Auckland District Health Board

Psychiatrist, Dr C

A Report by the

Health and Disability Commissioner

(Case C09HDC01156)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. Mr B came under the care of Auckland District Health Board (ADHB) mental health services having had symptoms suggesting a major mental illness for about two years. Mr B had ongoing contact with ADHB mental health services, including admission to the inpatient mental health service (the Unit). His care in the community was managed by Agency 1 and Agency 2.[1]

2. In early 2007, Mr B was admitted to the Unit, via another hospital in Auckland. In the second week of this admission, it was planned to discharge Mr B. However, Mr B was found smoking and consuming alcohol in his room, and he was advised that he was to be discharged the next day. Mr B stated that he intended to travel south of Auckland. He was given a summary of his admission to present to the mental health unit at the public hospital in that region, if necessary, and a prescription for medication. Mr B had no further contact with the ADHB mental health team (except for a phone call to the Crisis Team when he reported being on the street and cold) but there was some contact with his family. Mr B was arrested a few weeks later in relation to a serious event.

Summary of findings

3. The Commissioner found there was an inadequate assessment of Mr B during his admission to the ADHB inpatient mental health unit in 2007, he was discharged without adequate discharge planning, and there was ineffective communication between the teams involved in his care.

4. These failings were, in part, the result of clinical decision-making but also the result of systemic issues, the lack of clinical governance and quality structures.

5. Clinical Director and Team Leader, psychiatrist Dr C's assessment of Mr B, and his evaluation of Mr B's risk, were superficial and incomplete. In addition, he did not adequately record his assessments. Dr C therefore breached Rights 4(1)[2]and 4(2)[3] of the Code of Health and Disability Services Consumers' Rights (the Code).

[1] These agencies are part of ADHB's mental health services.
[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[3] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

6. ADHB did not have appropriate checks and balances in place to ensure that the protocol for liaison between the inpatient and community services was followed. Systems failings within the DHB's mental health services contributed to inadequate communication, discharge planning and follow-up care. Accordingly, Auckland DHB breached Rights 4(1) and 4(5)[4] of the Code.

Investigation process

7. On 29 April 2009 the Health and Disability Commissioner (HDC) received a third party complaint from Mr A about the services Auckland DHB and psychiatrist Dr C provided to Mr B. The following issues were identified for investigation:

The appropriateness of the care provided to Mr B by Auckland DHB over a period of two months in early 2007.

The appropriateness of the care provided to Mr B by psychiatrist Dr C over a period of 12 days in early 2007.

8. An investigation was commenced on 21 July 2009.

9. The parties directly involved in the investigation were:

Mr A	Complainant
Mr B	Consumer
Dr C	Psychiatrist/Provider
Auckland District Health Board	Provider
The Unit	Inpatient mental health service
Agency 1	Community mental health service
Agency 2	Community outreach service
Agency 3	Community mental health service

Also mentioned in this report:

Mr J	Mr A's father (dec)
Dr L	Psychiatrist
Dr K	Forensic psychiatrist
Dr M	Psychiatrist
Dr N	Clinical Director
Ms O	Mental health nurse
Mr P	Mental health nurse
Dr Q	House surgeon
Dr R	Psychiatrist registrar
Ms S	Social worker
Mr U	Registered nurse
Mr T	Registered nurse

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

Dr V	Psychiatrist

10. Information was reviewed from:

Auckland District Health Board	
Dr C	
Mr B	
Dr D	Medical Officer Special Scale (MOSS)
Dr E	Psychiatrist
Mr F	Community mental health nurse
Mr G	Keyworker, community mental health nurse
Mrs H	Consumer's mother
Ms I	Consumer's sister

11. Independent expert advice was obtained from psychiatrist Dr Nick Judson. Dr Judson's report is attached as **Appendix A**.

Information gathered during investigation

Note: Further background information about Mr B has been removed to protect his privacy.

Background

12. Mr B first came to the attention of ADHB Mental Health Services in 1997. He was diagnosed as having schizophrenia and commenced on oral antipsychotic medication. Mr B was under the care of the team who administered this medication, for two years. When Mr B was discharged from the team, he was followed up by a community mental health service (Agency 1). Mr B proved to be difficult to follow up and, at times, failed to keep contact with Agency 1 and take his medication. For a time he was given depot injections[5] of antipsychotic medication.

2006

13. Mr B was followed up by Agency 2 throughout 2006. He was compliant with regular depot injections of the antipsychotic Piportal, and remained well. However, Mr B's Community Treatment Order (CTO) was not renewed, and in July 2006 the order lapsed.[6] Auckland DHB advised that the decision to discontinue or apply for a continuation of a CTO (under section 29 of the Mental Health Act) when it is due to expire is typically the decision of the responsible clinician in consultation with the clinical team. However, due to a clerical error within the mental health team, Mr B

[5] Monthly intramuscular injections of antipsychotic medication.

[6] There are many factors taken into account in assessing whether the compulsory care order is still necessary, and each case is dealt with on an individual basis. Once a community treatment order has expired, in order to reinstate it, the clinician must:

- submit an application under section 8A of the Act; and
- undertake an assessment in accordance with section 8B of the Act.

was not on the list for review in June 2006. Mr B refused the depot/intramuscular injections after this.

14. Agency 2 considered reinstating Mr B's treatment order. However, Dr E considered that this was not justified. Mr B had been free of psychotic symptoms for about a year and compliant with his oral medication under the family's supervision. There was concern that enforcement of intramuscular injections would damage therapeutic relationship.

15. Mr B's parents were consulted and an agreement was reached that if Mr B stopped taking his medication, the treatment order would be reinstated.

16. From November, Mr B became more itinerant..

2007

17. Early in 2007, Agency 1 nurses Mr G, Ms O and Mr P recorded a number of interactions with Mr B. When Mr G tried to talk about lifestyle goals, Mr B told Mr G he reminded him of his father, and said, "Look what happened to him."

18. Over the next two days Agency 1 was notified that Mr B had told by the manager to leave the lodge where he was living.

19. On 9 Month1, Dr E recorded that she, Mr G and other Agency 2 staff visited the lodge intending to see Mr B when he failed to attend an appointment at Agency 1. The team discussed how to manage Mr B and it was decided that as his behaviour and functioning improved when he was on depot injections then this medication should be reintroduced. Dr E noted, "MHA (Mental Health Act) should be used since there is hx [history] of very serious risk to others." The plan was for Agency 2 to try to trace Mr B, and to advise his parents about the plan regarding the reintroduction of the depot medication.

20. On Saturday 10 Month1, Ms O recorded that she had seen Mr B that morning in the ADHB Emergency Department. Ms O recorded he was complaining of psychosis.

21. Mr B told Ms O that he was worried that he had nowhere to live, no money and no food. Ms O told him that the only accommodation she could suggest in the circumstances was the night shelter. He said that he was not welcome there. When Ms O told him that the only thing she could offer him at that time was intramuscular Piportil, he told her to "F..k off".

22. On 11 Month1, Mr B again came to the attention of mental health services when he injured his right foot.

23. Ms O went to see Mr B in hospital. It was suspected that he had broken a bone in his foot. Mr B refused to tell Ms O what had happened, and did not respond when asked if his jump was a suicide attempt. Ms O gave him medication, which he took immediately. Mr B then asked Ms O to leave.

24. Ms O contacted the psychiatric liaison nurse and Mr B's father about the event. She documented a plan to await the outcome from ED, and noted that admission to the Unit "may be suggested for a few days which would mean that [Mr B] could then be put under the [Mental Health Act] for community treatment for [intramuscular injections]". Agency 2 arranged for Mr B to be admitted to the Unit that day.

Inpatient admission

25. Mr B was admitted to the Unit under Team 1.[7] Dr C was the team leader supported by Medical Officer Special Scale (MOSS) Dr D and house surgeon Dr Q. As Dr D was on leave on 11 Month1, one of the other team psychiatric registrars, Dr R, together with a psychiatric liaison nurse, admitted Mr B.

26. Dr R's summary of the admission assessment was that Mr B was a schizophrenic who had previously been well on intramuscular depot medication, but at that time was homeless and non-compliant with oral medication. Mr B's concerning behaviour had been escalating over 9 and 10 Month1, and he was willing to be admitted informally.

27. During the admission interview, Mr B stated that he wanted to kill someone, but when he saw that Dr R was recording his statements, he wanted to view what had been written. He stated that he wanted it recorded that he had only made the statement because he was "off his head with painkillers".

28. Dr R discussed Mr B with Dr L, who had treated him in 2005. Dr R noted that Dr L "felt that we should seize the opportunity of informal admission to allow for a period of assessment and establishment of IM depot". Dr R noted the 9 Month1 meeting, and the community team's suggestion of using the Mental Health Act to re-establish intramuscular injections.

29. On 12 Month1, social worker Ms S recorded that she had contacted Mr B senior to advise him of his son's admission. Ms S noted that Mr B "was anxious that [Mr B] is not discharged before he is better this time and that he is not allowed to wander around the town". Ms S advised Mr B senior that his son would be given leave as he had been admitted to the "open" ward.

30. The nursing notes from 12-13 Month1 indicate that Mr B was depressed about his personal situation, that he had nowhere to live and considered that the boarding houses he had been placed in were not pleasant.

31. On 13 Month1, Dr Q recorded at a multidisciplinary meeting regarding Mr B, "The imp[ression] is that he does not have schizophrenia, but is suffering from some existential angst — lost friends, homeless, substance abuse. When asked about

[7] ADHB advised that the Unit has 50 beds and has four clinical teams. Team 1 was responsible for the "acute heart" of Auckland — the transient, homeless and visitors. Team 1's catchment area was an area that has many boarding houses. The Team comprised Dr C (who was also the Clinical Director for the Unit), Dr D and Dr Q, but the team had no registrar. Dr D advised that the other the Unit teams had a full team of a 0.5 full-time consultant, registrar, house surgeon and support staff. The Team had no care co-ordinator, who normally would co-ordinate the care plan with a social worker.

schizophrenia c/o [complaining of] vague Sxs [symptoms] — probably secondary to substance abuse."

32. Later that day Dr C recorded his examination of Mr B. He noted that although Mr B "carries a diagnosis of schizophrenia", there were no psychotic symptoms evident when he was admitted. Dr C recorded that Mr B spoke to him of his "existential sense" of failure. He admitted to heavy alcohol use and homelessness owing to social conflicts, and that he was lonely and lacked direction in his life. Dr C noted:

> "On exam, I saw no evidence of psychosis or disorganisation. [Mr B] was sad and seeking support to get his life back on track. He is accepting of quetiapine at present.
>
> A) I am uncertain of [Mr B's] Axis I diagnosis but, regardless of a possible psychotic disorder, he does not appear to be actively psychotic at present. However, he is homeless and sad.
>
> B) Brief stay while [Mr B] secures accommodation. We will liaise with [Dr E] regarding treatment. One report suggests that she favours the use of the MHA and IM pipthoriazine [sic].[8] [Mr B's] commitability at present is questionable, in my opinion."

33. On 14 Month1, Mr G called into the Unit to visit Mr B.[9] Mr B refused to talk to Mr G and told him to return the next day. Mr G recorded that he spoke to the Unit nursing staff about Mr B. the Unit nurses reported that Mr B had "no evidence of florid illness". Mr G talked to them about the difficulties of managing Mr B in the community. He recorded that the staff would "keep [Agency 2] in the loop as to [Mr B] commencing depot medication on a voluntary basis", and that Dr C was to talk to Dr E about the depot medication.

34. Over the next four days, the nursing notes record that Mr B was pleasant and compliant around the ward, but refusing to make any effort to find accommodation.

35. On 18 Month1, registered nurse Mr U noted that Mr B showed no evidence of psychosis. Mr U recorded that he had seen Mr B hide his tablets in his mouth in an attempt to avoid taking his medication. When Mr U asked him to swallow the tablets, Mr B became agitated and walked away. Mr U followed him, and Mr B reported that he had swallowed the medication.

36. Later that day, Mr B told Mr U that he liked being in the Unit and did not wish to be discharged to any accommodation. When asked why he spat out his medication, Mr B informed Mr U that he needed to be in hospital because he was "insane". He then reported feeling angry and needing something to calm him down. Mr U recorded in

[8] Pipothiazine, an intramuscular injection (also known as Piportil).
[9] Mr G advised HDC that the role of the Community Mental Health Nurse keyworker, when a client is in the Unit, is to have liaison with inpatient staff, to be available to attend discharge meetings and planning meetings, and to visit clients as appropriate.

Mr B's clinical record that, when provided with lorazepam, Mr B "quickly placed his hand in his pocket" and turned away.

37. On 19 Month1, Mr B again attempted to avoid taking his oral medication. Dr D was advised and talked to Mr B about starting depot injections, but Mr B refused. Dr D asked Mr B to "think about plans after discharge" and told him that he would visit again the next day. Mr G called into the Unit to see Mr B, but he was not in the Unit.

38. On 19 Month1, Mr B told Mr U that he had not taken any medication since being admitted to the Unit because he did not need any "mad pills", and was adamant that he would not accept any medications or intramuscular injections now or post-discharge. He again stated that he did not wish to be discharged to any accommodation and would ask Agency 2 to arrange for him to continue to be accommodated in the Unit.

39. On 20 Month1, Dr Q recorded a multidisciplinary meeting and noted that Agency 2 had been contacted with regard to Mr B's discharge and were "going to put him on an injection of Piportil". Dr Q noted that Mr B was homeless and would have trouble finding suitable accommodation because of his past offences. The plan was for Mr B to decide whether to accept injections of Piportil or be discharged, and that accommodation issues would need to be addressed if he was for discharge.

40. At 9.01pm on 21 Month1, registered nurse Mr T recorded that Mr B had been displaying the "positive aspects" of his personality that day, and was quietly spoken and respectful to the other people in the Unit. Mr T noted:

> "Pharmaceuticals aside [Mr B] appears to have benefited from being in a stable supportive environment for a length of time, and he has been presenting calmer and more positive and more respectful over the last few days. No irritability noted, no overt signs of psychosis, mood appearing eurhythmic but with possible underlying unease over his future in general."

41. On 22 Month1, Dr Q, Dr D, a registered nurse and a medical student met with Mr B to discuss his discharge plans. Mr B said that he wanted to live "somewhere quiet where he can skate [board]". He told them that he was looking for accommodation but had not found anything so far. Dr Q noted that Mr B's safety was "not formally assessed, but appears to be of no risk to self/other/self care".[10] The plan was recorded as:

> "1) To continue to look for accommodation: please make any resources available
>
> 2) To report on progress to [Dr D] tomorrow ?d/c [possible discharge]

[10] ADHB's policy, "CSW [Community Support Work] & ADHB Clinical Keyworker — Integrated Planning & Liaison" states, "The clinical keyworker must identify that the client is ready for discharge and initiate an integrated discharge plan with the CSW [Community Support Worker]. … The Integrated care plan must outline the role and responsibilities of the CSW/Clinical Keyworker in the event of crisis."

3) To be D/C'd [discharged] by Monday, [26 Month1] whether accommodation or not."

42. At 4pm Mr T found Mr B drinking alcohol and smoking in his room. Mr B walked out of the Unit and refused to discuss the issue. Dr D was notified, and asked Mr T to advise Mr B on his return to the Unit that he would be discharged the next day.

43. When Mr B returned to the Unit, Mr T told him about Dr D's decision. Mr B stated that he had money and thought that friends in other towns would "put him up".

44. On 23 Month1, Dr D recorded Mr B's discharge from the Unit. He detailed Mr B's history and summarised his Month1 2007 admission, noting:

> "[Mr B] was admitted to the open ward informally for evaluation and the possible establishment of a depot antipsychotic — piportil. Repeated discussions with him about the start of this and also about finding himself accommodation proved fruitless as he bluntly refused to accept piportil and did not make efforts to find accommodation. [Mr B] expressed a wish to reside in the hospital and repeated conversations with him motivating him to find accommodation went unheeded.
>
> His mental state remained settled, with little or no sign of psychosis. His self cares were adequate, he attended to his own ADLs and was pleasant and amenable to staff and other service users. There was no concern for any danger to himself or others.
>
> His hospital stay eventually came to an end as the result of becoming intoxicated in his room (yesterday) and we agreed today that he be discharged.
> …
>
> Management Plan/Recommendations (including changes since admission).
>
> After ongoing discussion with [a nurse] from [Agency 2], we are discharging [Mr B] to the community. He has no fixed place to return to, but thinks that he may go to [another town] to see a friend there. We have agreed with him that he contacts [Agency 2] to make an appointment on his return. We are giving a copy of this discharge summary to him should he need to show it to MH services in [the area].

> Follow up Arrangements.
>
> Agency 2 — Should [Mr B] be readmitted due to relapse or non-adherence, we advise that consideration be given to the compulsory administration of a depot antipsychotic medication. It is known that piportil was effective previously, but whilst informal and he refuses, a re-challenge with this medication is impossible."

45. Mr B was given a prescription for quetiapine (Seroquel) 25mg for the morning, and 375mg at night, and zopiclone 7.5mg at night (for sleeping). His care was transferred to Dr E and Agency 2.

46. Dr E said she was on leave at the time Mr B was discharged and was not able to comment on whether there had been any discussion between Dr C and Agency 1 staff about the decision to discharge Mr B.

47. There is discrepancy in the information provided about the involvement of Agency 1 in Mr B's discharge planning. Mr G advised HDC that he was not involved in the decision to discharge Mr B, and that the discharge took place without consultation with Agency 2. Mr G stated that he was advised by the Unit staff that Mr B had been discharged to "No Fixed Abode".

48. However, Dr C advised HDC that the decision to discharge Mr B was unanimous, and the decision was made in collaboration with Mr G.

49. Dr C stated:

> "We considered evoking the MHA and treating [Mr B] coercively but decided against it. There were several reasons for this decision.
>
> a) The community team did not see fit to place him under the Act prior to his admission;
>
> b) he did not display any symptoms that suggested he was becoming psychotic during the admission;
>
> c) he was accepting oral anti-psychotic medication.
>
> In our opinion, therefore, [Mr B] did not meet the criteria for commitment."

50. Dr C noted that Mr B's notes at the time of his discharge from the Unit show that he was not expressing any thoughts of harming himself or anyone else. There was no evidence that he was psychotic, depressed, suicidal or homicidal. Dr C commented that it was important for Mr B's ongoing care that he continue to regard the hospital as a place he could come to if he became unwell in the future, "A place where he could be treated not imprisoned." Dr C noted that it was Mr B's usual practice to treat the Unit in this way, and if involuntary treatment had been imposed in these circumstances, the ongoing relationship would have been damaged and the likelihood that he trust the Unit when he became unwell in the future would be reduced. Dr C

stated that the decision of the team not to invoke the Mental Health Act "flowed from our interpretation of the concepts of recovery and the optimisation of autonomy". The team did, however, recommend treatment with antipsychotics because Mr B was at risk of becoming unwell at some point in the future.

Post-discharge

51. On 26 Month1, Ms S received a telephone call from Mrs H, who wanted to know the address her son had been discharged to. When Ms S advised her that Mr B had told the Unit staff that he would be staying in another town, Mrs H said she believed this was the "gang" house her son had stayed at shortly before he assaulted his father. Mrs H asked Ms S to pass her concerns on to Mr G. Ms S noted, "Contact family should we have any contact from [Mr B] or services in [the town]."

52. On 29 Month1 Mr G recorded contact with Mr B's family. He noted that there had been no news about Mr B (he was possibly in another town), and his plan was to maintain contact.

53. Mrs H advised HDC that at about 10pm one night early in Month2 (she was unable to remember the date) she was telephoned by the St John's Ambulance Service in a town further south in the North Island to ask her if she knew a Mr B. Mrs H confirmed that this was her son and told them that he had a mental health history. She was told that it was apparent by his behaviour that this was the case, and that they would transport him to the nearest public hospital. Mrs H was advised to wait an hour before telephoning the hospital for information. When Mrs H telephoned the hospital she was asked what medication her son was taking, as they were unable to obtain any details from him. Mrs H advised that she was not up to date with his current medications, and that they should contact the DHB.

54. Mrs H telephoned the hospital the next morning to check on her son. She was told that he had been put on a bus for Auckland. Mrs H was astounded by this action and worried about what would happen if he became difficult and was put off the bus.

55. On 3 Month2, Mr G recorded that he had received a call from Mrs H advising that her son was in hospital. On 4 and 5 Month2 Mr G telephoned Mr and Mrs H's house but received no reply.

56. On 17 Month2, Mr G recorded that he had been advised by the ADHB Crisis Team that Mr B had made contact during the night reporting that he was "on the street and cold". He wanted medication, somewhere to sleep and some warm clothing, but was told that the Crisis Team could not provide these things, which he had accepted "with good grace".

57. On 2 Month3, Mr G recorded that Mr B's mother and sister had been seen by Family Liaison "last week", and that Mr B "had personal contact" with his sister, who

thought he "might be unwell".[11] Mr B refused to tell his sister where he was staying. Mr G recorded that his plan was to "inform team".

58. Mrs H stated that around this time her son arrived at the house at about 4am, looking very unwell. He said he needed his medication. She reminded him that he had taken all the medication they were holding when he left his accommodation. Mrs H called the Crisis Team. Mrs H recalls that she told the Crisis Team that it was an emergency. At first they were unable to find Mr B on the computer as his name was entered incorrectly, but when he was located, Mrs H was told that they would not attend and she was advised to call the Police. Mrs H contacted the Police and advised that she and her husband had a Protection Order against their son, who was at the house. The Police arrived, and Mrs H believed they took her son to the Crisis Team.

59. Although it is routine practice for the Crisis Team to report at daily meetings with Agency 2 any contact with community-based clients over the preceding 24 hours, there is no Crisis Team record of any contact with Mr B, no record of any contact with him being communicated to Agency 2 or Agency 1, or any contact by the Police in early Month3. Nor did Mr G record any reference to the Crisis Team.

60. On 10 Month3, Mr G recorded that Mrs H had telephoned to inform him that Mr B had turned up on Saturday (5 Month3) asking for food. Mrs H told Mr G that her son had arrived at their house during the night ("this am @ 0400hrs"). He had not been aggressive, was clean and tidy and told her that he was taking his medication. He said he had been staying with someone in Auckland who was known to [a service for people with drug and alcohol problems], but this person had "got drunk and called the Police asking [Mr B] to leave" and he now had nowhere to live. Mr G recorded that his plan was to maintain contact and inform the team.

61. On the morning of Friday 11 Month3, Mr B again arrived at his parents' home. Mrs H gave him some breakfast

62. It appears that Mr B then went to the home of Mr J where he had recently been staying. When Mr J arrived home, a serious event occurred.

[11] Ms I stated that on Sunday 29 [Month2], her brother arrived unannounced, and she spoke to him for about an hour. She said:

> "[Mr B] was clearly very unwell, in fact I would say that he was the sickest I had ever seen him. I thought about calling the Crisis Team, but having been told previously by them (the Crisis Team) that either they would not come without the Police present because he was too dangerous or that they were too busy, I drove [Mr B] into town. On the way he threw his sleeping bag out of the car window. When we got to town I dropped him off by the waterfront. I was uneasy about leaving him in this state but had no other options available to me."

Additional information

Coroner

63. On 12 May 2009, the Auckland Coroner advised HDC that when the Commissioner concludes his investigation, he will hold a wider inquest into the death of Mr J.

Dr E

64. Dr E advised HDC that she holds a 0.3 Consultant Psychiatrist position at ADHB. In this position in 2007, Dr E was responsible for the follow-up of all the people referred to Agency 2. The average number of patients Agency 2 has to follow up is between 50 and 70. The clients referred to the team are mental health clients in the greater Auckland area who have no accommodation. The team, which comprises Dr E, two full-time psychiatric nurses and a social worker, receives referrals from acute psychiatric services and the Police. There are no clear definitions for the roles of Agency 2 staff,[12] but they work as a team to try to find accommodation for their clients.

65. Agency 2 clients are difficult to manage in a residential setting because they do not just have mental health problems, they often substance abuse and have disagreements with accommodation providers, and are on occasions very transient. These clients lack money and they would prefer to spend the money they have on things other than rent. The clients can be non-compliant with medication. Some are given depot injections, which last for two to four weeks (but they still need to present for the next injection). If the client is co-operative and will take tablets, then he or she will be given medications in a blister pack. Others come into Agency 3 for their medication.

66. When a patient is to be discharged from the Unit, there is ideally a discharge planning meeting, but there is such pressure on beds at the Unit that this is not always done. If the client is under the Mental Health Act, the responsible clinician is responsible for care until the patient's transfer is accepted by another clinician. However, if the patient is not under the Act, then responsibility remains with the inpatient team until discharge, when the patient's care is passed to the community team. Where this is the case, on discharge from the inpatient unit a form allocating a keyworker is faxed through to the team or keyworker being assigned. If the patient's current location is unknown, the team makes enquiries with organisations like the City Mission that the patient may have contacted.

67. Contacts with other ADHB mental health services were entered into the computer system. If the client had been in contact with the Crisis Team, this would be brought to the attention of Agency 2. The Crisis Team and Agency 2 meet at Agency 3 every morning to discuss patients who have come to the attention of the Crisis Team in the previous 24 hours.

Dr C

68. Dr C submitted that it is important to note that Mr B was not considered a high-risk patient at the time of his discharge. He was neither delusional nor hostile, which had

[12] ADHB confirmed that in 2007 ADHB did not have specific policies and procedures in place for the Agency 2, but the generic Mental Health Service policies would have applied.

been the two necessary elements in his prior pattern of violence. There was no evidence that he had been delusional or hostile for the six months prior to his admission in 2007. This was despite not being under compulsory treatment and not receiving intramuscular antipsychotic medications. Previously he had displayed violence only against his father, and it was unprecedented for these feelings of rage to be triggered by another individual. Dr C stated that, in his opinion, the attack on Mr J was an unpredictable event.

69. Dr C stated that he was the primary author of the Unit's revised "philosophy of care" articulated in a document entitled "Service User's Journey", which was based on the "Recovery Concept". He acknowledged that some of his colleagues disagreed with his recovery-based approach to acute hospital care. The controversial tenets of his interpretation of the service delivery philosophy, and his interpretation of the "Recovery Concept" included: the opinion that traumatic events during the course of a person's life are often responsible for the emergence of symptoms of major mental illness; that admission to an acute psychiatric hospital, especially when it is against that person's will, can easily become another traumatic event and exacerbate an acute illness; and the belief that "it is the responsibility of hospital staff to minimise coercion and traumatisation, and maximise service user collaboration, consistent with safety". The emphasis on respect for the autonomy of the person is a cornerstone of a recovery-inspired approach, and this raises the threshold for implementation of unilateral and involuntary interventions. Dr C stated that although mental health professionals generally support these concepts in principle, in his opinion, the threshold for abrogating the autonomy of the mentally ill service user remains relatively low for many psychiatrists. He believes that the disempowered person often reacts badly to coercion that flows from involuntary treatment, feels re-traumatised, ignored and helpless, and becomes unable to trust the mental health professionals.

70. Dr C advised that in 2007 he participated in supervision with a psychotherapist, was also a participant in a monthly peer supervision group, and sought the advice of other senior medical officers (SMOs) working at the Unit. Weekly multidisciplinary team meetings were held at which cases were discussed and treatment plans reviewed.

ADHB

71. In 2007, ADHB had a protocol, "Integration between [Agency 1] & [the Unit]" (the protocol). The protocol covered topics such as: responsibilities for liaison during inpatient stay, accommodation, and the criteria for change of level of care from the Unit to Agency 1. It was designed to ensure clear communication between the services, and to co-ordinate and plan a change to the level of care in the inpatient facility and at discharge to the community.

72. In relation to liaison during inpatient stay, the protocol stated:

"The responsibilities are as follows:

[The Unit] (ALL teams)	**[Agency 1]**
• Care co-ordinator, including Pacific co-ordinator and Kai Atawhai have primary responsibility for ensuring recovery plan is reviewed and implemented collaboratively. • Maintain contact with community Keyworker with information significant to the service user's progress. • Consult with community Keyworker around any planning decisions e.g. leave. • Communicate and document changes in level of care. • [The Unit] Psychiatrist to consult with [Agency 1] Psychiatrist about any major diagnosis or treatment changes. • Kai Atawhai maintain links with involved Maori community service. • Ensure appropriate cultural services advised. • Discharge summary to be in HCC within 72 hours.	• Psychiatrist and/or community Keyworker to establish contact within 72 hours of change to inpatient level of care. • Maintain regular contact with visits with service user during hospitalisation. • Participate in planning meetings, particularly discharge meeting. Representative from [Agency 1] to attend if no key worker assigned. • Keep up to date with information communication from weekly reviews. • Formal review of [Agency 1] management plan. • Service users on the Unit are given priority for allocation of a community key worker. • Keyworker or representative ensures links maintained with involved Maori and other cultural/community services. • Keyworker or representative to provide updates to the inpatient team to regularly inform the review meeting."

73. In relation to accommodation, the protocol outlined that, for a consumer who is known to the service to have no accommodation, "[the Unit] will continue nominal liaison with [the relevant agency]".

74. In relation to discharge, the protocol stated that the criteria for discharge include:

> • "All parties (consumer, family, inpatient and community treating teams) agree that discharge is the best decision.
>
> • The goals of the collaborative management plan have been planned, achieved or may be further met by discharge/transfer to AHBS [acute home-based service].
>
> Consistent with the collaborative model outlined in this document, clinicians are expected to reach a consensus re timing and details of discharge."

75. Where agreement cannot be reached, a "joint, on-site, clinical evaluation by [Agency 1] and [the Unit] Psychiatrists involved will occur within 1 working day". If agreement still cannot be reached, the Clinical Leader, Mental Health Services, "will be asked to arbitrate urgently".

Subsequent events

ADHB — internal review of mental health service

76. In May 2007, ADHB conducted a Serious Incident Review (SIR) meeting to examine the circumstances of Mr B's management and discharge in Month1 2007, and subsequent involvement in a serious event. Present at the meeting were the Unit and Agency 1 staff involved in Mr B's care. The Mental Health Services Clinical Leader, Dr N, chaired the meeting.

77. The SIR report noted that there was still an issue of access to the regional forensic mental health unit, because of pressure from the Courts and prisons for admission of patients. Aside from the regional forensic mental health unit, there is a 20-bed facility for men at another DHB in Auckland. ADHB has access to about three of these beds. However, the waiting list for admission for forensic services is extremely long and the threshold for being on the list is very high.

78. The system for following up on extensions to Community Treatment Orders was examined. This was a paper-based system between Agency 1 administration staff and the clinical staff. As a result of the review, this function is now linked electronically, which allows the administration staff to provide timely alerts to the clinical staff.

79. The recommendations arising from the meeting were that the following processes should be reviewed:

- Communication between Agency 1 and Court Liaison.
- Mental Health Act administration in Agency 1.
- Planning for high-end rehabilitation, including locked rehabilitation and an intensive community team.
- Interface between general and forensic mental health services.
- Clarification of responsibility for actions of people with personality, addiction and psychosis problems, and the development of better services for dual diagnosis.

ADHB — external reviews of mental health service

80. In July 2007, Dr N arranged for an external review of the ADHB mental health service in relation to the management of Mr B, by an experienced psychiatrist, Dr V. Dr V made six recommendations, which included the redevelopment of Agency 2, further training for senior medical and nursing staff regarding diagnosis, assessment and management of individuals with comorbid substance use disorders, and closer integration of mental health and addiction services.

81. In November 2007, ADHB, in collaboration with the Ministry of Health, commissioned an external review of aspects of ADHB's adult mental health services

in response to four recent separate events involving clients of the service ("index cases"), which had resulted in serious outcomes.

82. The review looked at the service as a whole and the practice of Dr C in particular. A report of the review noted that ADHB agreed with the review findings that there had been "failings" within the service. As a result of the external reviews and internal processes, an action plan was developed and changes implemented to:

- the Unit leadership
- the inpatient management model
- observation procedures
- the community service outreach model
- audit tools
- staff development, and training in dual diagnosis.

83. In March 2008, ADHB requested a review of Dr C's clinical practice by two consultant psychiatrists.[13] The reviewers recommended changes to the senior nursing structure in the mental health service and the associated systems of oversight, support and development of nursing practice within the acute adult inpatient service to ensure that younger, less experienced staff are assisted in maintaining a broad-based approach to the management of mental health problems.[14] They also advised that there should be clear criteria for the routine triggering of a complex case review, and that Dr C have supervision and performance monitoring.

Dr C

84. On 28 April 2008, Dr C resigned as Clinical Director of the Unit, and returned to clinical practice as a consultant psychiatrist. On 8 August the Medical Council of New Zealand conducted a review of Dr C's competence to practise. On 30 October, the Medical Council recommended a programme of educational supervision. Dr C now works at Agency 1 and Liaison Psychiatry and meets monthly with his supervisors and ADHB mental health management. Dr C stated that, since the time of Mr B's admission in 2007, he has "participated in a significant amount of educational training and supervision, which has been more focussed than the supervision and support offered to me in 2007".

Update on recommendations arising from review

85. On 10 August 2009, ADHB provided HDC with an update on the actions taken to comply with the various reviews' recommendations. Action has been taken to comply with all the recommendations arising from the External Review, the SIR and Dr V's recommendations.

[13] An earlier external 360 degree review of Dr C's practice had been conducted by one of the reviewers, which was reported on 28 Month1 2007 to Dr N. There had also been an earlier meeting, on 27 July 2006, between Dr C and Dr N, to discuss the issue of Dr C discharging patients prior to a follow-up care plan being agreed with the consumer and Agency 1.

[14] In April 2010, ADHB advised HDC that there is now a policy for "Supervision of Allied Health Practitioners & Mental Health Nurses". The purpose of the policy is to define and describe the different types of supervision relationships and identify the roles and responsibilities of all parties.

Follow-up with families

86. ADHB did not contact Mr J's family in the immediate aftermath of Mr J's death. Mr J's son, Mr A, contacted ADHB in January 2008, and a meeting was arranged for the family to meet with the ADHB General Manager Mental Health Services, the Director Mental Health Services and a legal counsel to discuss the family's concerns.

87. ADHB provided Mr J's family with information about Mr B's clinical history and the circumstances of his admission, after obtaining consent. The Director of Mental Health Services explained the challenges evident in treating Mr B and predicting events such as this. It was noted that Mr B was stable at the time of discharge in Month1 2007 and there were few indications to the events that occurred seven weeks later. The Director of Mental Health Services told the family that it is difficult to say with any certainty what would have happened if Mr B's discharge had been managed differently. However, ADHB acknowledged the criticisms made by the external reviewers and accepted that aspects of Mr B's care could have been managed better. The steps the DHB had taken to implement the recommendations made in the External Review report [15] were explained. The General Manager Mental Health Services apologised for any failings on the part of the DHB that may have contributed to the outcome.

Responses to provisional opinion

88. The families of Mr B and Mr J responded to the "Information gathered during investigation" section of the provisional opinion, and their comments and changes have been incorporated into the revised report where relevant.

89. Dr C and Auckland DHB also responded to the provisional opinion. Their responses are summarised as follows:

Dr C

90. Dr C responded to the provisional opinion stating that he is very concerned that he has been "unreasonably singled out for investigation and criticism" in relation to the service provided to Mr B in 2007. Dr C advised that he was not Mr B's treating physician. He was the Clinical Director at the Unit, and had a supervisory role, but was not responsible for the oversight of all Team 1 or Dr D's patients.

91. Dr C said, "[B]y no means was I providing oversight of all Dr D's patients (as I would to a registrar)." Dr C said that, in making this comment, he is not suggesting that he disagreed with Dr D's clinical decision-making. The point he wanted to make was that he was not the primary clinician responsible for Mr B's care.

92. Dr C stated that Mr B was well known to him as a result of his admission to the Unit in 2005, and he had a good therapeutic relationship with Mr B following his discharge in 2005. Dr C said that it is not the role of an in-patient psychiatrist to work in the

[15] The External Review report Event Summary, which has not been released publicly, was released to Mr A.

community with patients who have been discharged, but his "unprecedented post-discharge involvement" with Mr B was necessary because the community team refused to treat him.

93. Dr C stated that Dr Judson had "sparse access" to information from Mr B's 2005 admission, and without this information, Dr Judson could not know the extent of his knowledge of Mr B and therapeutic relationship with him. He said that the community team had refused to accept the transfer of Mr B's care, arriving at this "extraordinary decision" because they believed he was not manageable in the community. However, Mr B attended every one of his scheduled 2005/06 meetings with Dr C, and was "warm and disclosing and willingly accepted treatment". During this time Dr C came to know Mr B and believed that trust was established. Dr C stated that this was "crucial to the understanding of [Mr B's] potential for responsible engagement", and he drew on this experience in 2007. Dr C believes that Dr Judson's criticism that his assessment of Mr B "was 'cross sectional' and 'superficial'" ignores this important previous history. He said that he was "keenly aware" of Mr B's longitudinal history, including his erratic behaviours in the context of increased drug and alcohol use in the community.

94. Dr C outlined the course of Mr B's interactions with the mental health services, the lapse of the community treatment order, his refusal to accept intramuscular medication, intermittent adherence to the regimen of oral medication, and itinerant living. Dr C stated that despite these issues, there was very little evidence of Mr B having a psychosis. Dr C stated:

> "I consider [that Agency 2 considered invoking the MHA but elected not to despite multiple opportunities] is significant in the light of the criticisms made about [Mr B's] in-patient treatment. If the opportunities to invoke the MHA in February and early [Month1] 2007 are contrasted with the way in which he presented while an informal patient in [the Unit], it is clear that the in-patient team did not have any more compelling grounds on which to invoke the MHA; arguably, less."

95. Dr C stated that he conducted his own mental state examination on Mr B on 13 Month1 2007, after he reviewed the community notes and the recently conducted assessments. Dr C noted Dr E's comments regarding the use of the Mental Health Act and depot injections. His initial plan was to liaise with Dr E regarding Mr B's treatment, but he was not aware that she was going on leave.

96. Dr C said that Mr B was reviewed daily by the nursing staff and by the clinical team at the morning meetings and the weekly multidisciplinary team meetings. At no time did any staff member assessing Mr B express an opinion that there were grounds to invoke compulsory treatment. Dr C stated, "Had there been any evidence of psychosis and dangerousness, then treatment refusal would undoubtedly have generated a recommendation for a compulsory treatment order. If there is any suggestion that my initial assessment precluded this, I refute that."

97. Dr C also refutes Dr Judson's comment that he was "out of step with diagnostic opinion". He said he did not discount the diagnosis of schizophrenia for Mr B, but "did avoid foreclosure on the stigmatising", and what he considered to be an inadequately supported diagnosis. He said that he never denied or doubted that Mr B experienced periods of psychosis and that the administration of antipsychotic medication (and illicit drug abstinence) reduced these symptoms.

98. Dr C said that he believes the key question must be whether his views on Mr B's diagnosis materially affected his management in relation to the decision regarding compulsory treatment and discharge. He said that there is no evidence that this is the case.

99. Dr C stated that it is speculative to suggest that Mr B's presentation in Month1 2007 suggested a deterioration of his schizophrenia and early signs of psychosis, and ignores the likely explanation that his use of drugs and alcohol were affecting his intermittent mood and behavioural dysregulation.

100. Dr C noted Dr Judson's opinion that Mr B was stable in the aftermath of stopping the Piportil injections because it took months for the drug to leave his system, and that in Month1 2007 he was unwell again. Dr C stated that Mr B refused to continue having Piportil voluntarily because he had experienced side effects from the medication. The community team's concern not to adversely affect their relationship with Mr B by invoking the Mental Health Act after the treatment order lapsed, was taken into account by the Unit.

101. Dr C believes that throughout Mr B's 12-day admission to the Unit he presented no evidence of an emerging psychosis, and his low mood lifted. Dr C stated that "despite the team's strong encouragement for him to accept intramuscular antipsychotic medications and secure an appropriate accommodation, he refused to do either". The inpatient team "assessed risk factors multiple times each day, reviewed [Mr B's] history, liaised with the available community clinician ([Mr G] in the absence of [Dr E]), and made an informed decision not to invoke the Mental Health Act and involuntary treatment". Dr C stated that these are the fundamental aspects of inpatient care. He stated that he would have expected the formal risk assessment forms to be completed but, "the fact that they were not is not evidence that risk assessment was not performed".

102. Dr C stated that Dr Judson's criticisms of the circumstances of Mr B's discharge were unrealistic where they imply an expectation that the Unit ought to have done more to ensure that expected follow-up occurred. He said, "That [Mr B] was discharged without a fully arranged follow-up plan was not ideal." Dr C stated that it is inevitable that there will be unknown factors such as the suitability of chosen accommodation and relapse of illness and drug and alcohol abuse. These issues cannot be avoided and patients cannot be kept indefinitely as an inpatient.

103. Dr C stated:

> "I do not deny my role on [Mr B's] inpatient stay and I endorse [Dr D's] comment on his discharge summary that the unanimous decision (that is, of the multidisciplinary [MDT] team) was that [Mr B] should be discharged. However, I am not prepared to accept the inference that is conveyed by your Provisional Opinion that I was solely responsible for those decisions, or that my initial plan somehow adversely affected the care provided to [Mr B]. The impact of the decisions made by the community teams prior to, and after discharge has been minimised."

104. Dr C stated that there is a "significant discrepancy" between the Agency 2 team's intention, prior to Mr B's admission to the Unit, to place him under the Mental Health Act, and their failure to liaise with the crisis team about a follow-up plan after his discharge. Dr C noted that after discharge Mr B contacted the community team seeking oral medication, and was rebuffed on two occasions.[16] Dr C stated that he cannot understand why, if the plan was to maintain contact with Mr B, the crisis nurse did not action Mr B's request for his prescribed medication. He stated:

> "I am not setting out to criticise the care provided to [Mr B] and I have acknowledged that his case was challenging for all concerned. However, the inattention of Dr Judson and in the Provisional Opinion to these matters contrasts with the harsh criticisms of me, and reinforces my view that I have been singled out for criticism."

105. Dr C provided HDC with letters of apology for Mr A and the members of his family. These letters were sent on 13 July 2010.

Auckland DHB

106. ADHB noted Dr Judson's view that Dr C's opinion and management plan for Mr B was accepted as a basis for the diagnosis and treatment plan and influenced the assessments and plans made by other the Unit staff. The DHB stated, "While [Dr C] was the senior consultant responsible for [Mr B], he did not operate in isolation. Other clinicians and nurses were directly involved in [Mr B's] care and critical decisions such as the decision to discharge were made by the team."

107. The DHB commented that Dr Judson correctly noted the importance of a longitudinal view when assessing risk. However, the patient's current presentation cannot be ignored when consideration is being given to invoking the Mental Health Act. Multiple clinicians and nursing staff had interactions with Mr B, and the team's view was that Mr B was not psychotic in Month1 2007.

108. Mr B's family were notified about his admission to the Unit, but were not consulted about his discharge. ADHB noted that although there was no statutory obligation to do so in this case, as Mr B was not under the Mental Health Act, consultation with the

[16] Dr C appears to be mistaken when he made this comment. The records show that Mr B made contact with the ADHB Crisis Team (CT) on only one occasion — on 17 Month2 (see paragraph 65 of the report) when he requested medication, somewhere to sleep and some warm clothing, and was told that the CT could not provide these things.

family is important. Since these events ADHB has taken steps to improve communication with families by:

- restructuring the position of the family advisor into the senior management team;
- undertaking an audit of practice; and
- improving consultation policies and accountability.

109. The DHB noted that Mr B was a voluntary patient, which limited the options for ensuring that his follow-up care was adequate. However, the DHB acknowledged that the provision of adequate support for patients at discharge is "vitally important".

110. ADHB stated that it employs qualified and experienced staff who make individual decisions based on their clinical expertise and judgement, and it is necessary and reasonable for the DHB to rely on its staff to exercise appropriate clinical judgement. However, the DHB acknowledges that aspects of Mr B's care, particularly in relation to his discharge, could have been managed in a "more proactive, creative and integrated manner".

Actions taken

111. ADHB provided a summary of the actions it has taken to address the recommendations arising from the external and internal reviews of its adult mental health services.

112. These actions include: improvements in the processes between community mental health services and Court liaison, improved interface between general and forensic mental health services, implementation of staff training regarding dual diagnosis, and establishment of an Assertive Community Outreach Service.

113. The DHB advised that its integration of care and discharge planning is now "significantly more robust".

114. The DHB stated that it has engaged with Mr J's family, expressing its regret at the events leading up to Mr J's death. ADHB noted that Mr B's care has been the subject of three previous reviews. ADHB mental health services has been the subject of an extensive external review, and very significant structural, management and practice changes have occurred over the last three years.

Code of Health and Disability Services Consumers' Rights

115. The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Other standards

116. New Zealand Standard National Mental Health Sector Standards 2001 (NZS 8143:2001)

6	SAFETY	The activities and environment of the mental health service are safe for the person receiving the service, their families, whanau, staff and the community. …
10	FAMILY, WHANAU PARTICIPATION	Family, whanau are involved in the planning, implementation and evaluation of the mental health service. …
11	MINIMISING THE IMPACT OF MENTAL ILLNESS	The mental health service works with the person who is receiving the service to minimize the impact and distress of their ongoing mental illness. …
15	ASSESSMENT	Treatment and support of each person who received the service is based on a comprehensive assessment that is completed by a health team with appropriate knowledge and skills. …
15.2		The assessment is comprehensive, appropriate for the pupose, and is conducterd using accepted evidence based and culturally safe methods and tools. …
16	QUALITY TREATMENT	The mental health service provides a range of quality treatment and support services, and makes referrals to

	AND SUPPORT	other services based on the individual's needs to promote recovery. …
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, whanau receives assistance to develop a plan that identifies early detection or warning signs of a relapse and the appropriate action to take. …
16.22		Ongoing follow-up arrangements for each person receiving the service are planned prior to their exit from the mental health service.
16.23		The mental health service ensures that each person receiving the service has been referred to other services and has established contact and that discharge does not occur until arrangements for ongoing follow up are established and are satisfactory to the person, their family, whanau and other services. …
17	COMMUNITY SUPPORT OPTIONS	The mental health service facilitates access to a range of community support options that maximize choice, safety and quality of life for each person receiving the service. …

Commissioner's opinion

Introduction

117. When Mr B was admitted to the ADHB acute adult inpatient mental health unit in 2007, he had been under the care of the ADHB mental health services for ten years. Mr B often presented with psychotic symptoms in the context of substance abuse, and this led to some diagnostic uncertainty. Clinicians had differing views as to his diagnosis. There were some long periods, when he was taking regular medication, that he was symptom-free.

118. Mr B preferred oral medication and, although there were concerns with his compliance at times, he was generally willing to take medication when under supervision. Alcohol and substance abuse was a persistent feature, even during periods when he was described as being free of psychotic symptoms. In 2005 Mr B was admitted to the Unit under the Mental Health Act. He was discharged into the community after four months of inpatient care, and managed by Agency 2 until his voluntary admission in 2007.

119. In Month1 2007, psychiatrist Dr C was the Clinical Director of the Unit. He was also the team leader for Team 1, which consisted of Medical Officer Special Scale (MOSS) Dr D and house surgeon Dr Q. ADHB has not provided copies of Dr C's position description or key responsibilities. However, he acknowledges that as the clinical leader of the Unit he had a supervisory role.

120. It is important to acknowledge the need to avoid "hindsight bias", which could be seen to influence my decision on this matter. The avoidance of hindsight bias requires that the serious event regarding Mr J does not have an influence on whether the care provided to Mr B was of an appropriate standard.

121. While Mr B was under the care of ADHB inpatient mental health services in Month1 2007, he had the right to have services provided that complied with the Code. In my opinion, there were acts and omissions by Dr C and ADHB that did not comply with accepted standards and breached Mr B's rights under the Code.

Breach — Dr C

Assessment — Month1 2007

122. In Month1 2007, Mr B was homeless and non-compliant with medication, and his concerning behaviour had been escalating. On 11 Month1 2007, Mr B was admitted to the Unit by on-duty psychiatric registrar Dr R. Dr R noted that Mr B was a man with a diagnosis of schizophrenia. He had been well throughout 2006 while on intramuscular depot antipsychotic medication. His Community Treatment Order had lapsed in July 2006 and was not renewed. Mr B refused to have further depot medication from that time, but continued to take oral antipsychotics. Dr R recorded that Mr B was willing to be admitted to the Unit.

123. Dr R discussed Mr B's admission with a psychiatrist who had treated him during an earlier admission to the Unit in 2005, and was advised that the mental health team should take the opportunity of informal admission to allow for a period of assessment and establishment of intramuscular depot medication. However, Mr B refused to accept the depot injection.

124. Two days later, on 13 Month1, the Team 1 house surgeon, Dr Q, recorded her impression that Mr B did not have schizophrenia, but was suffering from "existential angst" as he was complaining of only vague schizophrenic symptoms, which were "probably secondary to substance abuse". Later that day, Dr C reviewed Mr B, and recorded that he saw "no evidence of psychosis or disorganisation". Dr C noted that he was "uncertain of [Mr B's] Axis 1 diagnosis but, regardless of a possible psychotic disorder, he does not appear to be actively psychotic at present". Dr C recorded that Mr B would have a "brief stay" while he found accommodation, and noted his plan to liaise with Mr B's community psychiatrist, Dr E, about treatment options and noted that she favoured the use of the Mental Health Act and IM pipothiazine for him.

125. My independent expert psychiatrist, Dr Nick Judson, advised that it is concerning that when Mr B was admitted to the Unit in Month1 2007, the assessment appears to have focussed entirely upon the lack of positive symptoms, such as delusions and hallucinations. He stated that the early signs of relapse of a schizophrenic illness are often subtle disorganisation and behavioural and mood changes, and that florid hallucinations and delusions are characteristic of the acute phases of the illness.

126. Dr Judson noted that Mr B had continued to take his antipsychotic medication for about three months after his intramuscular depot antipsychotic stopped. Dr Judson stated that it is widely recognised that there is a period of three to six months between stopping established depot antipsychotic medication and the symptoms of psychosis recurring. Therefore it is likely that Mr B had a significant level of antipsychotic medication in his system until late in 2006.

127. Dr C agreed with Dr Judson's statement that Mr B may well have remained more stable if the injections had continued, but pointed out that this does not justify involuntary treatment for patients who are stable when assessed. In his opinion Mr B was sad and seeking support, and there was no evidence that he had been psychotic during the previous six months despite being in the community on his own and not receiving involuntary treatment. Dr C said that the relevant consideration for the inpatient team regarding their assessment and treatment plan was the community team's concern that invoking the Mental Health Act and recommencing involuntary treatment would adversely affect the relationship with Mr B.

128. Dr Judson noted that changes in Mr B's mood, organisation and behaviour had been documented from late 2006 until the time of his admission on 11 Month1 2007, and these changes were consistent with the early signs of schizophrenic relapse. He was concerned that no consideration was given to the longitudinal pattern of Mr B's illness, and the possibility that this was the early emergence of psychotic symptoms in a patient who had discontinued antipsychotic medication after a prolonged period of stability.

129. Dr C stated that although he has never denied that Mr B experienced periods of psychosis, and that antipsychotic medication (and avoidance of alcohol and drugs) reduced these symptoms, he believed it was important not to stigmatise Mr B on the basis of an inadequately supported diagnosis. He commented that Mr B was evaluated each day by a number of experienced staff, and at no time did any staff member express an opinion that there were grounds to invoke compulsory treatment. I note that Dr C had planned to discuss with Dr E her preference for compulsory treatment but, as she was on leave in Month1 2007, he was not able to do so.

130. Dr Judson stated:

> "I would be concerned that [Dr C's] views appeared to be significantly out of step with other clinicians' views on the diagnosis: this does not mean that he was necessarily wrong, but clearly such a dissenting viewpoint requires a very careful justification, based on a thorough review and documentation of all the available evidence."

131. Standard 15.2 of the National Mental Health Sector Standard 2001 relates to patient assessment and states that an assessment must be "comprehensive, appropriate for the purpose, and is conducted using accepted evidence based and culturally safe methods and tools". Dr Judson advised that Dr C's assessment of Mr B was "superficial and incomplete".

132. Dr Judson advised that Dr C's assessment appears to have discounted the contribution of psychosis, despite the diagnosis of schizophrenia, focussing entirely on Mr B's immediate presentation and the more obvious presenting feature of existential crisis, while ignoring the established historical pattern. This led to the development of a treatment plan that was appropriate for what Dr C assessed to be Mr B's need, but was ultimately unhelpful.

133. Dr C stated that he conducted his own mental state examination on Mr B, and reviewed the community team's records and the recent assessments. He had noted Dr E's comments that she was considering using the Mental Health Act to treat Mr B with depot medication. However, his view was that "[Mr B's] commitability at present is questionable, in my opinion". Dr C stated that he did not discount Mr B's diagnosis of schizophrenia. He said he was "keenly aware" of Mr B's longitudinal history, including his erratic behaviours in the context of drug and alcohol use in the community.

134. This Office has frequently emphasised the importance of good record-keeping. Dr Judson noted that Dr C's notes may not have fully reflected his assessment. However, I would expect that Dr C would have documented in detail his review and justification for the treatment approach. I am not satisfied that he did this. I accept Dr Judson's advice that Dr C's assessment of Mr B, as recorded in Mr B's notes, was "superficial and incomplete". Dr Judson considered this to be a moderate to severe departure from an acceptable standard.

Evaluation of risk

135. I acknowledge that Dr C was not Mr B's treating psychiatrist in 2007, and that his care was provided by a multidisciplinary team. Dr C stated, "By no means was I providing oversight of all [Dr D's] patients (as I would to a Registrar)", and he is adamant that he was not the primary clinician responsible for Mr B's care. However, as the leader of the team, Dr C had a supervisory role, and provided oversight to his MOSS, Dr D, and the rest of the team.

136. In a previous opinion,[17] the Commissioner stated, "Leadership is critical for safe health care.[18] Clinical leadership (leadership of clinicians, by clinicians) is increasingly recognised as a key factor in promoting clinical quality.[19]" In my view, irrespective of whether or not he was providing supervision to Dr D, Dr C should have shown leadership, especially in light of his longstanding relationship with Mr B.

[17] Southland District Health Board Mental Health Services February–March 2001(October 2002), page 83.
[18] Berwick DM, Leape LL, "Safe Health Care: are we up to it?" BMJ 2000, 320:725.
[19] Malcolm L, Wright L, Barnett P, Hendry C, *Clinical Leadership and Quality in District Health Boards in New Zealand*, Clinical Leaders Association of New Zealand (2002).

It is reasonable to expect that, for a patient with a history such as Mr B's, Dr C would have been careful to ensure an appropriate assessment and evaluation of risk was carried out and documented when he saw Mr B on 13 Month1.

137. Dr C advised HDC that Mr B was not considered a high risk. He said that if Mr B had been motivated to seek out and harm another person, and this was a concern to the clinical team, then he would have expected him to be treated assertively until the intensity of the symptoms had abated and the acute risk diminished. Dr C said that this was not the case during Mr B's Month1 2007 admission. He had not been delusional or hostile for the six months prior to his admission, which had been the two necessary elements in his prior pattern of violence.

138. Dr Judson commented that Dr C correctly observed that Mr B's previous violence had been based on delusional belief, but what he did not take into account was that there had been episodes of verbalisation of possible violence, just before and on the day of his admission.

139. Four days before Mr B's admission, on 7 Month1, when a community mental health nurse tried to get him to talk about lifestyle goals, he referred to a previous violent incident. On 10 Month1, a member of the Crisis Team, a community mental health nurse, was called to see Mr B at ADHB Emergency Department. Mr B told the nurse that he had been experiencing hallucinations, he was seeing people in front and behind him, which was scaring him, and he was hearing voices. The nurse recorded, "[Mr B] complaining of psychosis" and that she had offered him Piportal, which he refused. Then, during the admission interview on 11 Month1, Mr B told Dr R that he wanted to kill someone, but retracted the statement when he saw that it had been recorded, giving the excuse that he had made the statement only because he was "off his head with painkillers".

140. Dr Judson is of the view that these verbalisations, taken in the context of a patient who had an established history of violent behaviour based on delusions, should have been properly explored and taken into account when assessing Mr B.

141. Dr C clearly did not believe that Mr B was committable under the Mental Health Act.

142. Dr Judson acknowledged that in the absence of any clear evidence of a mental disorder, use of the Mental Health Act was not justified. I accept that, during the time Mr B was in the Unit, it was open to the team to conclude that there was insufficient basis to institute compulsory treatment under the Mental Health Act. However, Dr Judson advised that the risks and benefits of compulsory treatment were not fully explored and set out. He stated, "There is no real justification of why the historical pattern of illness and risk was dismissed in assessing whether or not compulsory intervention was required." Dr C stated that the historical pattern of illness and risk was not dismissed, but the historical pattern could not be relied upon as the sole foundation for compulsory treatment. He asserts that the failure to complete the formal assessment of risk forms is not evidence that risk assessment was not performed.

143. In my view adequate documentation of the assessment of risk was vital, especially considering that on 9 Month1, Dr E of Agency 2 had recorded her concerns about Mr B's escalating concerning behaviour and the need to reintroduce the depot injections because of his "history of very serious risk to others".

144. I acknowledge that it was not Dr C's role to complete the risk assessment or to consult with family members prior to discharge on 23 Month1. However, Dr Judson advised that Dr C's assessment of Mr B's risk on 13 Month1 was superficial and did not attempt to explore some of the more obvious indicators of potential risk, such as Mr B's verbalisation of potential violence. Dr Judson stated that this was a moderate to severe departure from the accepted standard.

Summary

145. I am advised that a reasonable and competent clinician, when confronted with the combination of a patient with a history of violence, medication non-compliance and reluctance to co-operate with treatment plans, would have done a more thorough assessment and evaluation of risk. In my opinion, Dr C did not adequately assess Mr B or evaluate the risks of his treatment plan at that time by taking a longitudinal view and identifying that Mr B's mental health was unravelling. In addition, Dr C did not adequately record his assessment, and therefore did not provide Mr B with services with reasonable care and skill.

146. Overall, in my opinion, Dr C breached Rights 4(1) and 4(2) of the Code in relation to his assessment of Mr B in Month1 2007.[20]

Breach — Auckland DHB

Introduction

147. In response to my provision opinion, ADHB accepted responsibility for any identified shortcomings in policy or process and the extent to which these impacted on staff decision-making, but asserted that the DHB was not responsible for the exercise of clinical judgement unless it failed to provide adequate support for staff. In my view ADHB had a responsibility to take all reasonable steps to ensure that Mr B received services of an appropriate standard.

Compulsory Treatment Order

148. Although the lapse (and non-renewal) of Mr B's Community Treatment Order (CTO) in July 2006 is outside the time frame covered by this investigation, it is relevant to note it in the context of this opinion.

149. When Mr B became aware that the treatment order had lapsed he refused to continue to have the intramuscular depot antipsychotic medication, although he did continue

[20] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill." Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

for some months to accept the medication orally. Dr Judson stated that the accidental lapsing of an order is an "unsatisfactory state of affairs". As a result, there was no opportunity for Mr B to be properly reviewed to judge whether or not continuing compulsory treatment was required. The decision to apply for an extension would have allowed for a careful review of the risks and benefits, consultation with the family, and the presentation of a carefully formulated plan at that time. While the Month1 2007 admission later provided full opportunity for that assessment, I agree that the accidental lapse of the order in 2006 is unsatisfactory.

150. ADHB has reviewed the systems in place in Agency 1 that allowed the clerical error to occur and resulted in Mr B's CTO lapsing without review by the clinical team. The system in place in 2006 for the administrative staff sending out reminders to the clinical team was paper-based. As a result of the review, this type of reminder has now been linked to the electronic system which allows for appointments regarding reviews to be made directly into the appropriate clinical staff diaries.

Communication

151. A failure of communication between services occurred when Mr B presented at the ADHB Emergency Department on 10 Month1. A member of the Crisis Team, a community mental health nurse, recorded that she had been called to see Mr B. Although she recorded that he was complaining of psychosis, it appears that he was not taken seriously, and his behaviour was not considered in the context of a deteriorating psychosis. The nurse told Mr B that all she could offer him was Piportal, which he refused. The day before this assessment, Dr E and other members of Agency 2 had been trying to locate Mr B because he had failed to attend an appointment, and there was concern about the deterioration in his behaviour and functioning. Dr E considered that Mr B needed to be restarted on his depot injections, and if he refused then the Mental Health Act should be considered as he had a "history of very serious risk to others". This information would have been available to the Crisis Team when Mr B presented at the Emergency Department, and therefore the fact that he was there was important information that should have been conveyed to Agency 2. Instead, it appears that, as Dr Judson noted, when Mr B became abusive, he was treated as an obnoxious young man who would be escorted from the Emergency Department by the security staff if he did not leave voluntarily. Mr B made contact with the Crisis Team again that night and re-presented the next day (when he was admitted to the Unit).

Discharge planning

152. When a patient is to be discharged from the [Unit] to the community, ideally there should be a discharge planning meeting with the relevant providers. ADHB's protocol "Integration between [Agency 1] & Acute Inpatients" stated that the Unit staff had a responsibility to maintain contact with the community keyworker with information significant to the consumer's progress, and to consult with the keyworker around any planning decisions.

153. Section 16.4 of the National Mental Health Sector Standard 2001, headed "Quality Treatment and Support" states that "[t]he identification of early warning signs and relapse prevention is included in the individual plan. Each person receiving the

service and their family, whanau, receives assistance to develop a plan that identifies early detection or warning signs of a relapse and the appropriate action to take".

154. On 14 Month1 2007, Mr B's keyworker, community mental health nurse Mr G, visited Mr B in the Unit to discuss issues related to his discharge. Mr B refused to talk to Mr G, who then spoke to the ward staff about the difficulties of managing Mr B in the community. When Mr G visited again on 19 Month1, Mr B was not in the Unit.

155. On 19 Month1, the Unit staff started to plan for Mr B's discharge. On 22 Month1, the team's psychiatric house surgeon, a medical student and a ward RN met with Mr B to discuss his pending discharge. The team's house surgeon noted that Mr B appeared to be no risk to himself or others, although his safety issues had not been formally assessed. Dr C noted that he would have expected the formal risk assessment forms to be completed for Mr B but, "the fact that they were not is not evidence that risk assessment was not performed". Dr C said that the inpatient team assesses risk factors multiple times a day. However, he considered that when Mr B was discharged he was not a high risk, as he was neither hostile nor delusional.

156. The SHO's discharge summary of 23 Month1 noted that there had been "ongoing discussion" with Mr B's keyworker (Mr G) about the discharge. However, Mr G advised HDC that he was not involved in the decision to discharge Mr B in Month1 2007. Although I note that there had been some previous discussions with Mr G about Mr B's care, there is also no evidence in Mr B's notes that the Unit staff consulted with Mr G or any other Agency 1 staff about the decision to discharge Mr B.

Decision to discharge

157. Mr B was admitted informally in Month1 2007. Dr C indicated that Mr B was in the Unit for a brief stay while he secured accommodation. Staff at the Unit encouraged Mr B to arrange accommodation for himself, but he indicated that he wanted to remain in the Unit, and made little effort to find somewhere to live. Apart from some reluctance to take his medication, Mr B appeared to benefit from being in a stable supportive environment, but on 22 Month1 he was found drinking and smoking in his room. He was advised that he would be discharged the following day.

158. On 23 Month1, Mr B's discharge was actioned by Dr D. Although Dr C was not actively involved in Mr B's discharge, he has confirmed that Mr B's discharge was a unanimous team decision.

159. Mr B had only a vague notion of where he would live. Agency 2 were faxed the details of Mr B's discharge, and the family notified by telephone after he was discharged. The family's involvement and their important contribution in supporting a family member with mental illness, including their role in risk management, should be recognised. Mr and Mrs H had expressed their concerns to the team and were proactive in following up with the mental health service staff and expressing their concerns about, and wishes for, their son's ongoing treatment. However, they were not consulted about the proposal to discharge Mr B. Three days after her son's discharge, Mrs H contacted the community mental health team, to enquire about his discharge address. When advised of the discharge address Mr B had nominated, she

had important knowledge that this setting was likely to increase his risk of exacerbating his illness. Had the family been involved before discharge, this knowledge could have been taken into account.

160. Section 16.22 of the National Mental Health Sector Standard 2001 states that "[o]ngoing follow-up arrangements for each person receiving the service are planned prior to their exit from the mental health service", and section 16.23 requires that the service ensures that the discharge "does not occur until arrangements for ongoing follow-up are established and are satisfactory to the person, their family, whanau and other services".

161. Dr Judson noted that it appears that the plan to discharge Mr B from the Unit had been made before he was found with alcohol in his room, irrespective of whether he had arranged appropriate accommodation. Dr Judson said that if the assessment that Mr B was not psychotic and capable of taking responsibility for his health and accommodation was correct, then the discharge plan would have been reasonable. However, Dr Judson was of the opinion that it was almost inevitable that Mr B would experience a worsening of his illness when, in the context of a deteriorating pattern of behaviour, he was discharged with no effective follow-up, to an environment where he had access to drugs and alcohol. The expectation that Agency 2 would be able to track and manage him was unrealistic.

162. The communication between the ward and the community mental health team (in particular, Agency 2) was not as good as it should have been. The discharge plan was based on an assumption that Mr B would continue to take his medication, when it was already evident that he was non-compliant and resented taking "mad pills". It was unrealistic to expect that Mr B would keep in contact with the community teams, when he had exhibited a reluctance to interact with his key community worker while in the ward. As has already been discussed, Mr B's family were also not involved in the planning. Dr Judson advised that the decision to discharge Mr B without a clear or effective plan of follow-up was inappropriate.

163. The discharge plan was that, although Mr B had no accommodation organised and thought he might go to another town, it was "agreed" that he would contact Agency 2 on his return to Auckland. The follow-up arrangements were that, should Mr B require readmission owing to relapse or non-adherence, Agency 2 was to consider restarting his compulsory treatment of Piportil. As previously noted, the discharge plan was not well thought out. The plan was naïve in its intention that Mr B would keep contact with mental health services and comply with his medication. It would have been helpful if ADHB mental health staff had had a clear, documented plan for the action to be taken should Mr B present to any section of ADHB's mental health service.

164. The only reference in ADHB's policies on how to deal with a consumer with no current accommodation is in relation to liaising with the appropriate community mental health service, which provides for a consumer who is known to the service to have no accommodation. The policy states: "[the Unit] will continue nominal liaison with [the relevant agency]." In my view, while I appreciate the difficulty in planning

discharge where there are no obvious accommodation options, this policy is not sufficient for consumers such as Mr B, who found it difficult to find and retain accommodation. I also note that Team 1, which was responsible for Mr B's care, did not have a care coordinator (whose role it was to co-ordinate the care plan with a social worker) at the time Mr B received services.

165. Dr Judson advised: "The decision to discharge [Mr B] without any clear or effective plan or follow up, into an environment in which it was likely that his psychosis would deteriorate … represents a moderate to severe departure from an accepted standard."

166. I am left with some disquiet about ADHB's oversight of the Unit. I note that, in July 2006, Dr N met with Dr C to discuss the issue of his discharging patients prior to a follow-up care plan being agreed with the consumer and Agency 1. ADHB acknowledges that aspects of the care provided to Mr B in Month1 2007, in particular in relation to his discharge, could have been managed in a more "proactive, creative and integrated manner". Given that it was on notice that this was an issue, I am not satisfied that ADHB took appropriate action. I consider that ADHB did not have appropriate checks and balances to ensure that the protocol for liaison between the Unit and Agency 1 in relation to discharge was being followed.

167. In these circumstances, I consider that ADHB did not provide Mr B with services of an appropriate standard. ADHB's policy, which was intended to provide staff with guidance on discharging a consumer who is known to the service to have no accommodation, was not sufficient. ADHB also did not have appropriate procedures, or take appropriate action, to ensure that the protocol for liaison between the Unit and Agency 1 regarding discharge was being followed by staff. In my view, this contributed to Mr B being discharged into the community without adequate liaison and consultation with his keyworker (or other Agency 1 staff), and without definite accommodation and appropriate plans in place for action should he make contact after discharge.

Follow-up after discharge

168. Mr B had been discharged into the care of Agency 2, which comprises a part-time psychiatrist, two full-time psychiatric nurses and a social worker, and is responsible for following up between 50 and 70 transient mental health clients. Patients under the care of Agency 2 are, by their very nature, difficult to follow up. The team members work together to try to find accommodation for their clients, and liaise with other agencies that have contact with transient homeless people.

169. While there was a system in place for the Crisis Team to report each day to Agency 2 any contact it had with one of its patients in the previous 24 hours, this was unhelpful for patients who did not have a fixed abode or contact details. Furthermore, Agency 2 did not have any documented plan specifying that any opportunity of contact should be seized in order to carry out a proper assessment.

170. On 17 Month2 Mr B made contact with the Crisis Team stating that he was on the street and cold, and that he wanted medication, somewhere to sleep and some warm clothing. He was told that the Crisis Team could not provide these things. My expert

advisor, Dr Judson, commented that this response appears inappropriate and unhelpful in the context of a young man with a deteriorating psychotic illness. An assessment to consider the appropriateness of the medication Mr B was requesting should have been undertaken.

171. Following 17 Month2 2007, there is no further record of the Crisis Team being contacted about Mr B. While Mrs H recalls speaking with the Crisis Team when her son turned up at 4am on the morning of 10 Month3, there is no record in Mr B's notes of this contact. Mr B's family did have contact with Agency 2 (Mr G) on 2 and 10 Month3, and reported their concerns that Mr B was "not quite right" and might be unwell. However, given that Mr B did not have any fixed abode or other means of contact, the action Agency 2 could take was limited.

172. As Dr Judson commented, patients under care of Agency 2 are always likely to be difficult to follow up. Yet there was no plan of what to do should an "elusive" patient such as Mr B make contact. Given that from 2005 there had been a history of documented concerns about Mr B's risk of violence in certain circumstances, a clear plan for his future care and the involvement of Agency 1 should have been agreed upon, and activated, before he was discharged.

173. As a result, there was a lack of response when Mr B made contact with the Crisis Team on 17 Month2. This was a missed opportunity. I am not satisfied that ADHB had appropriate systems in place to ensure co-operation between the Crisis Team and Agency 2, and therefore the quality and continuity of services for consumers under the care of Agency 2. Overall, I do not consider that ADHB responded appropriately to Mr B's request for assistance, given his history.

174. ADHB advised that since these events it has taken steps to improve communication between the mental health service and families. The DHB has restructured the position of family advisor, undertaken an audit of practice, and improved consultation policies and accountability.

Summary

175. For the reasons outlined above, in my opinion ADHB did not provide services of an appropriate standard to Mr B, in relation to his discharge, continuity of care and the follow-up in the community, and this amounted to a departure from the accepted standard. Accordingly, ADHB breached Rights 4(1) and 4(5) of the Code.

Recommendations

Auckland District Health Board

176. I note that ADHB apologised verbally to Mr J's family at a meeting in early 2008. However, I recommend that ADHB apologise in writing to both families for its breaches of the Code. The written apologies should be sent to the Commissioner by **27 May 2011** for forwarding to the families.

177. I recommend also that ADHB take the following actions:

1. Develop clear performance criteria and processes for review of performance of the Unit's Clinical Director and all mental health service medical staff.
2. Develop a clear mechanism to resolve any disagreement between and within the community and inpatient teams in relation to proposed treatment or discharge plans, including when clinicians have markedly different views.
3. Develop a system whereby a "red flag" appears in the electronic record when a patient comes to the attention of one of the mental health services because of a relapse or non-adherence to treatment, and whose historical pattern and clinical records indicate a history or risk of violence.
4. Contract an independent reviewer to critically appraise the appropriateness of the changes made to ADHB mental health services as a result of the recommendations arising from the 2007/2008 reviews, in particular the:
    - discharge protocol;
    - interface between the Unit and Agency 1 regarding discharge planning;
    - interface between mental health and addiction services;
    - inpatient management model;
    - observation procedures;
    - criteria for triggering a complex case review;
    - training for senior medical and nursing staff regarding diagnosis, assessment and management of clients with comorbid substance use disorders; and
    - Unit leadership.
5. Provide evidence that internal auditing and monitoring processes have been introduced to audit compliance with ADHB mental health services policies and procedures.

ADHB is to respond to HDC by **30 August 2011** on the steps taken to address these issues.

Ministry of Health
I note that ADHB has made service changes to its mental health services. I recommend the Ministry of Health monitor ADHB's progress with these changes, and the recommendations above, and provide an update to HDC by **30 November 2011**.

Follow-up actions

- A copy of this report will be sent to the Coroner and the Medical Council of New Zealand.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case and ADHB, will be sent to the Royal Australian and New Zealand College of Psychiatrists, and it will be advised of Dr C's name.
- A copy of this report with details identifying the parties removed, except the name of the expert who advised on this case and ADHB, will be sent to the Ministry of Health, the Mental Health Commission, the Mental Health Foundation, and the

Schizophrenia Fellowship, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent expert psychiatric advice

The following expert advice was obtained from psychiatrist Dr Nick Judson.

"You have asked me to provide independent expert advice about whether psychiatrist [Dr C] and Auckland District Health Board provided an appropriate standard of care to [Mr B].

Background to the Complaint

Throughout 2006, [Mr B] continued to be monitored in the community with assistance from his parents regarding medication compliance. In June 2006 his Compulsory Treatment Order (CTO) lapsed, and due to communication errors within the mental health team this was not renewed.

On 11 [Month1] 2007, [Mr B] was readmitted to [the Unit] following a possible suicide attempt (which he denied). [Mr B's] diagnosis at this time was schizophrenia. On 23 [Month1], he was caught smoking and drinking in his room and was discharged from the Unit to be followed up by [Agency 1] and [Agency 2]. No further contact was made (except on 17 [Month2] when [Mr B] telephoned the Crisis Team because he was on the street and cold), until [the serious incident involving Mr J] [a few weeks later].

The Complaint

The appropriateness of the care provided to [Mr B] by Auckland District Health Board from 11 [Month1] to 18 [Month3] 2007.

The appropriateness of the care provided to [Mr B] by psychiatrist [Dr C] from 11 to 23 [Month1] 2007.

You have asked me to provide expert advice as follows:

[Dr C]

Please comment generally on the standard of care provided to [Mr B] by [Dr C].

If not answered above, please answer the following, giving reasons for your view:

1. Was the treatment plan for [Mr B] appropriate?

2. The relevance of the 'Axis I' diagnosis, [Dr C] referred to in his 13 [Month1] 2007 progress note.

3. Was the decision to discharge [Mr B] on 23 [Month1] appropriate given that he had no accommodation arranged?

4. Was there an adequate risk assessment conducted before discharge?

5. Was the discharge plan appropriate?

6. Was there adequate communication between the inpatient and community mental health teams in relation to [Mr B's] ongoing management?

7. Were there alternative steps that could have been considered in relation to [Mr B's] care?

8. Any other comment you wish to make.

Auckland DHB

Please comment generally on the standard of care provided to [Mr B] by Auckland DHB.

If not answered above, please answer the following, giving reasons for your view:

1. Whether the systems error that resulted in [Mr B's] detention under the Act lapse in June 2006, and the decision not to reinstate the order, had any bearing on subsequent events.

2. Was the oversight of [the Unit] appropriate?

3. Whether there were adequate systems in place to facilitate communication between inpatient and community mental health teams.

4. Whether the follow-up systems within [Agency 2] were adequate and effective.

5. Any other comment you wish to make.

If, in answering any of the above questions, you believe that [Dr C] and Auckland DHB did not provide an appropriate standard of care, please indicate the severity of the departure from that standard.

Are there any aspects of the care provided by [Dr C] and Auckland DHB that you consider warrant additional comment?

Information

My opinion is based on the information provided:

- Complaint from [Mr A], received HDC on 29 April 2009
- Further information received from [Mr A] on 13 May 2009
- Response received from ADHB on 29 June 2009
- Further response from ADHB on 16 July 2009
- Notes taken during an interview with [Mrs H] on 29 July 2009
- Notes taken during an interview with community mental health worker [Mr F] on 7 September 2009
- Response from ADHB (and [Dr C]) dated 7 September 2009
- Notes taken during an interview with MOSS [Dr D] on 29 October 2009

- [Mr B's] 2007 inpatient clinical records received from ADHB on 10 November 2009
- Further information provided by [Dr C] to HDC on 9 November 2009
- [Mr B's] 2007 community clinical records received from ADHB on 20 November 2009
- Notes taken during a telephone call to community mental health liaison nurse [Mr G] on 27 January 2009, (and questions posted 2 December 2009)
- Notes taken during an interview with psychiatrist [Dr E] on 6 November 2009, and responses to questions, dated 28 January 2010
- Report of Serious Incident Review dated May 2007
- Supplementary Sentinel Event Review, [Dr V], July 2007
- External Review of ADHB adult mental health services, January 2008.

Background history

This background has been removed to protect Mr B's privacy.

In September 2006 the Community Treatment Order lapsed — it appears that he had not been reviewed because of 'poor communication'. The Incident Review notes that 'the view of the team was that it would have been difficult to argue for an extension of the Order at that time.' [Mr B] elected to discontinue his depot medication and to continue with oral medication. It appears that he continued the oral medication for about three months. His living situation became unstable after the hostel where he had been living closed in November 2006. The Incident Review noted that 'reinstatement of the Mental Health Act was considered, given that his life had become less stable with regard to accommodation. This was not thought to be justified as he had been free of psychotic symptoms for almost a year and not been aggressive during that time.' Also 'there was concern that if used the Mental Health Act to enforce intramuscular injections in the community might damage therapeutic relationship and lead to [Mr B] disappearing from the area.' (sic)

From mid-February 2007 he became more difficult to contact, and was apparently using more alcohol and drugs. Although there were 'no apparent signs or reported symptoms of psychosis', he accepted an increased dose of his oral antipsychotic, but there were further reports of behavioural problems including aggressive attitude and damage to property in the context of drug and alcohol use.

On 5 [Month1] 2007 he rang to seek an appointment with the doctor, stating that he was unwell and was unable to wait until 9 [Month1]. He was seen by a community nurse on 7 [Month1], when he appeared 'neat and tidy, well groomed' and while he was described as being 'anxious and passive aggressive, with too excessive eye contact and inappropriate smiles', no other signs of psychosis were observed. The nurse noted that [Mr B] commented that he

reminded him of his father 'and look what happened to him'. *(This appears to be a veiled threat of violence)*. Later that evening the crisis team received a phone call to indicate that he had broken a window to get into his room, and had been probably drinking and intoxicated.

On 8 [Month1] 2007 [Mr B] was discussed in the multidisciplinary team meeting (it is not recorded who was present at the meeting). The note records 'Recent contacts discussed. Historical complications in presentation. Agreed, however that when under the MENTAL HEALTH ACT and receiving depot medication there was a period of stability. Therefore team agreement to place him under the MENTAL HEALTH ACT, decision taken on historical grounds.' A doctor's appointment was planned for the following day, but [Mr B] did not attend.

On 9 [Month1] 2007 the community nurse recorded that he had been informed by the manager of the lodge where [Mr B] was staying that he had been asked to leave. [Dr E] visited the residence after he had failed to attend his appointment and recorded:

'Team discussion — since his behaviour and functioning was much better when he was on depot injections we should reintroduce it. If he refuses — MENTAL HEALTH ACT should be used since there is a history of very serious risk to others.'

She further noted that [Agency 2] would try to trace him, and that his parents would be informed about this plan.

On 10 [Month1], he was seen at the Emergency Department The assessing nurse noted that he was now homeless having smashed a window when he was intoxicated. The nurse noted that he talked about seeing visions of people and that this was becoming more real which is scaring him. He spoke about hearing voices.

After discussion with staff from [Agency 2], who were happy to come and see him, he was offered medication — Piportil IM, but refused this, stating that he had been taking his oral medication even though he did not know where it was.

Later that night, he was assessed by a crisis team nurse at the night shelter. He did not appear intoxicated. He was described as appearing 'dysphoric with subdued affect'. He accepted a dose of a sleeping tablet, Imovane, and made arrangements to sleep under a skateboard ramp for the night, stating that he would contact [Agency 2] the following day.

2007 Admission

On 11 [Month1] 2007 [Mr B] presented to [a public hospital] with a soft tissue injury to his right ankle. The assessing psychiatric registrar noted that he denied that this had been a suicide attempt, stating that he 'just wanted to have some fun'. He did however admit to assessing staff that he had suicidal thoughts and feelings of wanting to die, describing his mood as 'agony', stating that he had

been feeling very low since January, but unable to link any adverse events to the deterioration. He described experiencing 'hallucinations' but was unable to elaborate on content. He was 'very guarded' when asked about paranoid symptoms. The registrar noted [Mr B] 'blurted out that he was thinking of killing someone, then immediately retracted the statement and attempted to change the conversation. When I wrote in the notes he became very agitated and asking to see what I had written and saying he had been tricked into saying that.' The assessing registrar noted that he discussed the case with the consultant psychiatrist [Dr L], who felt that the opportunity of informal admission should be seized to allow for a period of assessment and re-establishment of IM depot. [Mr B] was admitted informally to [the Unit], with a note that the team would review the need for the IM depot.

On 12 [Month1] 2007, a social worker noted that [Mr B's] father had been informed of admission, and was pleased that he had been admitted. She noted that his father was anxious that [Mr B] 'not be discharged before he is better this time', and requested that he was not allowed to wander around town, but was informed that he would be given leave due to being on an open ward.

Nursing progress notes on 12 [Month1] indicated that at times he appeared distressed, but calmed with reassurance. His conversation centred around his feelings of low self-worth, not feeling that his life was worth living. It was noted that he expressed no intent to self harm, and said that he felt safe in hospital with people to talk to and nurses at hand.

On 13 [Month1] [Dr C] noted as follows:

'[Mr B] was admitted informally after voicing suicidal ideation in the community... Although he carries a diagnosis of schizophrenia, there were no psychotic symptoms evident upon admission. [Mr B] spoke to me of his existential sense of being a failure. He is lonely and lacks direction to his life. He admits to heavy alcohol use and homelessness due to social conflicts.

On exam, I saw no evidence of psychosis or disorganisation. [Mr B] was sad and seeking support to get his life back on track. He is accepting quetiapine at present.

A) I am uncertain of [Mr B's] Axis I diagnosis but, regardless of a possible psychotic disorder, he does not appear to be actively psychotic at present. He is, however, homeless and sad.

B) Brief stay while [Mr B] secures accommodation. We will liaise with [Dr E] regarding treatment. One report suggests she favours the use of the MENTAL HEALTH ACT and IM pipothiazine. [Mr B's] commitability at present is questionable, in my opinion.'

On 14 [Month1] community nurses [Mr G] and [Ms O] from Agency 2 visited him and noted that he did not wish to talk with them that day. [Mr G] noted:

'Staff report [Mr B] to be keeping a low profile. No evidence of florid mental illness. Discussed difficulty in managing [Mr B] in the community and his presenting behaviours. Staff will keep [Agency 2] in the loop as to [Mr B] commencing depot medication on a voluntary basis. [Dr C] is due, at some point, to liaise with [Dr E] to discuss depot medication.'

On 16 [Month1], the House Officer noted as follows:

'History of substance abuse, ?Schizophrenia, antisocial personality disorder. Stable on the ward, appears to be suffering from existential angst — no signs of psychosis or mental illness. Collateral history suggests that only shows psych signs when under the influence of substances. Homeless.

Plan:

1) Stay in as INFORMAL

2) continue with prescribed meds

3) needs addressing accommodation issues next week.'

On 18 [Month1], he was examined by a House Officer who noted that his ankle injury was improving. Nursing notes recorded that he appeared in better spirits, not as downcast, but was complaining of pain in his foot, and asking for stronger pain relief, as a result of which he was prescribed tramadol. He was noted to be complaining that he was still depressed and concerned about his future, but appeared less low in mood.

A nursing entry later in the day noted no evidence of any psychosis. The nurse noted that he had been observed to be defaulting on his medication, pretending to take them but spitting them out. He told the nurse that he needed 'a roof not medications' but also said that he needed to be in hospital because he was 'insane'.

Nursing notes on 19 [Month1] indicated that he again tried to avoid swallowing his medication. He was seen by [Dr D], and the possibility of recommencing the depot injection was discussed, and he was not interested in this option. The note indicates that he was asked to think about plans for after discharge. A later nursing note indicated that he continued to display no signs of psychosis. He disclosed that he had not taken any medications since he was admitted to hospital, adamantly denied any psychotic phenomena and did not want any medication or arranged accommodation.

On 21 [Month1] nursing notes recorded that he was polite and pleasant during interactions, describing his mood as 'so-so'. Nursing notes referred to him preparing for discharge the following day, and note that 'pharmaceuticals aside [Mr B] appears to have benefited from being in a stable supportive environment for a length of time, and he has been presenting calmer and more positive and more respectful of the last few days. No irritability noted, no overt signs of

psychosis, mood appearing euthymic but with possible underlying unease over his future in general.'

On 22 [Month1], the House Officer recorded a meeting involving [Dr D], nurse, medical student and house officer, in which it was noted that: '[Mr B] was neatly dressed, co-operative (with good eye contact), no abnormal behaviours were noted. Orientation and memory grossly intact. Affect appropriate, not intense, not labile. Mood euthymic both objectively and subjectively. Normal speech and thought; no perceptual abnormalities noted. Good insight. Safety not formally assessed, but appears to be of no risk to self/other/self-care.' It was noted that [Mr B] was seeking accommodation, and would report progress to [Dr D] the following day, and would be discharged by the following Monday whether accommodation had been found or not.

Later that day, he was discovered to be drinking cans of bourbon and Coke and smoking in his room. Nursing notes recorded that he walked out of [the Unit] after this had been discovered and refused to return so that the issue could be addressed. This was discussed with [Dr D], and that [Mr B] was informed that he would be leaving hospital the following day because of the drinking and smoking in his room. [Mr B] indicated that he may be able to stay with some friends in [other areas].

On 23 [Month1] [Mr B] was discharged after a review by Medical Officer [Dr D]. [Agency 2 was] advised by fax and family contacted by phone. Nursing notes indicate that [Mr B's] father was 'very angry at discharge, blaming clinical services for not caring for him appropriately'.

The discharge note by [Dr D] stated as follows:

'[Mr B] was admitted to the open ward informally for evaluation and the possible establishment of the depot antipsychotic Piportil. Repeated discussions with him about the start of this and also about finding himself accommodation proved fruitless as he bluntly refused to accept Piportil and did not make efforts to find accommodation. [Mr B] expressed a wish to reside in the hospital and repeated conversations with him motivating him to find accommodation went unheeded.

His mental state remained settled, with little or no sign of psychosis. His self-cares were adequate, he attended to his own ADLs and was pleasant and amenable to staff and other service users. There was no concern for any danger to himself or others.

His hospital stay eventually came to an end as the result of becoming intoxicated in his room (yesterday) and we agreed today that he be discharged.'

He noted: 'After ongoing discussion from [Mr G] from [Agency 2], we are discharging [Mr B] to the community. He has no fixed place to return to, but thinks that he may go to [another town] to see a friend there. We have agreed with him that he contacts [Agency 2] to make an appointment with them on his

return.' He further noted that: 'should [Mr B] be readmitted due to relapse or non-adherence, we advise that consideration be given to the compulsory administration of a depot antipsychotic medication. It is known that Piportil was effective previously, but whilst informal and he refuses, a re-challenge with this medication is impossible.'

Community care post discharge

On 26 [Month1] an [Agency 2] social worker recorded a phone call from [Mr B's] mother expressing concern about his discharge. His mother said that she believed [the address] was a 'gang house' where he had stayed before the assault on his father, and feared that he may go back to the state that he was in that time.

On 29 [Month1] community nurse [Mr G] noted contact with the family, that there was no news, and that [Mr B] was possibly in [another town]. The plan was to 'maintain contact'.

On 3 [Month2] a telephone call from family informed the team that [Mr B] had been admitted into [a public hospital in a region further south] having been found in the road.

On 4 [Month2], [Mr G] contacted [the] Hospital and was informed that [Mr B] had in fact not been admitted. He attempted to contact [Mr B's] parents.

On 5 [Month2] [Mr G] again tried to contact [Mr B's] parents without success.

The next note is in the early hours of 17 [Month2]. The crisis team received a telephone call from [Mr B] who was 'on street and cold' wanting medication and somewhere to sleep, maybe some warm clothing. The nurse recorded that [Mr B] 'accepted that I could not provide these with good grace.'

On 2 [Month3], [Mr G] noted that [Mr B's] mother and sister had seen him the previous week, and that his sister felt he might be unwell, but [Mr B] would not divulge where he was staying.

On 10 [Month3] [Mr G] spoke to [Mr B's] mother, who said he had gone to the family home asking for food and then he'd turned up that morning at 4am. He noted that his mother was unsure if he was 'not quite right'. He was not aggressive. He now had nowhere to live. His mother reported that he appeared clean and tidy, and he had informed her that he was taking medication. The plan noted was to 'maintain contact'.

On 12 [Month3] [Mrs H] informed the team that [Mr B] had been involved in a major incident.

Opinion

It is clear that the assessment and management of [Mr B] was complex and challenging. There appears to have been a reasonably clear diagnosis of schizophrenia, complicated by ongoing use of alcohol and drugs, and with a head

injury as a possible precipitating or complicating factor. There had evidently been some disagreement about the diagnosis, at least in terms of the contribution of his alcohol and drug use to his psychotic presentation, and his reluctance to engage with appropriate follow-up and treatment, together with his itinerant lifestyle, made management of his mental health very difficult.

Clinical responsibility:
[Mr B] appears to have been primarily under the care of [Dr D], but [Dr D] in his statement clarifies that he was on leave for the first week that [Mr B] was on the ward, and therefore [Dr C] (who was the clinical director of [the Unit] and also described by [Dr D] as a 'roving consultant') formulated the initial plan of management.

It seems clear that [Dr C's] opinion and initial plan of management was accepted as the basis for the diagnosis and treatment plan, and was most influential in the assessments and plans that followed while he was on the ward.

Mental Health Act:
The depot antipsychotic was maintained during the period that [Mr B] was subject to a Compulsory Treatment Order. The order lapsed in September 2006 because of a clerical error of some sort. I have not been provided with information about exactly what happened or why the error occurred. It is suggested, in the Serious Incident Review, that treating team were not convinced that it would have been necessary to extend the order even had it not lapsed. I am unable to comment on this. Nevertheless, the accidental lapsing of an order is an unsatisfactory state of affairs, as there is no opportunity to properly review whether or not continuing compulsory treatment is required. In particular, a decision whether to apply for a further extension of the order, which would at this time have been an indefinite treatment order, would have required a careful review of the risks and benefits, consultation with the family, and presentation of a carefully formulated plan to the court.

It appears clear that the depot medication was discontinued only because there was no longer any compulsory basis to continue this when [Mr B] wished to move to oral medication. The lapse of the treatment order therefore had a significant impact on the course of events. If the order had been maintained, it is likely that the depot antipsychotic would have been maintained, and that [Mr B's] mental state may well have remained more stable.

Assessment [Month1] 2007:
The records suggest that [Mr B] continued to accept oral medication for about three months following the cessation of the depot antipsychotic. After stopping a depot antipsychotic that has been established for a period of a year, it takes a period of some months before the drug is eliminated from the body. It is therefore likely that [Mr B] would have had a significant level of the antipsychotic in his system until quite late in 2006. If it is correct that he had been continuing to take some oral antipsychotic medication for a further three months, this suggests that he had not discontinued antipsychotic medication altogether until about the end of

the year. It is widely recognised that there is a period of delay after discontinuing antipsychotic medication before symptoms of psychosis re-occur. After stopping an established depot psychotic, this period is usually between three and six months, but may be longer if there is some adherence to oral medication in the meantime. In addition, the early signs of relapse of a schizophrenic illness are often of subtle disorganisation and behavioural and mood changes, rather than necessarily the more florid hallucinations and delusions that characterise the acute phases of the illness.

Were there to be any deterioration in [Mr B's] schizophrenia, it follows that the early signs would have emerged between three and six months after the depot antipsychotic had been discontinued. The changes in [Mr B's] mood, organisation and behaviour that had been documented from late 2006 until the time of his admission in early [Month1] 2007 seem to have suggested precisely such a pattern. It is of concern that when he was admitted to hospital in early [Month1] the assessment appears to have focused entirely upon the lack of 'positive' psychotic symptoms, such as delusions and hallucinations, and does not appear to have paid any heed to the longitudinal pattern, and the possibility of the early emergence of psychotic symptoms in a patient who had discontinued antipsychotic medication after a prolonged period of stability.

[Dr C's] assessment appears to have focused entirely upon [Mr B's] immediate presentation, and he appears to have discounted the contribution of psychosis, despite the established diagnosis of a schizophrenic illness, preferring instead to focus on the 'existential' crisis that was the more obvious presenting feature. In my opinion, this assessment was superficial and incomplete, focusing entirely upon a cross-sectional view of the patient, ignoring the established historical pattern. It is likely that [Dr C's] assessment at this stage would have been influenced by his previous view that the illness was based upon historical abuse and drug use, rather than schizophrenia. I would be concerned that his views appeared to be significantly out of step with other clinicians' views on the diagnosis: this does not mean that he was necessarily wrong, but clearly such a dissenting viewpoint requires a very careful justification, based on a thorough review and documentation of all the available evidence.

Assessment of Risk:
[Dr C] notes that '[Mr B] was not considered a high risk at the time of his discharge because he was not in the state of mind that had proved dangerous in the past during his admission. He was neither delusional nor hostile which had been the two necessary elements in his prior pattern of violence. Further, there was no evidence that he had been delusional or hostile for the previous six months prior to his admission in 2007. This was despite not being under compulsory treatment and not receiving intramuscular antipsychotic medications.'

He further noted that 'previously [Mr B] had only displayed violence against his father, [Mr B] having these feelings of rage triggered by another individual was unprecedented and in my opinion an unpredictable event'.

[Dr C] correctly notes that the previous violence had been based on delusional belief. What does not seem to have been explored or noted, is the fact that there had been two episodes immediately prior to his admission of verbalisation of possible violence — on 7 [Month1] when he had commented that the assessing nurse reminded him of his father 'and look what happened to him', which appeared to be a veiled but clear threat of violence, and the 'blurted' observation that [Mr B] made to the admitting registrar that he was is 'thinking of killing someone', a comment which he immediately tried to retract, suggesting that he had been tricked into saying it. These verbalisations of possible violence, taken in the context of what appeared to be the early deterioration of a schizophrenic illness, in a patient who had an established history of violent behaviour based on delusions, should have been properly explored and taken into account in any risk assessment. I could find no evidence that these matters had been noted or considered by the assessing clinicians in the inpatient unit.

The assessment of risk was superficial, and appears to have been based entirely upon the immediate presentation, rather than on any careful consideration of the historical pattern and the context of [Mr B's] presentation.

[Dr C] did not believe that [Mr B] was 'committable', on the basis that he was not exhibiting any psychotic symptoms. There is a reasonable argument that can be made that, in the absence of any clear evidence of mental disorder, the use of the Mental Health Act was not justified at that particular stage. I am however concerned that the risks and benefits were not more fully explored and set out, and the rationale for deciding that compulsory treatment would not be undertaken was not fully explained, despite the clear view to the contrary expressed by [Dr E] just shortly before the admission. In particular, there is no real justification of why the historical pattern of illness and risk was dismissed in assessing whether or not compulsory intervention was required.

Consultation:
It is not apparent, from the information that I have been provided with, that there was any significant consultation with [Mr B's] parents. It is clear that they had some strong interest in their son's welfare, as noted in his father's hope at the time of admission that he should be not discharged before he was better, and his father's anger at discharge and his mother's concern expressed shortly after the discharge. It would appear that previously, [Mr B's] parents had been closely involved with the treating services, and would have been expected to have useful knowledge about their son's illness and presentation. His mother's comment after discharge about her concerns about the address in [the town] to which he was apparently headed, would have been useful information to have obtained prior to his discharge, given [Dr C's] observations that the risk was heightened if [Mr B] were to be using drugs.

The consultation with the regular treating team appears to have been limited. [Dr C] had noted an intent to liaise with the usual treating consultant, but this had not occurred. I note however that [Dr E] had been on leave at the time of the discharge, so that this may have been a barrier to consultation.

Treatment 2007:
Despite his observations that [Mr B] did not present as psychotic, [Dr C] nevertheless wished quite reasonably to treat him with antipsychotic medication. In his comments, [Dr C] noted that [Mr B] had 'refused our strong recommendation for intramuscular medications but accepted oral quetiapine.' The clinical notes do not seem to indicate such a strong recommendation being made, and the statement that he was accepting of oral quetiapine seems very optimistic, to say the least, given that the nursing notes documented quite clearly that [Mr B] had been secreting his medication and not taking it during his time in the ward.

Discharge:
It is clear that the plan to discharge [Mr B] from the ward, irrespective of whether he had arranged appropriate accommodation, was already clearly in place before the incident in which he consumed alcohol and smoked in his room. This incident merely provided the final catalyst to action the planned discharge. If the assessment of the inpatient unit, that he was not psychotic and capable of taking full responsibility for his own health care and accommodation, was accepted, the plan to discharge could be seen as not unreasonable. However, in the overall context of the pattern of deterioration, I would have serious concerns about the plan to discharge him with no effective follow-up, into an environment where it was likely that he was going to be accessing further drugs and alcohol, with the almost inevitable prospect of serious worsening of his illness. The expectation that [Agency 2] would somehow be able to keep track of him and intervene if required was quite unrealistic.

Follow up:
The follow-up and assessment by [Agency 2] in the period leading up to the admission appears to be appropriate and perfectly reasonable. The team had become quite properly concerned about the pattern of deterioration that was becoming evident, and very sensibly contrasted this with the period of stability that had been seen while [Mr B] had been on regular medication under compulsory treatment. A decision was made that it would be appropriate to re-invoke the Mental Health Act and recommence depot antipsychotic medication. This decision was taken at the team meeting on 8 [Month1], and confirmed by Dr E the following day when she attempted unsuccessfully to carry out an assessment.

What is of some concern however is that, after it had been clearly noted that [Agency 2] would try to 'trace' him to carry out that plan, he was then seen twice by crisis staff on 10 [Month1] and neither of these contacts resulted in an attempt to follow through with the plan that had been made by his treating team. In fact, he was escorted by security staff from the emergency department when he became abusive. It appears that his behaviour was treated as merely that of an obnoxious young man, and was not considered in the context of the concerns of deteriorating psychosis.

Following the discharge in [Month1] 2007, [Agency 2] had no way of finding out where he was or of making contact with him. There was no real plan developed, other than to 'maintain contact' — it is not clear whether this meant contact with his parents or with [Mr B]. It would have been helpful to have had a clear documented plan in the event that [Mr B] were to present. Given the previous concerns, any presentation should have triggered a further assessment. The contact made by the crisis team in the early hours of 17 [Month2] appears to be an inappropriate and unhelpful response in the context of a young man with a deteriorating psychotic illness, but presumably was based upon the documented discharge information, which suggested that [Mr B's] problems were not due to psychosis, rather the result of drug and alcohol abuse. It is not at all clear why the assessing nurse felt unable to provide assessment to consider the appropriateness of the medication that [Mr B] was apparently asking for. Had there been a specific documented plan from [Agency 2] at that stage, that any opportunity of contact should be seized in order to carry out a proper assessment, then this would have alerted the crisis team to act more assertively when he made contact.

Turning to your specific questions.

In relation to [Dr C]:

1. Was the treatment plan for [Mr B] appropriate?
I am concerned that the assessment of the patient's needs was superficial and based on a cross-sectional view, without adequate consideration of the longitudinal picture. This in my view led to the development of a treatment plan that was appropriate for the *assessed* need, but ultimately unhelpful.

2. The relevance of the 'Axis I' diagnosis, [Dr C] referred to in his 13 [Month1] 2007 progress note.
[Dr C] was expressing some doubt as to whether the diagnosis of schizophrenia was appropriate. Axis I refers to the main clinical diagnosis in the multi-axial formulation based upon DSM IV, as opposed to Axis II, which refers to disorders of personality.

3. Was the decision to discharge [Mr B] on 23 [Month1] appropriate given that he had no accommodation arranged?
As discussed above, I do not believe that this was an appropriate decision in the overall circumstances.

4. Was there an adequate risk assessment conducted before discharge?
As discussed above, the risk assessment conducted before discharge was inadequate and failed to consider all of the appropriate information on which to base a proper assessment.

5. Was the discharge plan appropriate?
In my view the discharge plan was inappropriate, and based on a naive assumption that [Mr B] would continue to take his oral medication, when it had already been clearly observed that he was non-adherent to oral medication, and

that he would maintain contact with the treatment team, when he had already demonstrated that this was unlikely.

6. Was there adequate communication between the inpatient and community mental health teams in relation to [Mr B's] ongoing management?
There was clearly some communication, but in my view this was insufficient, and did not allow for a full consideration of the plan that had been formulated by the community team.

7. Were there alternative steps that could have been considered in relation to [Mr B's] care?
As discussed above, in my view, a more thorough and considered assessment during his inpatient care in [Month1] 2007, taking full account of his historical pattern, the experience of his parents and his community treating team, and the verbal indications of possible violence, may well have led to a more assertive and more appropriate plan of treatment.

Auckland DHB

1. Whether the systems error that resulted in [Mr B's] detention under the Act lapse in June 2006, and the decision not to reinstate the order, had any bearing on subsequent events.
It clearly did. This has been fully discussed above.

2. Was the oversight of [the Unit] appropriate?
It is difficult for me to comment on the oversight of the inpatient mental health services. The external review report suggests that there were some significant deficiencies. It seems clear that the consultant time available for a patient such as [Mr B] was insufficient, and the external review report suggests that a very idiosyncratic assessment and treatment style had developed within the service.

3. Whether there were adequate systems in place to facilitate communication between inpatient and community mental health teams.
I am unable to say, based upon this material, whether the communication between inpatient community mental-health teams was facilitated or whether there were significant barriers to such communication. The record system is an electronic one, and there is no barrier to any treating clinicians accessing records of other treating clinicians. The plan formulated by the community team would have been clearly available to the inpatient clinicians.

4. Whether the follow-up systems within [Agency 2] were adequate and effective.
There is no evidence from this review that there was any deficiency in the follow-up systems. Patients under the care of [Agency 2] would be, by their very nature, difficult to follow up, and it is clear that reasonable efforts were made to keep in contact with the patient concerned and with his family. Any criticism that may be levelled in this regard, is as discussed above, that there did not seem to be any plan of what ought to occur should the elusive patient make contact.

Conclusions

ADHB
In my opinion the care provided to [Mr B] by Auckland DHB from 11 [Month1] to 18 [Month3] 2007 was deficient in a number of respects.

The assessment of [Mr B's] presentation was superficial, and did not properly take into account the historical pattern of his illness. This in my view was a moderate to severe departure from an accepted standard.

The decision to discharge [Mr B] without any clear or effective plan or follow up, into an environment in which it was likely that his psychosis would deteriorate, was in my view naive and inappropriate. This represents a moderate to severe departure from an accepted standard.

Although [Agency 2 was] placed in an impossible situation following his discharge from hospital, there was no clear plan of response in the event that he did re-present, which led to a missed opportunity when he did make contact in mid [Month2]. This in my view was a mild departure from accepted standard.

[Dr C]
The assessment of [Mr B's] presentation was superficial, and did not properly take into account the historical pattern of his illness, and failed to appreciate the likely pattern of deterioration after the cessation of compulsory medication. This in my view was a moderate to severe departure from an accepted standard.

The assessment of risk was superficial, and did not attempt to explore some obvious indicators of potential risk such as the verbalisations of potential violence. This in my view was a moderate to severe departure from an accepted standard.

The decision to discharge [Mr B] without any clear or effective plan of follow up, into an environment in which it was likely that his psychosis would deteriorate, was inappropriate. This in my view was a moderate to severe departure from an accepted standard.

It appears that the communication with the community mental health team was not as good as it could have been, and there appears to have been no consultation with [Mr B's] parents. This represents a moderate departure from an accepted standard."

Additional advice

"I have read the responses by [Dr C] and ADHB, and have considered very carefully whether these alter my opinion.

[Dr C] expresses concern that my opinion may have been influenced by the material concerning the internal reviews by ADHB.

While I have tried to maintain a focus on the incident and the clinical care in this particular case, I acknowledge that it is difficult to avoid being influenced by this material to some extent.

[Dr C] also notes that he was not the principal treating clinician. I acknowledge this, but reiterate it did seem from my review that his assessment and opinion was strongly influential.

[Dr C] points to his historical knowledge of the patient and suggests that the longitudinal history was considered when decisions were made about his diagnosis, treatment and potential risk. This may indeed be correct, but is not evident from the written record. [Dr C] suggests that, with hindsight, the rationale for decision-making could have been better documented. I would accept that there was probably a lot more considered assessment and discussion about the case than is recorded in the notes. This would be by no means uncommon in the reality of clinical care on a busy unit, and it may not always be fair to draw conclusions based only on the written record. However, this is the only material that I had to go on, and can therefore only comment on the written record.

Other than these comments, I do not consider that these responses substantially alter my opinion."