following discharge is known to be a very high-risk time for people who have been suicidal. Mr A was particularly vulnerable immediately following discharge, and likely was heavily reliant on the engagement and sound decision-making of clinicians.

131. I consider that the onus was on CMDHB to initiate and complete the transfer of Mr A's care appropriately and within accepted guidelines. I do not consider it sufficient for CMDHB to have faxed a partially completed transfer of care form through the DAMHS Office with no date of Mr A's impending arrival, and to have notified Mr A's key worker by email only, with no clear acknowledgement of receipt.

132. The National Transfer of Care Guidelines are clear and concise, and I find that Mr A's transfer of care did not adhere to the guidelines. I am critical that particularly in the context of mental health care, more was not done by CMDHB to transfer Mr A's care. Overall, this led to a poor standard of care at the point of discharge. Accordingly, I find that CMDHB breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[24]

[24] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

133. The inadequate discharge and transfer of care represents a failure by CMDHB to communicate and cooperate with DHB2 to ensure continuity of care for Mr A. Accordingly, I also find that CMDHB breached Right 4(5) of the Code.[25]

Opinion: Dr C — adverse comment

Risk assessment and safety planning

134. Dr C initially assessed Mr A on his admission to the residential unit on 14 Month1. Dr C told HDC that prior to meeting Mr A, she reviewed his notes, including the risk assessment recorded in the admission note.

135. Subsequently, Dr C assessed Mr A on 20 Month1 and agreed to discharge Mr A to Mrs A's address. Dr C told HDC that when she reviewed Mr A on 20 Month1, he was doing well, his mood was stable, and he had no psychotic symptoms or suicidal ideation. Dr C said that she advised Mr A that although he was not at risk, his continued abstinence from alcohol was fundamental to maintain his mood and safety.

136. Dr C told HDC that Mr A was dismissive about engaging in treatment for substance use, but said that he would consider treatment. Dr C documented that Mr A's diagnosis was likely alcohol-induced mood disorder.

137. Dr Rajiah acknowledged Dr C's clinical experience and clinical reasoning in her assessment of Mr A on 20 Month1.

138. However, Dr Rajiah advised that there was a mild to moderate departure from accepted practice in the content of Dr C's assessment of Mr A. Dr Rajiah stated that Mr A had a significant psychiatric history that included episodes of psychosis that often included drug abuse. Mr A had been admitted to the ward following a serious suicide attempt, yet Dr C did not undertake a full assessment of the suicide attempt or further enquiry and assessment of Mr A's risk. Dr Rajiah also noted that Mrs A's collateral history would have been an essential aspect of Mr A's risk evaluation.

139. Considering that Mrs A was alert to Mr A's risk and always acted promptly when Mr A was particularly despondent, I agree with Dr Rajiah that Mrs A's contribution would have been invaluable in building up Mr A's risk assessment.

140. Dr Rajiah advised that there is an increased risk of suicide in the first three months of discharge from inpatient care, and that in the first week post-discharge the risk is elevated, and highest on the day after discharge. Dr Rajiah commented that alcohol and substance abuse and intoxication are strong risk factors for suicide, and that this was identified and included in Mr A's treatment and management plan. Dr Rajiah noted that Mr A improved

[25] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

clinically while an inpatient on the ward, he denied thoughts of harm, and he was being discharged to the care of a team who knew him well.

141. I accept Dr Rajiah's advice. In my view, the assessment undertaken on 20 Month1, immediately prior to Mr A's discharge, could have contained a more detailed exploration of Mr A's risk formulation, including management of identified risk, and protective factors and triggers. In addition, I am concerned that Dr C did not seek Mrs A's input.

Discharge

142. The National Agreement for the Transfer of Patient Care Across DHB Boundaries Mental Health Services[26] provided the agreed principles and procedures for DHBs (see Appendix C). The National Agreement states:

> "In cases involving patients at clinical risk or treated under the [Mental Health Act], Responsible clinician to Responsible clinician contact by *synchronous*[27] communication (phone, in person or by video conferencing) is considered the standard." (Emphasis in original.)

143. Dr C was the responsible clinician assigned to Mr A's care. However, there is no evidence that Dr C communicated directly with the accepting responsible clinician at DHB2, as directed by the National Agreement. Dr C signed a section 127 transfer of care form to transfer Mr A's care under the Mental Health Act to DHB2 Mental Health and Addictions as the referring responsible clinician, but the section for the name and signature of the responsible clinician who would be accepting the care was left blank.

144. Furthermore, Dr C told HDC that on 20 Month1 she did not think it was necessary to engage with DHB2 further, other than to send Mr A's discharge summary. Dr C said that she believed that Mr A would have been very well known to DHB2, and needed only an update on his care since he had left the region about two weeks previously.

145. I disagree. I consider that Dr C should have had direct contact with the responsible clinician who would be accepting the transfer of Mr A's care at DHB2, and this should have been documented in Mr A's notes. I note that the CMDHB review (see Appendix B) found that a direct telephone handover between CMDHB and DHB2 may have supported a more effective transition between the services. Had this occurred, it would have strengthened the discharge process and the continuity of care for Mr A.

Conclusion

146. I am concerned that Dr C believed that only minimal information needed to be communicated to DHB2 on transferring Mr A's care to its clinicians. I note that this belief likely prevented Dr C from contacting a responsible clinician at DHB2 on discharging Mr A, and from completing Mr A's transfer of care form to include the name of the clinician who would be responsible for his care. Dr C's belief was not based on the established national

[26] March 2018.
[27] Meaning at the time of transfer.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Transfer of Care guidelines (see Appendix C). The guidelines are clear that it was Dr C's responsibility to contact a responsible clinician prior to discharging Mr A.

147. I note that Dr Rajiah agreed with CMDHB and Dr C that Mr A's inpatient admission, care, and treatment at CMDHB was entirely appropriate. I also note that Dr Rajiah acknowledged Dr C's clinical experience and reasoning in regard to Mr A's treatment. I accept Dr Rajiah's advice on these matters.

148. I acknowledge that despite Dr C's lack of compliance with the Transfer of Care guidelines, there were systemic issues that affected Mr A's transfer, and therefore I do not find Dr C in breach of the Code.

Opinion: DHB2

Initial contact with Mr A — adverse comment

149. As discussed above, I consider that CMDHB failed to initiate and coordinate Mr A's transfer of care between its clinicians and DHB2 appropriately. This led to a significant delay in DHB2 reestablishing a therapeutic relationship and robust contact with Mr A and his whānau, which in this case was his ex-wife and support person, Mrs A. I note that DHB2's first face-to-face contact with Mr A was on 11 Month2 (21 days post-discharge), and this was initiated by Mrs A following her concerns about Mr A's possible suicidal intent. In her complaint about Mr A's care, Mrs A stated: "Had [Mr A] received appropriate intervention from Mental Health Services his [death] could have been prevented."

150. My independent advisor, Dr Rajiah, emphasised that the week following discharge from an inpatient admission is a very high-risk time for people who have been suicidal. The Ministry of Health guidelines for the assessment and management of people at risk of suicide (see Appendix D) state that a patient discharged from an inpatient mental health unit must have face-to-face contact with a clinician within seven days of discharge. Therefore, it was important for DHB2 to arrange a face-to-face appointment with Mr A on becoming aware of his arrival in the region.

151. Dr Rajiah stated that the person at risk should be reassessed regularly, particularly if there has been any change in their circumstances and social situation. I consider that in view of Mr A's history, it was imperative for DHB2 to reconnect with Mr A as soon as possible, and no more than seven days from when it was known that he had arrived.

Establishing contact following discharge

152. DHB2 told HDC that while it received the section 127 transfer of care form through the DAMHS office, it was not accompanied by a clinical handover, discharge summary, or any type of notice advising DHB2 clinicians that Mr A was due to arrive in the region on 20 Month1. DHB2 stated:

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

"We do not believe that [DHB2] could reasonably be considered to have departed from the standard of care or accepted practice, when the patient had not been appropriately transferred to our care, and at the relevant time, we were unaware that [Mr A] was in our region."

153. Whilst DHB2's lack of immediate response to Mr A on his return to the region did not adhere to the Ministry of Health guidelines, I accept that a poor handover by CMDHB contributed to DHB2's delay in reviewing Mr A. I have discussed my detailed reasoning for this conclusion in the section above relating to CMDHB.

Establishing contact following 28 Month1

154. Mr A's clinical record documents a prescription having been written for him by a psychiatrist, Dr F, on 28 Month1. I note that Dr F was standing in for Mr A's usual psychiatrist, Dr G. DHB2 could not say conclusively whether Mr A was seen face to face during this appointment. However, based on the brief entry in Mr A's notes, I am inclined to find that this was a prescription-only entry, and that Dr F did not have face-to-face contact or possibly any contact with Mr A on this occasion.

155. DHB2 told HDC that while individual clinicians are responsible for the services they provide, it would be reasonable to accept that at the point Mr A was given a prescription from DHB2 on 28 Month1, DHB2 would assume responsibility for his care, even though the relevant transfer of care and responsible clinician documentation and communication had yet to be completed.

156. I accept DHB2's acknowledgement, and I am concerned that DHB2 did not arrange a face-to-face appointment with Mr A within seven days of Dr F writing a prescription on 28 Month1, or at least initiate a consultation to assess Mr A's needs following his inpatient discharge. I again note that it was not until 11 Month2 that Mr A had his first face-to-face appointment with a DHB2 clinician.

First face-to-face appointment on 11 Month2

157. On 11 Month2, Mrs A contacted a Duty Clinician at DHB2 to raise her concerns about Mr A being at risk of suicide. DHB2 arranged an urgent face-to-face appointment for Mr A for the same day. Mr A was commenced on paroxetine (an antidepressant medication), and arrangements were made for him to be reviewed by his key worker and attend a recovery workshop for psychoeducation and support.

158. Dr Rajiah advised that DHB2 clinicians acted promptly and appropriately once DHB2 had been contacted by Mrs A on 11 Month2. I accept Dr Rajiah's advice. However, I note that on 11 Month2, the plan was for RN D to review Mr A the following day, but this did not occur. I discuss this further below in the section of the report relating to RN D.

Other comment — no breach

Response to suicide attempt on 13 Month2

159. On 14 Month2, Mrs A contacted the Crisis Assessment and Home Team at DHB2 and reported that Mr A had attempted suicide on 13 Month2. Ms I from the Mental Health and

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Addictions Service assessed Mr A over the telephone and advised him to attend the Emergency Department for a medical examination, but he declined. A face-to-face appointment was offered, but this was also declined. The plan was for Mr A to remain at home with follow-up by the community treating team the next day.

160. Dr Rajiah advised that overall, the best clinical decision was made at that time. Dr Rajiah stated:

> "It is arguable that the response could have been different due to the seriousness and lethality of the attempt … Post-[self-harm] medical examination is imperative … The option of calling an ambulance is often considered in these situations. I agree Police assistance would have caused undue distress and breach of the therapeutic alliance."

161. Ms I told HDC that involving the Police to compel Mr A to be seen would have been substantial coercive action. DHB2 told HDC that Ms I offered "support" to Mrs A.

162. I acknowledge that Mr A declined a review in the Emergency Department or a face-to-face appointment, and I agree that it was reasonable not to involve the Police to facilitate this plan at the time. Therefore, I accept Dr Rajiah's advice on this issue.

Assessment on 25 Month2

163. On 25 Month2, Dr H saw Mr A in the presence of RN D, for a review of Mr A's compulsory treatment order. Dr H documented that Mr A had attempted suicide 10 days previously. Dr H assessed Mr A as having a "low mood", "no psychotic features", and "suicidal ideas but no current intent". The plan was to continue the compulsory treatment order, continue regular medications, see RN D weekly, and attend a recovery group. Dr H stated that a discussion was had with Mr A about the option of admission to a psychiatric hospital, but he declined this.

164. Dr Rajiah advised that there was no strong indication for Mr A to be admitted to hospital on 25 Month2. Dr Rajiah said that Mr A did not seem acutely unwell in terms of his mood and anxiety, he was not psychotic, and he was not expressing thoughts or intent to commit suicide.

165. Dr Rajiah advised that Dr H's assessment on 25 Month2 was reliant on how Mr A presented on that day, and she considered that the assessment was reasonable with the information available to Dr H at that time.

166. Dr Rajiah also advised that it was reasonable to assume that more information may have been available to Dr H on 25 Month2 if there had been follow-up notes in the interim period by RN D. Dr Rajiah reiterated the role of the key worker by stating:

> "The purpose of the keyworker/case management involvement is for close follow-up and monitoring and for on-going assessment and information gathering, relevant to the person's progress and response to treatment, as well as factors that might be affecting or impacting on their progress, and risk."

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

167. I agree with Dr Rajiah. I discuss RN D's role and involvement in Mr A's care below. On the evidence presented to me, I cannot be critical of DHB2's decisions. I accept Dr Rajiah's conclusion that the assessing psychiatrist, Dr H, made a reasonable assessment of risk in the circumstances with the information available to him at that time.

Conclusion

168. The salient feature in this case remains the inadequate transfer of care between CMDHB and DHB2. I have accepted Dr Rajiah's and DHB2's opinions that Mr A's transfer of care by CMDHB was not in accordance with the relevant standards or protocols. The inadequate transfer led to a chain of events that delayed DHB2 establishing imperative therapeutic contact with Mr A on his return to the region. However, I am concerned that DHB2 missed an opportunity to establish the critically important therapeutic relationship with Mr A from 28 Month1, considering how crucial early intervention is following an inpatient admission.

169. Following Mr A's return, he and Mrs A experienced a rift in their relationship, and Mr A attempted suicide. I accept that DHB2 was prompt in responding to Mrs A's concerns about Mr A at this time, and arranged appointments with requisite clinicians without delay at critical times.

Opinion: RN D — adverse comment

170. My advisor, psychiatrist Dr Rajiah, advised that an early therapeutic relationship between a treating clinical team and a newly discharged individual from an inpatient admission is central to understanding that individual's situation and assessing and managing risk. Dr Rajiah stated that it was therefore ideal and important for an individual's key worker to be involved at the earliest opportunity.

171. RN D told HDC that she was a community mental health nurse at DHB2, and the key worker allocated to Mr A between Month1 and Month2.

Initial contact

172. CMDHB told HDC that as part of Mr A's discharge process, a registered nurse sent an email directly to RN D at 12.11pm on 20 Month1, informing her that Mr A was being discharged back to DHB2 that day. A copy of this outgoing email was provided to HDC. I am satisfied that an email was sent to RN D on 20 Month1.

173. CMDHB clinical notes on 20 Month1 contain a brief entry stating that DHB2 was aware of Mr A's return. CMDHB has not been able to verify what kind of acknowledgement it received from DHB2, or whether the entry in Mr A's notes refers to any response it received from RN D.

174. RN D told HDC that she was on annual leave on 20 Month1. Therefore, I am inclined to find that RN D did not acknowledge receipt of CMDHB's email informing her of Mr A's return.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

175. Ms B told HDC that on 25 Month1, she contacted RN D to request an appointment for Mr A with a psychologist. RN D told HDC that she recalls this conversation with Ms B, and on her return from leave a number of attempts were made to get Mr A "up the psychology list". DHB2 and RN D have not provided HDC with any records documenting this telephone call.

176. I am concerned that this conversation was not documented in Mr A's clinical records.

Follow-up on 8–12 Month2

177. On 8 Month2, RN D had a further discussion with Ms B about her concerns that Mr A was at risk of suicide, and an appointment with a psychiatrist was made for 12 Month2 (although Mr A saw Dr H on 11 Month2 at Mrs A's request). RN D again did not document these discussions in Mr A's record.

178. DHB2 told HDC that it was RN D's responsibility to review Mr A on 12 Month2, following his psychiatric appointment. DHB2 stated that ongoing follow-up should have occurred, and it was not acceptable practice that it did not. However, DHB2 acknowledged that because Mr A's psychiatrist was on unplanned leave, this meant that it was more difficult for RN D to consult with staff about Mr A's care.

Decision for Mr A to remain in community

179. On 15 Month2, Mr A had his first face-to-face appointment with RN D, following a serious suicide attempt on 13 Month2. The appointment took place 25 days after his discharge from CMDHB. Following the appointment, RN D concluded that the plan was for Mr A to remain in the community, and an urgent appointment with a psychiatrist was made for 15 Month2. However, the appointment was postponed because Mr A's usual psychiatrist was not available, and it was rearranged for 24 Month2.

180. There is no record that RN D had contact with Mr A or Mrs A from 15 to 24 Month2.

181. RN D told HDC that Mr A did not want daily contact, and that he was "inadvertently seen every other day". She explained that he was attending group sessions at the MHAS clinic, and she recalled catching up with him afterwards. RN D said that she discussed Mr A's care in the MDT meeting, and she was advised to review Mr A and arrange an urgent psychiatrist review if there were any concerns.

182. Dr Rajiah advised that RN D's care plan for Mr A to remain in the community and to have a psychiatric review nine days later implied that his suicide attempt had been assessed as having not been sufficiently serious, and that he was deemed not to be at further risk or in need of close support, monitoring, and follow-up.

183. Dr Rajiah noted that this plan was enacted despite Mr A having made a very serious suicide attempt, on the background of another serious suicide attempt within the previous month. Dr Rajiah also noted that Mrs A was not contacted or consulted, despite Mr A having reported that they were in the midst of significant conflict and difficulties in their relationship.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

184. DHB2 accepted that RN D's plan was insufficient and did not consider Mr A's immediate and long-term risk adequately. DHB2 stated that RN D was expected to discuss Mr A's care with a psychiatrist, the MDT, or a peer. DHB2 stated:

> "It is possible an increased frequency of mental state monitoring would have been recommended if this occurred. [RN D], however, did arrange for a psychiatric review, anticipating the psychiatrist would be back from unplanned leave. It is also timely to note the individual professional responsibility for every clinician to bring cases to discuss at MDT, particularly where there may be changing risk, crisis or vulnerability. This is an expectation that we have on all staff working in our community mental health teams."

185. I agree with Dr Rajiah and I acknowledge DHB2's comments and acceptance of the inadequacy of RN D's care plan. In view of Mr A's serious recent suicide attempt, I consider that his plan did not provide adequate follow-up care, support, and monitoring. Mrs A had expressed her concern about Mr A's wellbeing, evidenced by several telephone calls to DHB2 for support, and I consider that she should have been consulted before a decision was made not to admit Mr A to inpatient care.

Conclusion

186. As outlined above, Dr Rajiah identified gaps in the care RN D provided to Mr A, during a period when Mr A was despondent and at risk of suicide. I acknowledge that Dr Rajiah is not a peer of RN D. However, RN D is an experienced mental health professional, and I am confident that she is aware of the nature and requirements of her role as key worker. Having taken into account Dr Rajiah's advice and DHB2's acknowledgement that RN D's care plan and follow-up of Mr A did not meet accepted practice, I consider that RN D was responsible for these deficiencies in Mr A's care.

187. In particular I am concerned that RN D failed to document her interactions with Mr A and key parties involved in his care. I am also concerned that RN D did not provide adequate follow-up and monitoring of Mr A when this was warranted. RN D missed opportunities to establish an early therapeutic relationship with Mr A, and I am concerned that her first face-to-face appointment with him took place 25 days after his discharge from in-patient care.

188. However, despite the above, I acknowledge that RN D was disadvantaged by the incomplete transfer of care from CMDHB. I also acknowledge RN D's discussion of the paucity of doctors who could see Mr A, and these resourcing issues were echoed by DHB2. Furthermore, I accept that RN D had a period of leave around the time of Mr A's return, and accept that she should not have been expected to coordinate Mr A's care single-handedly in these circumstances. I also note that RN D took some responsibility for Mr A's care by arranging psychiatric assistance when this was requested or required. For these reasons, I find that RN D did not breach the Code.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Changes since events

CMDHB

189. CMDHB undertook work to improve the assessment and management of risk, including the development of a comprehensive safety assessment as the basis for treatment planning, and holistic assessment of safety concerns, and it increased the involvement of family and whānau in safety planning.

190. CMDHB told HDC that its existing discharge procedures were under review, and that the new discharge procedure would include the following:

a) Family/whānau participation in discharge planning;

b) Documented discharge plans for patients, including emergency contact numbers; and

c) A telephone-based handover between treating and receiving senior medical officers for transfers between regions.

DHB2

191. DHB2 told HDC that over time and within budgetary constraints, many steps were taken to implement a number of changes to its processes, as set out below.

a) All community teams were reminded of the significance and importance of completion of appropriate transfers of care for all services users.

b) The community mental health team was reminded of the importance of timely communication and handover processes where information is shared, and to ensure that documentation is completed in a timely way.

c) Electronic clinical records can no longer be edited at a later time.

d) Community caseload numbers and acuity are reviewed every three months.

e) The community mental health teams meet daily to discuss and review numbers of cases, acuity, and any clients presenting in crisis or with fluctuating risk levels.

f) Ongoing monitoring of post-seven-day discharge follow-up remains in place.

Recommendations

192. I recommend that Te Whatu Ora Counties Manukau:

a) Provide HDC with an update on the changes implemented in response to these events, and report on any further changes that occurred following implementation of the changes, within three months of the date of this report.

b) Consider developing a guideline about transport and supervision when a patient is to be transferred within Te Whatu Ora to a different district, and report back to HDC on the outcome it its consideration within three months of the date of this report.

c) Consider Dr Rajiah's recommendation for a review of the work pressures on staff in in-patient units, including staffing issues, demand for in-patient beds, and volume of admissions and discharges, and report back to HDC on the outcome of its consideration within three months of the date of this report.

d) Provide a written apology to Mr A's family for the breaches of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

193. I also recommend that Dr C update herself on the Transfer of Patient Care Guidelines, and familiarise herself with the duties of the responsible clinician.

194. I recommend that within three months of the date of this report, Te Whatu Ora 2 provide HDC with an update on the changes it has already implemented in response to these events, and report on any further changes that have occurred.

Follow-up actions

195. A copy of this report will be sent to the Coroner.

196. A copy of this report with details identifying the parties removed, except the expert who advised on this case and CMDHB/Te Whatu Ora Counties Manukau and Middlemore Hospital, will be sent to the Director of Mental Health and Addiction Services and the Ministry of Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

197. In addition, pursuant to section 59(4) of the Health and Disability Commissioner Act 1994, I will write to Te Whatu Ora|Health New Zealand to highlight the resourcing issues identified and referred to by DHB2. I will request that within six months of the date of this report, Te Whatu Ora provide HDC with information on how it intends to address the issues noted.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: Independent clinical advice to Commissioner

The following advice was received from Dr Jubilee Rajiah on 1 March 2021:

"Re: [DHB2]
Counties Manukau District Health Board
Ref: C19HDC02053

Thank you for your e-mail dated 13.10.2020, seeking further advice. The documents and responses from the providers were sent to me on 17.02.21.

I have been asked to review the responses from the providers to my initial advice on 23rd September and to let you know whether the responses amend my initial advice.

I have carefully read the responses and I have amended my initial advice.

I have copied the initial advice, and added the revised opinion/amended advice in bold font after each question that was addressed in the initial advice.

They are on pages 4 & 5, page 8, page 10, pages 18 & 19 and pages 20 & 21.

Please let me know if there are any questions or clarifications regarding this further advice.

Yours sincerely,

Jubilee Rajiah
Consultant Psychiatrist

Counties Manukau DHB

1. The care provided to [Mr A] from 14th [Month1] to 20th [Month1].

a. What is the standard of care/accepted practice?
[Mr A] was assessed by a Psychiatry Registrar at the Emergency Department on 14th [Month1] where he had been taken by ambulance following a serious suicide attempt …

He was admitted to the residential unit — [locked] ward under a Compulsory Inpatient Treatment Order.

He was commenced on medication, and an Alcohol Withdrawal Rating Scale was commenced.

The nursing records show he was under close observations, and this was modified according to his presentation after the first two days.

The Alcohol Withdrawal Rating Scale was carefully monitored and documented, appropriate medication was given, and his mental state while on the ward was regularly monitored and recorded, with particular mention of psychotic symptoms and suicidal ideation.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

His sleep was monitored and recorded in the reports.

[Mr A] was encouraged to participate in the ward group activities.

He remained in hospital until 20th [Month1].

Standard of care/accepted practice
[Mr A] was admitted to the inpatient unit after a serious suicide attempt.

He was under appropriate close supervision on the ward.

The level of support, observation and vigilance by staff reflected a good standard of care and accepted practice.

Psychopharmacological treatment was commenced promptly.

He was encouraged to participate in group activities on the ward.

A Social Worker was involved for the psychosocial aspects of his care.

There was clear evidence of gradual improvement in his mood and mental state while in hospital.

The departure from the standard of care and accepted practice was in the assessment of the suicide attempt which brought him to the ward, and further assessment of risk.

The assessment of [Mr A's] risk while an inpatient on the residential unit was based almost entirely on his presentation on the ward.

He exhibited some psychotic symptoms initially and it was prudent to await alleviation of the psychotic symptoms before undertaking a fuller assessment of risk.

It is possible that the initial focus was on safe containment and establishing a therapeutic alliance.

It was a short admission.

The plan to discharge [Mr A] to [DHB2], to a team who knew him from a previous admission may have provided a false sense of security, and might have affected the approach taken, whereby a detailed and thorough assessment of his risk was not done or recorded.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) do you consider this to be? Please explain.

The departure from the standard of care and accepted practice was moderate, as his safety on the ward was clearly being attended to, and he was well cared for during his inpatient stay.

There is mention in the admission notes that he had [harmed himself].

This was not followed up by detailed enquiry into the circumstances and context of this suicide attempt, his mental state at the time, the factors that triggered the suicide attempt, and there was no enquiry regarding previous history of suicide attempts.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

This is essential to identify the factors and issues that may have caused or contributed to his risk.

A comprehensive assessment is essential for formulation of risk, including details of intent and lethality of the attempt, the means available to [Mr A], risk factors such as his mental illness, and level of impulsiveness or planning, psychosocial triggers and whether there were any protective factors.

Information could have been gained of any immediate or long-term risk factors, and any modifiable risk factors, such as acute and chronic mental illness, alcohol and drug use, and any significant interpersonal problems or social stressors.

The aim of such an assessment is to enable and inform treatment and care to prevent risk of future suicide.

It was evident that [Mr A's] wife had been concerned for a few days prior to his admission, and she had alerted the team to his recent [self-harm].

She does not appear to have been consulted for information, and the understanding and knowledge she would have had of his risk.

It is important to consult with and obtain information from family and friends whenever possible.

c. How would it be viewed by your peers?
My peers view the care and supervision that [Mr A] received as an inpatient was of a good standard, but view the risk assessment as lacking, and superficial.

d. Do you have any recommendations for how this aspect of care could be improved?
This aspect of care could be improved by a careful analysis of possible systemic issues which may have contributed to this departure from the expected standard of care.

Staffing issues, pressure to discharge patients due to demand on inpatient beds, time pressure for medical staff, and training issues may be partly responsible.

Training of all staff to undertake and record appropriate risk assessments with the intention to inform interventions, treatment, and care, and to establish an effective, personalised recovery plan would improve this aspect of care.

An undue focus on risk assessments and the mandatory filling of risk assessment forms is not necessarily helpful, relevant, or able to predict risk.

Risk prediction is notoriously difficult and unreliable.

A strong reminder and caveat to consult with family members and to gather corroborative and collateral information.

Family members have important information that can assist greatly in diagnosis, risk assessment and treatment planning.

e. Any further comments?
It was clear from the many contacts [Mr A's] wife had made with mental health services, and phone calls from [Ms B] that their involvement was necessary to establish a treatment plan, particularly in supporting [Mr A] and managing his risk.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

It is important to recognise this and to actively involve family, and the primary support person.

The issues mentioned with regard to assessment of the suicide attempt which brought him to the ward, and further assessment of risk are relevant to question 3, — [Dr C's] assessment of [Mr A] on 20th [Month1].

Revised opinion

I wish to reiterate that the standard of care provided while [Mr A] was an inpatient at the residential unit — [the ward] was of a good standard and within the bounds of accepted practice.

He had good support, appropriate levels of observation, vigilance, treatment, and care.

His treatment, and care was safe, timely, and effective and adjusted according to his level of improvement and progress. His mental state, and safety was carefully monitored.

It is important to note that there is an increased risk of suicide in the three months after discharge from inpatient care. This risk is especially elevated in the first week post-discharge and is highest on the day after discharge.

[Mr A] was admitted to the inpatient unit following a serious suicide attempt.

Alcohol and substance abuse and intoxication are strong risk factors for suicide, and this was identified and included in his treatment and management plan.

The Service Level Review conducted in December 2020, found that the inpatient assessment on 14 [Month1] conducted by [Dr C], in the company of two medical students and assigned nursing staff cites pertinent risk factors including past attempts, situational stressors, low mood, self-neglect due to poor oral intake, drug and alcohol misuse and negative findings (denies suicidal or homicidal ideation and auditory or visual hallucinations).

[Mr A] improved clinically while an inpatient on the ward and he was more able to express himself.

He denied any thoughts of harm to himself or others.

He was discharged to the care of a team who knew him well.

I note in the Response to the Health and Disability Commissioner's Request for Information, dated 21 December 2020, that [CMDHB] states:

> 'CMDHB is in the process of adopting a model of comprehensive safety assessment as the basis for treatment planning, and is working with staff, including doctors, regarding a holistic assessment of safety concerns and increased involvement of the individual and their family/whānau in safety planning. Our goal is to produce documentation that reflects a comprehensive assessment of the factors that impinge upon the person's safety, health, and wellbeing and to translate this into a plan that the person is invested in and active in implementing.'

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

My opinion does not change substantially. I would consider the departure from standard of care and accepted practice as mild to moderate for that episode of care.

I wish to restate my opinion as below:
The care and treatment [Mr A] received as an inpatient was of a good standard. The risk assessment and the individualised safety plan could be improved.

I do not intend my opinion to infer that someone is to blame, or that prediction of suicide is possible.

A history of a serious suicide attempt is the single best predictor of subsequent suicide.

There is important learning from this situation, as there often is from analysis of the standard of care and accepted practice.

I acknowledge the benefit of hindsight in analysis.

Neither do I intend to equate care given with the presence or absence of mandatory forms being filled in.

Risk status checklists and tick boxes have no empirical value of their own.

They are useful prompting questions to examine potential risk factors which are particular to each patient to work towards a risk formulation.

A risk formulation does not predict suicide but assesses risk so that actions are taken that are protective and helpful to the patient.

2. The adequacy of [Mr A's] discharges from Counties Manukau DHB.

a. What is the standard of care/accepted practice?
Discharge planning, and the discharge plan is discussed with the service user and with the person's main support person(s,) family or nominated friend and the clinicians who will be taking over their care.

Verbal and written reports are provided to the team taking over care of the person.

The family member or friend nominated as the main support should be informed of the person's risk, about the follow-up arrangements and provided with emergency contact details.

This would include the discharge date and discharge arrangements and written information regarding medication, treatment plan and follow-up arrangements whenever possible.

It is helpful to give the person and their nominated primary support person(s) a copy of the discharge summary or an overview of the whole treatment plan so that they have a clear understanding of the range of support and interventions recommended or put in place, and they don't leave the ward believing that they are only being prescribed medication.

Contact numbers of the community mental health team should be provided to the patient, and their family member/support person if Transfer of Care is being made to a community mental health team.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Phone numbers and contact details for emergency/acute situations should also be provided.

The discharge summary is also sent to the person's G.P.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) do you consider this to be? Please explain.

The notes on file regarding [Mr A's] discharge state that he continued to display a settled presentation, and that he was attending and participating in Occupational Therapy activity for the majority of the shift. He had been seen by [Dr C] and the decision made to discharge him home.

The notes state that [Mr A] was agreeable for discharge.

The diagnosis is recorded as Drug Induced Psychosis.

The reason for discharge is stated as completed treatment.

The Registered Nurse and Social Worker had tried to contact [Mr A's] ex-wife via telephone and left a message informing her of his discharge.

The Social Worker assisted him to make a booking on the bus to [the DHB2 region].

He was transported to the bus by a Patient Assistant.

Follow-up care plan/further information.

****ACNM emailed his Keyworker in [the DHB2 region], scribe was advised that they are aware of him returning to their catchment area.***

****No further follow up care from CMHC.***

[The] Clinical Director — Adult and Forensic Services, Mental Health and Addiction Services of [DHB2] in his letter to [HDC] dated 20th December 2019 states ***— 'No records and clinical transfer of care were received by [DHB2] following his discharge from Counties Manukau, although a legal status and transfer back to [DHB2] was noted on 21 [Month1].'***

(Please see appended copy of the letter from [the] Clinical Quality and Risk Manager, Mental Health & Addiction Services of Counties Manukau Health.

The letter states that the discharge information was faxed as it is noted in [Mr A's] clinical record, but they are unable to retrieve the fax records to provide specific evidence of this.)

The notes in italics and bold font below are copied from the time-line provided by [Ms B] who is the Family Worker who was supporting [Mr A's] wife.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

20th [Month1]

- ***I rang the hospital. [Mr A] on [the] ward. There was no discharge or safety plan. I emphasized how unwell [Mr A] had been as well as his serious suicide attempts. I also said that [Mr A] was still under a Compulsory Treatment Order.***
- ***[Mrs A] spoke with the ward social worker letting her know that [Mr A] had made two serious suicide attempts.***
- ***I was told the psychiatrist would be asked to ring [Mrs A].***
- ***[Mrs A] received a voicemail from the ward to say [Mr A] was being discharged today. He was told to get on a bus.***
- ***[Mrs A] was not told when [Mr A] would board the bus and did not know what time to pick him up.***
- ***[Mrs A] picked him up when he arrived in [the region] because she had a text from [Mr A].***
- ***[Mrs A] took him back to her flat to stay***.

The departure from the standard of care and accepted practice is moderate to severe.

The handover of care is an important aspect of all health care and treatment, and it is a vitally important process in mental health care, particularly with regard to issues of patient safety.

It is a Ministry of Health requirement that a patient discharged from an inpatient mental health unit should have face to face contact with a clinician within a 7-day period.

This is not possible if the discharge and transfer of care process is not followed.

It is standard and expected practice that patients should be followed up closely immediately following an inpatient admission.

The week following discharge is known to be a very high-risk time for those who have been suicidal. Therefore, discharge planning and communication between relevant parties at the time of discharge is crucial.

Breakdown in communication between services can also lead to difficulties for the patient navigating the system, and it is one of the leading causes of serious events.

c. How would it be viewed by your peers?
My peers agree that the discharge, and handover of care process was inadequate.

They also queried the decision to ask [Mr A] to take a bus back to [the region].

The expected practice would be that the service user is provided transport and is escorted by staff, or a family member or friend who is able to do this.

d. Do you have any recommendations for how this aspect of care could be improved?
This aspect of care could be readily improved by following and fulfilling the standard requirements and usual discharge and handover of care process.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Discharge planning should involve the service user and their family member/support person, the multidisciplinary team and the clinicians who will take over their care after discharge.

Clear formulation and communication of risk, treatment plan and follow-up arrangements both verbal and written, and contact details of the services involved and emergency contacts should be provided.

A copy of the discharge summary is also sent to the patient's G.P.

Systemic issues should be addressed in terms of the team as a whole, as it is unclear if there was clear delegation of tasks and responsibilities.

Particular attention needs to be paid to the verification and confirmation process to ensure that referral information, transfer of care and the discharge summary have been received by the team to whom care is being handed over.

The DHB policy and procedure regarding transport and supervision when the servicer user is being transferred to another city or town is unclear.

e. Any other comments?

The electronic notes from Counties Manukau clearly state ***— MH Smart In-Patient Discharge is completed.***

Document: To [Mr A]. Re: [the residential unit] Discharge Checklist.

Case Conference Location …

Discussed in the morning meeting

Discharged to [DHB2 region] and no longer require follow-up from the service.

Discharge form completed.

It appears that standard discharge process was followed, but evidence of this is missing.

[DHB2] state that they did not receive the discharge information.

A copy of Transfer of Care under The Mental Health (Compulsory Assessment and Treatment Act) 1992 is included in the documentation that was sent to me.

This is a formal process for change of Responsible Clinician. The copy of the form sent to me is not signed by the Responsible Clinician taking over the care of [Mr A].

It is also important to note that this transfer of care document/formality does not in any way replace or convey information that is necessary for transfer of clinical care.

It is a document of transfer of a statutory role.

The Service Level Review by the Counties Manukau District Health Board dated 15.12.20 has identified opportunities for improvement and recommendations for the discharge process.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

My opinion regarding the adequacy of [Mr A's] discharges from Counties Manukau DHB is unchanged.

2. [Dr C's] assessment of [Mr A] on 20th [Month1].
The assessment notes are copied below in bold and italics font.

20 [Month1] 11:20, [ward], [Dr C], SMO Version 2 20 [Month1]

'Created on': 20 [Month1] 12:11

([Ward] — INPATIENT NOTE)

Activity: Inpatient Location: [the residential unit]

SUBJECTIVE:
Patient is interviewed by … Present are [two people] and myself. Patient is feeling much better and is anxious to be getting on with his life. Unsure if he is going to continue with his present job or change to another. Also, unsure if he is staying in Auckland or [the DHB2 region] but does want to go to [the DHB2 region] for now. Patient is ambivalent about the need for CADS treatment, says he has quit drinking before and he believes he can do it on his own again.

OBJECTIVE: Patient is a Well Developed/Well Nourished … Male. Grooming and Hygiene are good. Mood and affect are congruent, appropriate, and euthymic. Though Process/Thought Content are Goal Oriented and Linear. Denies Suicidal Ideation, Homicidal Ideation, Paranoia, Grandeur, Auditory Hallucinations or Visual Hallucinations. Patient is Alert and Oriented to Person, Place and Date. Insight and Judgement are fair except as regards his Alcohol use, where they are poor.

ASSESSMENT:
Alcohol Induced Mood DO
Alcohol Use DO, Severe
PLAN:

1. ***Discharge to ex's address in [the DHB2 region]***
2. ***TOC back to [DHB2] Mental Health.***

- ***Document: … Re: Inpatient Discharge Summary***
- ***Document: … Re: Section 127 Transfer of Care***

a. What is the standard of care/accepted practice?
Review of an inpatient by a Senior Medical Officer (SMO), Psychiatrist in the inpatient unit often occurs after the patient has been assessed and admitted to the ward.

The initial assessment and admission notes are usually done by a Psychiatry Registrar or another colleague, and following admission to the ward, the patient may be reviewed by a junior doctor. The house surgeon undertakes the physical examination and physical health check.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The nursing notes provide considerable information regarding the patient's mental state and behaviour on the ward, response to medication, their sleep and general progress.

Therefore, the information gathering, and notes documented by the Senior Medical Officer may be brief and condensed, but they should contain an analysis and synthesis of the information already available regarding the patient, and further salient information obtained by the SMO directly from the patient.

<u>The standard of care/accepted practice for an assessment for someone admitted following a serious suicide attempt is outlined above in the response to question number 1.</u>

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) do you consider this to be? Please explain.

The departure from the standard of care or accepted practice is moderate to severe.

[Mr A] had been admitted to the ward following a serious suicide attempt.

He had a significant past psychiatric history which included episodes of psychosis, twice following drug abuse, and once occurring without drug abuse.

He had had a previous serious suicide attempt in [year].

When assessed at Counties Manukau, an initial diagnosis of Alcohol Induced Mood Disorder and Alcohol Use Disorder was made, but the reason for making this diagnosis is not entirely clear, nor was this further explored to clarify the diagnosis.

[Mr A] was described as disorganised in his thinking and behaviour initially, and there were some signs and symptoms of psychosis.

In addition, as explained in response to question 1, full assessment of the suicide attempt and further enquiry and assessment of risk was not undertaken.

Collateral history from his ex-wife [Mrs A] would have been an essential aspect of his risk evaluation.

[Mrs A] had contacted services raising concerns about his mental state and safety.

She was alert to his risk, acted promptly and she was asking for help for [Mr A].

c. How would it be viewed by your peers?

The assessment was viewed by my peers as brief and superficial.

They were careful to state that they do not mean to extrapolate that suicide is the result of inadequate risk assessments.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

They also raised the issue of the workload for the SMO.

The aim of a detailed assessment is to provide optimal care, and for planning individualised treatment based on the patient's needs and risk, not based solely on the perceived risk.

d. Do you have any recommendations for how this aspect of care could be improved?
I would recommend a careful review of the work pressures on staff in inpatient units, to include staffing issues, demand for inpatient beds, high volume of admissions and discharges, issues around possible burn-out among staff and any other systemic issues.

Addressing systemic issues would certainly improve this aspect of care.

Feedback could be provided regarding adequate and appropriate risk assessment, with an overarching focus on the information and details to be obtained in a full assessment to inform and improve patient care.

e. Any other comments?
In summary, overall [Mr A] did not receive well-coordinated care for his mental health issues.

The transfer of care of [Mr A] to the community in another DHB was insufficient for someone dealing with mental health and possible alcohol disorders and suicidality.

The departure from standard of care/accepted practice of particular individual steps on their own may have been mild to moderate, or moderate to severe but the cumulative departure from standard of care/accepted practice is of concern.

Revised opinion
This question is specifically about the assessment on 20 [Month1].

I agree with the findings described on page 4, paragraph c. of the Response to the Health and Disability Commissioner's Request for Information dated 21 December 2020.

It is headed — The adequacy of the assessment by SMO [Dr C].

I agree with the analysis regarding the diagnostic dilemma that [Mr A] presented with, and that the inpatient admission, care and treatment was entirely appropriate.

I wish to apologise and retract this statement — *When assessed at Counties Manukau, an initial diagnosis of Alcohol Induced Mood Disorder and Alcohol Use Disorder was made, but the reason for making this diagnosis is not entirely clear, nor was this further explored to clarify the diagnosis.*

I have read [Dr C's] response and acknowledge her clinical experience and clinical reasoning during the episode of care that [Mr A] was under her care.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

I would change my opinion to mild to moderate departure from standard of care and accepted practice with specific reference to the need for improvement in the area of risk assessment and formulation, and risk management planning.

Whether the care provided to [Mr A] by [DHB2] was reasonable in the circumstances and why.

Chronological sequence of events and [Mr A's] involvement with [DHB2] in the week before, and after he returned to [the DHB2 region] from Auckland.

13th [Month1]
It is recorded that a phone call was received by the Duty Clinician from [Ms B]. She advised that [Mr A] had [recently harmed himself].

It is noted that he may re-present at AMHS …

His care had recently been transferred to Counties Manukau District Health Board.

14th [Month1]
It is recorded that a telephone call had been received from [Ms B] by [a] Social Worker.

She informed him that [Mr A] had been admitted to the inpatient psychiatric unit at Middlemore Hospital in Auckland following [an episode of self-harm].

She thought he would be admitted to [the DHB2 mental health service] when he was well enough.

He was discharged from the inpatient unit in Auckland on 20th [Month1].

Transfer of Care under the Mental Health (Compulsory Assessment and Treatment) Act 1992 was received by [DHB2].

28th [Month1]
A prescription for zopiclone 15 tablets was provided by [Dr F], Psychiatrist in the absence of his usual psychiatrist [Dr G].

11th [Month2] 13:37
Phone call from [Mr A's] wife to the Duty Clinician.

She expressed concern that [Mr A] may be currently suicidal. This was based on a phone call to him by her. She had asked him to pick up their [child] from school (this was his task). He had reportedly said, "I don't think I can do that".

She was also basing her concern on his suicide attempt three weeks ago, and his expressed suicide thoughts.

His Keyworker was unavailable so two staff members from the same team undertook to visit him and assess the situation.

It is documented that [Mr A] agreed to transport himself to the clinic to see [Dr H].

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

It is also documented that [Mr A] was transported from the Clinic … to drop off [an employment] referral form and then transported back to the Clinic by the Support Worker.

Letter from [Dr H] to [GP at the medical centre] is typed verbatim below.

Dear Dr …

Re: [Mr A] — DOB …

[Contact details]

NHI: …

Seen urgently for South CMHT at request of [a] CMHN as his keyworker, [RN D] is away. His partner very concerned that he is struggling to cope.

He sees his main problem as being anxiety, doing little, scared of doing even that.

Dejected. Anxious, low.

Taking one step at a time.

Had an interview today for [job] — able to focus.

Presented himself well.

Did leave previous … job. Then unemployed. Not applied for others.

Was in [job]. Did not like it.

Living with ex-wife, [Mrs A]. Relationship with her ended when he had an affair, felt guilty and told her.

Had episode of drug-induced psychosis.

Taking ex-wife to work. Taking [child] to day-care.

Reduced motivation.

No housework. [Mrs A] does cleaning.

Zopiclone 7.5mg essential for sleep.

Risperidone 3mg/day

Promethazine 1tab/day — does not help.

[Mrs A] has been looking after medications.

Stopped alcohol. No illicit drugs.

Not much contact with [RN D] keyworker.

<u>Mental State Examination</u>
Well presented

Expressive, appropriate tone variation.

Not sure if he would kill himself — has things prepared …

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

But has hope of getting a job.

No psychotic features.

<u>For</u>

1. ***Re-prescribed zopiclone 7.5mg — uses … pharmacy***
2. ***Start paroxetine 20mg/day to improve mood and reduce anxiety***
3. ***Continue other medication***
4. ***Recovery workshop***
5. ***Crisis contacts reinforced — if he feels overwhelmed with thoughts of self-harm he will phone.***
6. ***Come tomorrow to see K/W***
7. ***F/U with usual consultant in 4 months***

Yours sincerely,
[Dr H]
Consultant Psychiatrist

<u>14th [Month2] 17:33</u>

<u>Clinical Notes: by staff member [Ms I]</u>
[Mrs A] had phoned and stated that [Mr A] and she were separated but living together. He had disclosed infidelity the previous day and she had kicked him out. He then [attempted to harm himself]. He had sent a suicide email to [Mrs A] and put it on a setting so she would receive it in the afternoon. She received the e-mail 10 minutes before she rang. He was sitting next to her at that time.

The notes by [Ms I] state that [Mr A] has a [child], who he and [Mrs A] look after.

<u>[Ms I's] notes</u>
I have spoken with [Mr A] who is under [Dr G] and [RN D] — [region]. Reports he is on risperidone and paroxetine. [Mr A] has guaranteed his safety for the night. Says he had a job interview last week and has one next Thursday and is looking forward to getting his life sorted. I asked him if they were to get into a further argument, what would he do if anything differently. He said he won't try that again because 'it hurt too much'.

Risk:

[Mr A] was happy to talk with me on the phone, does not feel he needs to see CAHT f/f. Assures safety. Agreeable to treating team f/u tomorrow … Feels safe in-home environment currently, if another argument is to occur, he is going to seek air bnb accommodation for the night.

Plan:

[Mr A] has guaranteed his safety tonight. Will call 0800# if anything changes.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[Mr A] agreeable to being followed up tomorrow by community treating team.

Medical advice given to [Mr A] and [Mrs A] that [Mr A] needs to attend ED following his [self-harm] yesterday. [Mr A] has refused. Denied experience any physical pain …

15th [Month2]
[RN D], Registered Nurse who was [Mr A's] Keyworker phoned him, let him know she was aware of the events of the weekend and asked him to attend the [medical centre].

Her notes are copied below:

[Mr A] is [a man in his thirties] with a diagnosis of Paranoid Schizophrenia, Substance-induced psychotic disorder, History of polysubstance use including … currently in partial remission. [Mr A] stated that he had told [Mrs A] about his infidelity. Stated that they are separated and thought that this was okay. Stated that he stayed over at the girl's home on Friday night. Stated that at least he did not have the girl in [Mrs A's] home. Stated that they had had an argument and [Mrs A] kicked him out. [Mr A] decided 'f…k it, I will kill myself'. … Had planned what he was going to do. Stated that the suicide note was delayed on purpose so that his body will be found. … Stated that it was enough to make him rethink his plan. … [Mr A] reiterated that he would not harm himself or others.

Writer spoke with Administrator r/t ? [Dr G] returning on Monday. Will require CTO review. Arranged a further review with [Dr G] on 24th [Month2] @1400 hours. [Mr A] aware, [Mr A] agreed.

Timeline of events and communication with [DHB2] outlined by [Ms B], who is the Family Worker for [support agency].

[The agency] is a non-clinical, non-government agency funded by [DHB2] to support family members and friends who are connected to someone with a mental illness diagnosed or undiagnosed.

Her role was not to work directly with the person with the mental illness. Her role is to support, advocate for and educate the family and friends.

25 [Month1]

- ***I contacted [Mr A's] keyworker to see if [Mr A] could see a psychologist about childhood trauma. [Mrs A] had rung 5 psychologists after [Mr A] had agreed to seek help. They all had long waiting lists. I was told the wait would be 8 months wait at ACMHS. [Mr A] also did not have an appointment with ACMHS until 17 [Month2]. The keyworker said she would try and move the appointment up.***

08 [Month2]

- ***[Mr A] tells [Mrs A] he still wants to kill himself.***
- ***[Mr A] can't get a private psychologist until [Month3]. She said she hopes he can wait that long.***

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- ***I contacted [Mr A's] keyworker to say that [Mr A] is still suicidal, and I think he needs to see a psychiatrist. I also sent an email from [Mrs A] it said that [Mr A] was very depressed, and her instinct tell her that he is going to kill himself. He has no hope, no job, and no family.***
- ***<u>[Mr A's] appointment with the psychiatrist at ACMHS was cancelled.</u>***

<u>11 [Month2]</u>

- ***[Mrs A] emailed me the following her instincts were telling her that [Mr A] is going to kill himself. He is so depressed, and it is easy for him to give up. His mental health appointment on Friday has been cancelled.***
- ***I emailed [Mrs A] the following. The ACMHS team are aware of [Mr A's] suicidality and that he won't tell them how he feels. Contact [Mr A's] keyworker at ACMHS [medical centre]. I also said that even though the Crisis Assessment Team (CAT) were hard to get hold of to give it a try. I also will try to contact the keyworker.***

<u>12 [Month2]</u>

- ***[Mrs A] emailed me that [Mr A] met with his keyworker and had been given antidepressant medication. He seemed to feel better. He again had sent [Mrs A] a delayed email about suicide attempt. [Mr A] had left his wallet at [Mrs A's] house. She had tried to phone him 30 times.***

<u>15 [Month2]</u>

- ***[Mrs A] phoned and was very upset because [Mr A] had attempted to kill himself …***
- ***[Mr A] said to [Mrs A] he had been seen by a caseworker in the C.A.T. team. [Mr A] said to the case worker that somehow … he had not died. He told the caseworker he would not do it again because it hurt.***
- ***I emailed [Mr A's] keyworker at ACMHS [the medical centre] to say [Mr A] had attempted suicide. In the email I put the name of the C.A.T. member whom [Mr A] had spoken to. I also sent the keyworker a list of [Mr A's] current medications which [Mrs A] had send me an update photo of. They were Paroxetine 20mg, promethazine 25mg. Risperidone 3mg and zopiclone 7.5mgs***
- ***The keyworker sent me an email to say that she was aware of [Mr A's] suicide attempt and that she had visited him.***

<u>19 [Month2]</u>

- ***I received an email from [Mrs A] to say that she had talked to [Mr A] and he was still very depressed and anxious.***

<u>30 [Month2]</u>

- ***I received an email from [Mrs A] that [Mr A] was supposed to pick up their [child] today but he didn't go. [Mr A] had left his wallet at their home and was not answering his phone.***
- ***[Mrs A] called the police and the C.A.T. team.***

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- ***[Mrs A] phoned me and said she was concerned that [Mr A] had tried to kill himself.***

<u>30 [Month2]</u>

- ***I emailed [Mr A's] keyworker to say that [Mr A] had gone missing on Monday.***

<u>[Date]</u>

- ***[Mr A] was found dead …***

<u>[DHB2]</u>

1. The adequacy of the risk assessments carried out and care provided to [Mr A] after his return to [the DHB2 region] on 20th [Month1].

a. What is the standard of care/accepted practice?
The standard of care/accepted practice for this period of [Mr A's] treatment and care is based on the premise that the week following discharge from an inpatient admission is a very high-risk time for people who have been suicidal.

There is an expectation and a Ministry of Health requirement that there should be close follow-up over the week following discharge from an inpatient setting.

And that face-to-face contact must occur within 7 days of discharge.

The person at risk should be reassessed regularly, particularly if there has been any change in their circumstances, and social situation.

A person who is suicidal is likely to have a fluctuating mood and mental state and risk.

The clinical notes should include the assessment of suicide risk, whether there are any concerns from the family, history of suicide attempts, and details of recent attempts, course of illness and treatment, and the risk/benefit ratio of the clinical decisions made. E.g. The decision to admit to an inpatient unit or not.

The person's whānau/family/primary support person(s) should be involved to obtain information for the assessment, and to formulate a safe management plan.

The therapeutic relationship with the members of the treating team is central to understanding the person and their situation, and in assessing risk and managing risk.

It is therefore ideal and important if the person's caseworker or Keyworker is involved at the earliest and there is continuity and consistency of care.

In assessment of risk, mere attention to risk factors that are known to be associated with suicide is not enough, but awareness of these factors and the complex problems and circumstances the person is facing informs the level of care, and treatment required.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The comprehensive assessment is to identity and treat the mental illness and address any alcohol or substance use, and to assess and manage risk.

The risk assessment should include information on the factors and context that led the person to consider suicide, and the factors and context that were operative when the person made the recent suicide attempts.

The assessment should include the person's thinking and motivation at the time of the attempted suicide to identify interpersonal problems, social and financial stressors and to identify anxiety, depression, and hopelessness.

The risk assessment may reveal immediate risk factors and/or long-term risk factors.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) do you consider this to be? Please explain.

The departure from the standard of care or accepted practice was severe.

[Mr A] was discharged from inpatient admission and treatment on 20th of [Month1].

He was not seen face to face for an assessment of his mood, mental state and safety until 11th [Month2].

This contact was initiated by his wife [Mrs A] when she contacted a Duty Clinician on 11th [Month2]. She expressed concern that he may be suicidal.

Two staff members went to visit him, and an appointment was arranged with a psychiatrist from another team who saw him on an urgent basis.

The letter to the G.P. detailing this assessment includes indicators of risk, as well as some indication that [Mr A] was future-focused. He had had an interview for a job that day and he was hopeful of getting a job.

He said he was living with his ex-wife. She was taking care of his medications. He hadn't had contact with his Keyworker.

Not sure if he would kill himself — has things prepared …

But has hope of getting a job.

He had agreed to attend the Recovery workshop.

Arrangements were made for him to see his Keyworker the following day.

The risk assessment in this instance did not elicit or include details of further enquiry into potential red flags.

[Mr A's] psychosocial situation and stress at that time.

He was struggling with anxiety, low mood and poor motivation.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

He was living with his ex-wife. It is not known if they were reconciling, or if there was conflict between them.

She was not consulted, though she had raised the alarm concerned about him.

He said he was not sure if he would commit suicide. He had identified …, but he was hopeful of getting a job.

It was not explored what would happen if he did not get the job. This might have been a foreseeable change that would impact on his risk.

A contingency and safety plan was not made.

[Mr A] had mentioned that he hadn't had any contact with his Keyworker, which meant he did not have a meaningful and consistent therapeutic relationship with anyone at that time, potentially increasing his risk.

The plan was for [Mr A] to see his Keyworker the following day, and to see his usual consultant psychiatrist in 4 months.

This gives the impression that he was not considered to be at risk of suicide, or to require close monitoring of his mood, mental state and safety.

He was not seen by the Keyworker the following day.

The next contact was on 14th [Month2], again initiated by [Mr A's] partner [Mrs A] who reported he had attempted to [harm] himself.

He was assessed over the telephone and deemed safe to remain at home.

He was advised to attend the Emergency Department due to the [self-harm].

His wife was not consulted or spoken to.

Follow-up was arranged with his treating team for the next day.

It is my opinion that this is a significant departure from the standard of care/accepted practice.

The situation of a serious suicide attempt by a potentially lethal method … required that [Mr A] was seen and assessed face to face, not by telephone.

His refusal to attend the Emergency Department for a medical assessment was accepted, whereas this needed to be insisted upon, and arrangements made for him to be seen by a psychiatric registrar or consultant for consideration of inpatient admission.

His wife who was his primary support person was not consulted or spoken to.

15th [Month2]

[RN D], Registered Nurse who was [Mr A's] Keyworker phoned him, let him know she was aware of the events of the weekend and asked him to attend the … clinic.

Her notes are copied below:

[Mr A] is a [man in his thirties] with a diagnosis of Paranoid Schizophrenia, Substance-induced psychotic disorder, History of polysubstance use including …, currently in

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

partial remission. [Mr A] stated that he had told [Mrs A] about his infidelity. … Stated that they had had an argument and [Mrs A] kicked him out. [Mr A] decided 'f…k it, I will kill myself'. … Had planned what he was going to do. Stated that the suicide note was delayed on purpose so that his body will be found. … Stated that it was enough to make him rethink his plan. … [Mr A] reiterated that he would not harm himself or others.

Writer spoke with Administrator r/t ? [Dr G] returning on Monday. Will require CTO review. Arranged a further review with [Dr G] on 24th [Month2] @1400 hours. [Mr A] aware, [Mr A] agreed.

I view this as a departure from standard of care/accepted practice.

[Mr A] had not been seen for a face-to-face assessment by his Keyworker since his discharge from the inpatient unit in Counties Manukau.

He was seen for a face-to-face assessment by his Keyworker 25 days after his discharge from hospital.

This contact was made by the Keyworker to follow-up on the recent serious suicide attempt, brought to the attention of the mental health service by his wife and [Ms B].

There is clear documentation in the assessment by his Keyworker of the marital conflict between [Mr A] and his ex-wife over a serious and difficult issue of infidelity.

She had asked him to leave due to his disclosure of infidelity.

This triggered his suicide attempt. …

He sent [Mrs A] a delayed suicide note, with the intention that she would get it after he had completed suicide.

The intent and the lethality of this attempt was very high.

The outcome of this assessment was that [Mr A] remained in the community, based on his assurances of safety. An appointment was arranged to see the psychiatrist for review of his Compulsory Treatment Order on 24th [Month2] which was nine days away.

This implies that the seriousness of his suicide attempt was not taken into account.

It also implies that he was not deemed at further risk and in need of close support, monitoring and follow-up.

This was despite him having made a very serious suicide attempt, on the background of another serious suicide attempt within the last month.

[Mrs A] was not contacted or consulted, despite [Mr A] reporting that they were in the midst of significant conflict and difficulties in their relationship.

c. How would it be viewed by your peers?
My peers agree with my opinion on this matter.

They reiterate that systemic issues, workload issues and pressure on the treating teams would need to be carefully explored.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

d. Do you have any recommendations for how this aspect of care could be improved?
This is a salient reminder of service users who get lost in the system.

Meticulous care will have to be taken to follow the Ministry of Health Guidelines for The Assessment and Management of People at Risk of Suicide — For Emergency Departments, Mental Health Services and Acute Assessment Settings, May 2003 and reviewed in 2008.

And the requirement by the Ministry of Health for Post discharge care in the community.

Staffing issues and pressure on mental health services are likely playing a significant role but is outside of the scope of this report.

2. The appropriateness of [Mr A's] management plan from 11 [Month2] onwards.
The response to this question is the same as the response to **question 1.** — the adequacy of the risk assessments carried out and care provided to [Mr A] after his return to [the DHB2 region] on 20th [Month1].

The management plan from 11th [Month2] onwards was not appropriate for the reasons outlined above.

3. Whether staff responded appropriately to [Mr A's] suicide attempt on 13 [Month2].
The response by staff to [Mr A's] suicide attempt on 13th [Month2] was not appropriate and does not reflect adequate care.

The reasons are outlined above, under the **response to question 1.** — The adequacy of the risk assessments carried out and care provided to [Mr A] after his return to [the DHB2 region] on 20th [Month1].

Revised opinion

I have read the letter to [HDC] from [DHB2]. The letter is dated 22 October 2020.

The issues around the transfer of care are fully outlined in this letter. [DHB2] and the clinicians involved were not aware of [Mr A's] discharge from Counties Manukau District Health Board.

This did mean that there was a departure from the National Transfer of Care Guidelines advice and practice.

I therefore change my opinion to state that the [DHB2] clinicians acted promptly and appropriately once they were contacted by [Mrs A] on 11 [Month2].

In terms of the appropriateness of [Mr A's] management plan from 11 [Month2] onwards, I accept that the assessment and plan was adequate. The keyworker was meant to review him the next day. This did not occur.

The [DHB2] accepts that this was not acceptable practice.

Whether staff responded appropriately to [Mr A's] suicide attempt on 13 [Month2].

It is arguable that the response could have been different due to the seriousness and lethality of the attempt. … Post-[self-harm] medical examination is imperative.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

However, the option of calling an ambulance is often considered. I agree Police assistance would have caused undue distress and breach of the therapeutic alliance.

I accept that the best clinical decision that could be made was made at that time.

I apologize and retract my statement regarding the departure from standard of care for this specific instance. It is a matter of clinical judgement.

The [DHB2] accepts that the follow-up arrangements following keyworker assessment on 15 [Month2] was insufficient.

Relevant issues regarding systemic issues, workload and pressure on treatment teams are addressed in the letter.

4. Whether, in your opinion, [Mr A] should have been admitted as a mental health inpatient on 25 [Month2].

[Mr A] was seen on 25th [Month2] by a consultant psychiatrist who was standing in for his Responsible Clinician who was on leave.

This was an arranged appointment for review of the Compulsory Treatment Order.

[Mr A's] Keyworker was present.

The clinical notes are copied in italics and bold font.

Clinical Notes:
Seen with [RN D]
Argument with [Mrs A]
Attempted self-harm …
10 days ago
Went back home
He sent an email.
Thinks it was stupid but wishes it had worked.
Surviving
No job — recent interviews unsuccessful
Suggested he ask for feedback
Managing at home, talking to [Mrs A]
Struggling to be calm
Anxious
Being occupied helps
Paroxetine — some help with anxiety and depression
Has not attended Recovery group.
MSE:
Slightly unkempt
Rather cursory answers, volunteering little
Low mood
Has suicidal ideas but no current intent
No psychotic features

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

For

Represcribed zopiclone 7.5mg/day although advised this will need to be reduced once established on paroxetine.
Represcribed paroxetine 20mg/day
Continue risperidone 3mg/day
Crisis contacts reinforced — he will keep number in his wallet.
He agrees to attend Recovery Group on Thursday at 10 a.m.
See [RN D] weekly — use one session for sleep hygiene advice
F/u before end of CTO

In my opinion, there wasn't strong indication for [Mr A] to be admitted to hospital on 25th [Month2]. He did not seem acutely unwell in terms of his mood and anxiety, he was not psychotic, and he was not expressing thoughts or intent to commit suicide.

It seems that this assessment/appointment was arranged for review of the Compulsory Treatment Order by a psychiatrist who was available when the Responsible Clinician, who was his treating psychiatrist was on leave.

The longitudinal history of [Mr A] may not have been known to the psychiatrist who saw him on 25th [Month2].

However, he had seen him on 11th [Month2] when he had mentioned that he had … He had then made a serious attempt on 13th [Month2].

This is documented in the notes of the 25th.

Despite the serious suicide attempt, there is no record of any follow-up, support, monitoring or review of [Mr A] in the intervening time between 15th [Month2] when he was seen by his Keyworker and 25th [Month2] when he was seen by the psychiatrist for review of the Compulsory Treatment Order.

There is no record of any contact made by the treatment team with him or with his wife [Mrs A].

If there had been appropriate follow-up and care in the interim period, information would have been available which would likely have influenced the decision regarding inpatient versus community treatment.

The psychiatrist would have had up to date and salient information regarding [Mr A's] progress, (or lack of), his psychosocial situation, and his mood and mental state during the interim period from the suicide attempt on 13th [Month2] and the day he was seen on 25th [Month2].

As it happened, the assessment on the 25th was reliant on how [Mr A] presented on that day.

It was a matter of clinical judgement and interpretation.

With the benefit of hindsight, it seems entirely clear that [Mr A] could or should have been admitted to hospital that day, but there was no compelling evidence either way on the 25th of [Month2] as documented in the notes.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

<u>**Revised opinion**</u>

'**If there had been appropriate follow-up and care in the interim period, information would have been available which would likely have influenced the decision regarding inpatient versus community treatment.'**

It is reasonable to assume that more information might have been available to the psychiatrist if there had been follow-up and care in the interim period by the keyworker. The purpose of the keyworker/case management involvement is for close follow-up and monitoring and for on-going assessment and information gathering, relevant to the person's progress and response to treatment, as well as factors that might be affecting or impacting on their progress, particularly risk.

This statement was not a criticism of the assessment, but merely to add that had [Mr A] been seen in the interim, more information may have been available that would have been helpful.

I agree that the assessing psychiatrist made a reasonable assessment of risk in the circumstances and with the information available to him at that time.

I hope this opinion is useful to the Commissioner. I am happy to be contacted if there are any queries or concerns regarding my report.

Yours sincerely,

Jubilee Rajiah
Psychiatrist."

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix B: Counties Manukau DHB Review

In summary, the Counties Manukau DHB review found:

> "Overall, the review has found that the care provided to [Mr A] in this case was clinically appropriate and of an acceptable standard. There were several examples of particular effectiveness of the care delivered, as well as, identified opportunities for improving care delivery. These are:
>
> Areas of effectiveness:
>
> - Risk of alcohol withdrawal was identified and monitored appropriately using a standardised scale.
> - Social worker and medical team had multiple contacts with [Mr A's] ex-wife, and had proactively established the discharge plan.
> - [DHB2] was informed in a timely manner of the discharge.
> - Discharge summary was completed in a timely manner and posted to the regional medical record.
>
> Opportunities for improvements:
>
> - A direct handover between CMDHB and [DHB2] did not occur and may have supported a more effective transition between services.
> - While the ACNM handover note and nursing discharge note provide evidence that the ACNM alerted [DHB2] of the discharge, there is no documentation of the content of communications (which includes information about the service user's treatment/management needs).
> - Although [Mr A] was advised to contact his keyworker at [DHB2] for follow up, his discharge summary did not contain emergency contact numbers for mental health follow up.
>
> While these findings provide useful insight into opportunities for the service to streamline its operations and improve care coordination with other DHBs, the review team did not identify any issues to indicate that the overall care provided to [Mr A] was not in accordance with our usual standard."

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix C: The Transfer of Patient Care Across DHB Boundaries Mental Health Services March 2018

"**Principles:**

1. Interpretation:

Departing Service — the area where the service user's last domiciliary address was held and where service was being provided from

Receiving Service — the area where the service user has or is moving to

2. The process of transfer of care is to be driven first and foremost by service user needs, goals and wishes. New Zealand law allows for full and free movement as well as individual choice in location of residence — except in a few, very specific circumstances. Competent adults are allowed to exercise these rights to the fullest extent and their mental health care must support these choices to the fullest extent as well.
3. It is acknowledged that the DHB in which the service user is ***physically located*** is charged with providing necessary mental health services to the fullest extent possible.
4. It is the responsibility of any previous DHB from which the service user has relocated to provide whatever expertise or record as would be required to promptly and fully allow the receiving service to assume both clinical and legal responsibility.
5. Timely and thorough communication of clinical information provided as a matter of urgency will be required to effect prompt transfer of care. The standard would be within 24 hours of request by the local clinical team.
6. In cases involving patients at clinical risk or treated under the MH(CAT), Responsible clinician to Responsible clinician contact by *synchronous* communication (phone, in person or by video conferencing) is considered the standard.
7. Where clients present for care to a local service, there is no 'stand down' period. Clinical responsibility is immediately transferred and legal responsibility is transferred as promptly as can be arranged.
8. When service users are believed to have relocated to another area, but have not presented for service at their new location, the area *from which they relocated* (Departing Service) continues to hold clinical and legal responsibility to arrange transfer of care. The 'referring' service may coordinate outreach by the local team in the new location to engage the service user. Once engaged, the local service (receiving Service) assumes responsibility. This arrangement also applies when the service user relocates without involving the treating team.
9. Transfer of care notification between RC's and between DAMHS offices is processed promptly by both parties with copies held by both services to verify the completion of the transfer process. The national DAMHS group have agreed it is unacceptable for a Change of RC form not to be signed on acceptance into DHB care and the DAMHS will be responsible to ensure an RC is allocated. Physical presence takes precedence with regard to clinical responsibility.

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

10. All services have an identified point of contact for such communications that is nationally available. All services make it a priority to assist with further direction to the appropriate clinical team as necessary.
11. Where service user travel is known ahead of time, it is considered in the service user's best interest for referring and receiving services to liaise and agree on a plan of transfer ahead of the known travel. However, actual transfer of care does not occur until the service user has contact with the service — by themselves or via outreach — at the receiving location.
12. In rare occasions where the law allows for return of clients to a referring location under compulsion, both receiving and departing area services cooperate to arrange for the smooth transfer back to the departing area considering as primary the safety of the service user. This may require a period of stabilization at the receiving site prior to transfer.
13. In the unusual circumstance that agreement on a plan forward cannot be determined by the respective first response clinicians, a synchronous discussion between responsible clinicians will follow in an attempt to reach consensus. Should this fail to resolve the matter, the respective DAMHS or clinical directors will conduct a synchronous discussion to come to agreement.
14. The DHB of Domicile is responsible for the payment of Inter-hospital transfers as per the Operational Policy Framework 2017/2018 (p55). Transport and accompanying staffing arrangements may be negotiated inter-DHB to ensure responsive and timely transfer arrangements."

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix D: The assessment and management of people at risk of suicide. Best practice evidence-based guideline. Ministry of Health 2003 (reviewed 2008)

“**Recommendations**

…

INVOLVING WHĀNAU/FAMILY/SUPPORT PEOPLE OF THE SUICIDAL PERSON

Whenever possible clinicians should involve whānau/family/support people/carers of the suicidal person when working with that person. This is equally true for the assessment component, crisis management and subsequent treatment. At any time families can give information to the clinician without it compromising the person’s privacy. If a person who is considered acutely suicidal declines involvement of others, the clinician may override that refusal in the interest of keeping the person safe.

ASSESSMENT OF SUICIDE

RISK

Anyone who seeks assistance from an emergency department following an act of deliberate self-harm, irrespective of intent, or who is expressing suicidal ideation, should be further evaluated by a suitably trained mental health clinician. Culturally appropriate services should be involved with assessment, crisis management and service liaison where possible, and if agreed to by the suicidal person. A suicide assessment should be conducted in a separate interview room that allows the person privacy when disclosing sensitive material. There is no evidence to suggest that directly asking about the presence of suicidal ideation or intent creates the risk of suicide in people who have not had suicidal thoughts, or worsens the risk in those who have. It is more likely that a calm and matter of-fact approach discussion of suicidality may allow people to disclose their previously ‘taboo’ thoughts.

…

ASSESSMENT OF INTOXICATED PEOPLE

People who present to emergency departments with suicidal ideation or following a suicide attempt whilst intoxicated should be provided with a safe environment until they are sober. Assessment should focus on their immediate risk (whilst they are still intoxicated). Enduring risk cannot be judged until the person is sober. People at risk of suicide should be strongly advised to stop using alcohol or illicit drugs due to their potential disinhibiting effects. Whānau/family members should also be told of this.

…

DISCHARGE PLANNING

Follow-up should occur in the first week post-discharge, as this is the highest risk time for a person discharged from hospital. This should happen even if the person fails to attend their outpatient appointment. If the person does not attend their follow-up appointment and is believed to still have a significant risk of suicide, the clinician must make efforts to contact

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.

that person immediately to assess their risk of suicide or self-harm. The discharge plan should be developed in consultation with the person and their key support people (including whānau/family if appropriate) and clinicians. Before leaving the hospital the person should have a clear understanding of discharge arrangements that have been made and a written copy with information about medication, treatment plans and key contacts to call, if needed. If appropriate, the person's whānau/family or nominated next of kin should be informed of the person's risk, told of their next appointment and invited to attend. They should also be involved in discharge planning processes. The continuing care provider/team must get at least a verbal report prior to discharge. They should also be included in any discharge planning meetings/decision-making processes. The person's general practitioner should also get a full copy of the discharge plan including any medication recommendations. If the general practitioner is the sole care provider, he/she should receive this prior to the person's discharge from hospital."

Names have been removed (except CMDHB/Te Whatu Ora Counties Manukau, Middlemore Hospital and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.