Bay of Plenty District Health Board

Psychiatrist, Dr C

A Report by the

Health and Disability Commissioner

(Case 10HDC00805)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This opinion concerns the care provided by mental health services to Mr A, who since 2006 had been variously diagnosed with bipolar affective disorder, personality disorder with mixed features, and cyclothymic disorder. This opinion concerns Mr A's care over a period of four months (Months 1-4) until his death by suicide, in 2010.

2. On 23 Month1 2010, Mr A's partner, Ms B, approached the psychiatric acute community team (PACT) reporting Mr A's non-compliance with medication and his abusive behaviour, which had caused her to move out of the house. PACT discussed with Ms B the possibility of compulsory treatment under the Mental Health (Compulsory Treatment and Assessment) Act 1992 (MHA) and advised her to see Mr A's GP, Dr G, but did not inform Dr G of this contact.

3. On 22 Month2 2010, Mr A attempted suicide, resulting in his admission to hospital. He was reluctant to engage in an assessment by PACT, and was discharged from the Emergency Department to a respite facility as he was homeless. He had brief daily checks by PACT but no further attempt was made to conduct a full mental state assessment.

4. On 26 Month2 2010, Mr A attended an outpatient assessment with psychiatrist Dr I, who made a diagnosis of lifelong personality disorder with acute decompensation in coping and risk in the context of social stress. During the assessment Mr A self-harmed which he later told staff was because Dr I had not diagnosed him with bipolar affective disorder. Mr A was admitted to the intensive care unit.

5. Mr A was discharged home from the intensive care unit on 28 Month2 2010, following an assessment by the consultation-liaison team psychologist who found no acute mental illness and no acute risk as "the relationship issues with his partner [appeared] to have now resolved". There had been no communication with Ms B about Mr A's discharge and no follow-up with mental health services was planned.

6. After two referrals from Dr G, Mr A was accepted for psychiatric outpatient reassessment by Dr C. The assessment on 4 Month4 2010 was also attended by registered psychiatric nurse Mr D. Dr C was unable to complete the assessment in one session and a further appointment was planned for one month's time, when Dr C returned from leave.

7. Dr C made an interim crisis plan in which Mr D was to be Mr A's point of contact for any concerns or crises during working hours. Only Dr C, Mr D and Mr A were aware of Mr D's role. The PACT was unaware that Mr A had been assessed by Dr C, or of Mr D's role in Mr A's care.

8. Dr C's handwritten notes were placed on Mr A's hard file but these did not document the crisis plan or the role of Mr D, and neither Dr G nor Ms B was informed of the assessment outcome.

9. Ms B approached the PACT three times between 15 and 17 Month4 2010 with concerns about Mr A's behaviour and threats of suicide. Apart from advising her to take steps to remove Mr A from her home, the PACT did not respond to these concerns. Although Mr A's electronic record showed that he had attended an outpatient appointment with Dr C two weeks earlier, the PACT overlooked this and did not access his paper file.

10. The mental health services were aware that the relationship breakdown and imminent eviction of Mr A were significant risk factors for his self-harm, however no arrangement was made to review Mr A.

11. Mr A was found dead from suicide a few days later.

12. When Dr C returned from leave, he dictated a reporting letter to Dr G about the 4 Month4 2010 assessment, which Dr G received on 6 Month5 2010.

Findings

13. It is important to note that that my role does not extend to determining cause of death. I am primarily concerned with the quality of care provided to the consumer and whether that care accorded with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). The breach findings of the Code do not imply any individual was responsible for Mr A's death.

14. Dr C failed to maintain adequate records and so breached Right 4(2)[1] of the Code. Dr C's failure to communicate with Dr G or take appropriate steps to communicate with Ms B, together with the failure to take adequate steps to ensure that the crisis plan was documented on Mr A's clinical record, meant that Mr A's continuity of care was compromised. Dr C thereby breached Right 4(5)[2] of the Code.

15. Mr D failed to ensure that his role as Mr A's point of contact within the mental health service was documented on Mr A's clinical record and failed to contact Mr A following the 4 Month4 2010 assessment. However, no breach was found due to the District Health Board's lack of clarity around Mr D's role as the second health professional.

16. Bay of Plenty District Health Board (BoPDHB) missed opportunities to assess Mr A on at least two occasions in mid-Month4 2010 when Ms B presented to the PACT with concerns about Mr A's mood, suicide threats, and impending eviction. Mental health staff failed to contact Mr A for assessment once his known risk factors occurred. Accordingly, BoPDHB breached Right 4(1) of the Code.

17. BoPDHB failed to take appropriate steps to discuss the discharge plan with Ms B and so did not comply with the National Mental Health Sector Standards and the

[1] Right 4(2) states "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[2] Right 4(5) states "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

organisational standards of discharge planning. Accordingly, BoPDHB breached Right 4(2) of the Code.

18. The failures in co-ordination between the Community Mental Health team (CMH), the PACT and Dr G impaired Mr A's continuity of care. Accordingly, BoPDHB breached Right 4(5) of the Code.

Complaint and investigation

19. On 12 July 2010, the Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided by mental health services to her late partner, Mr A. The following issues were identified for investigation:

- *The appropriateness of psychiatric care provided to Mr A by the Bay of Plenty District Health Board in 2010.*
- *The appropriateness of psychiatric care provided to Mr A by Dr C in 2010.*
- *The appropriateness of care provided to Mr A by Mr D in 2010.*

20. An investigation was commenced on 14 June 2011.

21. Information was reviewed from:

Bay of Plenty District Health Board – provider organisation
Ms B – complainant
Dr C – psychiatrist, BoPDHB CMH
Mr D – psychiatric nurse & case manager, BoPDHB, CMH
Mr E – psychiatric nurse, BoPDHB PACT
Mr F – psychiatric nurse, BoPDHB PACT
Dr G – general practitioner

Also mentioned in this report:
Dr H – psychiatrist
Dr I – psychiatrist
Mr J – clinical psychologist
Dr K – psychiatric registrar
Ms L – C-L psychologist
Ms M – CMH intake co-ordinator

22. Independent expert advice was obtained from psychiatrist Dr Murray Patton and is set out in **Appendix A**.

Information gathered during investigation

Background

23. In 2006, Mr A, then aged 45 years, was tentatively diagnosed with bipolar affective disorder by his GP, Dr G. He was commenced on lithium,[3] paroxetine[4] and buspirone[5] and there was an apparent improvement in Mr A's mood.

24. In 2007, Mr A first became known to Bay of Plenty District Health Board (BoPDHB) Community Mental Health team (CMH), when Dr G referred him for "diagnostic clarification and treatment review".

25. From August 2007 to February 2009, Mr A was a patient of the CMH service.[6] During this time he received separate psychiatric assessments from two consultant psychiatrists, Drs I and H, and 14 months of anxiety management and cognitive therapy from clinical psychologist, Mr J. The diagnostic conclusion by all three practitioners was that Mr A did not suffer from a major mood disorder. Rather, Dr I and Mr J felt Mr A had a significant personality disorder with mixed features including paranoid, narcissistic and avoidant traits, while Dr H suggested a diagnosis of cyclothymic disorder[7] or mood disorder NOS (not otherwise specified), noting that Mr A's motivation for a diagnosis of bipolar affective disorder was to put his eligibility for a WINZ benefit on a "sound footing". Mr A was discharged from CMH when he no longer wished to engage with the service, case management or have further contact with a psychiatrist.

26. In early 2009, Mr A met Ms B. At the time, he was living in a caravan park. Later he moved into Ms B's house with her.[8] During their time together, Ms B was of the opinion that Mr A was suffering from bipolar affective disorder and high functioning Asperger Syndrome. He had been estranged from all family members for several years and had no other significant relationships.

27. This opinion considers Mr A's treatment from Month1 2010 until his death by suicide in Month4 2010.

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[3] Medication used to treat the manic episodes of bipolar disorder - hyperactivity, poor judgment and aggression.

[4] Antidepressant medication also used in management of obsessive compulsive disorder, social anxiety disorder, panic disorder and post-traumatic stress disorder.

[5] Medication used in the management of anxiety disorders.

[6] The Bay of Plenty Community Mental Health Service comprises the CMH outpatient service and PACT. The service is divided into two teams according to geographically defined coverage. Each team includes dedicated acute/crisis response (PACT) staff, one of whom has the triage role for all new referrals to CMH. During business hours (0800-1600) Monday to Friday, outpatient assessment, treatment and review occurs by the CMH medical team, consisting of one registrar and three senior medical officers.

[7] A mild form of bipolar (manic depressive) illness with less severe mood swings.

[8] Ms B confirmed to HDC that she considers Mr A to have been her partner from this time until Mr A's death. Throughout the times of her moving out and requesting him to leave the house, she thought of him as her partner, but he was too unwell and "scary" to live with.

Month1 2010 — contact with the PACT

28. On 23 Month1 2010, Ms B approached the CMH crisis team (PACT),[9] concerned at the behaviour of Mr A, who was identified as her flatmate. She expressed concern that Mr A was unwell, agitated and abusive and had not been taking his medications for bipolar affective disorder. She described how Mr A would not talk to her, he had been isolating and controlling and she had moved out as she no longer felt welcome in her own house.

29. The note of this meeting records a discussion about the possibility of implementing the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) process for compulsory treatment. Ms B was advised to see Mr A's GP. No further contact with the mental health service was planned. CMH did not communicate with Mr A's GP about this contact.

Suicide attempts — Month2 2010

30. On 22 Month2 2010, Mr A was seen by CMH in the Emergency Department (ED). He had attempted suicide. Ms B stated that Mr A had stopped his medication months previously and his mood and behaviour had deteriorated.

31. Mr A was assessed by on-call PACT staff. The clinical notes record that the suicide attempt was precipitated by a "relationship break up" with "his partner [Ms B]", and "[he] has now been made homeless". There was no record of a mental state examination by the PACT at this ED consultation. The notes document Mr A's resistance and reluctance to engage in the assessment and that he expressed his unhappiness with treatment received from mental health services in the past, saying he "got the run around at CMH", had trouble getting on the sickness benefit, and was upset about his diagnosis. He said he hoped that one day he would get a referral from a psychiatrist at CMH to a private psychiatrist through ACC. The documented plan was for the PACT to reassess Mr A's mental state the following day.

32. Ms B declined Mr A's request to return to her home, but told nursing staff that she was very happy for the PACT to contact her. Mr A was discharged from ED to respite accommodation because he was homeless and at risk of further self harm.

33. Ms B told HDC that her decision that she could not live with Mr A was because he was not well or safe to be around. She stated that from her perspective "there were no relationship issues as such ... The issue was one of his illness not the relationship".

[9] PACT is a DHB-run community crisis team which sees new referrals triaged as requiring an urgent or acute response, as well as existing CMH patients who are exhibiting early warning signs or are acutely unwell (in collaboration with existing care providers). PACT staff are available 24 hours a day. Their job involves assessment of risk and urgency; the development of clear management plans to minimise risk; communication and documentation of all assessments and actions carried out as part of the crisis resolution function; consultation, liaison and educational activities via contact with referrers, patients and family members at any stage in the treatment process.

34. On 23 Month2, Mr A was discussed at the multidisciplinary team (MDT) meeting[10], and a plan was made for Mr A to have an outpatient assessment with psychiatrist Dr I, as a condition of Mr A being provided with respite care. The PACT was to provide daily follow-up while Mr A was in respite care.

35. Mr A's dislike of Dr I was known to Ms B, and she told HDC that Mr A had previously made a complaint about Dr I. However, despite expressing anger and indirect threats toward Dr I, Mr A accepted the outpatient assessment appointment and his respite stay was extended. Staff at the respite facility reported seeing no evidence of Mr A suffering an acute mental illness. PACT staff made phone contact with Mr A's GP to discuss his prescribed medication. A PACT review on 23 Month2 2010 records that Mr A was not at risk of suicide and describes him as "very sarcastic and projecting aspersions upon [mental health] services and its lack of ability to address or deal with any of his issues". It also notes that Mr A attributed the cause of most of his problems to CMH.

36. On 26 Month2, a phone conversation was recorded in the PACT notes, stating that Mr A's "ex landlord / ex-partner" had locked his belongings in her garage and was wondering who would be collecting these. It was also recorded that Ms B stated that she was worried about where Mr A would live and asked if CMH was arranging accommodation.

37. A further phone call, occurring one hour later, was also documented by the PACT, in which Ms B reported that Mr A had just been to her house and left stating that he was going to kill himself immediately. The PACT advised Ms B to call the police.

38. However, in her response to my provisional opinion, Ms B was adamant that she never made any telephone calls to the PACT. She stated that her only phone call was to the respite facility, to inform staff that she had some clothes and toiletries ready for Mr A's use to be collected from her house.

39. Later that day, Mr A attended the assessment with Dr I, during which Mr A attempted suicide. He was transferred to ED and the Intensive Care Unit (ICU).

40. Dr I identified that Mr A's main problems were anger and hostility associated with a "lifelong personality disorder with acute decompensation in coping and risk in the context of social stress". Dr I considered the possibility of a mood or anxiety disorder, but thought neither was acutely present.

41. Dr I felt Mr A's suicide risk was unacceptably high in light of his apparent inability to co-operate with psychiatric treatment and so Dr I initiated the MHA process to compulsorily treat Mr A.

[10] The multidisciplinary team meeting occurs each business day morning and is attended by the full CMH sector team including psychiatrists. There is a smaller version of the same which occurs at weekends.

42. On admission to ICU, Mr A's psychiatric care was transferred from CMH to the Consultation Liaison Psychiatry (C-L) service[11]. On 27 Month2 2010, Dr K, C-L psychiatric registrar, conducted a psychiatric examination of Mr A under section 9 of the MHA[12]. This assessment was undertaken in consultation with the on-call consultant psychiatrist. Dr K concluded that Mr A was not mentally disordered and was consenting to medical treatment, so the MHA process was stopped.

43. Dr K documented Mr A's recent relationship break-up with his attendant inability to cope and noted that, although Mr A had no current intent to commit suicide, he said he would if his needs were unmet. Dr K recalls that Mr A:

> "… indicated that he wanted input from mental health services particularly because he wanted to receive a diagnosis of bipolar affective disorder (BPAD) which was disputed. At the time of assessment it was clear that he was especially angry at services for not giving him this diagnosis and stated clearly to me that he had made a threat to kill himself … during [Dr I's] meeting because he did not get diagnosed with BPAD."

44. Dr K's plan was for the C-L service to review Mr A the following day and for there to be "CMH follow-up".

45. The DHB stated that CMH follow-up "was a logical assumption of the required follow-up but [Dr K] had not yet had a discussion with [Mr A] about his very hostile feelings toward the personnel at CMH."

46. The clinical notes from 27 Month2 2010, record Mr A telling a C-L nurse he was grateful for the care from ICU staff, saying "Don't worry I won't cause any trouble. My beef's not with them but those over there" (referring to CMH).

47. Ms B visited Mr A during his ICU admission. She said that she was "distraught that he nearly died". The ICU afternoon shift nursing note on 27 Month2 2010, records that Mr A was visited by his "girlfriend".

48. On 28 Month2 2010, Mr A was reviewed in ICU by C-L psychologist, Ms L, and a C-L nurse. Ms L concluded that Mr A had no acute mental illness or acute risk and she noted that Mr A's suicide attempts "occurred in the context of relationship issues with

[11] C-L Provides a mental health service for patients of the General Hospital and ED during normal business hours (0800 – 1630 Mon-Fri). Referrals are received from general wards and other mental health specialty services. Care of patients who are under the care of a CMH team and who are then admitted to the General Hospital are the primary responsibility of the C-L team. On discharge from the General Hospital, patients will be discharged from the C-L service too. If ongoing mental health follow-up is required, C-L will make a referral to the appropriate agency ie. GP, PHO services, CMH or other specialty mental health service.

[12] This is the psychiatric assessment examination by a medical practitioner, provided for in the Mental Health (Compulsory Assessment and Treatment) Act 1992, to determine whether the proposed patient is mentally disordered within the definition of the Act, and if so, whether further assessment and treatment may be required.

his partner, which appears to have now resolved …" It was decided that Mr A would be discharged from BoPDHB's mental health services.[13]

49. Ms B cannot recall anyone from the hospital contacting her to discuss Mr A's discharge arrangements, his accommodation, or their relationship status. BoPDHB has confirmed to HDC that it can find no reference to a documented discussion between hospital inpatient staff and Ms B regarding Mr A's discharge arrangements.

50. There is no record of any attempt to obtain Mr A's consent to discuss his situation with Ms B or any contact with Ms B to ascertain her views about the relationship and whether the "issues" had in fact been resolved. The DHB sentinel investigation report states, "It would have been insensitive for staff to question [Mr A's] statements that the relationship had resolved and that he was returning to his address."

51. Ms L said that she discussed Mr A's case with consultant, Dr I. Ms L advised that the discharge plan did not provide any CMH or outpatient follow-up because of Mr A's candid dislike of Dr I, his disagreements with CMH over diagnosis, and his reluctance to engage with CMH. She said that the role and availability of the PACT was reiterated to Mr A.

52. There is an apparent discrepancy between this plan and the medical discharge letter sent from ICU to GP, Dr G, which stated "continue psych outpatients". However, in her discharge letter to Dr G, Ms L made it clear that no CMH follow-up was intended and she suggested treatment options of primary care funded (CPO) counselling, Community Relationship Services and the Living Without Violence programme. Ms L's letter gave a likely diagnosis of antisocial and narcissistic personality disorder.

53. Ms B said that Mr A walked out of ICU and straight to her door "with a big grin on his face". She had already had the locks changed but did not feel she could turn Mr A away as he had nowhere else to go, so Ms B agreed Mr A could stay, on the condition he took his medication. She organised for his pills to be dispensed in blister packs in an attempt to keep track of his compliance. However, within weeks, he stopped taking them again and became increasingly aggressive.

Re-referral to CMH by GP

54. On 5 Month3 2010, Dr G referred Mr A back to CMH because Mr A had been declined for CPO counselling because he was felt to be at too high a risk of self harm for the primary mental health care programme. The CPO Co-ordinator and CMH Clinical Co-ordinator discussed the inappropriateness of the referral, given Mr A's

[13] Note on discharge processes: Protocol MHAS.A1.31 of the BoPDHB provides that all service users who receive mental health services must have a discharge plan that is developed collaboratively with the patient and family/whānau/caregivers (where the patient's consent is given), that identifies and manages risks associated with the discharge, including expressed concerns of the family/whānau. Evidence of review must be documented in the clinical notes. Arrangements must be satisfactory to the patient, their family/whānau and to the other providers prior to their discharge.

high score of 39 on the Kessler Questionnaire.[14] Apart from the high Kessler score, there was no indication in Dr G's referral of any change in Mr A's presentation or circumstances.

55. Dr G's referral was triaged as "non-acute" by CMH intake co-ordinator, Ms M,[15] and the referral was discussed at the MDT meeting on 11 Month3 2010. On 11 Month3, Ms M wrote to Dr G declining the referral for CMH follow-up, stating: "… based on the information provided, [the referral] did not meet the criteria for acceptance to our service" and reiterating the appropriateness of community relationship counselling options. The CMH team did not contact Dr G for further information.

56. Psychiatrist, Dr C, was present at the MDT meeting and recalls the referral was declined because it contained "no useful clinical information". Dr C said that Mr A had been comprehensively reviewed recently by Dr I, Dr K and Ms L, and the assessments had consistently failed to find any evidence of a major mood disorder or psychotic illness. Dr C said that Mr A's reluctance to engage with treatment was also taken into consideration and he stated: "The acute crisis had resolved and there were no new concerns".

57. The DHB's investigation report notes that the team who declined the initial referral was a different team from that which had previously assessed and managed Mr A's care. The DHB concluded that this team would therefore not have been aware of Mr A's previous history of high-risk behaviours at the end of other relationships. However, it stated that the paper records and electronic health records are accessible by the staff.

58. On 14 Month3 2010, Dr G again referred Mr A to CMH, expressing astonishment that Mr A did not fit the acceptance criteria for the service, and noting the CPO Mental Health Service had formally declined to see Mr A. Dr G described Mr A's decline in mental state over the past five years, from previously being high functioning, to becoming increasingly agoraphobic.

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[14] The Kessler Psychological Distress Scale (K10) was developed in 1992 by Kessler for use in population surveys. Research has revealed a strong association between high scores on the K10 and diagnosis of anxiety and affective disorders. There is a lesser but significant association between the K10 and other mental disorder categories and with the presence of any current mental disorder. Mr A's score of 39 was consistent with severe anxiety or depression.

[15] The triage intake co-ordinator (one per CMH sector team) processes all new referrals and categorises them according to required priority of assessment: 1. Urgent – passed to PACT immediately for contact within 4 hours; 2. Acute - contact within 24 hours by PACT or designated case manager (if in working hrs); 3. Non-acute - taken to MDT meeting for discussion and review within 1 week of receipt. At the MDT, a case manager is allocated, contact and assessment timeframes established and appointments booked. It is standard practice to obtain prior records when considering GP referrals and this is the responsibility of the intake coordinator. If a referral is not comprehensive, BoPDHB policy dictates that the intake co-ordinator "will contact the referrer and/or client, and using the triage form, gain further information to clarify appropriateness of the referral and assign priority if indicated". In the case of referrals triaged as not meeting criteria for the mental health service, the intake co-ordinator is responsible for writing to the referrer and providing advice about alternative pathways for service if appropriate.

59. This second referral was triaged as non-urgent by Ms M, and discussed at the MDT meeting on 20 Month3. Dr C, who again was present at the meeting, said that Dr G's second referral "also did not contain any psychiatric symptoms, risk or mental state findings on which we could make an informed decision" and that the tone was "threatening and unhelpful".

60. Dr C discussed the case with Drs I and K. He said that he remained unclear "who actually wanted the assessment and for what particular reason" and that "the pressure to assess Mr A was not on the basis of clinical information or need but rather the bullying remarks by the GP and how best to manage this situation".

61. The DHB record of that meeting indicates "[Dr C] will contact GP", however, there is no documentation in the clinical notes of any contact having occurred. Because the MDT could not reach a consensus on the best pathway forward, Dr C decided to complete a full file review and present the case to the Senior Medical Officers (SMO) Peer Review for clinical guidance on 28 Month3 2010.

62. Dr G advised HDC that he was attempting to re-refer Mr A to CMH because "the PHO rightly declined his counselling assessment." Dr G commented that some criticism of the content of the referral letters may have been valid if these letters had been his sole communication with CMH, "however in the context of a compendious written dialogue spanning 4 years, and the PHO referral accompanying, any reasonable person would recognise my increasing concern for [Mr A's] welfare."

63. The SMO group suggested completing another assessment because of the complex personality issues involved, and to support the GP. Dr C recorded this decision by hand on the triage referral and there is a handwritten note by a CMH secretary that an appointment was made for Mr A to see Dr C on 4 Month4, prior to Dr C going on three weeks' leave. The upcoming appointment was entered into Mr A's BoPDHB electronic (Webpas) file on his "Patient Visit List" screen. Dr C told HDC that there was no clear clinical indication to see Mr A urgently, and if he had not seen Mr A in early Month4, Mr A would have had to wait one to three months, which is the common waiting time for non-urgent GP referrals.

Case management

64. At BoPDHB CMH, the case manager for a service user is the primary person for contact in treatment planning and co-ordination of care for that person. Responsibilities include ensuring smooth transitions along the care pathway for service users and their families, resolution of distress and effective management of mental health issues, and re-integration with family and primary care networks.

65. Case managers are usually appointed as a result of a staff member volunteering for the role, or else the role is assigned by the Team Leader (consultant) at the clinical MDT meetings. If a patient is known to the service, the case manager may be allocated at the time of referral.

66. The consultant can request that the case manager attend the initial assessment, but that person may not necessarily continue as the patient's case manager (eg. where a RN attends the appointment, but it would be more beneficial for an occupational therapist or social worker to case manage). The case would be discussed at the clinical meeting and a new case manager allocated.

67. If an initial psychiatric assessment is needed because of the patient's complexity or the need for diagnostic clarity, then the case manager might not be allocated until after the assessment at which the diagnosis and treatment plan are formulated.

68. At the MDT meeting prior to Mr A's assessment, psychiatric registered nurse Mr D agreed to attend the interview with Dr C. There is conflict about the capacity in which Mr D attended. Dr C said that Mr D was "clearly identified as the case manager" at the MDT meeting. Dr C also stated in response to my provisional opinion: "I arranged a case manager five days before I saw [Mr A]". The DHB investigation report refers to Mr D's role as the "case manager pending the completion of [Dr C's] report". However, Mr D told HDC that at no point was he requested to be engaged in case management, as Mr A had not yet been accepted by CMH.

69. Mr D said that if the assessment determined that Mr A was an appropriate CMH patient, then either he or another colleague would be appointed case manager. Mr D said he understood that he was present at the interview "to discuss with [Dr C] [his] thoughts of [Mr A's] assessment and to communicate this within our MDT discussion". Mr D stated, "I was asked to attend an assessment. [Mr A] was not allocated to me at the time of the referral and I could not have accepted a case management role until after the assessment and discussion at MDT." The DHB stated that case manager appointment usually occurs through the clinical meetings, but added: "Allocation is sometimes done at the time of referral if the person is known to the service and has been previously care managed by the team."

70. There was no linked referral made on Mr A's electronic (Webpas) file, to indicate that a case manager had been assigned to him (the usual way of circulating this information to internal providers such as the PACT) and no communication, by phone or in writing, of case management to external providers (such as the GP). BoPDHB has confirmed it is the responsibility of the person appointed as Case Manager to circulate this information.

71. HDC requested that BoPDHB supply the minutes of the meeting at which the case manager was allegedly appointed. BoPDHB advised that the relevant team was the "[X] team". All sector teams meet each morning. The discussions at the meetings are recorded in a book and then transcribed to the sector team minutes and relevant entries are made in patients' clinical records. HDC obtained the relevant sector team meeting minutes, which do not refer to the appointment of a case manager for Mr A and his clinical records do not refer to the appointment of a case manager.

72. BoPDHB advised that each team has a separate weekly meeting which they also record in a book; however, the X team's book for the period in question is missing.

73. In his response to the provisional opinion, Dr C provided a copy of his personal diary from 31 Month3 to 6 Month4 2010. On 31 Month3 he has handwritten: "9.00 MDT→ [Mr A] – update – need CM". Below this is written "[Mr D] [sic] ✓". Dr C stated that this entry "proves [Mr D] did agree to be a case manager."

74. On 4 Month4 2010, Mr A attended the assessment with Dr C. Dr C advised HDC that he took care to engage Mr A in a therapeutic alliance. Dr C said he felt the interview process was positive and that Mr A felt heard and respected. However, Dr C said that as a result of Mr A "dominating the discussion" the assessment could not be completed in the allocated 90 minutes.

75. Dr C said his impression was that Mr A suffered from acute adjustment disorder[16] which was improving. This had been triggered by Mr A's recent separation and accommodation issues, which had now been resolved. Dr C said he found no evidence of major depression, bipolar affective disorder or Asperger syndrome, and no impairment of insight or judgement. Dr C said he considered Mr A's risk of harm and reached a view that there was no immediate concern, given that he had identified no recent new stressors or dynamic (modifiable) suicidal risk factors. Dr C noted Mr A "had a low risk of deliberate self-harm but a chronic risk of aggression and violence toward others."

76. A further appointment was scheduled for a month's time, on 5 Month5 2010, when Dr C returned from leave. This appointment was for the purposes of completing the assessment and discussing management options, which were likely to include a psychotherapy referral. No interim contact was planned. Mr D stated that "The second health professional/observer would provide ongoing follow-up if a need had been highlighted in the assessment and a plan had been agreed with the doctor and patient ... I did not feel I needed to foster a further therapeutic alliance when there had not been a decision about offering care and no indication in the assessment of need to engage further."

77. Dr C said he discussed a crisis plan for the interim period with Mr A. Mr D agreed to be "a point of contact" within the CMH service, should Mr A need it for any concerns or crises that arose during normal working hours. After hours, Mr A was to contact the PACT.

78. Dr C stated that there was no clear clinical case management role he could identify for Mr D because there were no medications, acute suicidal risk, mental state concerns or psychosocial stressors that needed monitoring, but he encouraged Mr A to make contact with CMH service if he had any concerns.

79. Dr C said he believed that the crisis plan was realistic, given that Mr A had engaged with the PACT a few weeks earlier and had attended psychiatric assessments voluntarily, even if there was some "acting out" behaviour. Dr C said that "[Mr A] did

[16] An acute psychological response to an identifiable recent stressor that causes significant emotional or behavioural symptoms, lasting less than six months, that do not meet the criteria for anxiety disorder, post traumatic stress disorder, or acute stress disorder.

want help to get on with others, unfortunately his own personality and intolerance of others inevitably got in the way." Dr C stated that he was mindful of Mr A's dislike of individuals within CMH who he perceived as rejecting and invalidating, but he believed positive steps towards engagement had been achieved during the interview and that Mr A felt respected and validated by him. He stated, "My clinical judgment at the time of assessing [Mr A] is that he would make contact with services if he needed support. He did attend regular therapy sessions with [Mr J], psychologist, previously."

80. Dr C's handwritten notes were placed in Mr A's clinical hard file, which was held in the central file room and was accessible to all mental health staff. However, no entry was made on Mr A's electronic file until 29 Month4 2010, after Dr C returned from leave and was notified of Mr A's death, at which time Dr C dictated a ten-page reporting letter to Dr G which was typed and entered onto Webpas. That letter states "[Mr D] was also present at the interview and his role as case manger [sic] was explained". However, the handwritten notes made no reference to the role of Mr D.

81. Dr C stated no entry was made on Mr A's electronic file on 4 Month4 because he had not yet completed a full assessment (he intended see Mr A again to complete the assessment on his return from holiday) and he had agreed to show Mr A his final report in draft form first. However, in contrast, Dr C also stated in response to my provisional opinion "Doctors do not write in the electronic notes system". Dr C said the handwritten notes were available on the paper file and Mr D was aware of the clinical outcome.

82. Dr G did not receive Dr C's psychiatric outpatient clinic report letter until 6 Month5 2010, two weeks after Mr A's death. Dr C stated to HDC "there was a delay in the dictation of the report for the GP but no delay in providing a clinical record. There were hand-written notes available in the file … I do routinely use hand-written notes for acute psychiatric assessments … I am not aware of any situation where hand-written notes of clinical information is an unacceptable practice."

83. The BoPDHB standards for documentation in health records are contained in the "Health Record – Content and Structure Policy 2.5.2, protocol 2". This states that each entry must be legible and complete and include accurate date and time, full signature and designation of the health professional. No blank spaces are to be left in any section. If a space is not completed, a line must be drawn through the space across the section and this must then be signed and dated. Documentation is required to be completed as soon as practicable after any event/interaction with the patient. If any information cannot be recorded, reasons for this must be documented.

84. The hand-written notes were recorded on a standard psychiatric assessment form. The copy supplied to HDC is not dated or signed by the author. There is no indication of who else was present at the interview besides Mr A. There is no "working diagnosis" documented. Under "Action plan" the only entry made is "Group → disclosure. [Quetapine]??". On the final page is written "F/U 1. → Copy of letter. 2.→ F/U 1/12". There is no mention of Mr D or his role, and no effective crisis plan.

85. In his response to my provisional opinion, Dr C informed HDC that the date, time and who was present was recorded on his "clinic list" and therefore he had "no need to transpose this important information to my assessment form as this would be duplication of known and already documented information." The clinic list he refers to is a computer generated appointment schedule for the Adult Mental Health "Clinic for [Dr C]" of "Fri 04 [Month4] 2010 at 09:30". Mr A's name is typed in the 9.30am appointment slot and the capital letters "[of Mr D's initials]" are handwritten alongside, but no name is stated. However, Dr C stated "[The clinic list] clearly identifies, time, date, doctor and case manager."

86. Dr C informed HDC that he and reception each hold a copy of the clinic list. When the patient arrives, the receptionist identifies the psychiatrist and case manager, and informs both. However, Dr C's clinic list for 4 Month4 2010 was not attached to the handwritten assessment or filed anywhere in Mr A's paper clinical record. There is no electronic (Webpas) record, either on Mr A's "patient visit list" or on Dr C's outpatient clinic list, of Mr D or anyone else being present, or of Mr A having a case manager assigned.

87. Dr C further stated that he does not routinely sign his CMH assessments as he is the only doctor on his team and the written summary is always replaced by the dictated summary on the file. Dr C advised that in Mr A's case, "There was no clinical reason to inform the GP or PACT immediately as there was not [sic] acute crisis evident" and that "I did discuss a crisis plan in detail as I do with all my patients where relevant."

88. Mr D said he was aware that Dr C had made hand-written notes, but was not aware that Dr C did not enter his report onto Mr A's electronic record until 29 Month4. Mr D did not make any record of the assessment or of his role as first point of contact on Webpas.

89. In its response to my provisional opinion, the DHB advised that, "As the second health care professional, regardless of whether he had clarified his on-going case management role, [Mr D] was required to adequately document his contacts with [Mr A]."

90. Dr C told HDC that, as doctors do not write in the electronic notes system, "it was not helpful that Mr D did not write notes on Webpas after the assessment". He stated, "There was an electronic date on Webpas confirming my appointment and I expected the Case Manager to document the outcome of our assessment of [Mr A]." Dr C further stated that, regardless of case management assignment, he expected Mr D to document notes in Webpas, as the other health professional present at the assessment.

91. As a result, while Mr A's "patient visit list" on his Webpas file showed he had attended an outpatient visit with Dr C on 4 Month4, the only clinical record of this assessment was Dr C's undated, unsigned, hand-written notes on the paper file. Furthermore, there was no record anywhere on Mr A's clinical records of Mr D having been present at the assessment or having been assigned as the CMH point of contact should Mr A present in crisis.

PACT contact with Ms B

92. Ms B said that in the weeks following his discharge from ICU on 28 Month2, Mr A again stopped taking his medication, his mood deteriorated and his aggression escalated. Ms B said she contacted Dr G and was aware the GP was trying to refer Mr A back to CMH.

93. Ms B said that by mid-Month4, Mr A got "really scary" so she left the house and stayed with a girlfriend. Ms B said that when she told Mr A she was leaving, he threatened to kill himself and she believed he would carry through with the threat.

94. Mr A's GP records state that Ms B presented to the practice "in crisis" at 2:15pm 15 Month4 2010, reporting that Mr A had become profoundly paranoid and disinhibited, verbally abusive and was threatening to physically abuse her. She was advised to leave the house and keep herself safe, to ring the Police for assistance and to immediately notify the crisis team.

95. Ms B said she went to two Police stations "begging for assistance", but found the Police "belligerent" and nothing happened. She approached the PACT three times, on three separate days, although only two of these occasions, on 16 and 17 Month4 2010, are documented.[17] The other visit was not documented by the PACT staff as it was categorised as a general information enquiry from a member of the public about Asperger Syndrome. On each visit, Ms B was seen by two PACT nurses (involving a total of four staff members). Mr E, a registered nurse (RN) and duly authorised officer for a sector team, spoke with Ms B on all three occasions.

96. The exact nature of what was said at these visits remains in dispute. Ms B said that on each occasion, she told the PACT that Mr A was suicidal and asked for him to be assessed. She stated that she told them that Mr A had discontinued his medication and was unwell, but the nurse, Mr E, kept "stonewalling" her and said "why don't you kick him out?" She said Mr E told her to get a Trespass Order, but she didn't feel this had anything to do with the issue. Ms B said she went to the PACT because she needed help with Mr A, and stated "the accommodation – I could sort that out. But I couldn't sort out his mental problems."

97. Dr G advised HDC that, when he called the PACT, he was told "that woman has been ringing all weekend".

98. Mr E recalls that on 16 Month4, Ms M asked Mr F and him to see Ms B. Mr E said that Ms M informed them that Mr A was not currently a client of CMH as a recent GP referral had been declined. Apparently no one in the PACT noticed on Mr A's electronic Webpas "Patient Visit List" that Mr A had attended an outpatient appointment with Dr C on 4 Month4 2010, and the PACT did not access Mr A's paper file, which contained Dr C's handwritten assessment.

[17] BoPDHB has confirmed that the 16 Month4 visit was incorrectly dated in the clinical notes as 15 Month4 2010.

99. Both Mr E and Mr F had reviewed Mr A at the respite facility in Month2. The PACT records from 16 Month4 document that Ms B told the PACT that Mr A was not taking his medication, had thrown a clotheshorse outside, and had the TV up loud. Ms B told the PACT she had already been to the Police. Mr E and Mr F gave advice about trespass and how to serve a trespass notice, because they considered Ms B's concern was "about how to remove an abusive man from her home". Ms B was given the PACT 0800 phone number and Mr E told her the PACT was available for Mr A should he request support.

100. Mr E and Mr F returned to the PACT office and discussed their findings with Ms M and the information was discussed again at the 3pm handover meeting, to ensure the entire team was aware of Mr A's possible deterioration should he be evicted.

101. Mr E recalls that the second PACT contact with Ms B was similar. His notes from 17 Month4 2010 record:

> "Discussion with [Mr A's] landlord [Ms B]. She came requesting that we take [Mr A] from her home and find him accommodation in a caravan park. A long discussion ensued again around [Mr A] making threats to [self harm] once again should she make him leave her home. [Ms B] has given [Mr A] to Sunday 20th [Month4] to find alternative accommodation ... Once again we informed [Ms B] that [Mr A] can contact at any time for support but in the past he has made it clear that he has no faith in the mental health system. Currently he is distressed at the ending of his relationship and being asked to leave his place of residence. There is no current evidence [of] psychotic illness and when the police attended yesterday he denied any imminent intention to self harm".

102. Mr E recalls that, because this was the second approach to the PACT with concerns about Mr A's risk in two days, they had a long discussion about the case at the PACT handover. The team agreed with Mr E's assessment that the case should be taken to the sector MDT for discussion of Mr A's ongoing management. This occurred the following morning.

103. All active PACT work is discussed at the daily MDT meetings, at which all staff, including psychiatrists, are present. Mr E stated that the MDT discussion is a "core process for safety of the PACT team" and the only timetabled direct medical input for the PACT.[18]

104. The DHB's investigation report states that the contact between the PACT and Ms B was discussed at the CMH meeting on 18 Month4 2010. It states: "PACT became aware that [Mr A] had a case manager and as a consequence he was taken off the PACT case load" and that the MDT confirmed that Mr A did not require an immediate assessment. The report states: "The meeting was informed that an assessment was in the process of being done by a psychiatrist and a case manager was designated".

[18] During working hours there is no dedicated medical officer available to PACT. PACT is reliant on the sector psychiatrists to juggle their sector work in order to respond to acute PACT requests.

105. Mr E stated that from 18 Month4 2010, the CMH sector MDT assumed responsibility for Mr A's ongoing care. Mr E said "I had no further discussion about [Mr A] and assumed that [Mr D] had been appointed as case manager and assumed he would follow up".

106. Mr E also stated that on 16 and 17 Month4, he was not aware that Mr A had a case manager appointed. Mr E commented that if he had been aware of this, "PACT would not have become involved in this case as [Ms B] would have been appropriately directed to discuss her concerns with the case manager by the intake coordinator." Mr F also stated that he was not aware that Mr D was the case manager.

107. Mr E said he was also unaware that Dr C had conducted an assessment of Mr A on 4 Month4 2010 and said they "were in fact told that [Dr C] had declined the referral." Mr E stated:

> "If we had been aware that a recent assessment had been conducted we would have accessed that assessment and included that in our decision making process. I would also assume that [Dr C] would have with his formulation outlined a treatment plan with some indication of the shape of the treatment pathway to follow".

108. A few days later, Ms B rang Dr G's surgery to request a home visit for Mr A and was told to call the PACT. Dr G's practice nurse contacted the PACT and the information was passed on to Mr D, who phoned the house, but got no answer. Later that morning, Ms B went to the house to check on Mr A and found him dead. The Police notified the PACT of Mr A's death.

Actions taken

109. On 20 Month5 2010, Ms B made a complaint to the BoPDHB Mental Health Service. An investigation was commenced by BoPDHB, and a meeting held on 30 Month5 2010 between Ms B, her support person, the Clinical Co-ordinator of CMH, and the Acting Associate Director of Nursing. In response to her complaint, Ms B was advised by the DHB that "[Mr A] was discharged from [the] Hospital in a manner appropriate to the information available to staff at the time".

110. The DHB conducted a Sentinel Investigation into Mr A's case. It found that while there were administrative processes in CMH that resulted in poor communication at times in regard to Mr A's assessment and treatment, these did not contribute to Mr A's suicide. Recommendations arising from the Sentinel Investigation included:

- to conduct staff education about serious personality disorders;
- to include reasonable explanation and guidance on ongoing management in letters to GPs declining referrals;
- to complete all assessment documentation within required timeframes and prior to the assessing clinician taking leave; and
- to ensure clinicians' roles are clearly identified, documented and available to all service staff in the event of an emergency.

Changes implemented by providers

111. Dr C informed HDC that he now dictates a brief synopsis of his assessments for GPs with the statement that a comprehensive report will follow. He noted that in practice it is uncommon for him to require two assessments to reach a clear opinion.

112. Mr D stated that it may have been of benefit for Dr C or him to have documented on the clinical file that the assessment process had not yet been completed and the date planned for completion. He further indicated the importance of highlighting to the team when the period of assessment is continuing and when a person is acting as point of contact only, prior to a case manager being allocated. He stated that, with hindsight, it may have been best for all contacts to be directed to the PACT during this interim period, prior to case manager allocation.

113. BoPDHB has informed HDC that since the internal investigation into this complaint the following actions have been taken/proposed:

- A proposed change to Referral Protocol [MHAS A1.43] - Where the referrer does not accept an initial decline of the referral, the patient will be offered a full assessment to establish whether all the information about the referral was captured, in order to inform any decision to follow up.
- Proposed changes to the mental health service discharge process [MHAS A1.31] – when patients are discharged, it will be specified who will be responsible to engage with them when they represent again, and what the assessment expectations will be if this happens within a specific timeframe of 4 months or thereafter, including how the acuteness of the presentation will influence the actions.
- A review of the CMH Intake Co-ordinator role and the total process of referral triage, assessment and allocation. This has resulted in a discussion document and draft proposal which is currently out for consultation.
- Staff education programmes about the assessment and management of patients with serious personality disorders (by [doctor from] University of Auckland) occurred on 15-16 September and 24-25 November 2011.
- A nurses' working party review with clarification of the roles and responsibilities involved in case management as distinguished from a request to be a second health professional attending an appointment (as is customary practice for safety reasons when meeting a service user for the first time). The Nurses Forum established that the second health professional will be expected to document the nature of their role.

Response to provisional opinion

BoPDHB

114. BoPDHB accepted the factual accuracy of my provisional report. It acknowledged that there were a number of systemic issues resulting in deficiencies in care co-ordination between CMH, PACT, C-L, Dr G and Ms B. It advised that the complaints

about Mr A's case have been sentinel events for the mental health service and staff and that a number of change management projects are currently underway to improve acute response, embed the CAPA (Choice and Partnership Approach) model and strengthen the NASC (Needs Assessment and Service Co-ordination) functions in adult mental health services.

115. The Mental Health & Addiction Service advised that the comment forwarded by the DHB "that it would have been insensitive for staff to question statements in relation to the relationship" was unsatisfactory and does not reflect the culture of the service.

116. The DHB acknowledged that Mr A's discharge from ICU by the C-L psychologist lacked input from the psychiatric consultant or Ms B, and that this "discharge from mental health" lacked communication with, or input from, CMH, who had been instrumental in arranging Mr A's ED admission just two days previously.

117. The DHB agreed that there were identified incidents of unsatisfactory engagement with specific PACT members and that, as a result, a review of the PACT team is underway.

118. With regard to Mr A's clinical record, the DHB commented, "While [Dr C's] handwritten notes may have been sub-optimal in terms of clinical documentation, they were later transposed into an assessment that met accepted standards."

Ms B

119. Ms B provided comments which have been inserted into the information gathered where appropriate. Ms B said she is "aggrieved that no one with a clinical background contacted her at any stage during this saga."

Dr C

120. Dr C stated that he was Mr A's doctor. However, he also stated: "There was an electronic date on Webpas and I expected the Case Manager to document the outcome of our assessment of [Mr A]".

121. Dr C said he did not contact Ms B because Mr A did not request him to do so and it would have breached Mr A's privacy to consult Ms B without his consent. However, Dr C acknowledged that, in hindsight, contacting Ms B at the 4 Month4 assessment would have been wise. He advised that "I do engage with the families/whānau of my patients and would have expected that this would have been part of my engagement with [Mr A]."

122. Dr C stated that the 4 Month4 assessment did not appear to him to be a crisis situation requiring an immediate response, however, "[Mr A] was an acute risk subsequently when [Ms B] approached the PACT." Dr C noted that "[f]urther risk is a dynamic concept and all mental health clinicians are aware that risk can change quickly" and that "RN [Mr E] did not need my assessment to do an updated risk assessment and respond to [Ms B]. He was able to do this as a part of his own process. He had available to him the electronic record of CMH contact and the paper file."

123. Dr C stated that he does not accept that there was any failure in communication with Dr G following the 4 Month4 assessment. He stated, "There was an acceptable delay as a result of clinical indictors (no new information, no crisis, no change to his treatment) and the practical issues outlined which enhanced engagement at the price of incompletion of the assessment … [Dr G] wanted [Mr A] seen in CMH. He did not state any particular purpose and he did not ask for any specific treatment."

Mr D

124. Mr D reiterated:

> "I still dispute that case management was discussed and would like it noted … it was clear from the [4 Month4] assessment that no critical need for case management was identified, therefore no case manager was appointed. This is my rationale and supporting evidence for not proactively engaging with [Mr A] … As point of first contact there was no onus on me to 'initiate contact' but should [Mr A] request contact, he could request me by name."

125. Mr D submitted that he was not asked by Dr C to be more than a point of contact after the first part of the assessment was completed and that the information provided by Mr A "did not warrant contact".

126. Mr D observed that there is "a lack of clarity around the role of the second health professional/observer and when the intervention of case management should start … This leaves 'case managers' in a precarious situation with regard to expectations placed upon them." He further commented, "I have had almost two years to reflect on my practice since that event and feel that my only failing was not documenting that I was point of contact and that the assessment was incomplete."

Standards

NATIONAL MENTAL HEALTH SECTOR STANDARD NZS 8143:2001
"7 RECORDS AND CONFIDENTIALITY

An accurate and confidential record that promotes efficient and effective delivery of treatment and support is maintained for each person receiving the service.

Criteria

7.1
People receiving the service have an individual record including relevant and necessary information about their treatment and support in order to meet the requirements of The National Mental Health Sector Standard. The requirements for individual's records shall be recorded in the organization's policies and procedures.

7.2
Individual records are comprehensive, objective, factual and accurate, and provide a sequential record of the involvement with the service. Each entry in the individual clinical record is dated, signed (including designation) and is legible.

This shall include and is not limited to ensuring:

(a) Paper or computer records are unique to each person receiving the service within which their current status under any relevant legislation is clearly identifiable;

(b) Regular file auditing.

7.3
Each person who receives the service has access to his or her individual record in line with legislation.

7.4
A system exists by which the mental health service uses the appropriate information about the person who is receiving the service to ensure continuity of treatment and support for the individual. The record can be readily accessed for use in any contact with the service.

This shall include and is not limited to:

(a) A single record for each person who receives the service (this includes electronic records);

(b) Policies and procedures ensure that relevant and necessary information about the people who receive the service is shared between providers, and across all components of the service including inpatient and community.
…

10 FAMILY, WHĀNAU PARTICIPATION

10.1
The mental health service has policies and procedures relating to family, whānau participation, which encourages their appropriate involvement in the service.

This shall include and is not limited to:

(a) Ensuring the privacy, confidentiality and rights of any person receiving the service is not infringed as part of this process.

…

12 LEADERSHIP AND MANAGEMENT

12.3
The governing body ensures there are effective communication systems and working relationships in order to facilitate the delivery of co-ordinated services. This should

occur within and across the mental health service, and with other relevant organizations and individuals.

…

15 ASSESSMENT

15.4

Following assessment each person and their family, whānau, with their informed consent, is provided with information on the diagnosis, options for treatment, support, or referral and possible prognosis.

16 QUALITY TREATMENT AND SUPPORT

16.4

The identification of early warning signs and relapse prevention is included in the individual plan. Each person receiving the service and their family, whānau receives assistance to develop a plan that identifies early detection or warning signs of a relapse and the appropriate action to take.

16.19

The Transfer, Exit or Discharge Plan is reviewed in collaboration with each person who receives the service and with their informed consent their family, whānau."

Preliminary comments

127. Mr A was receiving services from a number of clinicians within CMH, as well as his GP. Mr A's partner and his GP recognised Mr A's deteriorating condition and attempted to obtain assistance from CMH. In such a situation, effective communication, both within the CMH team and between CMH and the GP, was essential. Mr A did not receive the services he needed because of a combination of individual failures and systemic factors.

128. In any healthcare system, there are a series of layers of protections and people, which together operate to deliver seamless service to a patient. When any one or more of these layers do not operate optimally, the potential for that level to provide protection, or deliver services, is compromised. When a series of such events occur, although each are often minor in themselves, the fabric that is wrapped around the patient in the delivery of a seamless service is torn. When a series of tears, or holes, line up, poor outcomes result. Patients are at risk of being harmed.

129. At the outset, it is important to note that that my role does not extend to determining cause of death. I am primarily concerned with the quality of care provided to the consumer and whether that care accorded with the requirements of the Code. In my view, the services provided to Mr A had multiple failings. A number of people were

aware of his deteriorating condition, but the failings hampered the ability of those people who were concerned about Mr A to access the required help for him.

Opinion: Breach – Dr C

130. Mr A had the right to receive services of an appropriate standard from psychiatrist Dr C. This included the right to have services that complied with professional standards of documentation,[19] and the right to co-operation among providers to ensure the quality and continuity of Mr A's care.[20]

Documentation

131. The typed report of Dr C's 4 Month4 2010 assessment was not entered onto Mr A's electronic record until 29 Month4 2010. Dr C stated that in the interim period, his handwritten notes were available on Mr A's hard file. However, these notes are hard to decipher and fall short of the DHB standard of clinical records being legible, complete and compliant with generally accepted standards.

132. The handwritten documentation contains much less detail than Dr C's final ten-page typed record of the assessment. There is no indication of a diagnosis or action plan besides the note "copy of letter", and a follow-up appointment for one month. There is no documentation of the interim crisis action plan agreed upon. In my view, these handwritten records were not of a reasonable standard and, even though other staff could access them, they were insufficiently clear to be meaningful. Despite Mr A's appointment with Dr C showing on the outpatient clinic schedule, other clinicians would not have been able to ascertain from the paper records when the assessment took place, who was present, and who carried out the assessment.

133. Dr C submitted in response to my provisional opinion that there was no need for him to enter identifying details such as date, who was present or signature, because they were accessible electronically on the 4 Month4 CMH outpatient clinic schedule. However, even if the appointment had been identified on Webpas, there was nothing on the written assessment to link it to that electronic appointment and there was also no indication on Mr A's file that Mr D was present or his role.

134. Dr C had handwritten Mr D's initials on his paper print-out of the clinic schedule, but this would not have been evident on Webpas, and its meaning is unclear. Further, I do not find that Dr C's omission to sign his psychiatric assessment can be justified by his being "the only doctor on the team" or that it was his "routine practice" not to do so. Dr C's handwritten notes were the only specialist documentation informing Mr A's care, between 4 Month4 and 29 Month4 when the typed report became available.

135. The clinical record, which may be contributed to by numerous providers, is a historical record of a patient's medical history. Its purpose is to inform all providers

[19] Right 4(2)
[20] Right 4(5)

within the DHB who provide services to that patient. It is important that other providers are able to identify the author of clinical records, so that person can be consulted with, or clinical information clarified, if the need arises. Given the possibility that Mr A's risk level might change, the crisis plan should have been evident from the records.

136. The National Mental Health Sector Standard requires records to be "comprehensive, objective, factual and accurate, and provide a sequential record of the involvement with the service. Each entry in the individual record is dated, signed (including designation) and is legible".[21] My expert advisor, consultant psychiatrist Dr Murray Patton, noted that records must inform further contact and outline the basis of conclusions with respect to the assessment and treatment plan. He commented that while "working notes" may sometimes be used as an outline that informs or supplements a more concise summary, such a summary was not completed by Dr C in a timely manner and was therefore not available to inform care. Dr Patton has advised that Dr C's documentation departed from accepted psychiatric standards by at least a moderate degree.

137. I consider that Dr C's handwritten documentation of the 4 Month4 assessment was well below that required in the National Mental Health Sector Standard and, accordingly, Dr C breached Right 4(2) of the Code.

Continuity of care

138. Dr C's involvement in Mr A's care commenced in Month3 2010, when Dr G's first referral of Mr A to the CMH was considered and declined. Later that month, Dr G again referred Mr A to the CMH. After consideration of that second referral, the MDT could not reach a consensus on the best way forward, so Dr C decided to take the referral to the senior medical officer peer review group for discussion.

139. Dr Patton commented that this decision was appropriate in light of Dr G's concerns, as was the decision to offer Mr A a timely appointment for a psychiatric assessment. That assessment was conducted by Dr C on 4 Month4 2010, but was not completed within the allotted time.

140. While Dr Patton considered the assessment itself to have been adequate, he was critical of the follow-up arranged. Firstly, while Dr Patton viewed Dr C's assessment of risk as reasonable as far as he could tell from the records of that assessment, he noted that risk is a dynamic concept and the most significant dynamic factor contributing to Mr A's risk was the quality of his relationship with Ms B. It would have been desirable to have planned interim contact between Mr D and Mr A to maintain a budding alliance and to assess Mr A's relationship with Ms B.

141. Secondly, Dr Patton viewed Dr C's plan for Mr A to proactively contact the mental health service should he be feeling distressed as 'optimistic', particularly in the absence of someone within the service with whom Mr A had a regular relationship.

[21] Criteria 7.2.

Mr A had been reluctant to co-operate with assessments after his suicide attempts and had expressed his dislike of the CMH.

142. Dr Patton noted that on 26 Month2 2010, when Mr A had been making threats to harm himself and Ms B, there was no evidence Mr A had any inclination to contact the PACT, despite his distress. On the other hand, Mr A had willingly accepted CMH contact in the past in the context of an ongoing psychotherapeutic relationship, such as during his 11-month period of psychotherapy with Mr J. Dr Patton considered that Dr C would have made a clinical judgment on whether a therapeutic alliance had been sufficiently established between himself, Mr D and Mr A, to expect that Mr A would make contact if distressed.

143. I note Dr C stated he did not contact Ms B on 4 Month4 because Mr A did not request him to do so. However, in my opinion, Dr C should have asked Mr A to give his consent for the crisis plan developed at this assessment to be communicated to Ms B, as a further safety measure. This would have been in keeping with the DHB's policy of involvement of whānau in patient care. Ms B was aware of changes in Mr A's risk factors and increases in his vulnerability. If made aware of the plan, she would have known to go directly to Mr D for help, rather than to the Police and PACT. I note that in hindsight, Dr C agrees that contacting Ms B would have been wise.

144. Dr C did not make a timely electronic record of the assessment or the crisis plan. He stated that he expected the case manager to document the outcome of the assessment. Apart from the confusion as to whether Mr D was the case manager, in any case as Mr A's doctor, Dr C was responsible for ensuring that his assessment of Mr A's condition, any diagnosis, and the plan (including the crisis plan) were clearly evident in the records. If Dr C expected Mr D to record Dr C's opinions, he should have clearly communicated this expectation to Mr D. I note BoPDHB has advised me that Mr D was required to "adequately document his contacts with [Mr A]". In my view, this requirement does not extend to documenting Dr C's assessment.

145. The PACT nurse, RN Mr E, stated that had he been aware of the recent assessment, the PACT would have accessed that assessment and included it in the decision-making process when Ms B approached them with concerns about Mr A's mental health. RN Mr E commented that he would also have assumed that Dr C would have given some indication of a treatment pathway to follow. Unfortunately, as noted above, even if the PACT had accessed the hard file, Dr C's handwritten documentation of the assessment would have been uninformative in this regard and would have given no indication of Mr A's crisis plan with Mr D as the first point of contact.

146. Dr G received no report of the 4 Month4 assessment until Dr C's letter was received at his GP clinic on 6 Month5 2010. Sadly, Mr A had died two weeks earlier. I find this delay in communication unacceptable. Both Mr A and Ms B remained in contact with Dr G and he was responsible for prescribing Mr A's psychotropic medications. Mr A and/or Ms B may have contacted Dr G in the event of a crisis arising. In fact, on 15 Month4 2010, Ms B did just that. In these circumstances, I believe that, at the very

least, prompt communication to Dr G that the assessment had taken place, the risk assessment, and the interim crisis plan, was essential for the continuity of Mr A's psychiatric care.

147. I appreciate that forging a respectful and positive therapeutic engagement was a sound clinical reason for extending Mr A's assessment over two interview sessions, and that it is unusual to require more than one interview to complete a CMH psychiatric assessment. Nonetheless, I believe such an occurrence is foreseeable and does not justify Dr C's failure to communicate with Dr G, at least by way of a phone call/message or brief note, rather than intending to wait over one month before communicating with the GP after the planned 5 Month5 appointment. This was particularly important given the time that was to elapse between the first and second appointments and the fact that Dr C was to be unavailable during that period.

148. I do not accept Dr C's contention that "there was no clinical reason to inform the GP or PACT immediately as there was not [sic] acute crisis evident". Within the preceding six weeks, Mr A had made two suicide attempts and had twice been referred back to CMH by his GP. While there may have been no significant psychiatric findings on 4 Month4, Dr C noted himself that, "Further risk is a dynamic concept and all mental health clinicians are aware that risk can change quickly." Dr C has confirmed that it was relevant for him to discuss a crisis plan in detail with Mr A. In my opinion, this was appropriate and demonstrates that the possibility of a crisis arising sometime over the next month could be anticipated. As such, to ensure continuity of care, I believe that the GP and PACT should at least have been informed of the crisis plan.

149. In my opinion, Dr C's failure to communicate with Dr G or Ms B, together with his failure to take adequate steps to ensure the crisis plan involving Mr D as point of first contact was documented on the clinical record, meant that Mr A's continuity of care was compromised. Dr C thereby breached Right 4(5) of the Code. I note that Dr C has acknowledged these shortcomings in communication and has made changes to his practice. These breach findings do not imply that Dr C was responsible for Mr A's death.

Opinion: Adverse comment – Mr D

Communication of role

150. Mr D became involved in Mr A's care when he agreed to attend the 4 Month4 psychiatric assessment. The reporting letter prepared by Dr C on 29 Month4 2010 states "[Mr D] was also present at the interview and his role as case manger [sic] was explained". However, the handwritten notes made on 4 Month4 have no reference to the role of Mr D. Whether he attended merely as a "second observer" or as a case manager is not certain. However, it is an undisputed fact that he agreed to be point of first contact at CMH for Mr A, should a crisis situation arise.

151. Mr D's role was particularly significant in Mr A's case, given that the other clinician with knowledge of the current assessment, Dr C, was going on leave and would not be available for the next month.

152. Mr D's position description includes: "Works and communicates effectively as a member of the multi-disciplinary team, demonstrating individual responsibility and accountability". As a registered health professional undertaking a key role in the crisis management plan for Mr A, Mr D had a professional responsibility to ensure that his role as the intended point of contact for Mr A at CMH, was readily evident in the DHB information system and/or otherwise communicated effectively to the PACT. This information should have been available when Ms B made contact with the PACT on 15 Month4 2010.

153. However, it appears that from 4 Month4 until 18 Month4, the only people aware that Mr D was to be the point of contact were Mr D, Dr C and Mr A. Neither the PACT nor Dr G was informed of Mr D's role and his role was not apparent from either the hard file or the electronic record. This compromised Mr A's continuity of care.

154. As stated, although Mr A was not felt to be at risk on 4 Month4 2010, risk is a dynamic concept and it was foreseeable that changing circumstances might change the risk level.

155. In my view, it was reasonable for Mr D to assume that Dr C, as the lead clinician at the assessment, would record the assessment. However, Mr D should have himself confirmed that the crisis plan and his role in it was entered into Mr A's record or otherwise communicated to the PACT. I am advised[22] that it is not unusual for psychiatrists to delegate documentation to psychiatric nurses, particularly in circumstances such as this, where the assessment is not yet complete, or due to time restraints, such as where the psychiatrist is immediately going on leave. Dr C has stated that he "expected" Mr D to document the outcome of their assessment. However, there is no evidence that any overt delegation occurred in this case. As a result, I do not consider a breach finding is warranted in relation to Mr D's failing to document his role in Mr A's care.

Case manager

156. I note that had Mr D been clearly assigned as Mr A's case manager, the BoPDHB job description of that role would have placed clear responsibility on him to inform others of his role. I agree with Dr Patton's observation that it is possible to see why Mr D was variously described as being the case manager, given that his expected role accorded with that of case management. The referral from Dr G had been accepted by CMH. More contact was planned. No one else was expected to have any role in that period, as Dr C had gone on leave and was unavailable. The clear expectation was that Mr D, as the first point of contact, would therefore have the responsibility for making further arrangements as needed should Mr A present to CMH. This is congruent with

[22] Phone communication with HDC expert psychiatric nursing advisor, Bernadette Paus, 18 January 2012.

the job description of a BoPDHB case manager. However, Mr D asserts that he did not believe the case management role had been assigned to him and there is no record in the team meeting minutes or Mr A's clinical records that a case manager had been assigned.

157. In light of my concerns about the DHB's practices around the appointment of case managers (discussed below), I do not find that Mr D breached the Code for failing to fulfil the duties required by a case manager. I do, however, regard his passivity as suboptimal.

Contact with Mr A

158. As mentioned above, it would have been good practice for interim contact to have been planned between Mr D and Mr A following the 4 Month4 assessment, to foster a therapeutic alliance and reassess issues of vulnerability. While Dr C was clearly the lead clinician at the assessment, I believe Mr D, as a registered psychiatric nurse, should have taken the initiative and ensured that Mr A had appropriate support and supervision. I note the role of a registered nurse at BoPDHB includes:

- undertaking a timely comprehensive nursing assessment and making nursing judgments; and
- engaging in robust ongoing assessment and management of risk.

159. In my opinion, Mr D's absence of contact with Mr A following the 4 Month4 assessment fell below this standard. I interpret "robust ongoing assessment" as setting an expectation of proactivity on Mr D, rather than passively waiting for Mr A to make contact with the service should his condition worsen. It seems this lack of proactivity accorded with Mr D's narrow view that he had a passive role as the second observer to an assessment. In my view, Mr D should reflect on his lack of initiative in this case.

Opinion: Breach – Bay of Plenty District Health Board

Introduction

160. A number of BoPDHB departments provided care to Mr A including ED, ICU, C-L psychiatry, CMH outpatients and the PACT. In providing this care, the BoPDHB had a duty to ensure quality and continuity within and across these services, and with external parties involved in Mr A's care, such as Dr G and Ms B. This was essential to ensure that Mr A was provided with seamless care of an appropriate professional and organisational standard.

161. In Month4 2010, there were failures in co-ordination between Mr D, Dr C and the PACT staff. The role of Mr D was unclear, the records of prior contacts with Mr A were not adequately accessed and, when situations arose which resembled those which had previously increased Mr A's vulnerability to self-harm, they were not adequately responded to.

162. Criteria 12.3 of the National Mental Health Sector Standard requires the DHB to ensure there are effective communication systems and working relationships in order to facilitate the delivery of co-ordinated services within and across the mental health service, and with other relevant organisations and individuals.

163. Dr Patton advised that "overall, the care was patchy". While some things were carried out well, others could have been improved, and there were several areas where Mr A's care fell below expected standards.

Service delivery - missed opportunities

164. Dr Patton has advised that the DHB psychiatric assessments performed by Dr I, Dr K, Ms L and Dr C were all of reasonable standard. However, he identified suboptimal aspects of the PACT care, which were of some concern.

165. On 22 Month2, when the PACT staff assessed Mr A in ED following his first suicide attempt, they did not document a mental state examination. It appears the examination may have been limited by Mr A having terminated the assessment. However, despite the documented plan to "reassess mental state tomorrow", when the PACT staff visited Mr A at the respite facility over the following days, only cursory attention to his mental state was recorded, with the assessments predominantly focused on whether Mr A had suicidal ideation.

166. In my opinion, optimal practice should have seen the visiting staff continuing their follow-up by attempting to explore whether Mr A had a mental disorder through systemic enquiry of his symptoms and a comprehensive mental state examination. I accept however, that arranging for a specialist review within a few days (by Dr I) was reasonable and that there was no evidence of acute mental illness reported by respite facility staff to the PACT.

167. Of greater concern however, is the PACT's interaction with Ms B in Month4. Between 15 and 17 Month4 Ms B contacted the PACT three times. It is documented that she was seeking information about to how to remove Mr A from her home and that he was threatening suicide and behaving in a threatening manner. The PACT provided practical information to Ms B. However, the implications of this eviction for Mr A do not appear to have been adequately considered by the various PACT staff.

168. As confirmed by BoPDHB, the PACT staff, as senior nurses and duly authorised officers, were expected to access Mr A's health record and prior service contacts and respond accordingly. Mr A's recent appointment with Dr C was noted on Webpas but this was evidently missed by the PACT triage co-ordinator and the PACT duly authorised officers. On 18 Month4, the MDT decided that Mr A did not require an urgent assessment and noted that a psychiatrist was in the process of assessing Mr A and that a case manager had been appointed in the interim.

169. Mr A's vulnerability at times of relationship stress and eviction was known to the service, and these had been clearly documented in his clinical record as risk factors

which had precipitated his previous suicide attempts. In my opinion, the warning signals were not responded to appropriately.

170. These circumstances should have prompted the PACT staff to contact Mr A directly for assessment and review, particularly on the second occasion that Ms B presented informing them Mr A was threatening suicide.

171. I am also critical of the PACT's apparent reliance on the Police's assessment of Mr A in its decision-making, particularly in the absence of any direct communication with Police on the issue. On 17 Month4, a PACT duly authorised officer, RN Mr E, spoke to Ms B and, as a result of information she provided, recorded "there is no current evidence [of] psychotic illness and when police attended yesterday he denied any imminent intention to self harm". RN Mr E did not speak directly to the Police.

172. In my opinion, any conclusions drawn by the PACT about Mr A's mental state and suicide risk, should have occurred through direct contact and assessment of Mr A by PACT staff themselves. Dr Patton commented on this issue:

> "[R]elying on information from people untrained in assessment of mental state or risk of self-harm in making a determination that there is no evidence of grounds for immediate concern, especially when there is no direct contact between the clinician and the person upon whose assessment reliance is being placed, is fundamentally flawed practice. In circumstances in which it could reasonably be assumed that there was an increased risk, which was acknowledged by the PACT staff, making a more active arrangement to directly review the person who might be at risk should be considered and options to do this should be explored." [23]

173. For the reasons above, I find the PACT's and MDT's inadequate responses when provided with information indicating that Mr A was experiencing a crisis meant that Mr A was not provided with services with reasonable care and skill, amounting to a breach by BoPDHB of Right 4(1) of the Code.

Continuity of care

Communication with Ms B

174. A further concern is the DHB's lack of consultation with Ms B about Mr A's care and discharge planning. Mr A had been estranged from his family for several years. His only significant personal relationship was with Ms B, who is variously described in Mr A's DHB clinical record as his flatmate, girlfriend, partner and ex-partner.

175. The National Mental Health Sector Standards require that patients and, with consent, their families or whānau, are provided with information on their diagnosis, options for treatment, support, or referral and possible prognosis. Similarly, discharge plans should be reviewed in collaboration with families or whānau.

176. On 23 Month1, Ms B moved out of her house as she could not cope with Mr A's behaviour. On 22 Month2, it was noted Mr A's suicide attempt was precipitated by

[23] Dr Patton's preliminary advice to the Commissioner, dated 2 May 2011.

the relationship break-up. Ms B refused to allow Mr A to return to her house when he was discharged from ED. On 26 Month2, Ms B made a phone call to the DHB, requesting that Mr A's belongings be collected from her garage. None of these events suggest her relationship with Mr A was back on good terms or that she was expecting him to return to live with her.

177. On 27 Month2, there is mention in the records that Mr A was visited by his "girlfriend". This, together with Mr A's own statements, seems to have been the basis for the PACT's and Dr C's assumptions that the relationship issues had resolved and Mr A's accommodation with Ms B was now stable. However, no steps were taken to obtain Mr A's consent for staff to contact Ms B to discuss or confirm these facts, despite the well-documented connection between relationship separation and Mr A's mental state and his clinical notes indicating that Ms B was happy to be contacted by mental health staff.

178. I find the DHB's statement that "it would have been insensitive for staff to question [Mr A's] statements that the relationship had resolved and that he was returning to his address", to be unsatisfactory. It is reassuring to note that BoPDHB has since agreed that the comment was unsatisfactory and does not reflect the culture of the service. The importance of good working relationships between mental health workers and family, particularly when a patient is being discharged from the DHB service, has been emphasised in previous HDC Opinions[24] and is recognised in National Mental Health Sector Standards, which encourage family involvement with the patient's consent.

179. I note BoPDHB's policy requires the discharge plan to be developed collaboratively with the patient and family/whānau; to identify and manage risks associated with the discharge including expressed concerns of the family/whānau; and for arrangements to be satisfactory to the patient and their family/whānau prior to the discharge. Ms B was effectively Mr A's only 'whānau' at the time and was intrinsically involved in his identified "dynamic risk factors" of relationship and accommodation issues.

180. In my opinion, it was not good practice for the DHB to plan Mr A's discharge from the mental health service on 28 Month2 on the basis of unverified facts suggesting that his relationship and accommodation-related risk factors had resolved. Moreover, it was unreasonable for the DHB to fail to take appropriate steps to obtain Mr A's consent to discuss the plan to discharge Mr A to Ms B's home with her. Given Ms B's known concerns about Mr A residing in her home and that difficulties in his relationship were a risk factor for him, the DHB should have verified the circumstances. By failing to ensure staff sought Mr A's consent to involve Ms B in Mr A's care and discharge planning, BoPDHB did not comply with the National Mental Health Sector Standards and the organisational standards of discharge planning and breached Right 4(2) of the Code.

[24] See Opinions 07HDC06607 and 09HDC08140.

Communication with Dr G

181. Ms B contacted the PACT on 23 Month1 2010, expressing concern that Mr A was unwell. Although the Mental Health Act (Compulsory Assessment and Treatment) Act 1992 (MHA) was discussed and Ms B was advised to consult Mr A's GP, the PACT did not contact Dr G directly.

182. Dr Patton advised that optimal clinical practice would have been to alert Dr G, so that he was aware of these background events should Mr A present to his practice. This was particularly important when the possible use of the MHA was being discussed. In Dr Patton's view, the omission to contact the GP in this circumstance would be viewed with disapproval by peers, although he noted that it is unlikely to have had any material effect on Mr A's care. In my opinion, the failure by the PACT to notify Dr G detracted from optimal continuity of care being provided to Mr A.

183. When Mr A was discharged from ICU following his self harming during Dr I's assessment on 28 Month2 2010, there were apparent inconsistencies in the follow-up plans communicated to Dr G between the medical discharge letter and the mental health discharge letter. The medical discharge summary suggested further psychiatric outpatient care would be forthcoming, but the C-L psychologist's letter to Dr G, made it clear no further planned CMH care would be offered. The C-L decision to "discharge from mental health" was apparently made without communication or input from CMH who had arranged Mr A's admission only two days prior. In my opinion, this discharge planning is another instance of poor co-ordination and continuity of patient care.

184. Dr G's referral of Mr A back to the DHB's mental health service on 5 Month3 2010 was considered at the multidisciplinary team meeting on 11 Month3. I note Dr G explained his letter was somewhat brief as he assumed it would be considered in conjunction with the service's knowledge of Mr A's "compendious" past history. The DHB sentinel investigation report suggests that the team considering the referral would not have been aware of his prior history of high-risk behaviours, as a different team had previously managed Mr A's care. This statement is difficult to reconcile with the DHB's standard practice of obtaining prior records when considering what action to take in respect of a referral.

185. Mr A's prior history should have been obtained by the intake co-ordinator and been available to the team. I find it concerning that there was a breakdown in this process, and that the intake co-ordinator did not access Mr A's records. A lack of information-sharing within a DHB clearly has negative implications on continuity of patient care. This may also go some way to explain the CMH's difficulty in assessing Dr G's referral.

186. Dr G's first referral was declined by the intake co-ordinator's letter dated 11 Month3, which stated that the criteria for entry to the service were not met. Dr Patton advised that the referral was declined on reasonable grounds (that there had been several recent assessments and the GP referral letter contained no indication of change in Mr A's condition). However, optimal practice of the CMH team at this time would have

been to have had a direct discussion with Dr G about the reasons for declining the referral.

187. I consider that in cases where CMH perceives difficulty with a GP referral, it should contact the GP directly to clarify the reasons for and expectations of the referral, to confirm any key facts (such as the relationship and accommodation status in Mr A's case) and to address any specific concerns relating to the assessment outcome. In this case, such direct discussion would have allowed Dr G to provide further information to assist with consideration of the referral.

188. On 14 Month3, when Dr G referred Mr A to CMH for a second time, expressing astonishment and frustration at the initial referral being declined, again no-one from CMH contacted Dr G directly. Dr C commented that the referral letter contained a "lack of information on which we could make an informed decision". Dr C was unclear "who actually wanted the assessment and for what particular reason", and the MDT was unable to reach a consensus on handling the referral.

189. I note the DHB has a policy that if a referral is not comprehensive, the intake co-ordinator will contact the referrer to gain further information to clarify the appropriateness of the referral and the urgency with which it should be handled. In my opinion, this policy should have been followed.

190. It seems clear from the promptness of his re-referral that Dr G had significant concerns about Mr A, notwithstanding the brevity of his referral letters. A phone call to Dr G could have clarified his concerns, provided him with management advice, and would have been an excellent opportunity for CMH to provide constructive feedback to him regarding the information required when making future referrals. I believe the absence of direct communication between Mr A's primary and secondary providers in these circumstances indicates a failure in the implementation of the DHB's referral handling process, which also was detrimental to the quality and continuity of Mr A's care.

191. CMH appears to have lacked insight into and acknowledgment of the importance of Dr G's role, which had implications for the continuity of Mr A's care.

Communication within the DHB

192. Dr Patton advised that the eventual decision to offer a specialist assessment was appropriate. However, he viewed the apparent failures in co-ordination within CMH subsequent to this with, at least, moderate disapproval.

193. The plan for Dr C to conduct a CMH outpatient psychiatric assessment was made at the senior medical officer peer review group. I am concerned that this plan was apparently not communicated to other key members of the CMH team, including the intake co-ordinator Ms M, who had responsibility for triaging and processing referrals. Ms M had triaged both referrals from Dr G. She had written the letter to Dr G declining the first referral. Ms M was the intake co-ordinator when Ms B presented to PACT in Month4. Ms M erroneously believed that Mr A's care had been declined

by the service. This misinformation was taken into account in the PACT's decision-making about Ms B's visits.

194. I consider the communication between the staff involved in the referral handling process was deficient. If Ms M had known Mr A had been assessed by Dr C on 4 Month4, she would have been in a position to investigate the outcome of the assessment when Ms B presented on 15 Month4, and if she found no electronic record of it, she could have accessed Mr A's hard clinical file. Unfortunately this would not have disclosed the crisis plan detailing the role of Mr D as the first point of contact, but would have enabled the PACT staff to be made aware of Dr C's recent assessment of Mr A.

195. The misunderstanding of Mr D's role in Mr A's care was a further example of poor communication processes within the DHB's mental health service. The process for case manager appointment was that the case manager could be appointed at the MDT meeting or during the referral process. Any subsequent documentation was completed by the case manager. As a result, there was no check that the person appointed was aware of their role. In addition, there was no record of Mr D's role in the team meeting minutes or in Mr A's records.

196. Mr D stated that he did not consider he was involved in the management of Mr A, and was simply an observer at the 4 Month4 assessment and a point of contact while Dr C was away. This is at odds with Dr C's understanding and underscores my view that the process of case management allocation was deficient.

197. In addition, while the DHB has indicated that it expected Mr D to have documented his contacts with Mr A, my investigation did not find any clearly defined role/expectations of the second 'observer' health professional present at a BoPDHB CMH assessment. It is important that the role and expectation of each team member is made clear at the time a role is allocated and that these roles are made clear to others.

Summary

198. BoPDHB failed to contact Mr A for further assessment following Ms B's visits to the PACT between 15 and 17 Month4 2010, when his increased risk factors for self-harm were known and identified. Accordingly, I find that BoPDHB did not provide Mr A with services with reasonable care and skill and so breached Right 4(1) of the Code.

199. BoPDHB failed to take appropriate steps to discuss the discharge plan with Ms B and so did not comply with the National Mental Health Sector Standards and the organisational standards of discharge planning. Accordingly, I find that BoPDHB breached Right 4(2) of the Code.

200. BoPDHB also failed to ensure continuity of care for Mr A. Of most concern was the failure in co-ordination between Mr D, Dr C and the PACT staff in Month4, when the crisis plan of Mr D as intended first point of contact was not made known to the PACT.

201. Other inadequacies in the flow of information and communication within the DHB are demonstrated by the misunderstanding between the medical team and psychiatric liaison service as to psychiatric outpatient follow-up; the fact that the CMH team considering the first GP referral was not aware of Mr A's prior history; the failure to inform Ms M of Mr A's acceptance for CMH assessment on 28 Month3; and the confusion about whether Mr D was appointed case manager. BoPDHB also failed to communicate adequately with Dr G after Ms B's visit to the PACT in Month1 2010, and when processing his two referrals to CMH in Month3 2010. The failures in co-ordination between CMH, the PACT and Dr G impaired Mr A's continuity of care. Accordingly, I find that BoPDHB breached Right 4(5) of the Code.

Comment on changes made by BoPDHB

202. I am not able to comment on any changes in respect of the Referral protocol and Discharge from MH&AS protocol reviews, as I have been advised by BoPDHB that these are on hold pending the review of the intake co-ordinator role.

203. BoPDHB has advised me that education sessions aimed at improving staff knowledge and expertise in dealing with patients with serious personality disorders have taken place. However, I agree with Dr Patton that education should be accompanied by ongoing support for implementation of the learning and practice change.

204. The DHB pointed to the expectation, as established at the nurses' forum, that a second health professional at an assessment will document their participation. However, I note Dr Patton's further advice that unless the practice is backed up by ongoing audit and supervision, this somewhat "soft" approach to practice improvement is likely to have only limited effect.

Recommendations

205. I recommend that BoPDHB:

- review its operating procedures and polices in light of this report and provide HDC with evidence by **31 October 2012** of changes made, staff training, and planned follow-up/audits, in respect of:

    1. The CMH referral handling process; specifically addressing direct communication with referrers, and internal communication of decision outcomes.
    2. The triage/intake co-ordinator role, including the requirement to access prior records, and direct communication with referrers/GPs.
    3. The training of mental health staff regarding discharge planning, and the involvement of whānau/family and other providers.
    4. The case management allocation process, documentation and training to ensure clarity of team members' roles.

5. Clarification of the role and expectation of health professional/s taking part in assessments.
6. Ongoing education and staff support relating to the management of patients with severe personality disorders.

- provide a written apology to Ms B for its breaches of the Code. The apology is to be forwarded to HDC by **15 October 2012** for sending to her.

206. I recommend that Dr C:

- provide a written apology to Ms B for his breaches of the Code. The apology is to be forwarded to HDC by **15 October 2012** for sending to her.

- undertake training on the DHB documentation standards protocol "Health Record – Content and Structure Policy 2.5.2, protocol 2" and provide HDC with evidence by **15 October 2012** of training having been undertaken, and report to HDC any changes made to his practice.

Follow-up actions

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

- A copy of this report with details identifying the parties removed except the DHB and the expert who advised on this case, will be sent to the Medical Council of New Zealand and the Nursing Council of New Zealand. The Medical Council of New Zealand will be advised of Dr C's name and the Nursing Council of New Zealand will be advised of Mr D's name.

- A copy of this report with details identifying the parties removed, except the DHB and the expert who advised on this case, will be sent to DHB Shared Services, the Royal Australian and New Zealand College of Psychiatrists, and the New Zealand College of Mental Health Nurses.

- A copy of this report with details identifying the parties removed, except Bay of Plenty DHB and the expert who advised on this case will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent expert psychiatric advice to the Commissioner

The following expert advice was obtained from Dr Murray Patton, consultant psychiatrist:

"**Complaint: [Mr A] / Bay of Plenty DHB**

Your ref: 10/0805

Thank you for your letter of 29 August 2011. You have asked me to provide advice in respect of this complaint about the psychiatric care provided to [Mr A] by the Bay of Plenty DHB (BoPDHB), further to the preliminary advice that I provided to you on 2 May 2011.

You are seeking my view about whether the BoPDHB, including [Dr C] and [Mr D] specifically, provided a reasonable standard of care. In addition you are asking whether there are any aspects of the care, systems or decision-making processes involved in this case that warrant additional comment or recommendations for improvement.

You have also asked me to comment on the changes implemented by the DHB in response to this complaint.

I cannot identify any conflict of any nature in providing you with advice on this matter.

You have provided me with supporting information bundled together in 2 files. Your letter identifies this supporting information as being:

1. Clinical notes from BoPDHB (complete file as supplied to HDC); pages 1 to 439
2. Copy of complaint; pages 442 443
3. Record of phone call with [Ms B], 9 August 2011; pages 444 to 446
4. [Dr G's] report to the coroner; pages 448 to 460
5. BoPDHB response to the complaint, 18 November 2010, including the DHB complaint file (pages 464 to 493) with Sentinel investigation report (pages 494 to 504)
6. Copy of my preliminary advice to HDC, paragraphs numbered as supplied to the providers; pages 505 to 515
7. Response to notification of investigation from [Mr D], dated 30 June 2011; pages 516 to 530
8. Response to notification from [Dr C], dated 28 July; 2011 pages 531 to 542
9. Response to notification from the BoPDHB dated 8 July 2011; pages 543 to 823

Was the care that was provided to [Mr A] in 2010 of a reasonable standard?
Overall, the care was patchy. I think there was a reasonable approach to the assessment and decision-making in respect of [Mr A], and there seems to have been

reasonable oversight of the various staff involved in decision-making and good coordination between them, but with some significant exceptions.

There are some aspects of the overall systems of care which appear to have been deficient and which contribute to the overall approach being not of a reasonable standard.

I shall discuss the various contacts over the course of 2010 to expand upon my overall conclusion in respect of the standard of care.

On 23 [Month1] [Ms B] attended the community mental health service concerned about the behaviour of [Mr A], who was identified as her flat mate. [Ms B] was concerned that [Mr A] was unwell. The records of that contact reflect that he would not talk to her and that he was spending most of the day sleeping. The records show very little exploration of other symptoms. Some background to the concerns is noted along with the advice given, that [Ms B] see [Mr A's] GP and possibly that the Mental Health Act be considered. No further contact with the Mental Health Service was planned. The file note of this contact appears to be only a single page of handwritten text in the body of the clinical notes[25] and 11 lines of typed text.

I can find no evidence of discussion or of any other communication with the GP about this contact.

Ordinarily it is useful to ensure that general practitioners are informed of contacts their patients make with specialist health services. Although in this situation it was not [Mr A] himself who made contact with the mental health service, the advice offered included the possibility of further contact with the GP.

The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights confirms that every consumer has the right to co-operation among providers to ensure quality and continuity of services. In accord with this and optimal clinical practice it may have been helpful to alert the GP in some manner to this contact in order that he had some background should [Mr A] present to the practice, to assist with that continuity of care. In my view this would be especially important when such an important consideration as use of the Mental Health (Compulsory Assessment and Treatment) Act was being discussed as a possibility.

In my view the omission of contact with the GP in this circumstance would be viewed with moderate disapproval. It is not evident however that [Mr A] had contact with the GP before he was seen again by the mental health service, so this omission on this occasion seems unlikely to have had any material effect.

[Mr A] was subsequently seen on 22 [Month2] by PACT staff when he presented to the Emergency Department following [a suicide attempt]. There is evidence of attention to recent stresses, to recent symptoms and to matters of ongoing risk. There is no record of an examination of mental state, although the record notes that [Mr A]

[25] Page 147 of the bundle of documents

was only partially cooperative with the assessment and it appears that the examination may have been limited by [Mr A] terminating the assessment. Ongoing assessment was planned and arrangements were made for respite care.

It is not clear whether the contact in [Month1] was known by the PACT staff subsequently involved on 22 [Month2], nor to what degree the details of prior contact over the period from 2007 to 2009 was known. I understand though, from the further information provided by BoPDHB, that the records would have been available to PACT staff.

Whether or not these records were accessed is not clear to me but the plans that were made appear reasonable given the nature of the information gathered at the time of this contact.

There was a discussion of the assessment and presentation in the team meeting on 23 [Month2]. The proposed approach was that he be offered an appointment with [Dr I], but that if this were declined he would "be let go on his way".

PACT staff subsequently reviewed [Mr A] at the respite facility. He agreed to see [Dr I] and the stay at the respite facility was extended.

[Mr A] was again seen on 24 [Month2] by PACT staff. On this occasion when the forthcoming appointment with [Dr I] was discussed [Mr A] became angry and somewhat threatening in nature and terminated the conversation.

The following day a phone call was made to the respite facility by PACT staff. No concerns were noted.

[Mr A] was visited again the following day at the respite facility. He confirmed his agreement to see [Dr I] later that day and declined the offer of help with transport. Staff of the respite facility noted that they had seen no evidence of acute mental illness.

These plans, to provide respite support and to have further contact with [Mr A] to review his presentation, were reasonable in these circumstances.

Despite the plan outlined on 22 [Month2] to "reassess mental state tomorrow" there is no clear evidence in the records of these further contacts at the respite facility of further attempts to obtain a detailed history or to undertake a mental state examination. The notes of contact with [Mr A] over the next few days reveal only cursory attention to his mental state, predominantly focused on whether there was suicidal ideation. It was arranged however that medical review take place.

In such circumstances where assessment has been limited because of the willingness of a patient to engage in the assessment, or for some other reason, it is important (as noted by the PACT staff) to try to continue the assessment, with appropriate arrangements in place to help address safety and which may facilitate access to more urgent assistance if required. For [Mr A] therefore the respite arrangements were

appropriate. It would have been optimal practice for the visiting staff to attempt to explore further features that might indicate mental disorder, through systematic enquiry in respect of symptoms and through detailed observations of a comprehensive mental state examination. However, arranging a review by a specialist psychiatrist within a few days is reasonable, particularly in circumstances where there is no immediate concern and it is not evident that more acute treatment is required.

A phone conversation is also recorded in the notes on 26 [Month2], apparently taking place at around the same time that staff were visiting [Mr A] at the respite facility. The records of this call reflect that [Mr A's] 'ex-partner' had locked his belongings in her garage. The records suggest that she was not expecting [Mr A] to return to live with her.

A further phone call is documented an hour later, again from the ex-partner. She reported that [Mr A] had just been to her house and left stating that he was going to kill himself. Advice was given to call the police. This was appropriate in these circumstances.

Although on each of these three days the records suggest that different PACT staff saw [Mr A], the records appear to indicate that there was an understanding of the nature of his presenting problems and the plans that were in place for ongoing assessment. There seems to have been reasonable continuity of care amongst those staff and there is some evidence of coordination with the GP in respect of medication while [Mr A] was at the respite facility.

On 26 [Month2], [Mr A] declined the offer of assistance with transport to the appointment with [Dr I], but did subsequently arrive for that assessment.

The review by [Dr I] was an appropriate plan given that he had previously had contact with [Mr A] and it did seem that psychiatric review was a prudent measure in the wake of the recent [suicide attempt] and complaints of mood disturbance.

[Dr I] saw [Mr A] with a member of the PACT staff. [Dr I's] record of that appointment reveals evidence of his awareness of the recent contact with PACT and the respite arrangements, as well as the precipitant for this.

The record outlines what appears to have been a reasonably thorough assessment. Reasonable consideration was given to the possibility of a mood or anxiety disorder, but neither was felt to be acutely present. The main difficulties were thought to be anger and hostility associated with a personality disorder and an acute decompensation in the face of social stress.

Overall, through this episode of care, there were reasonable plans in place to further the assessment and there appears to have been reasonable coordination and sharing of information between clinicians.

Proper consideration was given to how to manage what needed to be ongoing risk of self harm, in the face of [Mr A] apparently being unable to cooperate with a

therapeutic approach. Consideration was therefore given to whether compulsory assessment and treatment may be required, which was reasonable in the circumstances.

An application was made for compulsory assessment and treatment. This was appropriate in this situation. The use of the Mental Health (Compulsory Assessment and Treatment) Act did not however continue beyond the section 9 psychiatric examination. The examination set up by that section of the Act found that [Mr A] was not mentally disordered. The clinical report arising from that examination notes that after being sent to the emergency Department [Mr A's] mood settled and that he had no current intention to suicide, although said he would if needs are not met.

The more detailed clinical note completed following the assessment documents consideration by the assessing doctor of whether mood disorder or psychosis was present and notes consideration of further thoughts of harm.

In the circumstances and the apparent absence of clear evidence of mental illness and immediate risk, and in the face of [Mr A] being willing to remain engaged with immediate treatment, it was reasonable for the compulsory process to cease at this point.

I note that a psychiatric registrar conducted the examination set up by section 9. The Act itself requires that a psychiatrist complete this assessment, unless there is no psychiatrist reasonably available. In 2010 however it was not uncommon for suitably experienced registrars to undertake these assessments and it has only been in the course of 2011 that the Director of Mental Health has clarified that this previously established practice is not satisfactory when a psychiatrist could be available to undertake the examination.

[Mr A] was reviewed by the psychiatry liaison service while in the general hospital. Information about [Dr I's] assessment appears to have been available to the psychiatry liaison service. Although not seen directly by a psychiatrist during this period, the liaison psychiatry staff had access to and apparently consulted with [Dr I].[26] This was appropriate in these circumstances.

Once medically stable, [Mr A] was felt not to require ongoing care from the DHB Mental Health Services and the plans were for ongoing review by the GP, with counselling to be arranged for primary care funded counselling.

There does appear to have been some difference in understanding within the DHB about the plans for further care, at least as far as I can tell from the records provided to me. The liaison psychiatry file note dated 28 [Month2] is clear that it was felt that [Mr A] did not require psychiatric inpatient care, the record stating "...admission to Mental Health Unit not indicated".

The letter of 28 [Month2] to the GP, [Dr G], completed by the clinical psychologist

[26] From BoPDHB response to notification, at page 787 of bundle of documents.

from the liaison psychiatry service[27] refers to inpatient psychiatric admission not being required and only refers to PACT being available should [Mr A's] level of distress become acute or risk increase. There is no reference to planned outpatient psychiatric care.

What I understand to be the discharge summary of this medical admission[28] appears however to suggest that there may have been some arrangement for further psychiatric outpatient care. How the writer of this summary reached this view is unclear, as this does not appear to be in accord with the liaison psychiatry plan.

It seems reasonably clear that through this period of care there was appropriate transfer of information between the mental health clinicians and reasonable continuity of how [Mr A's] presentation was understood. Although it is concerning that the medical discharge summary suggested that outpatient psychiatric care might be forthcoming, there was direct written communication between the liaison service and the GP which made the intentions clear.

The psychologist's letter is a reasonable summary of the assessment by the liaison service. There is reference to the stress of the relationship disturbances and the impact this appears to have had on [Mr A's] presentation.

[Dr G] referred [Mr A] back to the Mental Health Service by letter dated 5 [Month3], apparently received by the service on 7 [Month3]. An attempt to engage [Mr A] with a primary care mental health programme had been unsuccessful. There was no clear indication in the referral of any other change in [Mr A's] presentation and no reference to [Mr A's] current circumstances. There is no evidence of the GP reviewing the risk or highlighting any information in respect of risk in the referral to the mental health service, or any other information that may have highlighted particular concern. In fact it is not even clear that the GP had undertaken any assessment himself of [Mr A] or considered the other advice given in the letter from the liaison service psychologist.

Apparently however [Mr A] was felt to be too high risk for primary mental health care programme, on the basis of high scores on the Kessler scale[29].

Sensitivity and specificity data analysis supports the K10 as an appropriate screening instrument to identify likely cases of anxiety and depression and to monitor treatment outcomes. [Mr A's] score was 39, consistent with severe anxiety or depression.

Screening tests such as the Kessler do not however replace a comprehensive

[27] Page 239 of the bundle of documents
[28] Page 183 of the bundle of documents
[29] The Kessler Psychological Distress Scale (K10) is a scale developed in 1992 by Kessler for use in population surveys. Research has revealed a strong association between high scores on the K10 and a current CIDI diagnosis of anxiety and affective disorders. There is a lesser but significant association between the K10 and other mental disorder categories and with the presence of any current mental disorder.

assessment. There is no indication in the referral that the GP reviewed the history and symptoms of concern, or himself undertook any examination of [Mr A's] mental state.

In repeated reviews, by [Dr I], [Dr K] and by [Dr L], consideration had been given to the presence of features of anxiety or depression and these were not felt to be significant to the point of needing specialist psychiatric care.

The advice that had been given to the GP, to arrange psychological therapy through the primary mental health care services does seem to have been appropriate in these circumstances. Similarly, attention to relationship factors was appropriate, as there does appear to have been a clear connection between stress in the relationship and [Mr A's] risk of harm.

This referral to the DHB Mental Health Service was declined by letter to the GP, dated 11 [Month3]. The letter simply states that criteria for entry to the mental health service were not met, although gave some suggestions of other options that might be suitable.

The summary of the investigation by the DHB outlines the full reason for the community mental health team declining this referral. The reason as outlined in that summary is that there had recently been comprehensive assessment of [Mr A] and that the conclusions had been congruent with earlier assessments, that [Mr A] did not have a major mood disorder or psychotic illness. There was also apparently some consideration of [Mr A] having been reluctant to engage in treatment.

All of this is reasonable. There had been several recent assessments and there had been consideration of the presence of mood or anxiety disorder. There was no evidence from the GP of his own clinical findings suggesting a change in [Mr A's] condition. However, optimum practice of the community mental health team at this time would have included direct discussion with the general practitioner in respect of these reasons for the referral being declined, with that discussion also serving as an opportunity for the GP to provide further information that might assist consideration of the referral. Similarly the GP, if seriously concerned that it appeared the mental health service had not properly taken into account some aspects of [Mr A's] presentation, could reasonably have telephoned the service to discuss his concerns or at the very least highlighted in the referral information findings from his own assessment that should be taken into account by the mental health team.

The incident summary notes that the team that considered this referral was a different team to that which had previously managed [Mr A's] care, and that this team would therefore not have been aware of the prior history of high-risk behaviours.

Information from the DHB however suggests that psychiatric records are held in a central file room in the community mental health building and that these are accessible to all mental health staff. At least in theory therefore information about this prior history should have been available to the team considering referral. Information from the DHB also outlines that it is standard practice to obtain prior records when

considering what action to take in respect of a referral and that this is part of the responsibilities of the intake coordinator.

This statement in the incident review however does seem to suggest that there was some deficit in the continuity of information about [Mr A] and it is difficult to reconcile the description of what should be standard practice in respect of gathering information and this statement in the incident summary.

[Mr A] was then referred again to the Mental Health Service by his GP by letter of 14 [Month3]. This referral once again makes no reference to the GP's own assessment of [Mr A's] current presentation. There is no evidence that the GP made telephone contact with the service to discuss what seems to have been some frustration with what he termed "pass the parcel".

The referral was apparently received on 18 [Month3] and was discussed at a referral meeting on 20 [Month3]. [Dr C] also discussed the referral and [Mr A's] background in a senior medical officer peer review group. This enabled a contribution to be made to the approach to be taken to the referral from other doctors who had some prior involvement in [Mr A's] assessment and management. This was a very appropriate decision by [Dr C].

In this period it appears to me that there were some deficits in communication. It appears that the GP was concerned that specialist services needed to be involved but he gave no information that would have helped the specialist team understand how [Mr A] was really unable to be treated effectively in a primary care setting.

The specialist team considering the initial referral, according to the incident review, appears not to have accessed information that was available about [Mr A's] prior contact with services. When re-referred, once again there is no evidence of direct discussion with the GP to consider whether there was additional information in respect of the GP's own assessment.

The decision however to offer an appointment was appropriate. In the face of what was apparently some concern from the GP, it was appropriate for this to be undertaken in a reasonably prompt manner.

An appointment was arranged for late [Month3] or early [Month4][30] for [Mr A] to see [Dr C], the timing of which appointment seems reasonable in the circumstances.

In his comments to the HDC, [Dr C] identifies that there was no clear clinical indication to see [Mr A] urgently. In the absence of any information from the GP suggesting an urgent need, I agree with this conclusion,

[30] I am a little unclear of the date this assessment actually took place. The incident review report identifies this taking place on 28 [Month3]. At page 3 of his response to the HDC, Dr C identifies that he "decided to review Mr A prior to my planned annual leave... on 4 [Month4]", and later (at page 7 of this document) comments "including my assessment on 4th [Month4]"

There is an implied suggestion that in the absence of information about any significant urgency, the 'standard' wait of a month or more for a non-urgent appointment may have been reasonable. That may be so, but I would generally only accept that as reasonable if there was a high level of communication with the GP to ascertain the true clinical picture and with clear advice about how to manage any concern during the waiting period.

When the appointment did take place [Dr C] appears to have taken some care to try to engage with [Mr A]. As a result however the assessment was incomplete because of the constraints of time. Appropriately, [Dr C] made plans to see [Mr A] again following his return from leave. [Mr A] was to contact the service should he wish to have more urgent attention.

[Dr C] notes that [Mr A] had previously engaged with the crisis team a few weeks earlier. This view appears to have underpinned the hope that should things change, [Mr A] would make contact with the service.

My understanding of that earlier contact however is that it followed [Mr A] presenting after having [attempted suicide] and his being somewhat reluctant to cooperate with the assessment when he was first seen. Records of that contact suggest that he was sarcastic and "projecting aspersions" about mental health services and their lack of ability to address any of his issues, commenting that being under the mental health service had caused most of his troubles.

Later, his dislike of mental health services is repeated in records of 26 [Month2]. There is no evidence that on 26 [Month2] when he was making threats to his partner to harm himself that he had any motivation to contact crisis staff because of his distress.

In these circumstances I think I was optimistic for [Dr C] to believe that [Mr A] might proactively contact the mental health service should he be feeling distressed. This seems to me to be particularly unlikely if there was not someone within the service with whom he had a regular relationship.

I accept the points [Dr C] makes in his response to the HDC. There were some indications that in some circumstances [Mr A] was willing to have contact, and there was evidence that this had happened when in an ongoing psychotherapeutic relationship in a prior episode of care. Having just taken some effort to try to engage with [Mr A], [Dr C] would have developed some sense of whether a therapeutic alliance might be beginning to form between himself, [Mr D] and [Mr A], which might facilitate him proactively making contact if distressed.

[Dr C] did consider risk in this assessment. He reached a view that there was no immediate concern and outlines to the HDC how he reached this view[31]. He comments that static risk factors were unchanged and that there were no new dynamic suicidal risk factors identified or reported. "On that basis the only conclusion I could

[31] At page 539 of the bundle of documents

make about his suicidal risk was low". He notes "He had a low risk of deliberate self harm but a high chronic risk of aggression and violence towards others".

This was a reasonable assessment of risk.

[Dr C], in his comments to the HDC, outlines his understanding of risk as a dynamic concept. He notes that at the time of the assessment there were no new acute modifiable risk factors. I agree, as far as I can tell from the records of that assessment. As before, it appears the most significant dynamic factor contributing to risk was the quality of his relationship with his partner, with the associated factors related to his housing.

The outcome of this assessment was apparently that [Mr D] would be involved in some way should [Mr A] make contact with the service, pending further assessment when [Dr C] returned from leave.

I think it would have been good practice for there to be planned interim contact between [Mr D] and [Mr A] to maintain a budding alliance. Given the quality of the relationship with his partner also being such a significant element of vulnerability for [Mr A], interim contact to assess and if necessary attempt to address such vulnerability would have been an additional safety measure.

I accept that otherwise there was no clear indication for contact.

I understand that there was no entry made in the information system indicating that the assessment had taken place.

[Dr C] made handwritten notes of this assessment. These notes are hard to decipher. I understand from the incident report summary that their significance may not have been clear to other staff when [Mr A's] partner presented again, if they were in fact available.

I cannot make out any clear conclusions in those notes and although the second point of what appears to be follow-up arrangements identifies an intention for follow-up in one month, I cannot determine what the first point means.

In my view these records were not of a reasonable standard. The DHB has provided information in respect of standards of clinical records. These include each entry being factual, consistent, accurate, legible, and complete and compliant with generally accepted standards for the profession. Implicit in this is that records must also inform further contact and outline the basis of conclusions with respect to the assessment and treatment plans.

These handwritten records fall short of this standard. I accept that 'working notes' may sometimes be made and that these serve the function of an outline that informs or supplements a more concise summary. Such summary was not completed in a timely manner however and thus was not available to inform care, and in my view the handwritten records, even if they had been visible to other staff, were insufficiently

clear to be meaningful.

In my view peers would view this with at least moderate disapproval.

There is a discrepancy between various people with respect to whether a case manager was assigned to [Mr A].

[Dr C] in his comments to the HDC reports that [Mr D] agreed to act as case manager prior to the assessment. The serious investigation report identifies that on 18 [Month4] PACT became aware that [Mr A] had a case manager.

According to the incident review summary, PACT staff who had contact with [Ms B] on 15 and 17 [Month4] did not know that there was a case manager assigned to [Mr A]. PACT only became aware of this on 18 [Month4] following their contact with [Mr A's] ex-partner being discussed at a team meeting.

There is no reference in those last records to that role being in place, and only on the second of these occasions was information to be passed on to the community mental health team.

[Mr D] however is clear that he was not taking on a case management role.

It seems to me that through this period the only people who knew that [Mr D] was to be the point of contact were [Mr D], [Dr C] and [Mr A]. There was no clear record of this available anywhere. Whether or not [Mr D] was taking a case-management role is perhaps even not the most significant issue to consider, as if the intention was for [Mr D] to be the point of contact, this should have been readily evident in the records and information system.

There are clear responsibilities for a case manager. The job description for registered nurse within the mental health and addiction services contains a section describing the role. This notes that the designated case manager for a service user is the primary person for contact in treatment planning and coordination of care for that person. The role includes facilitating coordination and access to care and ensuring smooth transitions along the care pathway for service users and their families, resolution of distress and effective management of mental health issues, and re-integration with family and primary care networks.

Entering information on the patient's clinical record and notifying other providers is described as being a case manager responsibility.

These functions seem to be in accord with the role that [Mr D] was expected to undertake over the month or so after the assessment. The referral had been accepted. More contact was planned. No one else was expected to have any role in that period and [Dr C] was away and unavailable. The expectation that [Mr D] would be the point of contact, and therefore have the consequential responsibility for making further arrangements as needed at the time of contact, is congruent with the description of the case management role. It is possible to see why [Mr D] is variously described as being

the case manager.

There are some aspects of the coordination of care that were not of a reasonable standard at this time. It should have been clear that an assessment had been undertaken by [Dr C] and that there were agreed outcomes. It should have been clear that [Mr D] was to be the point of contact. These details should have been available when [Ms B] made contact

There is evidence these PACT staff knew that the circumstances at that time resembled prior occasions at which [Mr A] was at increased risk of harm, but there is no information available that suggests [Mr D] was advised of these circumstances, or that he should specifically be informed.

I am not sure of the meaning of the comments in the analysis of this aspect of care as outlined in the incident review. The review notes that the significance of the handwritten notes and lack of information system entry was that when [Mr A's] ex-partner presented to PACT with her concerns these staff did not immediately know that [Mr A] had been accepted back into the service and had a case manager. The investigation team is reported to have considered this issue and concluded that while this information might have been of interest to the staff it would not have changed the interaction.

[Mr A's] ex-partner was seeking practical information about how about how she could move [Mr A] from her home. Information was provided. However, what appears to have been missing is consideration of the implications of this for [Mr A] given his vulnerability at times of relationship stress. Such vulnerability should have been evident from the prior notes.

In my view, this would have been an appropriate prompt for action of some sort, whether directly by PACT or through PACT referring the concern to a case manager or identified contact person, for further review of the impact of these events on [Mr A's] previously recognized vulnerability to self-harm.

In my view, it would have been appropriate for the service to make contact with [Mr A] directly.

In summary therefore, a number of things were carried out well. The arrangements for respite in [Month2] were reasonable and the psychiatric review was appropriately arranged. When in the general hospital, there was a reasonable level of psychiatric contact with appropriate arrangements in place for psychiatrist oversight of these contacts. Following the second referral from the GP, timely appointment was arranged. All assessments seem to have been of a reasonable standard.

Some aspects of care, whilst perhaps not optimal, could have been improved. This particularly was in respect to the lack of direct discussion between the GP and the service, on at least the occasion of the second referral.

Of more concern is the omission of communication with the GP in [Month1], and

some other aspects of care which would be viewed with mild disapproval, in my view. These include the failure of staff in [Month2] to further the assessment of [Mr A] while he was in the respite facility, despite though the plan was to do so, even though the review by a psychiatrist was planned. The misunderstanding between the medical team and psychiatry liaison service, as apparently evident in the medical summary recording that outpatient psychiatric review was planned, is also of some concern.

I am most concerned however about what appear to have been failures in coordination between [Mr D], [Dr C] and the PACT staff in [Month4], when the role of [Mr D] seems to have been misunderstood; where there seems to have been incomplete accessing of records of prior contact; and where factors resembling prior episodes of [Mr A's] increased vulnerability to self-harm were identified but not responded to. These would be viewed, in my opinion, with at least moderate disapproval by peers.

Comment on [Mr D]
[Mr D] is clear that he was not assigned as case manager. He saw his role solely to be that of a point of contact for [Mr A]. That may be technically correct, in so far as the standard systems of allocation of case manager were operated within the service.

I think however that to take this position reflects an inappropriately narrow approach to the role of a registered nurse.

Amongst domains of practice of the registered nurse, as set out in the description of that role, is the key task of clinical practice. Amongst the key performance measures within this key task area are included: undertaking a timely comprehensive and accurate nursing assessment; engaging in robust ongoing assessment and management of risk; developing individual treatment plans; and making nursing judgments.

[Mr D's] comments suggest that he was a passive observer in the assessment undertaken by [Dr C]. Although I have no detailed information from the DHB in respect of the purpose of having a second health professional perspective present at such assessments, I think it is unlikely the intention is simply to be completely passive participant. As a registered nurse, [Mr D] has had training in nursing assessment, including making observations and drawing conclusions from them. He has a professional responsibility to apply those skills, to supplement the observations of other clinicians.

[Mr D's] role description includes "engaging in robust ongoing assessment and management of risk". I do not interpret this as meaning passively awaiting someone, about whom there might be reasonable concern in respect of risk in particular circumstances, to make contact with the service when such circumstances were seen to apply. The reference to "robust and ongoing" in my view clearly sets an expectation of proactivity that was not evident in the way [Mr D] applied his role.

[Mr D] does of course operate in the context of a broader clinical team. This should serve as a safety net, with the processes of collective decision-making protecting individual clinicians from significant omissions of appropriate responses. A well-

functioning team process, which recognized the vulnerability of [Mr A] in such circumstances, could have prompted action by [Mr D], even if he himself had not spontaneously recognized the importance of doing something. Despite what the DHB advises in respect of team practice and systems of supervision, this does not seem to have occurred.

[Mr D] in his comments to the HDC appears to have reflected upon changes in nursing practice that may be useful. He notes that it is important to highlight to the team when the period of assessment is continuing and when a person is acting as point of contact only prior to a case manager being allocated. This may be an issue that will be taken into account in the work being undertaken by the DHB (see further below).

[Mr D] notes that it may have been of benefit for [Dr C] or him to document on the clinical file that the process had not yet been completed and what arrangement had been made to complete it. I agree, although it does seem remarkable that this might not be standard practice.

[Mr D] notes that he feels it is important to highlight when the process of case management is able to start. He reports it leaves a staff member in a precarious position if they are considered to be managing patients' care and have not had the opportunity to discuss the assessment, review and update risk management plan and agree a treatment plan. He feels it is in the best interest of the patient to have an assessment before allocating the most suitable and appropriate case manager.

In large part, I agree with these comments. What seems to be missing however is the element of individual initiative and responsibility to ensure that they have appropriate support and supervision in respect of any person with whom they are involved in care, and that the role they are taking is clear to others, no matter what the role.

Comment on [Dr C]

[Dr C] appears to have undertaken a reasonable assessment, within the constraints of trying to establish a relationship with [Mr A]. His view, that further planned contact to continue the assessment could wait until he returned from leave, was also reasonable. What did fall below standard however was the record of the assessment that was available to inform further care, should such care be needed before that further planned contact.

[Dr C] says the only change he has made to this practice is to dictate a brief synopsis of the assessment for the GP as a brief record with the statement that a comprehensive report will follow.

This is a very appropriate action to take.

He notes also that if there is a specific role for the case manager this is always discussed with a patient and included in a written record in the action plan. I am not clear whether this discussion would encompass what action should be taken should urgent assistance be needed, if there is no case manager assigned. It would be appropriate to ensure that this is discussed and understood, and that the scope of this

discussion includes identifying circumstances in which vulnerability might be increased and what action to take.

Other aspects of the care, systems or decision-making processes involved in this case which warrant additional comment or recommendations for improvement
Overall I think there was too much reliance upon written communication between the GP and the Mental Health Service. The referral information from the GP was poor, containing inadequate evidence of the GPs own assessment and conclusions, but no effort appears to have been made by either the GP or the service to contact the other party to clarify concerns and/or decision-making. I think the standard of the GP referral(s) would be viewed with at least mild disapproval, as would the failure by both parties to discuss these concerns directly.

It does appear that there were some deficits also in the process of discharge from the general hospital in [Month2] 2010.

The DHB has provided a copy of the protocol for discharge from Mental Health and Addiction Services. The version supplied has an issue date of [Month5] 2010. I am not clear whether this was a new protocol or whether this replaces an earlier version. Nonetheless, the protocol contains some elements that are in accord with what would generally have been good practice in respect of involvement of family in the planning process. The document refers to the discharge plan managing risks associated with discharge "…including expressed concerns of the family/whanau…" and notes "….arrangements are satisfactory to….family/whanau…"

As far as I can tell, there was no discussion with [Ms B] about [Mr A's] discharge.

The DHB notes[32] that [Mr A] was not a psychiatric inpatient during the period of hospital care in [Month2]. The comment adds that discharge was discussed with [Mr A] and that he was agreeable. Reference is also made to the record that the events leading to admission "took place in the context of relationship issues which appears to have been resolved since".

There is no record of discussion with [Ms B] in respect of her view of the relationship and whether these 'issues' had in fact been resolved. I think this is an important omission, especially in the presence of the clear understanding, as reflected in this record, that the relationship issues were a clear stressor.

I think this failure to discuss discharge with [Ms B] in these circumstances would generally be viewed with moderate disapproval.

I am not sure whether the DHB, in pointing out that this discharge was from a general hospital facility, is indicating that this standard does not apply. If that were the case, I would disagree. I suspect more likely the DHB is responding to the reference in the HDC question about the process of planning in respect of psychiatric inpatients.

[32] In response to the HDC request for a description of the discharge planning process for inpatients, at page 733 of the bundle of documents

Changes implemented by the DHB in response to this complaint
The DHB identifies some protocols that are under review. These include the Referral protocol and the Discharge from MH&AS protocol.

It is not possible to comment on any change in respect of these protocols as they are on hold pending the review of the intake coordinator function and role.

Review of the intake coordinator role is also described as being under way, but this has not been completed either.

An education program about assessment and treatment of patients with serious personality disorders has apparently been implemented with some dates identified for some educational sessions. This is aimed at enhancing staff knowledge and expertise relating to assessment and treatment of personality disorders.

Education may in some circumstances be useful. However, unless accompanied by ongoing support for practice change and for implementation of the learning, education has a relatively short washout period with little enduring benefit.

The DHB notes some work is under way in respect of case management allocation and the differentiation of this role from '2nd health professional' participation in assessments.

Without documentation of any change to the process of allocation of case managers it is not possible to comment usefully on this matter. I note however that it appears to have been emphasised that when someone participates as a 2nd health professional this participation will also be documented by the 2nd person. It does not appear to me to be particularly productive use of staff time for the second person to simply repeat information that is recorded by the principal assessing clinician, so it would be good for this work to include attention to the particular perspectives each clinician brings to this activity.

I note that the expectation in respect of this documentation was communicated at a Nurses Forum. Unless such communication is backed up by ongoing audit and supervision of practice this somewhat "soft" approach to practice improvement is likely to have only limited impact.

Although aspects of these changes are still incomplete, the general direction being taken by the DHB to address matters related to the care of [Mr A] seems appropriate. As noted however, it would be good to ensure that the improvements are backed up by systems to ensure ongoing implementation of practice change.

Yours sincerely

M D Patton