South Canterbury District Health Board

Psychiatrist, Dr D

Psychiatrist, Dr C

Registered Nurse, RN E

A Report by the

Mental Health Commissioner

(Case 15HDC01279)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Table of contents

Executive summary 1

Complaint and investigation 4

Information gathered during investigation 5

Opinion: South Canterbury District Health Board — breach 26

Opinion: Dr D — adverse comment 37

Opinion: Dr C — adverse comment 39

Opinion: RN E — adverse comment 40

Recommendations 41

Follow-up actions 42

Appendix A: Independent psychiatrist advice to the Commissioner 43

Appendix B: Independent mental health nursing advice to the Commissioner 66

Executive summary

1. Mr A was admitted to a public hospital on 7 Month1[1] 2015, after self-harming. He was diagnosed with adjustment disorder, alcohol dependence, and antisocial personality disorder. He declined voluntary admission to the Acute Psychiatric Unit (APU), so it was decided to treat him as an outpatient. He was prescribed quetiapine to help with sleep. He was then seen by the Triage Assessment and Crisis Team (TACT) several times, and referred by the TACT to the Alcohol and Drug Service (AOD).

2. On 19 Month2, Mr A called the Mental Health and Addiction Service (MHAS) TACT number, stating, "It's all over." He was taken to the police station and disclosed suicidal thoughts to the TACT. He was admitted to the APU the next day, as a voluntary patient. He was prescribed quetiapine to assist with sleep and reduce agitation. He was discharged on 22 Month2 by Dr C, with a moderate to high risk of harm to self and/or others. The documented plan was for ongoing AOD follow-up. That evening, Mr A called the TACT number saying "goodbye". He was taken to the police station and assessed early the next morning by registered nurse (RN) RN G from the Crisis Team, but Mr A denied suicidal ideation. The plan was to continue with follow-up by AOD.

3. On 24 Month2, Mr A sent an inappropriate text message to his AOD keyworker, RN E. The next day, he told her that he had abused prescription medication, but then retracted this statement. RN E informed Dr C, and it was agreed that Mr A was to return home from the appointment with two staff members and contact the Crisis Team if necessary. The plan was to continue with AOD follow-up. The following day, Mr A sent another inappropriate text message to RN E. This was discussed with Dr C, who suggested that a formal complaint be made to the police.

4. On 29 Month2, Mr A was admitted voluntarily to the inpatient unit after calling the TACT number and making suicidal threats while intoxicated. During his admission, on 2 Month3 he was visited by Mrs B, who offered support and was added as a contact person.

5. Mr A was discharged home later the same day of the visit. RN L recorded that Mr A continued to be a moderate to high risk in the community for harm to himself and others. She noted that he had the 0800 TACT number and a crisis plan. The crisis plan provided was the existing plan dated from 11 Month2, which stated that he was to attend weekly appointments with RN E, call TACT or the Police in high-risk situations, and call RN E for urgent review if necessary.

6. On 2 Month3, a Complex Case Conference was held to discuss Mr A's care. The meeting was attended by Dr D, Dr C, a police officer, Clinical Nurse Manager (CNM) CNM P, the CNM of the inpatient psychiatric unit, nursing staff from TACT, and RN E. As noted below, minutes were taken at the meeting, and RN E then drafted a Complex Case Conference Management Plan, which was reviewed by CNM P.

[1] Relevant months are referred to as Months 1-4 to protect privacy.

HDC

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

7. The minutes of the meeting state:

> "Agreement if any future presentations occur by [Mr A] which include threatening self harm and/or alcohol intoxication will be for [Mr A] to remain in police cells and review by TACT … The discharge criteria for [Mr A] from [AOD] will be non engagement with keyworker, non attendance of appointments [or] hostile behaviour."

8. The Complex Case Conference Management Plan included the following statement:

> "[I]f [Mr A] makes any threats of self-harm, harm to others, suicide and/or to kill specific others or makes … inappropriate comments or texts or intoxicated with alcohol while working with mental health and addictions staff, plan is as follows … Appointment to be cancelled immediately … Police to be contacted as soon as possible … [Mr A] to be discharged from [AOD]."

9. On 6 Month3, RN E discussed the plan at an appointment with Mr A, accompanied by a police officer. Mrs B supported Mr A. RN E's notes record that the Complex Case Conference Management Plan was discussed. RN E said that she still encouraged Mr A to seek support if he felt suicidal. Mrs B told HDC that RN E advised Mr A that she could not help him if he was going to continue to make suicidal threats.

10. During the appointment, Mr A reported having experienced some suicidal thoughts two days previously, but said that taking two quetiapine tablets from an old prescription had had a settling effect. RN E cancelled the prescription because of his recent disclosed abuse of prescription medication. Mrs B offered to supervise Mr A's medication administration (an area in which she has experience) and requested that this be discussed with a psychiatrist.

11. The next day, 7 Month3, RN E recorded that Mr A was discussed at the Multi Disciplinary Team (MDT) meeting and it was decided to consult Dr D about the possibility of a small amount of quetiapine being given to Mr A, as the psychiatrist present at the meeting was not familiar with Mr A's case. There is no documentation of a discussion with Dr D. RN E recalls that a prescription was decided against, owing to Mr A's changeability in mood and threatening behaviour when intoxicated, and the potential impact on Mr and Mrs B, (friends of Mr A).

12. Mr A sent RN E a text message on the evening of 15 Month3 stating that he wanted to die. RN E said that when she called him on 16 Month3, Mr A reported a number of stressors and stated that he did not want to live, although he denied any specific suicidal plans. RN E stated that during the call Mr A requested discharge from AOD. This was nine days after RN E had discussed the Complex Case Conference Management Plan with him.

13. Later that day, RN E visited Mr A and recorded that he had ongoing suicidal ideation, was huffing gas, appeared depressed, and was expressing thoughts of hopelessness. She also recorded that Mr A expressed no interest in addressing his issues regarding alcohol and substance misuse, and no intention of attending appointments with her. She informed him that he would be discharged from AOD owing to his unwillingness to engage in the treatment being offered.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

14. Dr D was informed of the visit and agreed that Mr A should be discharged from AOD. The Complex Case Conference Management Plan was updated that same day, confirming that Mr A would be discharged owing to non-engagement with the treatment plan.

15. On 22 Month3, RN E presented Mr A's case at an MDT meeting, at which Dr D was present. Mr A was discharged from AOD. The risk assessment recorded that Mr A was at chronic risk of suicide, and noted the current factors that placed him at high risk to himself, including limited social support.

Findings

16. It was found that South Canterbury District Health Board (SCDHB) failed to provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code, by:

    a) Failing to have in place an accurate and up-to-date crisis plan for Mr A prior to his discharge on 2 Month3, including failing to involve Mr A himself adequately, and, where appropriate, Mr and Mrs B;

    b) Developing and implementing a Complex Case Conference Management Plan that was not appropriate; and

    c) Discharging Mr A from AOD on 22 Month3 without greater consideration of other ways to foster engagement, including with Mr and Mrs B, given his ongoing risk, expressions of suicidal ideation and hopelessness, and substance abuse.

17. Adverse comment was made in relation to SCDHB not ensuring that Mr A's care was assimilated into a dual diagnosis understanding, the limited planning around early psychiatric input following Mr A's discharges, the lack of psychiatric input within the community, and the lack of an apparent strengths-based approach. While it was found that it was reasonable for Mr A's quetiapine to be cancelled, it would have been prudent for this to have been considered in a more timely manner, the rationale better explained to Mr A and Mr and Mrs B, and alternative options for tranquillisation considered, so that Mr A did not resort to substance misuse. Criticism was also made in relation to the lack of SCDHB policies in place to assist RN E in the performance of her role, and that AOD policies also held deficiencies in the guidance they provided in relation to psychiatric involvement.

18. Adverse comment was made that Dr D did not review Mr A prior to deciding whether to discharge him from AOD, given his ongoing risk, expressions of suicidal ideation and hopelessness, and substance abuse.

19. Adverse comment was made that Dr C did not document his concerns, his rationale for decision-making, and his management plan for Mr A during the 22 Month2 discharge of Mr A.

20. Adverse comment was made about RN E's lack of documentation of the meeting between Dr C and Mr A on 25 Month2. Adverse comment was also made in relation to RN E's documentation of an inappropriate Complex Case Conference Management plan following the 2 Month3 multidisciplinary Complex Case Conference.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Recommendations

21. In the provisional opinion it was recommended that SCDHB implement professional supervision for clinical staff working in the area of alcohol and other drugs services. SCDHB confirmed that it has implemented weekly professional peer supervision for the AOD.

22. It was also recommended that SCDHB undertake the following actions:

a) Assess its mental health and addiction services with reference to the expert's, Dr McMinn's, comments about strengths-based practice to identify service improvements, and obtain input from family/whānau and consumer representatives in that assessment. The assessment should include consideration of consumer and family/whānau engagement in care planning and ensuring that implementation of improvements identified by the assessment can be monitored.

b) Report back to HDC on the findings and actions taken as a result of SCDHB's independent review of the assessment, care, and treatment of clients with dual diagnosis.

c) Implement professional supervision for clinical staff working in this area.

d) Report back to HDC on progress in implementing new terms of reference for Complex Case Conferences that set out, amongst other things, lines of responsibility for decision-making and requirements for minutes to be taken.

e) Review policies and procedures in relation to boundary setting (including sexual safety for staff); professional supervision; incident reporting; discharge from the service, client engagement; and changing case workers, with reference to findings from this decision.

f) Review the orientation of new staff to ensure that they are provided with training and appropriate supervision in relation to the policies in (e) above, including knowledge of escalation pathways when issues arise.

g) Report back to HDC on the implementation of the above recommendations.

Complaint and investigation

23. The Commissioner received a complaint from Mr and Mrs B about the care provided to their friend, Mr A (deceased), by South Canterbury District Health Board. The following issues were identified for investigation:

- *Whether South Canterbury District Health Board provided Mr A with care of an appropriate standard between 7 Month1 and 20 Month4.*
- *Whether Dr C provided Mr A with care of an appropriate standard between 7 Month1 and 20 Month4.*
- *Whether Dr D provided Mr A with care of an appropriate standard between 7 Month1 and 20 Month4.*

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- *Whether RN E provided Mr A with care of an appropriate standard between 7 Month1 and 20 Month4.*

24. This report is the opinion of Kevin Allan, Mental Health Commissioner, and is made in accordance with the power delegated to him by the Health and Disability Commissioner.

25. The parties directly involved in the investigation were:

Mr B	Complainant
Mrs B	Complainant
Dr C	Psychiatrist
Dr D	Psychiatrist
RN E	Mental health nurse
South Canterbury DHB	Provider

26. Information was also reviewed from:

Coroner	
RN F	Mental health nurse
RN G	Mental health nurse
RN H	Mental health nurse
RN I	Mental health nurse
RN J	Mental health nurse
RN K	Social worker
RN L	Mental health nurse
RN M	Mental health nurse
RN N	Mental health nurse
RN O	Mental health nurse

Also mentioned in this report:

CNM P	Clinical Nurse Manager
Dr Q	Psychiatrist
Dr R	Locum psychiatrist
Dr T	Psychiatrist

27. Independent expert advice was obtained from a psychiatrist, Dr Jeremy McMinn (**Appendix A**), and a mental health nurse, Carole Schneebeli (**Appendix B**).

Information gathered during investigation

Background

28. Aged in his forties at the time of these events, Mr A had a long history of mental health and addiction issues. He was first referred to SCDHB's Mental Health and Addiction Service (MHAS) in 1995.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

29. Mr A's diagnoses included dysthymia,[2] anti-social personality disorder,[3] and alcohol dependence. Mr A had made two previous unsuccessful suicide attempts.

30. This report relates to the care provided to Mr A by SCDHB's MHAS between Month1 and Month4, including the care provided by Dr C, Dr D, and RN E.

Admission to the public hospital (7–8 Month1)

31. On 7 Month1, Mr A presented to the Emergency Department (ED) at the public hospital, after self-harming. It was recorded that he was feeling suicidal because one of his pets had died. Mr A was admitted to the medical ward for monitoring overnight.

32. The next day, psychiatrist Dr Q reviewed Mr A. Dr Q's diagnoses included adjustment disorder[4] with disturbance of emotions and conduct, alcohol dependence, nicotine dependence, and likely anti-social personality disorder. He documented:

> "Meeting him, whilst he is not frankly depressed, he is under stress by way of the acrimonious and volatile relationship that he has had with [his ex-partner] for about the past year … [A]t this time, his main issues are his excessive drinking … He does get angry/annoyed with anyone who criticises his alcohol use pattern … The suicidal gesturing is all in the context of his stressors and there are no specific other indelible, treatable neuropsychiatric pathology."

33. Mr A declined an offer of voluntary admission to the psychiatric inpatient unit, so Dr Q decided that Mr A was to be followed up as an outpatient by the TACT. Dr Q recorded: "The key here with any future engagement is to enable him to take responsibility for himself and in the first instance, he does need to attain some control over his significant alcohol consumption." Mr A was taken home by RN/Duly Authorised Officer (DAO)[5] RN F from TACT.

34. SCDHB told HDC that Mr A's discharge management plan was adequate, although a follow-up appointment with a psychiatrist should have been coordinated to ensure timely reassessment of Mr A's mental state, review his risk status, and formulate a treatment plan that took into account any new factors and established any new treatment goals.

TACT community follow-up (9–21 Month1)

35. On 9 Month1, RN F visited Mr A at home. Mr A denied suicidal ideation or thoughts to harm his ex-partner. RN F's plan was for TACT to discuss with Dr Q, on 11 Month1, a prescription of night-time sedation for Mr A, and for TACT to telephone Mr A on the same day, to discuss follow-up visits.

36. On 11 Month1, RN G discussed with Dr Q night-time sedation for Mr A, and obtained a script for quetiapine,[6] to be dispensed weekly. Between 11 and 16 Month1, TACT staff

[2] Persistent mild depression.
[3] Consistent disregard or violation of the rights and feelings of others, and an impoverished moral conscience.
[4] An inability to cope with stress, leading to the development of emotional and/or behavioural symptoms in reaction. Also called stress response syndrome and situational depression.
[5] A health professional with special responsibilities under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act) to give advice on the Act and help with compulsory assessments.
[6] An antipsychotic medication that is commonly used off-label as a sleep aid and for agitation.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

made several telephone calls to Mr A, but were unable to contact him. On 17 Month1, RN F conducted a further home visit. Mr A was noted to be quite inebriated, with passive suicidal thoughts, but future focused. The plan was to visit the next day to bring him the quetiapine Dr Q had prescribed.

37. On 18 Month1, RN F visited Mr A again. She gave him four quetiapine tablets from the TACT stock, with the instruction to take one tablet that night. RN F sent Mr A an e-text message[7] the next evening, asking about the efficacy of quetiapine the previous night. He replied that it had helped a little and she advised him, via an e-text message, to take another tablet that night. RN F told HDC that she recalls filling out the administration documentation for the quetiapine and having it signed by a co-worker and Dr Q, but cannot now locate that document in Mr A's clinical records.

38. On 20 Month1, RN G sent Mr A an e-text message requesting contact to assess the efficacy of quetiapine.

39. Also on 20 Month1, Mr A's friend called TACT to advise that Mr A was intoxicated and making threats to harm himself and others. The police were called and Mr A was taken to the police station. RN G and RN H visited him there, but decided to postpone their assessment until the next morning, as Mr A was intoxicated. At the subsequent assessment on 21 Month1, Mr A denied current risk to himself and agreed to outpatient follow-up.

40. Mr A was then referred to the Alcohol and Other Drugs Team (AOD). AOD is a team of addiction specialists who provide assessment and treatment for those experiencing a moderate to severe addiction. RN E was assigned as Mr A's keyworker. She told HDC that she received a verbal handover from RN G about Mr A's significant problems with alcohol use, difficult relationship breakup with a work colleague, history of suicidal ideation and suicidal attempts, and recent attempted suicide and TACT assessment.

AOD community follow-up (21 Month1–18 Month2)

41. On 21 Month1, RN E visited Mr A. She documented that he reported that things were not going well, and that he was concerned about relationship and work matters. RN E also recorded that Mr A was ruminating a lot about suicide. While initially he denied any specific plans, later he stated: "[J]ust off the record, if I really want to do it, I'll […]." Her plan, which she discussed with TACT and her manager, CNM P, was for Mr A to call TACT or the police if he was unable to manage his suicidal thoughts, and for her to visit again the next day. RN E told HDC that Mr A appeared open to engaging with AOD.

42. On 22 Month1, RN E visited Mr A again. She documented that he denied suicidal thoughts, but was still stressed about his ex-partner. RN E also recorded that Mr A did not want to stop drinking alcohol or attend residential rehabilitation, but that he acknowledged that he drank heavily when stressed, which increased his suicidal thinking, and was willing to work with RN E to drink safely.

43. On 28 Month1, RN E met with Mr A again, for a comprehensive assessment. She noted that Mr A had symptoms of post traumatic stress disorder[8]. RN E assessed Mr A as being at

[7] A message sent between a mobile phone and an email address.
[8] Persistent mental and emotional stress occurring as a result of a traumatic event.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

potential risk of suicide, secondary to stress, an inability to cope, and intoxication, and at potential risk of homicidal threats and physical aggression to others, secondary to relationship difficulties, emotional dysregulation,[9] and intoxication. She recorded that, while he had chronic suicidal ideation, his current risk was low, because of his agreement to engage with AOD.

44. On 4 Month2, RN E saw Mr A again. He denied any current acute suicidal intent or plans, but admitted ongoing suicidal ideation. At a further visit on 11 Month2, RN E documented:

> "We discussed the potential of him having a [doctor's] psychiatric [review] to clarify diagnosis of depression. He was also told this would only be possible if he stopped drinking alcohol [and] he admitted he does not plan to anytime soon."

45. RN E drafted a personal crisis plan for Mr A, which stated that Mr A was to attend weekly appointments with her, would call TACT or the police in high-risk situations, and could call her for urgent review if necessary.

46. RN E told HDC that, on 4 and 11 Month2, Mr A's mood appeared to have improved from her first three visits with him. However, she stated that he still did not recognise the significance of his alcohol use in contributing to his other difficulties, had low motivation to address his alcohol use, and made it clear that he was not prepared to work towards abstinence (as opposed to reduction in use). RN E stated that she provided Mr A with education about alcohol use and the impact on his mental state, and discussed strategies to decrease his use of alcohol. She said that Mr A had a number of ongoing stressors and liked having the opportunity to talk about his difficulties.

47. On 18 Month2, Mr A called RN E and cancelled his weekly appointment, owing to car troubles.

Admission to the public hospital (19–22 Month2)

Admission —19 Month2

48. On 19 Month2, Mr A called the TACT number, which is answered after hours by ward staff from the inpatient psychiatric unit. He spoke to RN I, who documented:

> "Intoxicated, distressed, stated 'it's all over, I have nothing to live for'. States he has handed in his notice at work, plans to [self harm]. Difficult to engage initially, called himself '[Mr A] shithead' and [said] 'I can't do anything about it'. States he has 'nothing to live for — things have turned to shit'."

49. Because TACT was unavailable at the time, RN I called the police. Mr A was detained and taken to the police station. RN G and RN F assessed Mr A at the police station at approximately 1.30am the next day. RN G recorded that Mr A continued to have strong suicidal ideation with a clear plan and disclosed intent. RN G consulted locum psychiatrist Dr C, and it was decided to admit Mr A to the inpatient psychiatric unit voluntarily. Mr A was then prescribed quetiapine to assist with settling overnight.

---

[9] Emotional responses that are poorly controlled and do not fall within the conventionally accepted range of emotive responses.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

20 Month2

50. On 20 Month2, Dr C reviewed Mr A and recorded:

> "He presented as angry [and] irritable. He was not depressed or suicidal. He said he was angry with the world in general [and] hated it. … Impression — Adjustment Disorder [and] Alcohol Abuse. Risk of harm to himself has been historical and cannot be ruled out. Plan to stay on the ward [and] review on [22 Month2] [and] refer back to AOD."

51. Dr C told HDC that he felt that Mr A's risk of harm was chronically associated with his alcohol use, and that Mr A's suicidal ideation appeared to be more an expression of revenge rather than due to a depressed mood.

52. Later that night, RN J documented that Mr A continued to report feelings of hopelessness, concerns for the future, and active thoughts of deliberate self-harm. She noted that he had minimal protective factors and a lack of insight into his alcohol use. RN J recorded that Mr A's risk could increase on discharge, owing to psychosocial stressors and an inability to cope, complicated by his alcohol use. She told HDC that she educated Mr A on the risks of substance abuse.

21 Month2

53. The next morning, 21 Month2, Mr A went outside for a cigarette. When he returned, he disclosed to nursing staff that he had picked up a piece of glass and placed it inside the cigarette packet. Mr A denied suicidal ideation, but stated that without his pets there would be no point in living. He asked to go home and was seen by Dr C, following which he agreed to stay another night. Dr C discussed with Mr A that Mr A's problems were related to his excessive drinking, but Mr A did not seem motivated to address the issue. Dr C recorded that Mr A was not expressing any thoughts of self-harm and there were no signs of depression. Dr C's plan was to discharge Mr A back to AOD the following day.

54. Later that night, RN J documented that Mr A reported feeling lost, hopeless and stressed about his "shit life", stating that his life was worthless and he would be better off if he killed himself. She challenged this thinking, but Mr A was stuck on these negative thought patterns. RN J noted that he felt safe on the ward, but was aware of his possible discharge the next day and stated that he did not care about anything anymore. She recorded that Mr A's risk of harm could increase to high if some of his psychosocial stressors and alcohol use were not addressed when he was discharged into the community. RN J documented that he was not open to a residential rehabilitation programme.

55. RN J told HDC that, at the end of her shift, she handed over her discharge plan, which included social worker input, an emergency benefit, food for Mr A's pets, food for him from a food bank, help from an employment agency,[10] and AOD input. She stated that she was aware that Mr A would be discussed at the MDT meeting the following morning. RN J also told HDC that she used motivational interviewing with Mr A during his admission and, at times, he showed some contemplation for change, although had no insight into the risks of alcohol/substance abuse. She stated that he was willing to have AOD follow-up, as recommended.

[10] An agency for people with disability, injury or illness.

HDC

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Discharge — 22 Month2

56. At the MDT meeting the next morning, 22 Month2, it was decided that Mr A should be discharged that day, with a social worker to address his financial issues and AOD to create a management plan before discharge. SCDHB told HDC that the MDT record does not adequately document the concerns raised or the agreed plan. The notes provided from this meeting state: "Discussion. TACT. A+OD follow-up."

57. Social worker RN K reviewed Mr A. She told HDC that he was reluctant to engage with the assessment process, and his main focus was on when transportation home could be organised. Although he was refusing to apply for a benefit, she gave him an application form.

58. RN L told HDC that, following the MDT meeting, Mr A continued to report suicidal ideation, so she asked Dr C to review Mr A again. Dr C documented that Mr A was very angry and irritable, and was making threats relating to another, as well as harm himself (but that these thoughts had been with him forever and would not go away). Dr C's impression was that Mr A was not depressed, but angry. Dr C offered Mr A a further night's stay in the inpatient ward, but recorded that he could not see any reason to treat him under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA). Initially Mr A accepted another night's stay, but then decided that he wanted to be discharged that day.

59. Dr C told HDC that, in his clinical assessment, Mr A was not suffering from a qualifying mental disorder under the Mental Heath Act (MHA), and his mental state was not deteriorating. Dr C stated that Mr A wanted to be back home with his pets, which were the most important thing to him, and that he agreed to outpatient follow-up and previously had called for help when needed. Dr C advised that, given that he was a locum, he wanted to try to support Mr A's relationship with AOD. Dr C stated that he spoke with Mr A about his use of alcohol and tried to encourage him to consider a rehabilitation unit, but his attempts at motivating Mr A to see his alcohol use as something that needed to change were unsuccessful.

60. SCDHB stated that Mr A did not meet the criteria for treatment under the MHA in the absence of a clear "serious mental disorder". It also stated that it was clear to staff that Mr A wanted to go home to be with his pets.

61. RN M from AOD reviewed Mr A prior to discharge, as RN E was on leave. The plan was for RN E to call Mr A in two days' time to arrange an appointment. RN M told HDC that Mr A was angry, aggressive, dismissive of attempts to discuss his future alcohol use, and lacked insight into his dependence on alcohol. She also noted that he was making threats to harm another person.

62. RN L told HDC that she and RN M discussed with a senior member of staff (either Dr C or the ward CNM, she cannot recall which) Mr A's threats towards another person. RN L stated that Mr A gave her assurances that he would not act on these thoughts, but she called the police to advise them of the threats and of his discharge.

63. Mr A's discharge summary noted his moderate to high risk of harm to self and others, especially when under the influence of alcohol, but that he was not exhibiting any signs of

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

depression at that time. He was given contact details for TACT, a copy of his crisis plan,[11] and a prescription for quetiapine and zopiclone.[12]

Community follow-up (22–29 Month2)

TACT assessment — 22–23 Month2

64. On the evening of 22 Month2, Mr A called the TACT number and spoke to a nurse from the inpatient psychiatric unit. She recorded that he was saying goodbye and thanking staff for all their help. She called the police and TACT. Mr A called again 20 minutes later and spoke to RN N. He reported that he would not be able to keep any appointments, that he had been headbutting the wall, and that he had been drinking. Mr A then terminated the call. RN N told HDC that, upon enquiry, she then found out that the police and TACT had already been called.

65. The police detained Mr A and took him to the police station. At 9pm, RN G attended the police station and recorded that Mr A was heavily intoxicated. RN G returned at 1am with an RN to assess Mr A. RN G documented that Mr A was now sober, denied any previous or current plan to self-harm, and was agreeable to AOD follow-up. RN G told HDC:

> "Given his recent discharge and discharge plan, the similarity on his presentation to that he had presented on discharge, the absence of any new feature to his AXIS[13] presentation, [Mr A's] assurance of safety, active planned follow-up by AOD services and the availability of the MDT meeting in only 7 hours where [Mr A's] case could be considered, it was not felt that readmission was indicated at this time. … Consideration was given to speaking with the on call psychiatrist but this was felt to be unnecessary for the above reasons and that the matter would be presented to the MDT in the morning."

66. Mr A was discussed at the MDT meeting later that morning, on 23 Month2. Those in attendance included Dr D, Dr C, CNM P, and another RN. The minutes state:

> "[Mr A].
>
> Discussion.
>
> TACT.
>
> [AOD] follow-up."

67. SCDHB told HDC that the MDT record does not meet an adequate standard of clinical documentation, and is only a slight record of the important MDT discussion held.

AOD follow-up — 24–26 Month2

68. On 24 Month2, RN E attempted to contact Mr A, but was unable to do so. She went to his house to check on him and he returned home as she was leaving. Following this visit, Mr A

---

[11] The crisis plan from 11 Month2 2015.

[12] A medication used to treat insomnia.

[13] The *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, uses a five axis system of diagnosis. Axis I relates to clinical disorders, Axis II relates to personality disorders and mental retardation, Axis III relates to general medical conditions, Axis IV relates to psychosocial and environmental problems, and Axis V relates to a global assessment of functioning.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

sent an inappropriate e-text message to RN E. RN E told HDC that she informed CNM P of the inappropriate e-text message and that she intended to address it with Mr A.

69. The next day, 25 Month2, Mr A attended an appointment with RN E. She spoke to him about the inappropriate e-text message and recorded that, while he apologised, he tried to justify his actions. She told HDC that it may have been clearer for Mr A if another person had been present when discussing boundary setting, but that she never felt any immediate safety concerns.

70. During the appointment, Mr A disclosed that the previous night he had ingested all his pills from his prescription of quetiapine and zopiclone. When told that RN E would have to notify others about this, he laughed and stated that he had been kidding. RN E told HDC that it is standard practice to terminate an interview if a client comes into a meeting intoxicated (which Mr A appeared to be), but she did not do so in this case because he disclosed overdosing on medication.

71. RN E told HDC that, because she was concerned that the disclosed overdose may have been a suicide attempt, she called Dr C, who met with Mr A briefly. Dr C told HDC that, in the context of Mr A's known complex way of engaging with MHAS, his presentation to RN E as being well, and his calls on 22 Month2 initially suggestive of, but then denying suicidality, he told RN E that he was happy for Mr A to stick to his existing plan of remaining at home and re-engaging with AOD. RN E recorded that the plan was for Mr A to contact TACT over the next three days, if needed, and for her to support him with his Work and Income New Zealand (WINZ) appointment on 29 Month2. She told HDC that, due to the inappropriate text message, it was decided that two AOD staff members should escort him home. RN E stated that, while this rationale was not documented, the staff who took him home were aware of the reason for the increased staffing.

72. SCDHB told HDC that it considers that this management plan was appropriate. It said that it is recommended that when a statement is made in regard to a suicide attempt or suicidal ideation, this is discussed with a psychiatrist. SCDHB acknowledged that RN E's progress note does not state that Dr C reviewed Mr A briefly, or whether Dr C's review included consideration of use of the MHA, and no notes are recorded by Dr C to document his assessment.

73. The next day, 26 Month2, Mr A sent another inappropriate e-text message to RN E. RN E recorded:

> "Conversation [with] [Dr C] — updated regarding [Mr A] sending inappropriate text messages. Plan is for 2x persons transport to WINZ [appointment] on Monday [and] present … for [discharge] on Tuesday. [Dr C] has advised formal complaint to police to be completed. [Telephone call] to [policeman], he reported not a criminal offence in regards to sexually inappropriate texts from [Mr A], however it was up to the service to decide whether or not to discharge [Mr A] due to inappropriate contact."

74. RN E told HDC that she and Dr C had a discussion about Mr A's engagement with AOD and his ongoing management in light of this.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

75. RN E told HDC that she also spoke to her manager, CNM P, about the inappropriate e-text messages and was not advised to complete an incident form. RN E stated that, although inappropriate, the e-text messages were not threatening and she believed she had addressed them appropriately. She said that there were only female keyworkers working at AOD at the time, so Mr A could not be transferred to a male keyworker.

Telephone calls to MHAS — 26–28 Month2

76. Later that day, Mr A made multiple telephone calls to the Community Mental Health Team, stating that he needed help. A nurse recorded that he sounded extremely intoxicated and was referring to himself as "dumbass". She ended the call because he became verbally aggressive and was shouting incoherently. The police and TACT were informed.

77. On 28 Month2, Mr A called the TACT number and spoke to a nurse in the inpatient psychiatric unit. He advised that he wanted to cancel his WINZ appointment for the next day, as his car had broken down. The nurse discussed the telephone call with RN N, who told HDC that Mr A had reported feeling safe, and it was agreed that a message would be passed on to AOD.

Admission to the public hospital (29 Month2–2 Month3)

TACT assessment — 28–29 Month2

78. Later on 28 Month2, Mr A called the TACT number again and made suicidal threats. A nurse from the inpatient psychiatric unit documented that he reported having inhaled liquid petroleum gas (LPG), drunk alcohol, smashed up his place and spray-painted his arms, because Satan had told him to. While the nurse was on the telephone with Mr A, RN N called the police and TACT.

79. Mr A was taken to the police station. At 1am on 29 Month2, RN G and RN F assessed him there. RN F documented that Mr A was still suicidal and distressed, and thought that Satan was ordering him to commit suicide. She noted that his despair regarding his future and the increasing incidents requiring police detention were of concern. RN F consulted locum psychiatrist Dr R and it was decided that Mr A should be taken to the ED and then admitted voluntarily to the inpatient psychiatric unit after medical clearance. RN F also recommended a Complex Case Conference for Mr A's future management.

Admission — 29 Month2

80. On admission, Dr R reviewed Mr A and noted his escalating suicidal gesturing in recent weeks. She also recorded that Mr A disclosed to her that he had overdosed on quetiapine earlier in the week. Dr R noted that he was not overtly depressed, but was continuing to voice suicidal ideation and intent. Her impression was adjustment disorder with depressed mood and conduct problems, alcohol dependence, cannabis abuse, and anti-social personality disorder. Dr R prescribed quetiapine, diazepam,[14] thiamine,[15] and multivitamins.

81. Later that day, 29 Month2, RN E and Ms RN K accompanied Mr A to his WINZ appointment, where a benefit was organised. RN E told HDC that she also discussed with Mr A the potential of working towards addressing his alcohol and LPG use in a supportive environment of residential treatment, but he continued to decline this.

---

[14] An anti-anxiety medication that is also used to treat alcohol withdrawal symptoms.

[15] Vitamin B1. Alcohol abuse often leads to thiamine deficiency.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

82. Dr C reviewed Mr A at around 2.30pm. Dr C's impression was that there was no evidence of any mental disorder, and that Mr A's problems were all related to his alcohol intoxication. Dr C told HDC that when he saw Mr A he was not experiencing any abnormal phenomena, and Dr C's conclusion was that the reported hallucinations were the direct result of substance intoxication. He stated that Mr A declined an offer to attend a drug and alcohol rehabilitation unit.

83. Later that day, Mr A was discussed at an MDT meeting and it was decided that he should have no medication, other than thiamine and multivitamins, and that a Complex Case Conference should be organised. Dr C later prescribed quetiapine to be used at night to aid sleep, if required.

84. That night, RN I recorded that Mr A was still angry with his ex-partner and continued to see no future for himself, with his pets as his only protective factor. She told HDC that Mr A was given time to vent how he was feeling and appeared more settled after this.

30 Month2

85. The next day, 30 Month2, Dr C assessed Mr A again, with RN O present. It was noted that Mr A was not exhibiting any delusions or hallucinations, and that he was future focused, although at times there was a veiled threat of making sure that he was shot by police. Dr C recorded that Mr A was not inclined to go to residential rehabilitation, because he was worried about his pets, but was happy to be on the ward, as talking to staff helped him. The possibility of a "green card"[16] was discussed with him. Dr C's plan was to discharge him the next day, with RN E to work with him on obtaining a green card. Dr C also instructed ward staff to discuss with Mr A the possibility of residential rehabilitation, if his pets could be looked after.

1 Month3

86. On 1 Month3, Mr A was informed that some of his pets had escaped from his property. RN O contacted TACT, who went to his house to check on his pets and reported that they were all still there. RN E called an animal control officer who advised that possibly the SPCA could provide a home for Mr A's pets for a short time for a nominal fee. The animal control officer checked on the pets and spoke to Mr A's friends, who confirmed that they were feeding the pets. Mr A was also taken home to check on his pets.

Discharge — 2 Month3

87. On 2 Month3, RN L recorded that Mr A continued to have a negative attitude about his WINZ benefit, as he would "only just be able to cover bills". She encouraged him to think more positively. Mr A was visited by his friend Mrs B, who was then added as a contact person for Mr A.

88. Dr C met with Mrs B, who advised that she and her husband, Mr B, were happy to support Mr A and to call TACT if there was a crisis. Mr and Mrs B told HDC that nothing tangible was decided around the best way for them to support Mr A. Dr C told HDC that he discussed the need for Mr A to take responsibility for his actions, and Mrs B was in agreement.

[16] A green card allows a service user to access secondary services immediately without referral or delay.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

89. Dr C and Mrs B then met with Mr A, who was noted to be cheerful and ready to go home. Dr C stated that there were no grounds to detain Mr A under the MHA, and the key issue to be addressed was his substance abuse. Dr C said that, even had it been possible, invoking the MHA would likely have undermined the relationship between Mr A and AOD.

90. At 11.10am, Mr A was discharged home, with a prescription for multivitamins and thiamine. He had an appointment scheduled with RN E for 6 Month3 and was given a food parcel. RN L recorded that Mr A continued to be a moderate to high risk in the community for harm to himself and others. She noted that he had the 0800 TACT number and a crisis plan.[17]

Complex Case Conference

Meeting

91. At 3.10pm on 2 Month3, a Complex Case Conference was held to discuss Mr A's care. Dr D, Dr C, a police officer, CNM P, the CNM of the inpatient psychiatric unit, nursing staff from TACT, and RN E were present. SCDHB explained that such meetings are held between healthcare staff and other support agencies, to ensure a comprehensive package of care, and that family and support people do not attend these meetings. It stated that Mrs B was informed of this at the time. RN E acknowledged that the situation could have been handled differently, with a separate meeting held to include Mr A and Mr and Mrs B.

92. The minutes of the meeting state:

> "Agreement if any future presentations occur by [Mr A] which include threatening self harm and/or alcohol intoxication will be for [Mr A] to remain in police cells and review by TACT … Current medications include Multivitamins and Thiamine only. [AOD] service to continue supporting [Mr A] as an outpatient for a brief period with the aim of the development of a green card admission. For two workers to be present at outpatient appointments at [the hospital]. No home visits. [Mr A] is independently able to keep arranged appointments. [Police officer] will attend next [AOD] outpatient appointment and outline expectations to [Mr A]. The discharge criteria for [Mr A] from [AOD] will be non engagement with keyworker, non attendance of appointments [or] hostile behaviour."

93. Dr D told HDC that there were concerns voiced by AOD about staff safety when dealing with Mr A, based on his history, including threats to others, his level of intoxication when presenting in crisis, and the inappropriate e-text messages. She stated that the outcome of the Complex Case Conference was to continue to support Mr A as an outpatient with a clear safety plan in place. Dr D said that a clear safety plan does not equate to poor care or a desire to discharge Mr A from MHAS. She stated that discharge criteria were discussed at the meeting and that, as with all AOD clients, Mr A was expected to participate in his treatment actively by engaging with his case manager, attending appointments regularly, and behaving in an acceptable manner without hostile or threatening behaviour.

94. Dr D said that it is not uncommon to discharge clients from AOD, provided there is no major mental illness influencing poor engagement or hostility. She stated that often clients will re-engage in the future when they are more open to addressing their substance use. Dr

[17] The crisis plan from 11 Month2 2015.

HDC

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

D stated that the plan formulated satisfactorily addressed Mr A's need to take responsibility for his behaviour in the absence of a major mental illness, while at the same time identifying his need for outpatient treatment with AOD. She said that decisions to discharge patients from the AOD service are not done lightly.

95. Dr C stated that the plan formulated was intended to restore a more constructive interaction between Mr A and AOD, while appropriately managing any risks to staff presented by his behaviour.

Management plan

96. Following the meeting, RN E drafted a Complex Case Conference Management Plan, which was reviewed by CNM P. It stated:

> "Should [Mr A] make contact via [0800 TACT number] or by phoning 111 threatening self-harm, harm to others, suicide and/or to kill specific others with or without alcohol intoxication; plan is as follows:
>
> 1. Police to be notified immediately, attend as per usual protocol, including proceeding with criminal charges if relevant.
>
> 2. To remain in police cells/custody and review by TACT. Normal TACT assessment procedures to follow including medical clearance from ED if required, then discharged home.
>
>   If [Mr A] makes any threats of self-harm, harm to others, suicide and/or to kill specific others or makes sexually inappropriate comments or texts or intoxicated with alcohol while working with mental health and addictions staff, plan is as follows:
>
>   1. Appointment to be cancelled immediately. (All appointments to take place at [the hospital]. 2 x staff must be present) NO HOME VISITS!!
>
>   2. Police to be contacted as soon as possible.
>
>   3. [Mr A] to be discharged from [AOD]."

97. RN E acknowledged that the Complex Case Conference Management Plan could have been expressed less punitively. She stated that this was the first Complex Case Conference she had attended, and CNM P asked her to prepare the plan immediately, which gave her only a very short time to complete it. RN E said that she is now aware that usual practice is to send a draft plan to all parties involved in order for mutual agreement before it is finalised. She stated that, having just come from the meeting where the focus was on a cohesive response to Mr A by various services, the plan was too focused on this, with the intention to continue to support Mr A and how this could be achieved not as developed as it could have been.

98. Dr D acknowledged that the tone of the Complex Case Conference Management Plan is punitive. She stated that she does not recall reviewing this document prior to its release, and would have made changes had she been consulted. Nonetheless, Dr D told HDC that if there

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

had been any new concerns about Mr A's mental state, TACT would have discussed these with the on-call psychiatrist and an alternative plan made.

99. After the Complex Case Conference, Mr A's discharge summary was completed by RN L for Dr C, and reflects the Complex Case Conference Management Plan.

AOD community follow-up (2 Month3–13 Month4)

Discussion of Complex Case Conference Management Plan — 6 Month3

100. On 6 Month3, Mr A, accompanied by Mrs B, attended an appointment with RN E and a police officer. RN E stated that, in hindsight, it would have been beneficial for a meeting to have been held that included other members of the MDT, so that supports could be discussed in a more collaborative way. RN E recorded:

> "[Police officer] attended meeting and spoke about streamlining process for crisis management. We then explained crisis management plan as per outcome of meeting [2 Month3], including immediate cancellation of [appointment] if [Mr A] threatens to harm himself or specific others or sexually inappropriate behaviour towards staff. [Mr A] and [Mrs B] shown crisis management plan and both are aware of conditions for [Mr A] to be engaged with service."

101. RN E told HDC that the Complex Case Conference Management Plan was directed at ensuring that Mr A took some accountability for making serious threats of self-harm designed at gaining a high-level response, then denying the threat, given his recent history of doing so; and his acknowledgement that his alcohol use increased the chances of this type of behaviour occurring, but refusing to address his alcohol use. RN E said that she still encouraged Mr A to seek support if he felt suicidal.

102. Mrs B told HDC that RN E advised Mr A that if he was going to continue to make suicidal threats, then she could not continue to help him, and that he needed to take responsibility for his actions.

Quetiapine — 6–7 Month3

103. During the appointment, Mr A reported having experienced some suicidal thoughts two days previously, but that he had taken two quetiapine tablets from an old prescription, which had had a settling effect. RN E cancelled the prescription, owing to his recent threats of overdosing. Mrs B offered to supervise Mr A's medication administration (an area in which she has experience) and requested that this be discussed with a psychiatrist. RN E told HDC that Mr A was happy to wait for her to discuss this at the MDT meeting the next day. She recorded that he denied any current suicidal ideation.

104. The next day, RN E recorded that Mr A was discussed at the MDT meeting and it was decided to consult Dr D about the possibility of a small amount of quetiapine being given to Mr A, as the psychiatrist present at the meeting was not familiar with Mr A's case. RN E recalls discussing quetiapine use with CNM P, and believes she would have discussed this with Dr D, but this is not documented.

105. Dr D told HDC that she has some recollection of a discussion about quetiapine taking place, but does not recall providing a script. RN E recalls that a prescription was decided against, owing to Mr A's changeability in mood and threatening behaviour when intoxicated, and

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

the potential impact on Mr and Mrs B. RN E stated that Mr A's poor coping ability, ongoing suicidality, and minimal protective factors caused concern for the team in light of Mrs B offering to administer his medications, because of the potential risk of harm to Mr and Mrs B if Mr A's perceived needs were not met, especially if he became intoxicated, and in light of his history of aggression.

106. Mr and Mrs B stated that Mr A was upset at not being allowed quetiapine, and told them that he "might as well just end it".

AOD follow-up — 9–16 Month3

107. On 9 Month3, RN E called Mr A, who disclosed that his pet had been diagnosed with cancer, that he was struggling with this, and that he had been drinking. RN E noted his potential risk to self, but that he was willing to remain engaged with treatment and seek support from Mr and Mrs B. She told HDC that she spoke with Mrs B about Mr A's telephone call, and Mrs B stated that she and Mr B would check on Mr A and make contact if they had any concerns.

108. On 13 Month3, Mr A left RN E a voicemail message stating that he was unable to attend their next three scheduled appointments, was doing much better, and was no longer interested in working towards getting a green card. RN E recorded that he thanked her for her help and said goodbye. She told HDC that she attempted to contact him and left a message.

109. Mr and Mrs B told HDC that Mr A cancelled the appointments because he felt that AOD did not help him, just told him what to do.

Discharge from AOD

Contact with AOD — 15–16 Month3

110. In the evening on 15 Month3, RN E received an e-text message from Mr A, stating that he wanted to die and that no one understood. She saw the message the next morning and called him. Mr A reported a number of stressors, including his pet being likely to die if it did not have treatment, and his medical certificate for his WINZ benefit being about to expire. RN E noted that he had very little tolerance for distress, and his coping skills were extremely limited. She recorded that he expressed that if his pet died, he was going to die too, and that he could not take it anymore and did not want to live, but that he denied any specific plans, owing to fear of the police being called. RN E told HDC that Mr A denied sending the e-text message and requested discharge from AOD.

111. RN E called Dr D. Dr D told HDC that she suggested that RN E advise Mr A to call the TACT number when needing urgent help, and that she assess his request for discharge and offer community-based support in the form of an alcohol and drug counsellor.

112. RN E visited Mr A, accompanied by the police, and recorded:

> "He expressed ongoing suicidal ideation, […] was huffing gas […]… No threats to others safety and as [Mr A] was expressing vague passive suicidal threats, no further police intervention required at the time … [Mr A] appeared depressed in mood, expressing thoughts of hopelessness … [Mr A] expressed that he isn't interested in addressing his issues regarding alcohol and substance misuse, has no intention of

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

attending appointments with writer or working towards a green card for crisis respite admissions to ward […] … [Mr A] informed that he would be discharged from [AOD] due to unwillingness to engage in treatment being offered."

113. RN E stated that CNM P and Dr D were informed of the visit, and both agreed that Mr A should be discharged from AOD, with him being aware that he could re-engage if he chose to address his alcohol dependence or if experiencing suicidal ideation and thoughts he was unable to manage independently. Dr D told HDC that Mr A did not have a disorder of volition, so was free to make his own choices regarding his treatment.

Updated Complex Case Management Plan — 16 Month3

114. On 16 Month3, RN E updated Mr A's Complex Case Conference Management Plan:

"[Mr A] expressed he no longer wants to address his [alcohol and other drug] addiction or work towards a green card for planned respite admissions to ward 10. [Mr A] will be discharged from [AOD] at next MDT (21 [Month3]) due to non-engagement with treatment plan as discussed with [Dr D] and managed if presenting in crisis as per plan and protocols."

115. RN E said that although her documentation following the Complex Case Conference on 2 Month3 may have been more punitive than intended, her communication with Mr A remained compassionate and considerate. She stated that following the meeting, she was careful to ensure that the risks and response to risks were documented, and this may have affected the focus in her notes.

Discharge — 22 Month3

116. On 22 Month3, RN E presented Mr A's case at an MDT meeting, at which Dr D was present. Mr A was discharged from AOD. RN E's risk assessment stated:

"[Mr A] is chronic risk of suicide due to recent [history] [and] extensive [history] of parasuicidal behaviour in the context of intoxication by [alcohol] [and] psychosocial stressors. Limited social supports, loss of employment, financial difficulties [and] emotional dysregulation, ongoing use of alcohol [and] inhaling LPG [and] sick [pet] current factors placing [Mr A] at high risk to himself."

117. Under the "Management of Risk" section, RN E recorded that Mr A was to use his crisis plan and seek support from appropriate services. He was aware of the TACT number, was given the number for the Alcohol and Drug helpline, and was to engage with a support agency. RN E documented that if Mr A was readmitted to AOD, his treatment would be residential rehabilitation.

118. SCDHB told HDC that Mr A's discharge from MHAS followed the SCDHB discharge process. SCDHB noted that there is no record on whether the MDT review included consideration of use of the MHA. It acknowledged that the quality of the MDT record is not adequate, either as a full record of the breadth of concerns, or as a full and adequate record of any agreed outcome.

119. Dr D stated that sometimes discharge is the most appropriate treatment, with clear expectations of what needs to occur should the patient wish to re-engage. She stated that Mr

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

A was still able to access TACT, and could have requested re-engagement with AOD at any time. Dr D said that Mr A was not reviewed by a psychiatrist prior to discharge, as MHAS had spent considerable time working with him to engage him, and there was little to be gained from review by a psychiatrist. She stated that she had been kept very up to date with his care and had faith in the team working with him that all that could have been done to engage him had been done. She accepts that, in hindsight, it would have been better if she had arranged to review Mr A, but does not consider this to represent a lack of reasonable care or skill.

120. Mr and Mrs B felt that they were left to support Mr A with no professional assistance. They told HDC that over the next few weeks, Mr A appeared to be managing things more easily. However, on 19 Month4, he seemed tired and down, stating, "[W]hat's the point of living?" The next morning, Mr B visited Mr A. Mr A was very angry, and Mr B said that he would return in a couple of hours. When he returned, Mr A did not answer door, so Mr B called Emergency Services. Emergency Services broke into Mr A's home, and discovered that Mr A was dead.

Further information — Mr and Mrs B

121. Mr and Mrs B believe that Mr A did not want to die, and that he was calling out for help. They stated that he felt let down and betrayed by the care he received from MHAS, and that there was a total lack of awareness and concern from MHAS staff around the specific support needs for Mr A, or support for them. Mr and Mrs B also stated that there was a lack of empathy and consideration, with staff being judgemental and impersonal, and totally disregarding Mr A's feelings. They stated that it felt as if staff "washed their hands" of him and that, with more support from MHAS, the outcome may have been different.

Further information — Dr D

122. Dr D pointed out that Mr A was reviewed by Dr Q, Dr C, and Dr R, all of whom assessed him as not having a major mental illness, but having chronic substance use problems, chronic suicidal ideation, and anti-social personality disorder. She stated that none of these psychiatrists used the MHA to enforce treatment because they did not believe Mr A had a serious mental disorder, and therefore he did not meet the criteria under the MHA. She noted that care is to be provided in the least restrictive environment, and that Mr A's issues and risks remained the same throughout Month1 to Month4. Dr D also stated that compulsory treatment would have been counter-productive, as Mr A did not want to address his substance use, and enforced detention would not have changed this, but would have put nursing staff at risk of violent outbursts and damaged beyond repair any relationship they had with Mr A. She stated that his risk was fuelled by his frequent alcohol intoxication, and that addressing this in a voluntary way would have contributed significantly to reducing his risk.

123. Dr D also stated that Mr A refused to engage with the ward social worker and there was no opportunity to involve the clinical psychologist, as Mr A continued to use alcohol and other substances and was not committed to case management. She explained that, in the usual course of events, as clients settle into case management, they are offered therapies. Dr D stated that there has to be some engagement and willingness to address relevant issues when the main problem is substance abuse and personality difficulties, as opposed to a treatable major mental illness.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

124. Dr D stated that Mr A's clinical file minimises the lack of responsibility he took for his own care and the poor choices he made. She stated that he was a manipulative man who sought to get his own needs met while never having the intention of following through with the treatment options that were offered to him. She noted that Mr A had been known to SCDHB MHAS since 1995 and had declined opportunities for input. She noted that one's approach to a patient is influenced by the patient's history.

125. Dr D stated that AOD recommended abstinence and a residential programme, but Mr A declined. Case management subsequently focused on reducing his alcohol use, understanding drivers for alcohol use, exploring the link between alcohol intoxication, stress and suicidal thoughts, and alternative strategies to manage stress. Despite this, Mr A made no progress, and much of his time in case management was focused on crisis solution. She noted that ward staff also spent considerable time trying to educate and inform him about the impact his alcohol use was having on his mental state and risk. These attempts were unsuccessful, and he was also reluctant to address any of his psychosocial stressors despite support to do so. There was an expectation that Mr A would take some responsibility for his conditions and engage in evidence-based "treatment as usual".

126. Dr D stated that she always impresses the importance of detailed documentation, especially in complicated or risky cases, and will continue to do this.

Psychiatrist opinion obtained by Dr C and Dr D

127. As part of their response to HDC, Dr C and Dr D obtained an opinion from psychiatrist Dr T on the care provided.

128. Dr T considered that Mr A received a high degree of support in Month1, but that, ideally, he should have been reviewed by a psychiatrist as an outpatient, although this is not a significant departure from the standard of care.

129. In relation to Mr A's discharge from the inpatient psychiatric unit on 22 Month2, Dr T advised that she can find no fault in Dr C's assessment that there was no reason to treat Mr A under the MHA.

130. Dr T noted that Mr A's discharge planning involved consideration of engagement, support of recovery, reconnecting with the things that gave him meaning and hope, the MHA, treatment in the least restrictive environment, coordination with the police, good liaison between services, social worker assessment, MDT review, and provision of a discharge summary. She stated that she would have expected to see a documented plan for TACT follow-up, including timetabling a psychiatrist review, but she does not consider that the discharge plan was limited, and does not consider it to be a departure from the standard of care.

131. Dr T advised that if overdose had been ruled out on 25 Month2, it was not an unreasonable plan for Mr A to return home and call TACT if he needed to, given his alcohol dependence and that he was already engaged with AOD. She stated that perhaps more proactive input from AOD or TACT to check in with Mr A the next day may have been useful, rather than a date some four days away. Dr T is unsure whether the medical or psychiatric effects of a potential overdose were considered, whether an ED admission or use of the MHA were considered, or whether it was thought that the overdose had indeed happened. She stated

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

that another brief admission may have made it possible to make more headway with the situation, but not doing so would not be a departure from the standard of care on account of the lack of an acute mental disorder.

132. In regard to the 29 Month2 to 2 Month3 admission, Dr T does not consider that discharge planning was limited, and stated that she is unsure what else might have been employed. She considers the planned follow-up appointment the next morning with RN E[18] to be above the standard of care, with organisation of a service-wide complex case review on the day of discharge to be evidence of a system that embraces oversight, MDT input, and collegiality. She stated that, in her opinion, the only meaningful service-led intervention that could have been employed in Mr A's case was residential rehabilitation, and there is evidence that this was put to him, and he refused consistently. She noted that there was no mention of consideration of the Alcoholism and Drug Addiction Act 1996, although on account of its impracticality it is rarely mentioned in any treatment setting. Dr T advised that Mr A's discharge was appropriate, and that it was also appropriate not to prescribe quetiapine.

133. Dr T considered it appropriate that RN E cancelled Mr A's prescription on 6 Month3, given his previous overdose and that it was not currently prescribed, and stated that it would have been risky not to do so. Dr T acknowledged that, with hindsight, the cancellation of the script potentially may have been perceived to have been unsupportive or invalidating by Mr A or his support people, but this would not justify continuation of non-prescribed potentially risky medication at that point. Dr T stated that quetiapine has no role in alcohol dependence, personality disorder, adjustment disorder or solvent abuse, and there is a risk of sedation and interaction with other central nervous system depressants such as alcohol. She stated that, ideally, the medication issue would have been discussed with Dr D in a more timely manner.

134. Dr T advised that it was appropriate for staff safety to be considered in the Complex Case Conference on 2 Month3. She stated that the plan for Mr A to be discharged if he made threats of self-harm was somewhat "black and white" and failed to allow for intoxication or a change in mental state or presentation, although there was mention that there would be TACT follow-up. She stated that failure to respond to suicidal intent or plan by a mental health service would be a "dereliction of duty" by a mental health service overall, but it is not so to be discharged from AOD if other provisions for assessment and treatment are met (ie, by TACT or community mental health). She stated that the notes read as though there is an increased focus on potential threats to staff safety, at the expense of a discussion of factors that might facilitate change.

135. Dr T advised that although Mr A refused AOD input on 16 Month3, it was somewhat concrete to take him at his word, given that he was likely intoxicated and had a history of being unreliable when intoxicated. However, she stated that it was not unreasonable for his entire case to be reviewed to examine whether any progress was being made, especially given his ongoing reluctance to attend to his severe dependence issues. She said that it is difficult to understand clearly the full reasoning and rationale for discharge, as the discussion with Dr D is not documented. Dr T stated that Mr A's abrupt withdrawal from services, and the fact that one of his pets had cancer, may have been concerning signs and

[18] The planned follow-up appointment with RN E was for four days later, not the next morning.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

should have precipitated wider discussion at the MDT meeting. She said that she does not find sufficient evidence that Mr A was mentally unwell, so cannot come to the conclusion that he should not have been discharged from the service, but she thinks that this deserves further exploration at a service level. She stated that often services are quick to discharge patients similar to Mr A, because of the lack of treatability in the face of refusal of treatment.

136. Dr T stated that, overall, there seems to have been little outpatient/community follow-up with psychiatrists after admission, but Mr A's crisis presentations largely took over what might have been a reasonable community-based follow-up plan for review.

137. Dr T considers that a broader focus could have been taken in thinking about Mr A's suicidal ideation and formulation of his longitudinal presentation. Dr T acknowledged that the themes of worthlessness and hopelessness running through the nursing notes could have been re-formulated as to their significance and any bearing they could have on the treatment plan.

138. Dr T stated that there is no mention of treatment for alcohol dependence (other than diazepam, multivitamins, and thiamine) or discussion about harm-reduction strategies, or problem-solving barriers to treatment, although there are several notes that Mr A refused rehabilitation, and a note that he refused input from the counselling service.

Further information — RN E

139. RN E acknowledged that she forgot to inform Mr and Mrs B about a support service[19] after they became involved in Mr A's care on 2 Month3, as she assumed that a referral had been made from the inpatient psychiatric unit.

140. RN E stated that throughout her involvement with Mr A's case, she often discussed his management with CNM P, the AOD team as a whole, and Dr D. RN E also noted that Mr A was discussed regularly at MDT meetings. She stated that, upon reflection, what is not clear from her documentation is the treatment options that were offered Mr A, which he declined.

141. RN E stated that she has reflected considerably on Mr A's care. She has become more focused in some areas of her practice, and particularly mindful of ensuring that all conversations are documented. She also takes a notepad into MDT meetings so that she can record updates in patient files accurately.

142. RN E stated that Mr A's case was a challenge for all professionals involved and, in hindsight, there are areas that could have been improved. She said that she has become more reflective in her nursing practice and places a greater emphasis on ensuring that she is mentally, physically, and spiritually well in order to provide the most effective nursing care she can. RN E also stated that she is now participating in supervision in order to discuss with an objective person any complex issues regarding her caseload, and to help her to reflect on nursing processes and organisational specific considerations.

[19] Provides a support service for family members of people with mental illness.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Further information — SCDHB

143. SCDHB stated that, in its assessment, the care provided to Mr A was appropriate. It noted that Mr A was regularly assessed and reviewed by a psychiatrist, and that a diagnosis was formulated early and subsequently confirmed. There was regular, consistent clinical engagement with Mr A in order to establish a therapeutic relationship and address his underlying stressors.

144. SCDHB apologised that Mr and Mrs B were not referred to the family support service. It stated that it is standard for this additional support to be offered to support people, and this oversight has been communicated to the relevant staff.

145. SCDHB acknowledged that after each inpatient discharge or acute contact with TACT, a follow-up appointment with a psychiatrist should have been coordinated to ensure timely reassessment of Mr A's mental state and review of his risk status, to formulate a treatment plan that took into account any new factors relating to his clinical presentation or circumstances, and to establish any new treatment goals. SCDHB told HDC that, on reflection, this is a clear area of quality improvement.

146. SCDHB identified the engagement of people who have a complex diagnostic profile and are exhibiting challenging behaviour as an area of improvement. It acknowledged that there may be aspects in the model of care that require an independent critique in regard to the care and treatment planning process for people who present with co-existing problems — eg, a dual diagnosis of alcohol and other drug issues, together with a mental illness. SCDHB stated that it plans to commence an independent review of the assessment, care, and treatment of these people. It is also seeking arrangements for professional supervision for clinical staff working with such people.

147. SCDHB stated that at a meeting of Duly Authorised Officers, the matter of contacting the on-call psychiatrist was discussed in relation to the management of people with suicidal ideation. At a community mental health team meeting, staff were reminded to be aware of policies and procedures.

148. RN E has been provided with procedures and guidelines, and is being supervised by a senior registered nurse and the Clinical Nurse Coordinator of AOD. A specific focus of the supervision is documentation and understanding of procedures and guidelines. RN E is also attending one-on-one risk training.

149. Risk training now includes procedure and documentation standards in the management of suicidal people. A second session of interviewing skills has been added, to develop collaborative treatment and management plans and ensure that all parties are included in plan development. Staff are required to undertake two sessions annually. Scenarios have been included where inappropriate behaviour such as social media or text messages are reported as an incident.

150. SCDHB stated that the two registered nurses involved in the preparation and/or review of Mr A's management and crisis plans have received individual professional development in this area. Additional components have been added to the induction programme, including signing off that they understand policies and procedures. RN E is to complete the new induction programme.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

151. SCDHB stated that it is developing terms of reference for a complex case review, which include key accountabilities, and process and documentation requirements, including outcomes and how client and family support will be included in the process.

152. SCDHB stated that it provides a Strength Recovery Focus approach, but this is not reflected adequately in the documentation. It said that it provides training for staff twice yearly on this approach. It plans to review the education of strengths documentation delivered to staff, undertake a peer review audit of clinical documentation to ensure that it is reflective of strengths-based evidence, and incorporate documentation review as part of the monthly administration supervision. In addition, the monthly administration supervision checklist has been amended to ensure that documentation is reflective of the strengths-based or recovery approach.

153. SCDHB stated that it has developed a Transition to Wellness Plan and a Patient Care Plan for the Inpatient Unit.

154. SCDHB said that information on the MHA and Alcoholism and Drug Addiction Act is communicated through the orientation booklet, and DAOs are available for guidance and education. DAOs have training at their monthly meetings, and refresher updates for all staff have been added to the annual training calendar.

155. SCDHB has two staff on an external group who ensure that SCDHB training is aligned to the regional approach. It said that there is an expectation that MHAS staff keep abreast of current research and good practice, with best practice educational resources available.

156. SCDHB stated that it is reviewing its Suicidal People, Co-existing Problems, and Failure of Client to Keep Appointment protocols.

Responses to provisional opinion

157. Mr and Mrs B were provided with the relevant sections of the "information gathered" section of this report. Mr and Mrs B told HDC:

> "[I]f we had been consulted and involved in these [MDT] discussions, then we would have been able to provide information on how best we could have supported [Mr A] at the time, and/or any ongoing issues we may have encountered."

158. RN E was provided with an opportunity to respond to the relevant sections of the provisional opinion and had no further information to add.

159. Dr C was provided with an opportunity to respond to the relevant sections of the provisional opinion. Dr C accepted that his documentation "could have been better". He also told HDC:

> "While there were discussions between the clinicians about the discharge, the combination of limited time available in the unit and the pressure of other aspects of my work resulted in my notes being briefer than I would have liked."

160. Dr C also stated that he was working part time, and no junior doctors were available to assist.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

161. Dr D was provided with an opportunity to respond to the relevant sections of the provisional opinion. She told HDC that she would have made changes to the Complex Case Management Plan if she had been consulted on it, and would never have endorsed a management plan written in that way.

162. SCDHB told HDC that the crisis plan guidelines in the Clinical Documentation Guidelines — Mental Health are clear that the perspective of family supports should form part of the plan, and that crisis plans are living documents that are to be reviewed every three months or as clinically indicated. SCDHB also said that whether the crisis plan required updating was a clinical decision for autonomous health professionals involved in Mr A's care. In terms of ensuring compliance with organisational policies, SCDHB told HDC that mental health service staff complete an induction process under which they have to certify that they have reviewed and are familiar with the documentation standards, and they also sign a Code of Behaviour, which sets out that failure to follow organisation policies, procedures, and rules will amount to misconduct. SCDHB said that there is a point at which an organisation relies on its staff to follow organisation policies and to use tools developed by the DHB.

163. SCDHB told HDC that it believes that its existing policies and procedures deal with all aspects of Complex Case Management Planning, and that to the best of its knowledge there is no express requirement for terms of reference in relation to Complex Case Conferences.

164. A second provisional opinion was issued addressing SCDHB's submissions. SCDHB advised that it carefully considered the information in the second provisional opinion and that it accepts the findings.

Opinion: South Canterbury District Health Board — breach

165. Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), Mr A had the right to have services provided with reasonable care and skill. District health boards are responsible for the operation of the clinical services they provide, and can be held responsible for any service-level failures. In my view, several aspects of Mr A's care were suboptimal. While I have also made criticism of individuals involved in Mr A's care, I consider that the failings in the care provided represent systemic issues for which SCDHB is responsible.

Complex Case Planning and Management from discharge on 2 Month3

Crisis plan provided on discharge — 2 Month3

166. On 29 Month2, Mr A was admitted voluntarily to the inpatient unit after calling TACT and making suicidal threats when intoxicated. During his admission, on 2 Month3 he was visited by Mrs B, who offered support and was added as a contact person.

167. Mr A was discharged home later that same day. RN L recorded that Mr A continued to be a moderate to high risk in the community for harm to himself and others. She noted that he had the 0800 TACT number and a crisis plan. The crisis plan provided was the existing plan dated from 11 Month2, which stated that he was to attend weekly appointments with RN E, call TACT or police in high-risk situations, and call RN E for urgent review if necessary.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

168. SCDHB told HDC that the crisis plan guidelines in the Clinical Documentation Guidelines — Mental Health are clear that the perspective of family supports should form part of the plan, and that crisis plans are living documents that are to be reviewed every three months or as clinically indicated. SCDHB also said that whether the crisis plan required updating was a clinical decision for autonomous health professionals involved in Mr A's care. In terms of ensuring compliance with organisational policies, SCDHB told HDC that mental health service staff complete an induction process under which they have to certify that they have reviewed and are familiar with the documentation standards, and also sign a Code of Behaviour, which sets out that failure to follow organisation policies, procedures, and rules will amount to misconduct. SCDHB said that there is a point at which an organisation relies on its staff to follow organisation policies and to use tools developed by the DHB.

169. My expert advisor, mental health nurse RN Carole Schneebeli, considers that the crisis plan was not of an acceptable standard in preparation for Mr A's discharge. She is concerned that there appears to have been little development of the supports needed for his ongoing care in the community, when he had many ongoing stressors and his risk assessment was sitting on moderate to high for self-harm behaviours. She noted that there was heavy reliance on access to secondary health services and the police, and there was no inclusion of Mr and Mrs B, who had been identified as a contact for support. RN Schneebeli considers this to be a moderate departure from acceptable standard.

170. I am guided by this advice. While I acknowledge that SCDHB had guidelines in place regarding crisis plans, and that health professionals were responsible for following these, the guidelines are not clear about whose responsibility it is to update the crisis plan on an ongoing basis. There were a number of ward staff involved in Mr A's care and discharge planning, and none of them updated his crisis plan during his admission. I am concerned that Mr A's crisis plan was not developed during his admission, before his discharge on 2 Month3, particularly to reflect his ongoing need for supported care in the community and the fact that he now had Mr and Mrs B supporting him. Given the complexity of his case and his ongoing risk, it was important that his crisis plan was accurate and up to date, and appropriately reflected his needs.

171. I am also concerned that there does not appear to be any further oversight or monitoring by SCDHB regarding the creation and updating of crisis plans after the induction of staff, and do not consider this to be sufficient. In my view, the fact that no staff updated Mr A's crisis plan raises questions about the organisational culture and practice regarding the updating of crisis plans and ensuring that consumers were supported appropriately. For these reasons, I consider that the failure to update the crisis plan adequately represents a service-level issue for which SCDHB is responsible.

Complex Case Conference Management Planning — 2–6 Month3

172. On 2 Month3 a Complex Case Conference was held to discuss Mr A's care, attended by Dr D, Dr C, a police officer, CNM P, the CNM of the inpatient psychiatric unit, nursing staff from TACT, and RN E. As noted above, minutes were taken at the meeting, and RN E then drafted a Complex Case Conference Management Plan, which was reviewed by CNM P.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

173. The minutes of the meeting state:

> "Agreement if any future presentations occur by [Mr A] which include threatening self harm and/or alcohol intoxication will be for [Mr A] to remain in police cells and review by TACT … The discharge criteria for [Mr A] from [AOD] will be non engagement with keyworker, non attendance of appointments [or] hostile behaviour."

174. As outlined in more detail above, the Complex Case Conference Management Plan included the following statement:

> "[I]f [Mr A] makes any threats of self-harm, harm to others, suicide and/or to kill specific others or makes sexually inappropriate comments or texts or intoxicated with alcohol while working with mental health and addictions staff, plan is as follows … Appointment to be cancelled immediately … Police to be contacted as soon as possible … [Mr A] to be discharged from [AOD]."

175. Dr D told HDC that the outcome of the Complex Case Conference was to continue to support Mr A as an outpatient with a clear safety plan in place. She stated that, as with all AOD clients, Mr A was expected to participate in his treatment actively. Dr D said that the plan formulated satisfactorily addressed Mr A's need to take responsibility for his behaviour in the absence of a major mental illness, while at the same time identifying his need for outpatient treatment with AOD.

176. RN E acknowledged that the Complex Case Conference Management Plan could have been expressed less punitively. She said that this was the first Complex Case Conference she had attended and that CNM P asked her to prepare the plan immediately, which gave her little time to do it. RN E acknowledged that it was too focused on a cohesive response to Mr A by various services, and that the intention to continue to support Mr A was not as developed as it could have been. RN E said that she is now aware that it is usual practice to send a draft plan to all parties for mutual agreement before it is finalised. Dr D also acknowledged that the tone of the Complex Case Conference Management Plan is punitive. She said that she would have made changes to the document if she had been consulted on it, and would never have endorsed a management plan written in that way. However, she stated that had there been any new concerns about Mr A's mental state, TACT would have discussed these with the on-call psychiatrist and an alternative plan made.

177. On 6 Month3, RN E discussed the plan at an appointment with Mr A, accompanied by a police officer. Mrs B supported Mr A. RN E's notes record that the Complex Case Conference Management Plan was discussed. RN E said that she still encouraged Mr A to seek support if he felt suicidal. Mrs B told HDC that RN E advised Mr A that she could not help him if he was going to continue to make suicidal threats.

178. Dr D obtained an opinion from psychiatrist Dr T. Dr T stated that the plan for Mr A to be discharged if he made threats of self-harm was somewhat "black and white" and failed to allow for intoxication or a change in mental state or presentation, although there was mention that there would be TACT follow-up. She advised that failure to respond to suicidal intent or plan by a mental health service would be a "dereliction of duty" by a mental health service overall, but that it is not so to be discharged from AOD if other provisions for assessment and treatment are met.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

179. My psychiatrist expert advisor, Dr Jeremy McMinn, advised that the minutes of the Complex Case Conference "indicate a focus on the ways [Mr A] would be obliged to behave to ensure he could receive care". Dr McMinn noted that this translated into a plan that Mr A would be discharged from AOD in response to threats to harm himself or others, and advised:

> "This represents a gross dereliction of duty of care on behalf of MHAS, where the expression of (psychiatric) illness leads directly to the denial of treatment."

180. Dr McMinn further expressed concern about shortfalls in planning how to respond to repeat presentations of expected behaviours (substance use and distress); a treatment plan that constrained the expression of suicidal ideation; and a focus on patient behaviour prioritised above patient needs.

181. RN Schneebeli also advised that she has significant concerns about the management plan and its implementation. She noted that there is no evidence that it was developed in collaboration with Mr A, and that it reads as punitive, with an emphasis on him focusing on engaging with services and taking responsibility for his alcohol dependency. It also required him to attend appointments to address his alcohol and substance abuse issues. She stated that the management plan, and the crisis plan, were very restrictive for Mr A regarding his ability to access support for his escalating stressors.

182. SCDHB told HDC that it believes that its existing policies and procedures deal with all aspects of Complex Case Management Planning, and that to the best of its knowledge there is no express requirement for terms of reference in relation to Complex Case Conferences.

183. In my view, the Complex Case Conference Management Plan arising out of the multidisciplinary Complex Case Conference on 2 Month3 was inappropriate. I acknowledge the complexity of Mr A's case and that it was appropriate to set boundaries around behaviour and engagement. However, there still needed to be appropriate focus on providing appropriate care and support. I am particularly concerned that the plan prescribed discharge from AOD services in response to threats to self or others, but am also concerned that the plan was developed without Mr A's input and did not make reference to Mr and Mrs B. While the minutes of the meeting are not phrased as punitively as the plan itself, they also focus on dictating Mr A's behaviour, rather than on his needs. I also acknowledge that the Complex Case Conference Management Plan was not circulated around all the staff members involved for their consideration and to facilitate agreement or approval, and that the written plan and the minutes may not have reflected the full discussion of the meeting. However, I am concerned that what RN E took away from the meeting was a focus on Mr A's behaviour rather than how he would be supported.

184. In addition, I am concerned that an inappropriate plan that had been written by a staff member who had attended her first Complex Case Conference was not only created, but was in fact implemented. In my view, this raises questions about the level of support provided to staff who attend these conferences. While SCDHB told HDC that existing policies and procedures deal with "all aspects of Complex Case Conference Management Planning", there is no reference to any particular written policies, procedures, or terms of reference setting out clear processes (including around documentation) and lines of responsibility in relation to these complex case conferences, including for decision-making,

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

to ensure that outcomes are robust and appropriate. SCDHB has also not described any usual practice around these conferences that existed at the time, and it is apparent that RN E was not aware of any usual practice for finalising these plans. As she was provided with the plan for review, CNM P was also either not aware of the usual practice, or she did not ensure that any such usual practice was followed.

185. While I support a multidisciplinary approach to care management, I am concerned that SCDHB did not have in place clear policies, procedures, or terms of reference for Complex Case Conferences that included clear processes and decision-making responsibilities and accountability. In this case, for the reasons set out above, I consider that this lack of clarity meant that an inappropriate plan that was focused on dictating Mr A's behaviour rather than supporting him, was able to be developed and communicated to him. I note Dr D's comment that she would never endorse a plan written in the way it was, but that she did not see it. Therefore, I consider the inappropriate Complex Case Management Plan to be a service-level failing for which SCDHB is accountable.

186. I note that SCDHB has told HDC that it is developing terms of reference for complex case reviews, which include key accountabilities, process and documentation requirements, requirements for outcomes, and details of how client and family support will be included in the process. I believe this to be an appropriate action for SCDHB to take, and am of the opinion that providing clear guidance to staff on the value of family/whānau support, and how to include it, will better equip SCDHB staff members to assist vulnerable consumers who may present with behaviours that are difficult for staff to manage appropriately.

Discharge from AOD — 22 Month3

187. As discussed above, Mr A sent RN E a text message on the evening of 15 Month3 stating that he wanted to die. RN E said that when she called him on 16 Month3, Mr A reported a number of stressors and stated that he did not want to live, although he denied any specific suicidal plans. RN E stated that during the call Mr A requested discharge from AOD. This was nine days after RN E had discussed the Complex Case Conference Management Plan with him.

188. Later that day, RN E visited Mr A and recorded that he had ongoing suicidal ideation, was huffing gas, appeared depressed, and was expressing thoughts of hopelessness. She also recorded that Mr A expressed no interest in addressing his issues regarding alcohol and substance misuse, and no intention of attending appointments with her. She informed him that he would be discharged from AOD owing to his unwillingness to engage in the treatment being offered.

189. Dr D was informed of the visit and agreed that Mr A should be discharged from AOD. The Complex Case Conference Management Plan was updated that same day, confirming that Mr A would be discharged owing to non-engagement with the treatment plan.

190. On 22 Month3, RN E presented Mr A's case at an MDT meeting, at which Dr D was present. Mr A was discharged from AOD. The risk assessment recorded that Mr A was at chronic risk of suicide, and noted the current factors, including limited social support, that placed him at high risk to himself. Dr D told HDC that sometimes discharge is the most appropriate treatment, with clear expectations of what needs to occur should the patient wish to re-engage.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

191. Dr T advised that although Mr A refused AOD input on 16 Month3, it was somewhat concrete to take him at his word, given that likely he was intoxicated and had a history of being unreliable when intoxicated. However, she stated that it was not unreasonable for his entire case to be reviewed to examine whether any progress was being made. Dr T stated that it is difficult to understand clearly the full reasoning and rationale for discharge, and that Mr A's abrupt withdrawal from services and one of his pets having cancer may have been concerning signs, and should have precipitated wider discussion. She concluded that she was unable to find that Mr A should not have been discharged from AOD, but that this should be explored further at a service level.

192. Dr McMinn noted that both Mr A and staff from SCDHB sought Mr A's discharge. Dr McMinn also noted that Mr A's requests for discharge followed expressions of hopelessness, intermittent suicidal ideation, and depressed mood. Dr McMinn expressed concern that Mr A's difficulties were framed in somewhat simplistic ways, and gave the following as an example:

> "[T]aking a request for discharge in a man in a state of hopelessness at face value, without explicit consideration of whether his capacity to decide upon his own suitability for discharge was impaired by his state of mind."

193. While Dr McMinn advised that the care provided by individual staff in relation to Mr A's discharge was appropriate, he also stated:

> "[A]ssimilation into a sufficient package of care at the time of his discharge that could be termed reasonable was not achieved. In particular, the trajectory toward an inappropriate discharge was indicative of care that did not reach a reasonable threshold overall …
>
> In my opinion, reasonable care in this case would not have included discharge at a time of active and risk-laden symptoms; without the exploration of further ways to foster engagement, including considering a change in case manager and greater involvement of health and non-health service supports … Renewed consideration of the use of compulsion, either under the Mental Health Act or the Alcoholism and Drug Addiction Act should have been recorded.
>
> The departure from the standard of care was moderately significant … A man in need was not provided with assistance as he became more distressed. Psychiatrist peers would look upon this with disappointment, with expectations of relevant service changes to minimise the likelihood of recurrence."

194. SCDHB suggested to HDC that the decision to discharge, made during the MDT meeting, was a clinical decision for which it does not consider it can have liability, regardless of the number of staff involved.

195. I am critical that Mr A's request for discharge was taken at face value, and that he was discharged from AOD without greater consideration of other ways to foster his engagement, given his ongoing risk, expressions of suicidal ideation and hopelessness, and substance abuse. I am particularly concerned given that it followed the communication to him of the punitively worded Complex Case Management Conference Plan discussed above. I am

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

guided by Dr McMinn's advice that discharge at a time of active and risk-laden symptoms without exploring further ways to foster engagement was a moderate departure from the accepted standard of care. This could have included considering a change of case manager and/or actively involving Mr and Mrs B, who had offered their support but had not been included in the crisis plan or Complex Case Conference Management Plan. As discussed below, I consider that Dr D holds some responsibility for Mr A's discharge. However, this was a decision made at an MDT meeting involving multiple staff, and there does not appear to have been wider multidisciplinary discussion of the appropriateness of discharge or alternatives in this context, despite the circumstances of Mr A's request for discharge and his complexity. I am concerned about how the decision to discharge was made in this case.

196. SCDHB did not have clear policies, procedures, and/or terms or reference for MDT meetings setting out clear lines of responsibility and accountability, including for decision-making, and so responsibility for this discharge cannot be clearly attributed to any individual clinician. As stated above, SCDHB has overall responsibility for the operation of the clinical services it provides. Accordingly, I consider Mr A's discharge as a result of the MDT meeting in the circumstances set out above, and without the multidisciplinary team exploring further ways to foster engagement, to be a service-level failing for which SCDHB is accountable. As already discussed above in relation to Complex Case Conferences, I consider that SCDHB should have had clear policies, procedures, and/or terms of reference for MDT meetings, which included clear processes and decision-making responsibilities and accountability, to ensure that meeting outcomes were appropriate and robust.

Conclusion

197. I acknowledge that Mr A's needs were complex and that he required support from both mental health and addiction services, and that police support and intervention was at times required. However, it was the role of SCDHB and its staff to provide Mr A with appropriate and adequate care, taking account of that complexity. It was also the role and responsibility of the DHB to ensure that SCDHB staff, who had responsibility for both assisting complex consumers and also ensuring their own safety, were supported appropriately. I am concerned that towards the end of Mr A's care, emphasis appears to have been placed on dictating Mr A's behaviour, and support and guidance for staff were lacking. I consider that a more compassionate and consumer-focused approach could reasonably have been taken.

198. As I have stated above, notwithstanding the individual responsibility for some of the shortcomings in Mr A's care, overall I consider many of the failings exhibited in this case to be systemic issues for which SCDHB is accountable.

199. In summary, I find that SCDHB failed to provide services with reasonable care and skill by:

a) Failing to have in place an accurate and up-to-date crisis plan for Mr A prior to his discharge on 2 Month3, including failing to involve Mr A himself adequately, and, where appropriate, Mr and Mrs B;

b) Developing and implementing a Complex Case Conference Management Plan that was not appropriate; and

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

c) Discharging Mr A from AOD on 22 Month3 without greater consideration of other ways to foster engagement, including with Mr and Mrs B, given his ongoing risk, expressions of suicidal ideation and hopelessness, and substance abuse.

200. As a result, I find that SCDHB breached Right 4(1) of the Code.

Overall care — adverse comment

201. My expert advisors raised a number of further issues about the overall approach to Mr A's care. As discussed below, while I agree with my expert advisors in relation to the criticisms made, I encourage the steps being taken by SCDHB to improve service delivery in these areas.

Dual diagnosis

202. Dr McMinn raised concern about Mr A's problems being categorised as either addiction or as mental health, without an effective assimilation into a dual diagnosis understanding (eg, that substance use can escalate in periods of distress in someone with limited psychological resources). Dr McMinn advised that the assessment of Mr A's mental state and his pattern of substance and alcohol use to effect artificial change was not addressed with any sophistication.

203. In particular, Dr McMinn observed that during this period of care Mr A's persistent thoughts of suicide had moved to the forefront of his presentation following long periods where he had presented minimally. Beyond linking these thoughts to substance and alcohol use, Dr McMinn noted that there was no other work done with Mr A in this area, such as exploration of how and why the suicidal thoughts had changed, and whether they had changed from low-risk existential reflections to more intense and imminent desires to end life.

204. I agree with Dr McMinn and am critical that Mr A's care was not effectively assimilated into a dual diagnosis understanding. However, I also note that SCDHB has acknowledged that engaging with people who have a complex diagnostic profile and are exhibiting challenging behaviour is an area for improvement. SCDHB told HDC that it has plans to commence an independent review of the assessment, care, and treatment of clients with dual diagnosis, and is arranging professional supervision for clinical staff working in this area.

205. I consider these initiatives proposed by SCDHB to be appropriate steps to address the deficiencies identified by Dr McMinn and evidenced throughout Mr A's care.

Psychology and psychiatry input

206. Dr McMinn raised concern about limited planning around early psychiatrist review. He advised that there was no sign of community psychiatry input; variable involvement of psychiatrists out of hours despite significant and minimally managed risks; and no formal second opinion for a man with a high risk and complex presentation incongruently heading for discharge.

207. Further, Dr McMinn noted that there was no involvement of a psychologist either directly with Mr A or to view the group dynamics that left MHAS fixated on his perceived risk to staff at the expense of effective intervention. Dr McMinn stated:

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

> "Psychiatrists and psychologists may be better placed than other staff to assimilate system conflicts and respond to expertise deficits. Accordingly, the involvement of these disciplines should be greater in complex cases."

208. SCDHB stated that, in its assessment, Mr A received appropriate treatment. It said that Mr A was assessed and reviewed by a psychiatrist regularly, and there was regular, consistent clinical engagement with Mr A. However, SCDHB has conceded that after each inpatient discharge or acute contact with TACT, a follow-up appointment with a psychiatrist should have been coordinated. SCDHB told HDC that this was a clear area for quality improvement.

209. In relation to availability of a second opinion, Dr D noted the involvement of three separate psychiatrists over the course of Mr A's engagement with the service.

210. In response to Dr McMinn's comments regarding psychologist input, Dr D stated that Mr A refused to engage with the ward social worker, and there was no opportunity to involve the clinical psychologist, as Mr A continued to use alcohol and other substances and was not committed to case management. She explained that in the usual course of events, as clients settle into case management they are offered therapies. Dr D stated that there has to be some engagement and willingness to address relevant issues when the main problem is substance abuse and personality difficulties, as opposed to a treatable major mental illness.

211. I agree with the concerns raised by Dr McMinn. Although Mr A was reviewed a number of times by psychiatrists when he presented in crisis, there was limited planning around early psychiatric input following Mr A's discharges from inpatient care, and no psychiatrist input within the community. I am critical of this. In addition, I note Dr McMinn's comment about the value of psychological input in complex cases, and note that SCDHB's approach to psychological input appears to be "black and white". I encourage SCDHB to reflect on these criticisms and how they could influence improved service provision in the future.

Strengths-based approach

212. Dr McMinn noted that the SCDHB position descriptions emphasise practice styles that seek to draw collaboratively on the patient's resources and reference "strengths based" and "strengths Model process using the Strengths Assessment".

213. However, in terms of the clinical documentation relating to Mr A's care, Dr McMinn advised that a strengths-based practice was difficult to discern. He said that there was no strengths-based description of Mr A, no clear treatment plan with shared goal identification and focus as an outpatient approach, and no Wellness Recovery Action Plan or similar. His deficiencies, by contrast, were listed comprehensively.

214. Dr McMinn acknowledged that the documentation may not be a complete reflection of the practice of SCDHB staff, but considered that the practice styles emphasised in the position descriptions could be echoed in the documentation more substantially at all levels. He suggested that this issue of good practice could be improved by a change management process informed substantially by consumer representation. I agree and am critical that a strengths-based approach is not apparent in the care provided to Mr A, particularly from 2 Month3 onwards.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

215. SCDHB stated in response that it provides a strengths-recovery focus approach, but acknowledges that this is not reflected in the documentation. SCDHB further advised HDC that plans are underway to review the staff education in this area, and to undertake a peer review audit of clinical documentation to ensure that it is reflective of this approach. Documentation review will also be part of the monthly supervision. I acknowledge and encourage the steps being taken.

Response to request for quetiapine — 6–7 Month3

216. During the appointment with RN E on 6 Month3, Mr A reported having experienced some suicidal thoughts two days previously, but said that taking two quetiapine tablets from an old prescription had had a settling effect. RN E cancelled the prescription because of his recent threats of overdosing. Mrs B offered to supervise Mr A's medication administration (an area in which she has experience) and requested that this be discussed with a psychiatrist.

217. The next day, 7 Month3, RN E recorded that Mr A was discussed at the MDT meeting and it was decided to consult Dr D about the possibility of a small amount of quetiapine being given to Mr A, as the psychiatrist present at the meeting was not familiar with Mr A's case. There is no documentation of a discussion with Dr D. RN E recalls that a prescription was decided against, owing to Mr A's changeability in mood and threatening behaviour when intoxicated, and the potential impact on Mr and Mrs B.

218. Mr and Mrs B stated that Mr A was upset at not being allowed quetiapine, and told them that he "might as well just end it".

219. Dr T considered it appropriate that RN E cancelled Mr A's prescription on 6 Month3. Dr T acknowledged that, with hindsight, potentially the cancellation of the script may have been perceived to have been unsupportive or invalidating, but this would not justify continuation of non-prescribed potentially risky medication. Dr T stated that quetiapine has no role in alcohol dependence, personality disorder, adjustment disorder or solvent abuse, and there is a risk of sedation and interaction with other central nervous system depressants such as alcohol. She stated that, ideally, the medication issue would have been discussed with Dr D in a more timely manner.

220. In relation to the decision not to prescribe quetiapine on discharge on 2 Month3, Dr McMinn advised that "[i]t would be legitimate to be cautious about providing tranquillisation in an unsupervised context". However, regarding the 6 Month3 appointment, Dr McMinn advised:

> "[Mr A's] taking of the quetiapine for appropriate tranquillisation could have been appraised as an encouraging break through in his care. He had chosen to use a substance with low potential for harm, for the same reasons as given in hospital, instead of his habitual use of more toxic and increasingly dangerous alcohol and inhalant misuse. He used the right substance, for the right reason, in what was probably the right amount, with the option for future amounts to be dispensed in measured quantities or supervised by his friend to minimise overdose risk."

221. Dr McMinn advised that in a compassionate and responsive service, the further provision of quetiapine would have been actively considered at the earliest opportunity for the potential

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

benefit Mr A had identified. Instead, the medication was withheld immediately, and re-approval was then delayed. Dr McMinn stated that this may not represent a departure from the accepted standard of care, but appears to demonstrate a standard at the lowest end of practice quality.

222. In my view, it was reasonable for Mr A's quetiapine to be cancelled and for a further prescription to be decided against, given the risks involved. However, it would have been prudent for this to have been considered in a more timely manner, the rationale better explained to Mr A and Mr and Mrs B, and alternative options for tranquillisation considered, so that Mr A did not resort to substance misuse. The way in which this request was managed compounds my concerns about the approach to Mr A's care management following his discharge on 2 Month3, in particular the focus on patient behaviour over needs.

Policies and procedures — adverse comment

223. From the nursing perspective, RN Schneebeli was critical of the lack of policies/processes to assist RN E in performance of her role in relation to Mr A's care.

224. As outlined above, RN E advised HDC that it is standard practice to terminate an interview if a client comes to a meeting intoxicated. She also recorded on 16 Month3 that she told Mr A that he would be discharged from AOD because of his unwillingness to engage in the treatment being offered, and this was then noted on the updated Complex Case Conference Management Plan of the same date.

225. RN Schneebeli advised that there was a deficiency in the DHB's policies in relation to guidance on terminating an interview if the consumer attends intoxicated, and discharging a consumer for lack of engagement. She stated that if these are indeed processes, they need to be addressed in policies and included in an information pamphlet for services users and family/whānau.

226. Further, as noted above, between 24 and 26 Month2, Mr A sent a series of inappropriate e-text messages to RN E. On 25 Month2, RN E met with Mr A, alone, to discuss them. While RN E did report the incidents to CNM P and Dr C, she did not complete an incident form, and told HDC that she was advised not to.

227. RN Schneebeli advised that "greater support of [RN E] in regards to the complexity of this case and the risks should have been given to her by the team and manager", given that RN E advised her manager of the inappropriate e-text messages and was new to community nursing. RN Schneebeli also considered that an incident report should have been completed. She was also critical of the lack of SCDHB policies on addressing gender/sexual safety.

228. I agree with RN Schneebeli and consider that SCDHB should have had policies in place to assist RN E in addressing the inappropriate e-text messages with Mr A, including in relation to having another person present when discussing boundary setting and planning ongoing care. I am also critical that CNM P did not provide greater support to RN E in this regard.

229. Dr McMinn expressed concern that there were no strategies in place to limit premature discharge. He is of the view that there were deficiencies in the DHB's AOD policies in particular. He considers that the direct and active involvement of psychiatry in the AOD

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

service is not clear, but is of the view that a high level of psychiatrist involvement should be facilitated. He also noted that the AOD policies seem limited to brief interventions, when a wealth of approaches can be taken in addiction treatment.

230. I consider that additional direction in all of these areas would have assisted the staff involved in Mr A's care. I am critical of these deficiencies in SCDHB's policies and procedures.

Opinion: Dr D — adverse comment

Discharge from AOD — 22 Month3

231. As noted above, RN E told HDC that in a telephone call on 16 Month3 Mr A requested discharge from AOD. Her record of a meeting with him later that day included that he had ongoing suicidal ideation, appeared depressed, was expressing thoughts of hopelessness, had no interest in addressing his alcohol and substance misuse, and had no intention of attending appointments with her. She informed him that he would be discharged from AOD owing to his unwillingness to engage in the treatment being offered.

232. RN E stated that Dr D agreed that Mr A should be discharged from AOD. Dr D told HDC that Mr A did not have a disorder of volition, so was free to make his own choices regarding his treatment.

233. On 22 Month3, Mr A's case was presented at an MDT meeting, at which Dr D was present. As noted above, Mr A was discharged from AOD. The risk assessment recorded that Mr A was at chronic risk of suicide, and noted the current factors, including limited social support, that placed him at high risk to himself. Dr D stated that sometimes discharge is the most appropriate treatment, with clear expectations of what needs to occur should the patient wish to re-engage.

234. Dr D said that Mr A was not reviewed by a psychiatrist prior to discharge, as MHAS had spent considerable time working with him to engage him, and she had been kept very up to date with his care and had faith in the team working with him that all that could have been done to engage him had been done. She accepts that, in hindsight, it would have been better if she had arranged to review Mr A. She said that decisions to discharge patients from the AOD service are not made lightly.

235. As discussed above, Dr T advised that although Mr A refused AOD input on 16 Month3, it was somewhat concrete to take him at his word, given that likely he was intoxicated, and he had a history of being unreliable when intoxicated. However, she stated that it was not unreasonable for his entire case to be reviewed to examine whether any progress was being made. Dr T stated that it is difficult to understand clearly the full reasoning and rationale for discharge, and that Mr A's abrupt withdrawal from services, and one of his pets having cancer, may have been concerning signs and should have precipitated wider discussion. She concluded that she was unable to find that Mr A should not have been discharged from AOD, but said that this should be explored further at a service level.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

236. Dr McMinn concluded that the individual care provided by Dr D was not unreasonable; however, as noted above, he also raised concern about "taking a request for discharge in a man in a state of hopelessness at face value, without explicit consideration of whether his capacity to decide upon his own suitability for discharge was impaired by his state of mind".

237. Dr McMinn advised that a further face-to-face review with a psychiatrist would have been appropriate. He stated:

> "The decision not to review, or lack of decision to review, was not unreasonable, given the findings *in toto*. However I do not think it was right that the decision was made to discharge this vulnerable and ambivalent patient, with a return of active symptoms/substance use and at an early stage of outpatient care, without review. I believe that many psychiatrists would have acted with more caution, even in the expectation that the outcome was unlikely to change."

238. In terms of the decision to discharge more generally, again I note Dr McMinn's advice:

> "[A]ssimilation into a sufficient package of care at the time of his discharge that could be termed reasonable was not achieved. In particular, the trajectory toward an inappropriate discharge was indicative of care that did not reach a reasonable threshold overall …
>
> In my opinion, reasonable care in this case would not have included discharge at a time of active and risk-laden symptoms; without the exploration of further ways to foster engagement, including considering a change in case manager and greater involvement of health and non-health service supports … Renewed consideration of the use of compulsion, either under the Mental Health Act or the Alcoholism and Drug Addiction Act should have been recorded.
>
> The departure from the standard of care was moderately significant … A man in need was not provided with assistance as he became more distressed. Psychiatrist peers would look upon this with disappointment, with expectations of relevant service changes to minimise the likelihood of recurrence."

239. I am concerned that Mr A was discharged from AOD without greater consideration of other ways to foster his engagement, given his ongoing risk, expressions of suicidal ideation and hopelessness, and substance abuse. In addition, in my view Dr D should have reviewed Mr A before deciding whether to discharge him from AOD, given his ongoing risk, expressions of suicidal ideation and hopelessness, and substance abuse. I am concerned that she did not do so. I acknowledge that the decision to discharge Mr A was made at an MDT meeting that involved a number of staff. However, I consider that, as a psychiatrist, Dr D holds some responsibility for the decision to discharge Mr A from AOD without greater consideration of other ways to foster his engagement, such as those referred to by Dr McMinn, and without psychiatrist review.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Opinion: Dr C — adverse comment

Documentation surrounding discharge from inpatient unit 22 Month2 — adverse comment

240. At the MDT meeting on 22 Month2 following Mr A's voluntary admission to the inpatient unit on 20 Month2, it was decided that Mr A should be discharged, with a social worker to address his financial issues and AOD to create a management plan before discharge. SCDHB told HDC that the MDT record does not adequately document the concerns raised or the agreed plan.

241. Dr McMinn initially advised that the decision to discharge Mr A with such a limited management plan was a serious departure from the standard of care. However, following Dr C's detailed explanation of his rationale, Dr McMinn subsequently advised that he was not concerned about this issue.

242. While I acknowledge that given the further information provided, my expert advisor accepts that discharge was appropriate, I am critical that Dr C did not adequately document his concerns, his rationale for decision-making, and his management plan for Mr A.

Discharge planning from inpatient unit on 2 Month3 — other comment

243. Prior to Mr A's discharge on 2 Month3, Dr C met with Mrs B, who told him that she and Mr B were happy to provide support to Mr A and to call TACT if there was a crisis.

244. At 11.10am that same day, Mr A was discharged home. As above, it was recorded that Mr A continued to be a moderate to high risk in the community for harm to himself and others, and that he had the 0800 TACT number and a crisis plan. The crisis plan provided was Mr A's existing plan dated 11 Month2. The discharge plan, which was prepared by RN L for Dr C, reflected the Complex Case Conference Management Plan (outlined above) that arose out of the related meeting that afternoon.

245. Dr McMinn advised that the discharge planning for Mr A's discharge on 2 Month3 was limited in scope, sophistication, and detail, and that "it was not possible to discern a confident therapeutic alliance, considered timings, individualised treatment planning or innovation in the discharge plan". Dr McMinn stated that the clinical notes for the admission did not convey "a strong sense … that [Mr A] was helped to make sense of his thoughts, choices or difficulties", and that there was "limited input around his use of intoxicants …". Dr McMinn acknowledged that this work would not necessarily be done in an inpatient environment, but said that "it would then be reasonable to expect that any discharge plan included strategies to respond to the likelihood of a return of difficulties as [Mr A] returned home".

246. Dr McMinn also advised that the proposed appointment with a psychiatrist in one month's time was "distant" considering the context and noting that there was no change in treatment. He stated that a "review by the psychiatrist within the first week of discharge would have been more realistic". Dr McMinn also noted that there was no indication that Mr A's personal comments to RN E had been addressed with him directly. While Dr McMinn did not consider this to be a departure from the standard of care, it was at the lower end of practice quality.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

247. I note Dr McMinn's advice and suggest that Dr C take these comments into account in his future practice.

Complex Case Conference Management Plan of 2 Month3 — other comment

248. Dr C attended the Complex Case Management Conference that discussed Mr A's care on 2 Month3.

249. While I have criticisms of the punitive nature of the minutes and the written plan that resulted from this meeting, I acknowledge that Dr C was a locum provider, and that this meeting was held on his last day at SCDHB, and he may not have seen the minutes or the plan. For this reason I am not critical of Dr C in relation to the meeting or the plan.

Opinion: RN E — adverse comment

Documentation of response to disclosure of overdose on 25 Month2

250. On 25 Month2, Mr A attended a meeting with RN E. At this meeting RN E spoke to Mr A about the text messages he had sent her the previous day.

251. During the appointment, Mr A disclosed that the previous night he had ingested all the pills from his prescriptions of quetiapine and zopiclone. RN E told HDC that as she was concerned that the disclosed overdose may have been a suicide attempt, she called Dr C, who met with Mr A.

252. Following this meeting, RN E recorded that the plan was for Mr A to contact TACT over the next three days, if needed, and for her to support him with his WINZ appointment. She told HDC that because of the inappropriate text message, it was decided that two AOD staff members should escort him home. RN E's notes do not refer to Dr C's brief review of Mr A or any consideration of use of the MHA.

253. RN Schneebeli advised that RN E's documentation of these events is unclear, with no documented account of Dr C's assessment. RN Schneebeli said that while she does not consider the decision to use two people to escort Mr A home was outside standard practice, the rationale could have been presented more clearly in the clinical notes.

254. I am concerned about RN E's lack of documentation of the meeting between Dr C and Mr A, and the inadequate rationale for the number of people escorting Mr A. I consider that interactions in circumstances such as these are important to gain a complete picture of the care provided and to facilitate appropriate and effective continuity of care. I am therefore critical that these matters were not recorded accurately.

Complex Case Conference Management Plan of 2 Month3

255. RN E was one of those present at the Complex Case Conference held to discuss Mr A's care on 2 Month3. Following the meeting, RN E drafted the Complex Case Conference Management Plan, for review by CNM P.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

256. As outlined above, the Complex Case Conference Management Plan outlined what should occur if Mr A made contact with the service threatening self-harm, or harm to others. The plan focused on notification of police, and contemplates discharge from AOD services.

257. RN E has acknowledged that the Complex Case Conference Management Plan could have been expressed less punitively. She accepts that it was too focused on a cohesive response to Mr A by various services, and that the intention to continue to support Mr A was not as developed as it could have been.

258. As above, RN Schneebeli advised that the Complex Case Conference Management Plan was not of an acceptable standard, and she has significant concerns about the management plan and its implementation. She noted that there is no evidence that it was developed in collaboration with Mr A, and that it reads as punitive, with an emphasis on him focusing on engaging with services and taking responsibility for his alcohol dependency, and that it required him to attend appointments to address his alcohol and substance abuse issues. She stated that his management and crisis plan were very restrictive for him regarding his ability to access support for his escalating stressors.

259. In my view, the Complex Case Conference Management Plan arising out of the multidisciplinary Complex Case Conference on 2 Month3 was inappropriate. However, I acknowledge that RN E has said that this was the first such meeting she had attended, she was asked to draft the plan immediately and so had little time, and she was unaware of the practice of circulating the plan to other staff present for review and mutual agreement. I also acknowledge that the plan arose out of a conference in which a large number of staff were involved, including staff in much more senior positions than RN E. In addition, I note the appropriate concessions made by RN E regarding the punitive nature of the Complex Case Conference Management Plan, and the fact that it was provided to RN E's manager for review prior to finalisation. Therefore, while I am critical of RN E in relation to the plan, it is mitigated by these factors.

Recommendations

260. In the provisional opinion it was recommended that SCDHB implement professional supervision for clinical staff working in the area of alcohol and other drugs services. SCDHB confirmed that it has since implemented weekly professional peer supervision for the Alcohol and Drug Service. I recommend that SCDHB report back to HDC, within six months of the date of this report, on the outcome of the actions it has undertaken to complete, including:

a) The findings and actions taken as a result of SCDHB's independent review of the assessment, care, and treatment of clients with dual diagnosis; and

b) The progress in implementing new terms of reference for Complex Case Conferences that set out, amongst other things, lines of responsibility for decision-making and requirements for minutes to be taken.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

261. I also recommend that SCDHB undertake the following actions and report back to HDC within six months of the date of this report:

a) Assess its mental health and addiction services with reference to Dr McMinn's comments about strengths-based practice to identify service improvements, and obtain input from family/whānau and consumer representatives in that assessment. The assessment should include consideration of consumer and family/whānau engagement in care planning and ensuring that implementation of improvements identified by the assessment can be monitored.

b) Review its policies and procedures in relation to boundary setting (including sexual safety for staff); professional supervision; incident reporting; discharge from the service; client engagement; and changing case workers, with reference to findings from this decision.

c) Review orientation for new staff to ensure that they are provided with training and appropriate supervision in relation to the policies in (b) above, including knowledge of escalation pathways when issues arise.

262. I recommend that SCDHB take account of the findings of this report in finalising the terms of reference for its external audit of its mental health and addiction service, and report back to HDC with confirmation of this within three weeks of the date of this report.

Follow-up actions

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

264. A copy of this report with details identifying the parties removed, except SCDHB and the experts who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr C's and Dr D's names.

265. A copy of this report with details identifying the parties removed, except SCDHB and the experts who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN E's name.

266. A copy of this report with details identifying the parties removed, except SCDHB and the experts who advised on this case, will be sent to the Royal Australian and New Zealand College of Psychiatrists, the New Zealand College of Mental Health Nurses, the Director of Mental Health, and the Ministry of Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent psychiatrist advice to the Commissioner

The following expert advice was obtained from psychiatrist Dr Jeremy McMinn:

"Thank you for requesting expert advice on behalf of the Commissioner on the care provided to [Mr A] by South Canterbury District Health Board (SCDHB) Mental Health Services between 7th [Month1] and 20th [Month4].

You have provided a letter of instruction, dated, with the following enclosures:

A copy of [Mr and Mrs B's] complaint dated […], including attachment;

A copy of SCDHB's response dated

A copy of [Mr A's] clinical records from SCDHB dated [Month1] to [Month4];

A copy of [the medical centre's] letter to the Coroner dated, including enclosures.

Your letter of instruction outlines the background to [Mr A's] contacts with psychiatric services, including addiction services, between [Month1] and [Month4].

You have specifically requested my opinion on 8 listed issues. These are reiterated on this report in bold italics as headings for each section for ease of reference.

This report was originally issued on 14th December 2015. This is a re-issue with proof reading corrections.

The appropriateness of [Mr A's] management plan following his suicide attempt on 7th [Month1], including whether he should have been placed under the Mental Health Act;

[Mr A] was admitted on Thursday 7th [Month1] following [self harm].

When first seen, he was noted to be upset, aggressive, and ambivalent about living. As the evening progressed, he was noted to be stable, chatty, interactive and talked of his future plans. His discharge report noted he was remorseful, and did not sustain a desire to commit suicide. He was discharged from the medical ward on 8th [Month1].

He was seen by psychiatric services (TACT) while on the ward, and offered inpatient care. [Mr A] declined psychiatric admission, but agreed to outpatient follow up, which would allow him to return home to care for his remaining [pets]. He was dropped home by TACT and plans were in place for review the following day.

Outpatient treatment over the next 10 days focused on sensible ways of managing the relationship break-up and any difficult contacts with the ex-partner. He was supported by friends and his employer. He appeared to respond well to this care. He was prescribed low dose Quetiapine (an antipsychotic often used in low doses for sedative effect in non-psychotic patients when more addictive sleeping tablets may be problematic): this medication was dispensed in limited amounts each time.

Contacts by phone were problematic. He was reviewed in person on 17th and 18th and on both occasions had been drinking.

HDC

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

On 20th [Month1] he was held in the police station after he had become intoxicated and was making threats to kill [another] and himself. He was seen the next morning when sober, more settled and no longer threatening suicide (presuming the Health Professional Record of Examination by TACT nurse [RN H] dated 20 [Month1] was actually 21 [Month1]).

He was reviewed later that day at home. He had again been drinking (6 beers by 2.30pm) and was dishevelled and unwashed. He described ongoing difficulties with the ex-partner, seeing demons and hearing critical and commanding voices. He was ruminating on committing suicide. He engaged with a plan to manage his wellbeing until seen the next day.

The majority of these symptoms had settled when seen the next day, when sober and at work. He acknowledged the links between his drinking and increased suicidal ideation: he did not wish to stop drinking, but did want to look at drinking in a safer fashion. Arrangements were made for him to be assessed for alcohol treatment on 28th [Month1]. This assessment diagnosed Alcohol Dependence and he was taken under the care of the Community Mental Health and Addiction Services and seen for weekly appointments. He presented in crisis on 20th [Month2] and was admitted to the psychiatric ward.

The management of [Mr A] was broadly acceptable in this period. He was seen quickly after crisis events, and then frequently thereafter. He responded well to these inputs. His suicidal and homicidal ideation and more florid psychiatric symptoms appeared to be present only when intoxicated, and he was engaged to specifically focus on his dangerous drinking.

It was a reasonable decision not to use the Mental Health Act in this light, given the overriding doctrine of least restrictive care. He was offered admission, but chose instead an outpatient management plan of sufficient intensity to provide close supervision of his wellbeing and access to care. Given that outpatient treatment would allow him to care for his [pets] and continue his employment, this option had considerable merit.

However, his presentations were complex, with a number of possibilities for Axis I diagnosis in addition to Alcohol Dependence, underlying Axis II personality disorder, recurrent suicidal and homicidal ideation, and idiosyncratic lifestyle choices and function. The clinical file suggests he was only seen once by a psychiatrist, [Dr Q], in the period from 7th [Month1] to 20th [Month2]. In my view, this was insufficient to be confident that he was in receipt of a full specialist care package, although would not represent a significant departure from the standard of care.

The appropriateness of [Mr A's] discharge on 22nd [Month2] and his discharge management plan;

On Friday 19th [Month2], [Mr A threatened to kill himself]. He was held in the police station initially and admitted voluntarily to the psychiatric ward in the early hours of 20th [Month2]. He had given up his employment, had no other income, and his car was no longer legally useable.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The ward notes recorded his continued suicidal ideation and ideas of harming [another] through until his discharge on 22nd. He was noted repeatedly to be angry, irritable and aggressive. He intended to drink alcohol despite being aware this made him more impulsive and contributed to his suicidal ideation. He had no income nor was there a clear sense of how he would imminently gain any, having no job and no intention to collect a benefit or liaise with WINZ. He had spoken of being lost, hopeless and worthless. He had secreted […] as a means to harm himself on the ward, which he later gave up. He changed his mind about whether to stay longer on the ward. He had no petrol to attend outpatient appointments.

[Dr C] saw him on 20th, 21st and 22nd. Dr C noted [Mr A] was 'not depressed', had 'no signs of depression', and that treatment under the Mental Health Act was not required. [Dr C] also noted the persistence of [Mr A's] suicidal ideation over years.

Discharge arrangements appeared limited to sending [Mr A] home on [22 Month2], with the expectation that his Alcohol and other Drug (AoD) nurse would visit him on her return from leave on [24th]. He was given emergency team numbers, and the police were informed of his ongoing threats to harm his ex-partner and of his discharge.

It is difficult to understand why [Dr C] was not more cautious in his assessment. Suicidal ideation, irritability, hopelessness, worthlessness, thoughts of self-harm, a lack of intention or planning to improve one's situation would all be suggestive of a depressed mood or Mental Disorder as defined by the Mental Health Act. The risks present were explicitly to harm himself, harm others and to fail to adequately look after himself — less than 72 hours before, [Mr A] had […], and he was still making threats to harm on discharge.

The decision for discharge was precipitous. [Mr A] could have been asked to remain for further assessment and treatment. If he did not agree to stay voluntarily, consideration of the use of the Mental Health Act was warranted: the clinical file suggests he would have met both limbs of the grounds for involuntary detention.

From time to time, it may be appropriate to look for early discharge in cases where a moderate to high risk of harm will not be altered by inpatient or outpatient status. However, it was not evident that this was the case with [Mr A's] difficulties, his ongoing expression of intentions to harm, and the limited community cover at the time. There was a lack of adequate diagnostic formulation and service planning to determine that he was a candidate for early discharge.

The decision to discharge [Mr A] on the third day of his admission was disproportionate to the risks present and in the absence of much of a strategy to ameliorate those risks.

The expected standard of care would include:

An adequate diagnostic formulation to account for the new changes in mental state, even in the context of persistent (or more likely recurrent) suicidal ideation;

A treatment plan based on ameliorating both the distressed state of mind and the dangerous effects of the alcohol dependence;

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Adequate liaison with the community and emergency teams to compare findings and collaborate on an agreed treatment pathway.

In [Mr A's] case, 2 extra days of inpatient stay could have been expected to achieve substantial improvement on all 3 points.

The decision to discharge [Mr A] on 22nd [Month2] with such a limited management plan was a departure from the expected standard of care. The departure from the standard of care was serious and I believe psychiatric peers would view it with concern.

The appropriateness of [Mr A's] management plan following his Crisis Team assessment on 23rd [Month2], including whether he should have been placed under the MHA

[Mr A] had been in contact with psychiatric services after hours on the day of discharge, 22nd [Month2], in a manner that was concerning. He was expressing his farewells to staff, that he would not be keeping future appointments and was headbutting a wall […]. He was taken to the police station in a heavily intoxicated state.

He was taken to the cells at 19.10 on [22 Month2]. He was noted by the police at 21:00 to be heavily intoxicated. At 01:00 on [23rd] he was noted by [RN G] to be sober. When assessed by [RN G], [Mr A] denied previous and current suicidal intent, and requested outpatient follow up. He was subsequently allowed home.

How reliable an acute psychiatric assessment would be 4 hours after heavy intoxication with alcohol, albeit probably at least 6 hours since the last drink, is open to question. However, it is concerning that he re-presented to acute psychiatric services expressing then denying suicidal ideation within less than 12 hours of being discharged.

Again, the decision not to reconsider the limited management plan, which might already have been seen to be running aground, was disproportionate to the risks present. A readmission to allow further thought and the return of a key community staff member could have improved [Mr A's] management at relatively little cost.

There was no record of [RN G] discussing his finding with the on call psychiatrist.

Had [Mr A] presented outside of the context of his recent admission and background risks, [RN G's] acceptance of [Mr A's] return home may have been reasonable. In actual circumstances, it may have been appropriate for [RN G] to approach this decision with more caution: discussion with the on-call psychiatrist or a lower risk approach (re-admission) would have been warranted. However, [RN G's] actions need to be seen in the context of an earlier decision by the inpatient team to discharge [Mr A] even in the face of his likely return to excessive alcohol consumption and ongoing suicidal ideation. In effect he was only then continuing on with the predictable consequences of decisions already made by a wider group of professionals, who had seen [Mr A] over a longer period.

In short then, while [RN G's] approach could have been more cautious, if there was a departure from the standard of care in choosing not to pursue readmission or use the

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Mental Health Act, the departure reflects the further consequences of the earlier departure from the standard of care.

The appropriateness of [Mr A's] management plan following his key worker visit on 25th [Month2], including whether he should have been placed under the MHA;

[Mr A] was not reviewed in person on 24th [Month2] as planned as he was not home. He responded with a text later in the day, with unhelpful personal comments about [RN E]. When seen on [25th], he appeared under the influence of alcohol or some intoxicant. He laughed and was not suicidal, although was disorientated in time. He told the nurse he had consumed all his discharge sedatives in the previous day (quetiapine and zopiclone, a sleeping tablet).

He was returned to his home after the nurse discussed her findings with [Dr C]. The next expected appointment was for 29th, with [Mr A] invited to make contact with emergency services 'if needed' in the meantime.

The circumstances of and motivations behind the overdose were not recorded. [RN E] texted [Mr A] in the early morning on [26th] and received largely meaningless texts in reply. In the afternoon, he replied with unhelpful personal comments. [Dr C] and [RN E] considered whether charges could be pressed for the personal comments and planned for him to be discharged on 30th [Month2] after involving WINZ on 29th [Month2].

No arrangements were made to see [Mr A] at a time when he might be able to account for the overdose in a non-intoxicated state. No record was made of any consideration of whether his more buoyant intoxicated state was potentially misrepresentative of his underlying mental state, or whether the overdose was an attempt to commit suicide.

In short, follow up since his discharge from the ward had met with limited success, excepting that he had remained alive. With the doubtful exception of a 1am assessment in the police cells on 23rd, no adequate assessment of sober mental state had been achieved.

Little practical change had been achieved in changing [Mr A's] use of alcohol or in changing his intoxicated, distressed presentations to emergency services.

It might have been possible to make more headway with this situation by using another brief admission, if necessary with alcohol detoxification, or at least enough time to allow the effects of the quetiapine and zopiclone overdose to pass. This could have been offered as a voluntary patient. Using the Mental Health Act to achieve this at this stage would have been potentially justifiable, but somewhat restrictive in the light of a buoyant mood, even if artificially so.

On the other hand, staff aiming for discharge in response to unhelpful texts of a personal nature, without examining other strategies (eg male case worker) and without making significant progress is questionable. Had he been discharged on such grounds, this would indicate a failure of duty of care.

The appropriateness of [Mr A's] discharge on 2nd [Month3] and his discharge management plan, including whether he should have been prescribed Quetiapine;

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

On [29 Month2] (and probably [28 Month2]), [Mr A] was intoxicated on a combination of alcohol and […]. He had threatened to [harm himself]. He accepted voluntary admission from the police station.

The admission was largely uneventful. His mood varied between low and cheerful, he used the laundry facilities, and he accepted sedation to manage his active thoughts. He was seen as not wanting to change his use of alcohol. Arrangements were made for him to resume outpatient contact with [RN E] with plans to see a psychiatrist in one month.

Vitamin preparations were provided, but no other medications.

The clinical notes of this admission demonstrate that he recovered from the obvious effects of alcohol and […], his mental state was observed and he was supported in various practical steps. However, with the exception of some time with [RN I], there was not a strong sense from the file that he was helped to make sense of his thoughts, choices or difficulties. As far as can be understood from the notes, there was limited input around his use of intoxicants, other than to proscribe them and emphasise the link to his escalating threats to harm himself or the ex-partner.

It could be argued that this work would not necessarily be completed in an inpatient environment. However, it would then be reasonable to expect that any discharge plan included strategies to respond to the likelihood of a return of difficulties as [Mr A] returned home. It was not clear that the discharge planning took any more account of this than previously.

The proposed appointment to see a psychiatrist in one month was distant, considering there was no change in treatment, and the previous month had included […] and acts of deliberate self-harm. A review by the psychiatrist within the first week of discharge would have been more realistic.

There was no indication that [Mr A's] personal comments to [RN E] had been addressed directly with him.

The lack of provision of quetiapine was moot. For [Mr A], the quetiapine was being used as a tranquilliser. It would be legitimate to be cautious about providing tranquillisation in an unsupervised context. He had already demonstrated a propensity to taking sedatives in a dangerous manner. Other strategies to achieve tranquillity had not been established though, and it could be expected that he turn to alcohol or […] abuse.

Overall then, the discharge planning was limited in scope, sophistication and detail. It was not possible to discern a confident therapeutic alliance, considered timings, individualised treatment planning or innovation in the discharge plan.

Regrettably this may not represent a departure from the expected standard of care, although represents a standard at the lower end of practice quality.

Whether [Mr A] should have been prescribed Quetiapine after requesting this on 6th [Month3];

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[Mr A's] progress following his discharge on 2nd [Month3] was better than following the recent previous discharge. He had been upset by a known trigger (his [pet's] wellbeing). By his account, without disagreement from his support person [Mrs B], instead of using alcohol, inhalants or taking an overdose, he had taken a sensible amount of quetiapine for tranquillisation with good effect.

[RN E's] response was to immediately cancel the provision of further quetiapine to reduce the risk of overdose. The intention was to discuss the possibility of future use in the MDT on [7 [Month3], whereon the decision was to be put to [Dr D]. No discussion with [Dr D] was recorded before [16 [Month3], and the topic of quetiapine not noted.

[Mr A's] taking of the quetiapine for appropriate tranquillisation could have been appraised as an encouraging break through in his care. He had chosen to use a substance with low potential for harm, for the same reasons as given in hospital, instead of his habitual use of more toxic and increasingly dangerous alcohol and inhalant misuse. He used the right substance, for the right reason, in what was probably the right amount, with the option for future amounts to be dispensed in measured quantities or supervised by his friend to minimise overdose risk.

Instead [RN E] acted zealously to ensure the medication was withheld until re-approved. Re-approval was then delayed. This state of affairs could be seen as the opposite to what should have happened in a compassionate and responsive service. In such a service, the further provision of quetiapine would have been actively considered at the earliest opportunity for the potential benefit [Mr A] had identified.

Again, this may not represent a departure from the expected standard of care, but appears to demonstrate a standard at the lowest end of practice quality.

The appropriateness of [Mr A's] discharge from MHAS on 22nd [Month3], including whether he should have been placed under the MHA;

[RN E's] progress notes from 6th [Month3] through to 16th [Month3] record [Mr A's] descent into increasing hopelessness and despair. With his request for discharge on 16th, it seems clear he no longer believed contact with the service would assist him. He was not able to discuss plans to commit suicide or other concerns because of the correct belief that the response was likely to be a police notification and arrest. This position taken by the staff was emphasised, as well as the perceived need only to attend when accompanied by police.

On 16th [Month3], [Mr A] was noted to be 'depressed in mood, expressing thoughts of hopelessness'. His affect was restricted. He had given up on attending appointments or engaging in suggested treatment avenues. He had stepped back from the support of his friends, and was intent on […] while expressing a desire to end his life.

There can be no doubt that he would have met the criteria for involuntary detention under the Mental Health Act. He was mentally disordered, at risk to himself through harm and neglect, and perceived to be a risk to others.

Instead of recognising this, SCDHB MHAS remained committed to the plan to discharging him from their care. This was wrong-headed in the extreme.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[Mr A] should not have been discharged from MHAS in this state of mind, either at his own request or as a result of the position taken by MHAS. If necessary he should have been placed under the MHA: this would have allowed immediate treatment as an inpatient, away from intoxicants and thereby more able to work on his coping strategies, grief and loss of personal function.

His discharge from MHAS was a substantial departure from the standard of care. A man in need was denied assistance as he became more distressed. Psychiatrist peers would look upon this with opprobrium, with expectations of accountability and a review of services to minimise the likelihood of recurrence.

The clinical record suggests good grounds to agree with complainants [Mr and Mrs B's] concern that '[Mr A] was … let down … by health professionals … It is for staff to uphold a Duty of Care'.

Any other comment on the care provided

Denial of Treatment
A meeting was held of various health professionals and [the Police] on 2nd [Month3]. The timing suggests this meeting ran from 1510 to 1520, which seems too short to cover the degree of considered planning warranted. The minutes indicate a focus on the ways [Mr A] would be obliged to behave to ensure he could receive care.

By 6th [Month3], [RN E's] notes suggest that this had translated into a plan to immediately cancel any appointment [Mr A] threatened to harm himself or others. In the Complex Case Conference on 16th [Month3], this was explicitly reiterated, adding that the police must be called, and [Mr A] discharged in response to threats to harm himself or others.

This represents a gross dereliction of duty of care on behalf of MHAS, where the expression of (psychiatric) illness leads directly to the denial of treatment.

The impression taken from the clinical record is that staff became fixated with disproportionately perceived threats to their safety, with the result that minimal actual care was provided to [Mr A].

Medical and other Discipline Involvement
The file shows relatively little direct involvement of psychiatrists. [Dr C], a locum psychiatrist saw [Mr A] repeatedly during the admissions. However, there was no sign of community psychiatry input; variable involvement of psychiatrists out of hours despite significant and minimally managed risks; and no formal second opinion for a man with a high risk and complex presentation incongruently heading for discharge.

There were psychiatrists involved in the case conference(s), reliant on a translation of findings by [Dr C] and [RN E] predominantly.

From the New Zealand Medical Council register, it appears [Dr C] has a condition on his/her registration that his/her general scope of practice is limited to hospital-based practice. It is not clear to me what effect this has on [Dr C's] practice of psychiatry, if

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

any, and whether this has implications for decisions made for patient discharge to the community, while the patient may still be at risk.

I am concerned about [Dr C's] assessment and decision-making during the admission of 20th to 22nd [Month2], as noted above.

I would compliment the on call psychiatric doctor who completed a good assessment on 29th [Month2] at 2am, although he/she did not add a name to the signature.

There was no involvement of a psychologist, either directly with [Mr A], or to view the group dynamics that left MHAS fixated on his perceived risk to staff at the expense of effective intervention. The impression is that [RN E] was particularly caught in an inflexible adherence to the expectations and police control of [Mr A's] behaviour over therapeutic intervention.

Documentation

The clinical file was difficult to follow. This may have been enhanced by the removal of dividers in the copy of the file provided to me. Nonetheless notes from the same day or consecutive days were inserted in disparate locations in the file, making progression difficult to discern.

Progress notes made by [RN H] on [...] (date obscured by a holepunch and year overwritten), and 20 [Month1] bear a striking resemblance despite being 2 years part. The notes for 20 [Month1] are crammed on to the page, as if to fit in a required space. Were these notes contemporaneous?

The personalised detail provided by [Mr and Mrs B] in their document of 20th [Month4] stands in contrast to the impersonal pared down assessments record on the file, an unhappy dehumanising effect.

Missed Areas of Care

Suicidal Ideation.

Much appeared to have been made of [Mr A's] persistent thoughts of suicide, which may have contributed to this expression of distress being afforded less importance.

However, there was no account for how this expression had moved to the forefront of his presentation when sober and especially when intoxicated. Similarly, he was recorded to have made 'pseudo-suicidal' acts repeatedly, but little attention paid to the long periods (including a decade between 2003 and 2013) where he presented to services minimally.

There was no exploration of how and why the suicidal thoughts had changed, whether from low risk existential reflections to more intense and imminent desires to end life. It was not clear whether the thoughts were truly persistent, or actually recurrent. He had only re-presented to services in [Month1], 3 months before his death, yet was being seen as someone who was chronically afflicted by suicidal ideation.

Other than linking the thoughts to substance and alcohol use, there was no other work done with [Mr A] on this area.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

If the suicidal ideation was seen as a manifestation of his personality function or maladaptive help seeking, why was this [not] more substantially addressed, through problem-solving, mentalisation or other distress tolerance work? Measured amounts of quetiapine for potentially overwhelming distress after hours could have been a useful strategy.

Alternatively, if this was seen as personality-based acting out, why was not more priority given to establishing a compassionate stable therapeutic alliance? Was solution-focused psychotherapy, interpersonal psychotherapy or even anger management considered? The clinical file does not indicate these or similar interventions were contemplated.

Addiction.
I do not accept that [Mr A's] sudden change in behaviour was a simple direct result of his alcohol dependence. His consumption was noted to vary according to his mood. Presumably, his alcohol dependence had been long-standing and broadly stable before presentation, demonstrating the likelihood that other factors were in play to be usefully addressed.

That having been said, little direct assistance was offered for the Alcohol Dependence. He was provided with diazepam cover as an inpatient and thiamine. There was no Motivational Interviewing, involvement of Alcohol[ics] Anonymous, consideration of Naltrexone or Disulfiram (for higher risk periods). These interventions should be actively considered even in someone initially unwilling to stop drinking, but looking to control their consumption.

In addition, there was little indication of Harm Reduction advice around drinking and inhalant use. The alcohol drug assessment was limited. Patterns and triggers were not covered in detail. The possibility of long-standing inhalant use was not explored, given his description of demons in walls when seen on 21st [Month1] and employment with […].

Residential care was proposed but untenable with [Mr A's] responsibility for his [pets]. There was no record of the option to [organise professional care for] his animals, or invite his friends' assistance to care for them. There was no consideration of the use of the Alcohol[ism] and Drug Addiction Act for involuntary addiction treatment, for what was essentially life-threatening alcohol and substance misuse.

Dual Diagnosis.
MHAS assessment of [Mr A's] mental state and his pattern of substance and alcohol use to effect artificial change was not addressed with any sophistication. The inpatient environment was not used to greater extent to undertake AoD work — instead, there was a sense of looking to move [Mr A] back home as soon as possible with each admission.

Clinical Governance.
I find [the Clinical Governance General Manager's and Mental Health Service Manager's] response to [HDC] dated 7th October disappointing.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The letter defends the practice of MHAS staff and systems, where an alternative approach would have been to respond to [Mr & Mrs B's] well articulated and considered concerns as opportunities to make substantial improvements to SCDHB services.

I hope this report is of assistance. Please do not hesitate to contact me to address further or unclear issues.

Assessor's Qualifications
Dr Jeremy McMinn is a registered medical practitioner with the New Zealand and United Kingdom Medical Councils, a Fellow of the Australian and New Zealand College of Psychiatrists, a Fellow and NZ Branch representative of the Australasian Chapter of Addiction Medicine (a Chapter of the Royal Australasian College of Physicians). He is a member of the Australasian Professional Society on Alcohol and other Drugs and Co-Chair of the National Association of Opioid Treatment Providers (NZ).

He is currently employed as a Consultant Psychiatrist Addiction Specialist by Lakes District Health Board and a Consultant Psychiatrist (General Adult) by Hutt Valley DHB. He worked for over 10 years in a similar role for Capital and Coast DHB and was a Clinical Senior Lecturer in Alcohol & Drug Disorders for the University of Otago (in Wellington) and a RANZCP registrar educational supervisor.

He is an independent Medical Advisor to the Veterinary Council of New Zealand. He also provides independent medical assessments for the medical, nursing, dental, midwifery, and pharmacy councils, Health and Disability Commission and legal profession within his specialist areas of general adult psychiatry and addiction through McMinn and Quiller Ltd. He has appeared for both the prosecution and the defence."

The following further expert advice was obtained from Dr McMinn:

"Thank you for requesting further expert advice on behalf of the Commissioner on the care provided to [Mr A] by psychiatrists at South Canterbury District Health Board (SCDHB) Mental Health Services between 7th [Month1] and 20th [Month4].

You have provided a letter of instruction, dated 17th [Month1], with the following enclosures, previously provided:

A copy of [Mr and Mrs B's] complaint dated […], including attachment;

A copy of SCDHB's response dated;

A copy of [Mr A's] clinical records from SCDHB dated [Month1] to [Month4];

A copy of [the medical centre's] letter to the Coroner dated, including enclosures.

You have also provided further relevant documents, including —

A copy of SCDHB's response dated, including enclosures;

A copy of [Dr D's] response received;

A copy of [Dr C's] response dated;

A copy of statements from nursing and social work staff ([RN H], [RN L], [RN M], [RN N], [RN O] [RN G], [RN F], [RN K], [RN I], [RN J], and [RN E]);

A copy of SCDHB's response dated; and

A copy of [Dr D] and [Dr C's] further response dated, including [Dr T's] report.

You have requested that I review the enclosed documentation and advise whether I consider the care provided to [Mr A] by psychiatrists at SCDHB was reasonable in the circumstances, and why. You have asked me specifically to comment on 4 points. These are reiterated on this report in bold italics as headings for each section for ease of reference.

This report was originally issued on 26th June 2016. This is a re-issue with proof reading corrections.

Was the care provided to [Mr A] by psychiatrists at SCDHB reasonable in the circumstances, and why:

There can be little doubt it would be challenging for any organization to provide care for [Mr A], given his use of alcohol and other substances, his states of mind, his dangerous behaviours and his lifestyle choices. His case was complex, falling across different areas of mental health and addiction services, and with police involvement. The non-conformity of his lifestyle choices added further intricacy to decisions relating to his autonomy and degree of treatment assertion.

In such cases of similar complexity, there are a number of overarching themes to be considered, and potential pitfalls to be guarded against.

Mental Disorder as defined in the Mental Health Act 1992 is a *legal* definition, not a medical definition. While diagnosis is undoubtedly useful, the diagnosis of specific conditions, for example Major Depression, is not required for the definition of Mental Disorder to be met. In this case, emphasis has been placed on whether or not [Mr A] suffered from a particular diagnosis, *ie* Major Depression, with those directly assessing him contending he did not have this diagnosis. In fact, the presence or otherwise of this diagnosis is not necessary to meet the Act's requirement for a disorder of mood.

Furthermore, the abnormal state of mind may have an intermittent nature. In this light, presentations of disordered mood (or other abnormal state of mind) ultimately diagnosed as an Adjustment Disorder, or due to Personality Disorder can and do meet the definition of Mental Disorder in the legal sense.

Complex cases, which not uncommonly are more treatment resistant, may require more resources in terms of expertise, collaboration and time. The multiple components in a complex case increases the likelihood that individual staff will feel uncertain about some aspects — the anxiety this uncertainty generates may lead to staff unthinkingly wishing to distance the patient from them (potentially leading to premature discharge from wards or services).

People who do not recover in response to 'treatment as usual' can be subjected to blame for their conditions. This can be enhanced where the person appears to make

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

choices that fall outside of the usual lifestyle choices. The feelings that can be engendered in staff as a result can be difficult to acknowledge or guard against, but may result in changes in the quality of care. This may be difficult to admit, resulting in maladaptive defensiveness and anger.

Psychiatrists and psychologists may be better placed than other staff to assimilate system conflicts and respond to expertise deficits. Accordingly, the involvement of these disciplines should be greater in complex cases. By dint of expertise and status, psychiatrists expect, and are expected, to play leadership roles within the functioning of the teams in which they work (whether or not they are the identified team leader). This expectation is reflected in the SCDHB Consultant Psychiatrist Position Description provided.

In considering whether the care provided to [Mr A] was reasonable, the information provided indicates he died during a period of dangerous substance use and following the expression of repeated symptoms of distress. He had very recently been discharged from the services charged with treating these conditions. These conditions appear to have been intertwined, as might be expected. Neither condition was clearly on a trajectory of sustained recovery. While both conditions had been present historically, it seems likely that both were substantially more florid leading up to and at the time of his death.

Both [Mr A] and staff from SCDHB sought his discharge. [Mr A's] requests for discharge followed expressions of hopelessness, intermittent suicidal ideation and depressed mood. He did not appear to believe SCDHB mental health and addiction services would be helpful to him.

Even exceptional care may not always be successful — [Mr A's] death is not an indicator in its own right of a failure of care. Reasonable care is that which seeks, by providing sufficient compassion, professional skill and service logistics, that a patient stands an enhanced likelihood of recovery from his or her suffering, accepting that not all patients will recover.

One way to define the scale of 'reasonableness' is to measure the care against the expectations of peers. To determine whether [Mr A's] care by the psychiatrists at SCDHB is to bring the expectations of psychiatrist peers to bear.

In my report of 14th December, I have noted a number of areas of care that may have fallen below the expected standard of care. These can be categorized, as follows:-

Was sufficient expertise used to account for [Mr A's] difficulties (Formulation and diagnosis)

Were the resources available used in ways that could be expected to help [Mr A]

My concern would be that [Mr A's] difficulties were framed in somewhat simplistic ways, resulting in a diminished likelihood of achieving care of sufficient expertise and provision. There were examples of this, albeit that some may reflect an incorrect understanding of the facts on my part. Examples include:

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

the premise that the Mental Health Act cannot be used outside of certain diagnoses;

limited consideration of anger or irritable insecurity as a reflection of depressed mood, despite other signs of mood disorder (continuous or intermittent) seeming to be present;

problems being categorised as either addiction or as mental health, without an effective assimilation of these into a Dual Diagnosis understanding (*eg* that substance use can escalate in periods of distress in someone with limited psychological resources);

shortfalls in planning how to respond to repeat presentations of what should have been the expected similar combinations of behaviours (substance use and distress);

limited strategies to minimise premature discharge;

taking a request for discharge in a man in a state of hopelessness at face value, without explicit consideration of whether his capacity to decide upon his own suitability for discharge was impaired by his state of mind;

limited planning around early psychiatrist review or re-consideration of proposed management approach given the extent of risks;

putting together a 'treatment' plan that constrained the expression of suicidal ideation;

a focus on patient behaviour prioritised above patient needs.

The psychiatrists of SCDHB would be expected to provide leadership in these areas. Individual parts of [Mr A's] care were reasonable, but assimilation into a sufficient package of care at the time of his discharge that could be termed reasonable was not achieved. In particular, the trajectory toward an inappropriate discharge was indicative of care that did not reach a reasonable threshold overall.

The psychiatrists, as well as other staff, could have put more in place to avoid this endpoint. As outlined below, both [Dr C] and [Dr D] provided care individually that was reasonable, or at least not unreasonable, in as far as it went, but this did not result in care that was reasonable at the time of [Mr A's] discharge.

In my opinion, reasonable care in this case would not have included discharge at a time of active and risk-laden symptoms; without the exploration of further ways to foster engagement, including considering a change in case manager and greater involvement of health and non-health service supports. A genuinely Strengths-Based approach was difficult to discern; adherence to SCDHB policy was incomplete; and the psychiatric involvement in the outpatient treatment of addiction likely to be insufficient. Renewed consideration of the use of compulsion, either under the Mental Health Act or the Alcoholism and Drug Addiction Act should have been recorded.

The departure from the standard of care was moderately significant. In my original report, I concluded: 'His discharge from MHS was a substantial departure from the standard of care. A man in need was denied assistance as he became more distressed. Psychiatrist peers would look upon this with opprobrium, with expectations of accountability and a review of services to minimise the likelihood of recurrence'.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In the light of the further information provided, and on reflecting that even exceptional care may not have necessarily changed the outcome for [Mr A] at this point in his life, I would modify this conclusion. Instead his discharge from MHS was a departure from the standard of care of moderate significance. A man in need was not provided with assistance as he became more distressed. Psychiatrist peers would look upon this with disappointment, with expectations of relevant service changes to minimise the likelihood of recurrence

Comments on the reasonableness of the care provided by [Dr C]
[Dr C's] letter dated 7th March to [HDC] provides significantly more helpful detail of his care of [Mr A] than I could ascertain from the clinical file. This detail is both compelling and reassuring. It is now more clear to me that on each contact with [Mr A], he sought to assimilate his direct findings with historical details and the observations of non-medical staff. He considered differential diagnoses in looking to how best account for [Mr A's] difficulties. He drew on observations of the duration of symptoms and signs of illness towards valid conclusions that the crises presentations had been substantially borne of [Mr A's] substance use.

[Dr C's] account also indicates his reflections on how best to provide care to [Mr A] in the context of his life choices. The importance of the care of his [pets] was incorporated into his management. Thought was given to the potentially deleterious effects of compelling him to remain on the ward, an important issue given the other elements of his anti-authoritarian stance. Instead of compulsion, [Mr A] was offered additional assistance, some of which he declined.

[Dr C's] role was limited to [Mr A's] care on the ward, and his involvement with services was in the context of a short term *locum tenens*. It seems to me, his responsibilities towards [Mr A] were fulfilled in these contexts. [Dr C] considered how best to prepare the ground for [Mr A's] care beyond these contexts, by his considerations on how best to foster, rather than deter, [Mr A's] effective relationship with ongoing services. Given the complexity of [Mr A's] presentations, further review by a psychiatrist, during his care otherwise provided primarily by an AOD service would have been expected: [Dr C's] invitation of [Dr D] to the 2nd [Month3] Complex Case Meeting was a sensible approach to consider this.

[Dr C] stated that his recollection of the plan arising from the 2nd [Month3] Professionals Meeting or Complex Case Meeting was to achieve 'constructive interaction between [Mr A] and the AOD service while appropriately managing any risks to staff presented by his behaviour'. Given the end of his tenure on […], [Dr C] may not have seen the minutes of the meeting until much later. He was not employed at the time of the revision of the Complex Case Management Plan on 16th [Month3]. It is in this revision that the plan focuses almost entirely on immediate responses to the perceived threats that [Mr A] posed, in the absence of further strategies to foster otherwise therapeutic engagement towards providing actual care.

Noting all the above, I consider [Dr C's] care of [Mr A] was reasonable.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In page 12 of my original report, I noted 'I am concerned about [Dr C's] assessment and decision-making during the admission of 20th to 22nd [Month2]'. I now understand [Dr C's] reasoning more clearly: I am not now concerned about this practice.

I would also thank [Dr C] for his explanation of the Medical Council's condition on his registration: I do not consider it has implications for decisions made for patient discharge.

Comments on the reasonableness of the care provided by [Dr D]

[Dr D's] involvement with [Mr A] took two forms: as the psychiatrist overseeing the AOD service. Her involvement in the former role began at the 2nd [Month3] Professionals Meeting or Complex Case Review. She was involved in discussion around the provision of Quetiapine, around the 7th [Month3]. She was then involved in the decisions leading to the 16th [Month3] revision of the Complex Case Conference Management Plan, ultimately leading to his discharge on 22nd [Month3] during the Multi-Disciplinary Team Meeting, at which [Dr D] was present.

[Dr D] noted the repeated psychiatric assessments that found [Mr A's] difficulties were primarily those of substance use compounded by the effects of Adjustment Disorders, arising in the context of his long-standing challenging personality function. These findings were consistent over time, and, with the additional information provided by [Dr C] on 7th March, I am happy to accept were likely to be accurate diagnostically.

In the lead up to 16th [Month3], [Mr A] had expressed active distress related to his [pet's] terminal illness, which included end-of-life considerations for [Mr A] also. He expressed negative, hopeless statements, and conflicting statements about 'doing much better' and that someone else had sent messages on his phone. He was told about the intention for him to be discharged when intoxicated and depressed in mood.

[Dr D] did not arrange for a further psychiatrist review of [Mr A] prior to service discharge. This was despite significant risks, complex presentations, interpersonal staff–patient dynamics, and 2 recent Complex Case Reviews.

Given the circumstances, [Mr A's] resumption of excessive and potentially dangerous substance use had been a predictable outcome. [Dr D] noted '[Mr A] was always at risk of suicide by intent or misadventure however in the absence of a major mental illness and with intact volition he was able to make choices about his treatment. He chose not to engage to address his substance use and unfortunately suffered a fatal outcome'.

I do not materially disagree with this statement. I also see that [Mr A] had declined earlier overtures for AOD treatment when not intoxicated, and that his commitment to outpatient follow-up appeared poor.

Notwithstanding these facts, there remained potential opportunities to alter his trajectory. The notes suggest his refusal of treatment was ambivalent, indicative of at least some capacity for engagement and more sustained motivational interviewing: this is a common starting point for addiction treatment. Given his multiple practical needs and difficulties in negotiating with others (especially with organisations, one presumes), it might be expected there remained a number of ongoing avenues to build a therapeutic alliance, in a similar fashion to those pursued as an inpatient (food parcels,

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

re-approaching benefit seeking, *etc*.). Consideration of other approaches to engage him could also have included a change of case worker, if it was apparent this relationship was not proving effective (as suggested by the clinical file). Furthermore, psychiatrists are well aware of the dangers of the loss of hope in their patients: in [Mr A's] case, it is open to question whether his hopelessness played some part in his capacity to validly assess the potential for recovery.

A further face-to-face review by a psychiatrist during this period of active symptoms/substance use and disengagement might have allowed for a re-thinking of the Complex Case Management Plan that increasingly had little detail except for the safety response. Active plans to enhance engagement, identify treatment strategies and minimise drug harms were not included.

In the SCDHB Community (including AOD) Mental Health and Addiction Services Discharge Process, the Client requesting to disengage from service against recommendation should see the consultant psychiatrist before leaving the service 'if appropriate' (Original document composed, authorised by [Dr D] November 2015).

[Dr D] could have arranged for this review and did not. The decision not to review, or lack of decision to review, was not unreasonable, given the findings *in toto*. However I do not think it was right that the decision was made to discharge this vulnerable and ambivalent patient, with a return of active symptoms/substance use and at an early stage of outpatient care, without review. I believe that many psychiatrists would have acted with more caution, even in the expectation that the outcome was unlikely to change…

A letter to the GP by the psychiatrist was not provided, except from the ward discharge.

Does any of the additional information lead to amendments of original advice or to further comments

From the various accounts, I am happy to accept the duration of the Case Complex Meeting on 2nd [Month3] was significantly longer than the recorded 10minutes.

In page 12 of my original report, I noted 'I am concerned about [Dr C's] assessment and decision-making during the admission of 20th to 22nd [Month2]'. I now understand [Dr C's] reasoning more clearly: I am not now concerned about this practice.

I would also thank [Dr C] for his explanation of the Medical Council's condition on his registration: I do not consider it has implications for decisions made for patient discharge.

[Dr D] disagreed with my impression that [Mr A's] appointment would be cancelled if he threatened to harm himself. [RN E's] file note of 6th [Month3] states 'We then explained crisis management plan … including immediate cancellation of apt if [Mr A] threatens harm to himself …". I am not clear how else to understand this file note.

The adequacy of the relevant policies and procedures in place at SCDHB at the time of the events complained of, including any further changes that you consider may be appropriate

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

There are a number of areas where SCDHB policies were either lacking or not followed. These are listed with headings.

Strength-Based or Recovery Focussed Approaches
The SCDHB position descriptions emphasise practice styles that seek to draw collaboratively on the patient's resources, citing 'Strengths based', 'wellness', 'overcome obstacles', 'hope-inducing behaviours', 'Strengths Model process using the Strengths Assessment'.

These practice styles are not easy to discern from the clinical documentation. There was no strength-based description of [Mr A]. I could find no clear treatment plan that detailed convincingly shared goal identification and focus as an outpatient approach. Documentation of anything resembling a Wellness Recovery Action Plan (WRAP) or similar was not evident. In contrast, his deficiencies were listed comprehensively.

[Mr A's] My Support (CRISIS) Plan of 11th [Month2] draws very little on any elements of personal resources. His non-professional supports ([Mr and Mrs B], possibly others) were not involved. Notably, the 'Warning signs for when I may become unwell/or start using' lists exactly the sort of behaviours that were present at the time of his discharge.

Only in the 'Comprehensive Assessment' of 28th [Month1] can I find a clear statement on Protective Factors, the gist of this limited to [Mr A's] care of his [pets].

I accept that the documentation may not completely reflect the practice of SCDHB staff. The assistance in the ward setting around the care of his [pets] and the food parcels indicate that personalised care was provided that did not translate into a formalised Treatment Plan document. However, the practice styles emphasised in the Position Descriptions could be more substantially echoed in the documentation at all levels — in progress notes, letters to GP, in the Complex Case reviews, etc.

In summary, I am not confident that SCDHB demonstrated the Strength-Based practice it emphasises in its rhetoric. This is an issue of good practice that warrants significant change management. Consideration could be given to this change management being substantially informed, even led, by Consumer representation. In addition, [Mr & Mrs B's] well-articulated and considered concerns could be taken as a springboard to initiate further improvements to SCDHB services.

Policies not followed
SCDHB Protocol: Co-existing Problems — Mental Health and Substance Abuse Disorder states

> 'where both [mental health or substance use/disorder] are moderate/high level severity or complexity, mental health services are to take primary responsibility for the care of these clients. More specialized A&OD interventions and ongoing reviews are coordinated by mental health services'

In [Mr A's] care, this approach does not appear to have been followed. His substance use was dangerous/severe, and his mental health difficulties of changeable mood,

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

suicidal ideation and personality issues were complex. However his outpatient care was held in the AOD service.

SCDHB Protocol: Failure of Client to Keep Appointment states

> 'If High/Medium Risk identified … complete an Incident Report as per Incident Reporting and Management Policy'

No Incident Reports are provided. An incident review might have provided another mechanism to reflect on approaches to better engage [Mr A].

Missing or Inadequate Policies & Procedures
The SCDHB Protocol: Management of Suicidal People has little useful information pertaining to the management of chronically or repeatedly suicidal people. Perhaps reflecting this, it is not clear how well [Mr A's] management plan fitted with this policy.

There was no policy on issues relating to Client Engagement, or Changing Case Worker. It could be expected that policy changes to elicit more Recovery perspectives would include these issues.

The direct and active involvement of psychiatry in the AOD service was not clear. Given that around 50% of people with moderate to severe Substance Use Disorders will have significant other mental illness, access to a high level of psychiatrist involvement should be facilitated. It seems unlikely to me that [Dr D's] involvement as described can approach the number of face-to-face assessments expected. Does the capacity exist for psychiatric appointments for 30–50% of AOD clients (not including the Opioid Treatment clients)?

The AOD policies seem limited to Brief Interventions. There is a wealth of further approach in addiction treatment, not included to significant degree in the policies, procedures and flowcharts provided. The employment of medical staff and/or senior non-medical staff (a psychologist or Clinical Nurse Specialist) with expertise in Addiction would be a useful step, if these staff are not already in place. If they are already in place, consideration should be given to their greater involvement.

I hope this report is of assistance. Please do not hesitate to contact me to address further or unclear issues.

Yours sincerely

Dr Jeremy McMinn MBBS FRANZCP FAChAM
Consultant Psychiatrist Addiction Specialist

Addendum to original report of 14th December 2015, ref C15HDC01279

From the various accounts, I am happy to accept the duration of the Case Complex Meeting on 2nd [Month3] was significantly longer than the recorded 10 minutes.

HDC

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

On page 12, final paragraph, of my original report, I noted 'I am concerned about [Dr C's] assessment and decision-making during the admission of 20th to 22nd [Month2]'. I now understand [Dr C's] reasoning more clearly: I am not now concerned about this practice.

I would also thank [Dr C] for his explanation of the Medical Council's condition on his registration: I do not consider it has implications for decisions made for patient discharge.

In my original report [Page 11, para 6], I concluded: 'His discharge from MHS was a substantial departure from the standard of care. A man in need was denied assistance as he became more distressed. Psychiatrist peers would look upon this with opprobrium, with expectations of accountability and a review of services to minimise the likelihood of recurrence.'

In the light of the further information provided, and on reflecting that even exceptional care may not have necessarily changed the outcome for [Mr A] at this point in his life, I would modify this conclusion. Instead his discharge from MHS was a departure from the standard of care of moderate significance. A man in need was not provided with assistance as he became more distressed. Psychiatrist peers would look upon this with disappointment, with expectations of relevant service changes to minimise the likelihood of recurrence."

The following further expert advice was obtained from Dr McMinn:

"Thank you for requesting further opportunity to comment and amend my original report if necessary on the care provided to [Mr A] by psychiatrists at South Canterbury District Health Board (SCDHB) Mental Health Services between 7th [Month1] and 20th [Month4].

You have previously provided copies of:

[Mr and Mrs B's] complaint dated […], including attachment;

SCDHB's response dated;

[Mr A's] clinical records from SCDHB dated [Month1] to [Month4];

[The medical centre's] letter to the Coroner dated, including enclosures;

SCDHB's response dated including enclosures;

[Dr D's] response received;

[Dr C's] response dated;

Statements from nursing and social work staff ([RN H], [RN L], [RN M], [RN N], [RN O] [RN G], [RN F], [RN K], [RN I], [RN J], and [RN E]);

SCDHB's response dated; and

[Dr D] and [Dr C's] further response dated, including [Dr T's] report

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

You have subsequently provided copies of:

A report for HDC re [Mr A], by [Dr D], dated;

A letter to [HDC] from [lawyer] on behalf of the New Zealand Nurses Organisation, dated;

The Further Response from [RN E], dated;

A letter to you from [Acting] Chief Executive Officer of SCDHB, dated;

A letter to [HDC] from [the] Chief Executive Officer, dated;

Associated Policies and Procedures, Issues 1–6, including SCDHB Staff Service Level Induction;

Patient Documents requested by HDC received 15th [Month3];

HDC Additional Items, dated 21st [Month3];

Items 2, 3, 4 of Transition to Wellness templates, undated;

Addiction and the Brain educational material, undated;

SCDHB Mental Health and Addictions Services (MHAS) *Substance Use Assessment and Treatment Package*, dated February 2016;

SCDHB MHAS Depression Assessment and Treatment Package, dated February 2016;

SCDHB MHAS Anxiety Assessment and Treatment Package, dated February 2016;

Matua Raki Substance Withdrawal Management — Guidelines for medical and nursing practitioners in primary health, specialist addiction, custodial and general hospital settings;

Ministry of Health Te Pou Let's get real — Real Skills for People Working in Mental Health & Addiction Quick Reference Guide

Your instruction is for me to review this additional documentation and advise whether it causes me to amend my previous advice or make further comments. If there is amendment you have asked me to reissue my report or provide an addendum.

In my 2 earlier reports to you, there are proof-reading errors for correction, specifically the transposition of the word *stay* for *staff* (1st report, page 6 paragraph 1, sentence 2); incorrect inclusion of *were* (1st report, page 12, paragraph 5, sentence 3) and a missing *not* (2nd report, page 4, paragraph 3, sentence 2) that was meant to read 'As outlined below, both [Dr C] and [Dr D] provided care individually that was reasonable, or at least not unreasonable, in as far as it went, but this did not result in care that was reasonable at the time of [Mr A's] discharge'.

Given these corrections, and my additional comments, I have attached final, amended reports 1 & 2.

Does the additional information lead me to amend my original advice?
It does not, but there are proof reading corrections.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Does the additional information lead me to make further comments?
Yes, on two matters, with headings below.

Reflective and Widely Referenced Practice
I would compliment the DHB for the use of Te Ariari o Te Oranga, ALAC & Te Pou resources.

SCDHB is a small DHB. It seems to me that it would be important to guard against the risk of limited reference points for identifying standards of care, and against the risk of Groupthink.

With this in mind, various strategies could be employed, based on preferentially fostering opportunities for different viewpoints to be heard and considered at multiple points in organisational function.

The responses from SCDHB note that [RN E] has now commenced supervision. This suggests that supervision is not part of expected, standard practice in SCDHB for all registered mental health staff. It is in other DHBs (large and small) at which I have worked. Should all registered mental health and addiction staff not be supervised?

Staff may benefit from being involved in processes outside of SCDHB. The 2 staff members on the [external] Group is a good example of this. Given the relative small critical mass of the DHB, should there be special provision for external supervision for at least some staff in each team?

In a similar vein, there will be opportunities to secure expertise from alternative sources. With the intention to review the Strengths-Based approaches and documentation, the validity of the review might be significantly increased if reviews are performed by Consumer Advisors. This could be further enhanced if the Advisors are supported by national consumer organisations (*eg* Aotearoa Alcohol and Other Drug Consumer Network: similar more Mental Health-specific organisations will also exist).

Taking this approach, and with [Mr and Mrs B's] original complaint in mind, the DHB may wish to consider what standing roles an active Carer and Family committee play in maintaining good clinical practice, training and service development.

In the case of [Mr A], it may be useful to consider whether the same decisions for discharge would have been made if there were Consumer and Carer advice brought directly into his Complex Case Reviews (as is sometimes the case in other DHBs).

Independent Review of Services for Co-existing Problems (CEP)
I note and support the intention to review SCDHB's services for co-existing problems. To my mind, this review is likely to achieve more if conducted by reviewers able to draw from combined clinical, managerial and consumer expertise. I am aware that all Opioid Treatment Services are subject to audit and review periodically by a Ministry of Health appointed team of such combined composition. It seems likely that a team focussed on CEP services could be found or commissioned.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

I hope this report is of assistance. Please do not hesitate to contact me to address further or unclear issues.

Yours sincerely

Dr Jeremy McMinn MBBS FRANZCP FAChAM
Consultant Psychiatrist & Addiction Specialist"

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix B: Independent mental health nursing advice to the Commissioner

The following expert advice was obtained from mental health nurse Carole Schneebeli:

"I have been asked to provide expert advice to the Mental Health Commissioner concerning the above complaint. The Mental Health Commissioner has sought my opinion on the care provided to [Mr A] by the Mental Health Nurses at South Canterbury Health board during the period of [Month1] to [Month3].

I have read and agree to follow the Guidelines for Independent Advisors.

My qualifications include: My current role is Nurse Leader for Auckland Regional Forensics since January 2016. Prior to this I was from 2012 the Clinical Nurse Advisor for Regional Forensics, and CADS (AOD Services). I have an ongoing role in the coordination and oversight of the Regional DAO training in Northland. I completed my Masters in Philosophy in 2013 from AUT. Prior to this I completed my Post graduate diploma in Health Sciences — Auckland University.

Other areas of education and expertise include: Professional supervision, Quality Health Surveyor, Portfolio assessor, WDHB Coach, was previously in a role as the Undergraduate Coordinator of Mental health papers at Auckland University School of Nursing.

My current role is one of nursing leadership in regional forensics with key accountabilities in: pathways for nurses, quality improvement, strategic planning, service user safety, and service interface (primary health, district mental health and NGOs). Last year, I was involved in the credentialing of practice nurses around mental health and addictions care, in the wider Auckland area.

Referral instructions:
The Mental Health Commissioner has outlined the following areas they wish to seek my opinion on:

[Mr A's] assessment by [RN G] on 23 [Month2] and the appropriateness of the management plan following this assessment;

[Mr A's] assessment by [RN E] during her visit on 25 [Month2] and the appropriateness of the management plan following this visit;

The appropriateness of the actions taken by [RN E] in response to [Mr A's] inappropriate text messages of 24 and 26 [Month2];

The adequacy of the care provided to [Mr A] by nursing staff during his admission to APU between 29 [Month2] and 2 [Month3];

[Mr A's] assessment during [RN E's] visit on 6 [Month3] and the appropriateness of the actions she took following this visit;

The adequacy of the relevant policies and procedures in place at South Canterbury District Health Board at the time of the events complained of, including any further changes that you consider may be appropriate.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The information reviewed in order to give an opinion was:

Copy of [Mr and Mrs B's] complaint dated […], including attachment;

Copy of South Canterbury District Health Board's response;

Copy of [Mr A's] clinical records from South Canterbury District Health Board dated [Month1] to [Month4];

Copy of South Canterbury District Health Board's letter to the Coroner

Copy of [the medical centre's] letter to the Coroner

Copy of South Canterbury District Health Board's response, including enclosures;

Copy of [Dr D's] response;

Copy of [Dr C's] response;

Copy of statements from nursing and social work staff ([RN H], [RN L], [RN M], [RN N], [RN O], [RN G], [RN F], [RN K], [RN I], [RN J] and [RN E]);

Copy of South Canterbury District Health Board's response;

Copy of [Dr D] and [Dr C's] further response, including [Dr T's] report; and

HDC's Guidelines for Independent Advisors.

Summary of events collated from documents supplied for review:
[Mr A, was a man in his forties,] reported to be well known to the mental health services. He had a diagnosis of Adjustment disorder, Alcohol Dependence, and Antisocial Personality Disorder. He had a history of suicide attempts associated to his poor protective personal and social supports. He was reported to have poor coping strategies, and explosive angry outbursts. These poor protective factors were often exacerbated by alcohol abuse and dependency. He was reported to live in squalid conditions of […] with no electricity or heating. His main protective factors were his animals and his sense of responsibility to them.

[Mr A] has a documented […] history […] as well as a health history of suicidal behaviours and multiple Para suicide attempts whilst under the influence of alcohol and other substances. It was documented on several occasions that [Mr A] would disclose suicidal behaviours of concern to the health professionals then retract the statement. It was also noted by psychiatrists and key workers he was poorly engaged with health services and had significant issues with trusting services.

[Mr A] was admitted to the public hospital on the 7th of [Month1] following a serious self-harm attempt whilst highly intoxicated. […]. This recent self-harm attempt was in context of [various stressors]. He was assessed on the 8th of [Month1] by the psychiatrist, who reported that at this time there was no specific treatable neuropsychiatric pathology. [Mr A] declined a voluntary admission to the psychiatric inpatient setting and was then medically cleared and discharged home. He was discharged and followed up by the crisis team. After several visits from the crisis team he was then referred to the Alcohol and Drug Services (ADS).

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

On the 19th of [Month2], [Mr A] called the Mental Health and Addiction services (MHAS) stating 'it was over'. The police were called and he was taken to the police station and assessed by the crisis team. He disclosed suicidal ideation and was hence admitted voluntarily to the Adult Inpatient Unit (APU) and prescribed quetiapine to help him sleep and reduce his agitation. [Mr A] was then discharged home on the 22nd of [Month2], rated as at moderate to high risk of further self-harm. His care was to be followed up by the ADS team. The same evening of his discharge he contacted the APU and stated 'goodbye'. Subsequently, the police were contacted and he was taken to the police station, assessed by the Crisis Team [RN G], where he was noted to deny suicidal ideation. He returned home and was followed up by ADS.

On the 25th of [Month2], [Mr A] was reported to have told his ADS key worker [RN E], that he had overdosed on quetiapine and zopiclone, then retracted his statement. The ADS MDT plan was to continue follow up. [Mr A] was admitted to the APU on the 29th of [Month2], after making suicidal threats, associated to both distress and possible psychotic phenomena. Whilst in APU there was a complex case conference held on the 2nd of [Month3] that resulted in the development of a management plan that was distributed to services involved in his care. Prior to discharge on the 2nd of [Month3] [RN E] met [Mrs B] and became aware of her and her husband's role as supports for [Mr A]. He was then discharged home with support from ADS. He was prescribed multivitamins and thiamine but not quetiapine, as there were reported concerns he may attempt self-harm with this medication.

On the 6th of [Month3] [Mr A] requested another script for quetiapine to help him settle. The request was discussed with the Psychiatrist and was declined. On the 6th of [Month3], in accordance to his wishes, [Mr A] was discharged from MHAS. [In [Month4] he died.

Comments associated to the care given:

[Mr A's] assessment by [RN G] on the 23rd of [Month2] and the appropriateness of the management plan following this.

As crisis nurse on duty, [RN G] assessed [Mr A] around 0100am on the 23rd of [Month2]. His assessment included a review of the APS discharge summary and triage form. He then completed a 1:1 face contact. He discussed his findings with his RN colleague and determined that:

There were no new features to [Mr A's] presentation.

[Mr A] denied any further suicidal ideation.

[Mr A] appeared to be sober.

[Mr A] had agreed to be followed up by AOD services in the am (7 hours from this assessment) and hence appeared to be engaged with services.

The question of using the mental health act, in my opinion does seem redundant on the basis that [Mr A] was denying further suicidal ideation, appeared sober and of capacity to agree to follow up, indicating a willingness to be engaged with the services. In this instance, the least restrictive approach seemed warranted.

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

I do think that the actions of [RN G] to have only mildly departed from accepted standard of practice. My reasoning around this is due to the growing history of suicidal behaviours and significant risk factors for accidental suicide i.e. poor coping strategies and use of alcohol and other substances, and his recent discharge from hospital, did require a greater further consultation with the on-call psychiatrist. This may have not altered the decision to discharge home and have follow up by AOD services. Rather it is posed as a reasonable and safe approach to include all levels of consultation.

[Mr A's] assessment by [RN E] during her visit on the 25th of [Month2] and the appropriateness of the management plan following his visit.
[Mr A] was driven by community support worker to an AOD appointment at 1430. [RN E] noted that when he arrived he appeared to be under the influence of alcohol. She comments that it is standard to terminate an interview if they attend intoxicated. In the policy documents supplied, I could not find any reference to termination of interview if presenting intoxicated. Documents reviewed include:

Community CAPA Mental Health Services;
referral process
choice appointment process
partnership process
discharge process

[RN E] did not terminate the interview due to his disclosure of a suspected overdose of quetiapine and zopiclone. [RN E] requested he remain and be further assessed. [RN E] called for a consultant review by [Dr C]. Her note indicates she discussed her plans around him being transported home by 2 staff.

The accounts in [RN E's] statement indicates the decision to have [Mr A] transported home was that of [Dr C]. However, the progress notes indicate [Dr C] was consulted around [RN E's] assessment and was 'happy for [Mr A] to be taken home'. Documentation is unclear and there is no documented account of [Dr C's] assessment. Furthermore, the risk formulation in the progress note (25 [Month2]) indicated he is of a high (ticked box) chronic risk of impulsivity due to recent psychosocial stressors, alcohol intoxication and limited protective factors. In my impression, he had a period of three days to wait for further follow up. I believe, based on the risk formulation and increased social stressors noted in the progress notes, [Mr A] should have been formally seen by the consultant, the decisions made to be taken home should have been documented in support of [RN E's] notes. [Mr A] should have had follow up with the Crisis team.

I do not think that [RN E's] decision to have increased the escort to 2 people in the community, was outside of standard practice. I do however consider the rationale could have been presented more clearly in the clinical notes.

Appropriateness of actions taken by [RN E] in response to [Mr A's] inappropriate text messages of the 24th and 26th of [Month2].
[RN E] on 25th of [Month2], saw [Mr A] at an appointment and this was the first instance of [RN E] address[ing] the inappropriateness of the text message (24 [Month2] — 3.01 pm), with him. The progress notes indicate he initially apologised but quickly

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

resorted to defensiveness and blame. According to the progress notes, he then attempted to engage [RN E] in holding a secret of risk behaviours. [RN E] addressed this situation effectively by outlining her professional responsibility, to inform her team. This sits within safe practice around disclosure of risk.

I believe that [RN E] did need to address the texts with [Mr A] as a process of re-establishing an effective therapeutic and professional relationship with clear expectations and boundaries. However, from the progress notes it appears she interviewed him alone. I believe she should have had another person present when she addressed boundaries with him.

The documented history of [……] and his current intoxicated state, which could have increased his impulsivity and likelihood of acting out in the face of boundary setting. The situation heralds a need for a support person other than [RN E], to offer him support and to allow him to feel respected in the face of a challenging conversation (Right 1, 3, 8 of the code of health and disability services consumers' rights).

The need to protect [Mr A] from further misunderstandings by being alone with him (right 5, 6 — of the code of health and disability services consumers' rights).
On the 26th of [Month2] [Mr A] sent another text to [RN E] of a similar nature as the text on the 24th of [Month2]. [RN E] discussed both text messages with [Dr C]. According to [RN E's] statement this resulted in 2 staff members transporting him home. The response to the text messages was to increase the number of staff to be present when he was visited. I believe this was an appropriate response considering the increasing risk of his misinterpreting or misunderstanding the nature of professional boundaries and therapeutic engagement by female staff.

[RN E] in her statement, she reported that having gained advice from [Dr C], she contacted the police about [Mr A's] text messages and was advised by [a Police officer] it wasn't a criminal offence and suggested discharge from the service.

I am aware that [RN E] informed her manager of the inappropriate text messages, as addressed in her further response statement. Additionally, receiving further information from NZ NO 12th August, it does indicate that [RN E] had only been with the DHB for five months and was new to community nursing. In light of both points raised, I do agree that greater support of [RN E] in regards to the complexity of this case and the risks should have been given to her by the team and manager. [RN E] did mitigate some of the risk by increasing the number of staff visiting, as outlined in the DHB policy.

I could not however, find any policies that supported or guided staff in how to address gender/sexual safety.

As such, there was a mild departure from the accepted standard of care, in reporting this as an incident and in regards to the level of support given to [RN E] as a new DHB team member dealing with a very complex case.

The adequacy of the care provided to [Mr A] by nursing staff during his admission to APU between 29 [Month2] and 2 [Month3]

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[Mr A] was admitted informally to APU on the 29th of [Month2] at 0200am, after he threatening suicide whilst intoxicated. He was brought in by the police and the crisis team.

On admission he was initially placed on level 3 observations — being viewed every 5–15 minutes then reduced on the same day to level 4 — which is every 30 minutes. He was placed on a 4 hourly withdrawal scale. He was formally assessed by [Dr C], on the 30 [Month2], who indicated the plan was to discharge [Mr A] by 1 [Month3] and inpatient staff were to work with him towards possibility of rehabilitation.

During the weekend it was noted by staff that he did not present with obvious symptoms of withdrawal. It was reported in [RN L's] statement, that he had been prescribed prn (as required) quetiapine which was supporting him to sleep. The care plan reported he was not permitted to have leaves from the hospital. However, [Mr A] was supported to go home and care for his animals and [RN E] followed up with animal control to ensure any issues associated to [Mr A's] [pets] were addressed. He was supported to discuss his ongoing sense of despair around his escalating social issues during his stay in the inpatient. [Mr A] was reported to be appreciative of the support given by staff around the care of his [pets]. He had identified [Mr and Mrs B] as his main contact and gave consent to staff to talk to them.

[RN L] on the 2nd of [Month3] reported his HoNOS was at 14. I note that this had reduced from 32 on admission. I could not find the correlating HoNOS in the documentation provided, but could conclude it was at a similar rating as his community HoNOSs had been. He was discharged from inpatient in afternoon of the 2nd of [Month3].

I believe the care provided by the APU staff, in the hospital was within acceptable standards. The APU documentation was of an adequate standard.

However, I believe the crisis plan was not of an acceptable standard in preparation for his discharge. It was a moderate departure from acceptable standard. The last dated crisis plan I could locate was the 11 [Month2]. There appears to be little development on the supports needed for his ongoing care in the community. This is concerning, considering he had many ongoing stressors and his risk assessment was sitting on moderate to high for self-harm behaviours (taken from [Dr C's] discharge summary). The plan of action relies heavily on access to secondary health services and the police. [Mr and Mrs B] who were identified as a contact support were not included in this plan.

[Mr A's] assessment during [RN E's] visit on 6 [Month3] and the appropriateness of the actions she took following this visit.
[RN E] arranged an appointment that was attended by [Mr A], [Mrs B] and later in the appointment [the Police], on 6 [Month3] at 1300. The management plan was addressed in this meeting. The use of quetiapine was also addressed in this meeting.

[Mrs B] was reported to offer her support in following up with [Mr A].

It is my belief that the appointment with an identified support person was warranted to address the ongoing care requirements for [Mr A]. Yet, the report by [RN E] doesn't

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

indicate what [Mr A's] responses were. The documentation indicates that at the appointment he denied suicidal ideation, however his potential risk to himself and others remained.

During this appointment [Mr A] discussed his use of quetiapine. [RN E] responded by letting [Mr A] know that his further scripts of quetiapine would be cancelled at the pharmacy. On 7 [Month3], the request by [Mr A] for quetiapine prescription was addressed at the MDT. The decision was made to follow the management plan from 2 [Month3].

[RN E] had ongoing phone/voicemail and text contact with [Mr A], from 9 [Month3], 13 [Month3] and 16 [Month3]. Whereby, he continued to escalate in his distress associated to the ill health of his [pet]. On 16 [Month3], [Mr A] had expressed his distress and threat of suicide, denied alcohol intake but was not noted to be reliable and was considering discharging himself from the AOD services. [RN E] continued to remind him of the management plan and goals to be attained to get a green card. [RN E] arranged a visit to see [Mr A], to assess his mental state, with police support, due to the risk of his drinking. [RN E] documents many of the contacts over the day prior to her visit to [Mr A], that included Mr B, [Mr A], [Dr D], and [the Police]. From [RN E's] notes it appears that [Mr A] was visited and the management plan outlined again around his need to engage with the service and address his alcohol dependency issues. [Mr A] refused to engage or address his current alcohol dependency issues. The plan was to discharge from AOD services.

It is my impression that [RN E] did follow the process around risk assessment and safety in the community by appropriately arranging a visit to see and assess on 16 [Month3]. I also believe that due to the risk associated to his increased alcohol use and potential violence as well as his misunderstanding of boundaries, police support was warranted. However, I do have some significant concerns around the management plan and its implementation.

There is no documented evidence that the management plan was developed in collaboration with [Mr A]. The management plan reads as punitive, with emphasis on him engaging with the services and taking greater responsibility for his alcohol dependency. Additionally, the management plan indicates he must attend appointments to address his AOD issues.

The ongoing documentation by [RN E] from the 6th to the 16th in his progress notes, does appear to reflect a less considerate approach to his limited protective factors, than prior documentation. I am aware that written documentation doesn't always account for the 1:1 face contact or phone conversations that may have demonstrated this compassion.

My assessment of his presentation from the documentation supplied, was that he was at pre contemplation (on the wheel of change) — that being he is in denial of the harm his AOD has on his health and as such is not able to take on the advice or support offered from the DHB, Police or [Mr and Mrs B]. This became increasingly problematic as he also had limited protective factors. It is my belief that his limited protective factors and state of pre-contemplation placed him at a higher risk of engaging in suicidal

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

behaviours. His current management and crisis plan were very restrictive for him in respect to getting support for the escalating stressors.

I do believe that he was very challenging for the service. He had consistently denied his willingness to address his dependency issues. He had frequent presentations of ongoing suicidal and challenging behaviours involving many services and many resources i.e. the crisis team, police, AOD worker. I believe in the light of his reoccurring admissions and presentations to the police and crisis team that a complex case review would have benefited. This complex case review could have included clinicians, professional leads, and management to mitigate the risk that [Mr A] posed to the services he accessed.

In summary, I do believe that the management and crisis plan presented as a moderate departure from acceptable practice. There is no evidence of collaboration or involvement in the management plan and the crisis plan had not been adequately updated to reflect changes such as [Mr and Mrs B] as a social support. Additionally, the management plan had a punitive stance and implementation only further reduced his ability to access supports when distressed.

The adequacy of the relevant policies and procedures in place at South Canterbury District Health Board at the time of the events complained of, including any further changes that you consider may be appropriate.
From my process of review I have collated some areas that I believe could improve the support of staff when caring for someone like [Mr A] who was complex and utilised a multitude of resources/services.

The policies reviewed address the admission and discharge pathways and levels of engagement using the Choice and partnership model. I could not see in these policies a pathway for discharging a service user from the service if they are not engaged. Nor could I find a termination of appointments if intoxicated. If this is indeed a process this needs to be addressed in the policy and also in the information pamphlet for all service users and their family/whānau to be fully informed.

Challenges around gender/sexual safety need to be addressed in policy and procedure to protect staff and service users around acceptable boundaries.

The risk of staff becoming burnt out or professionally challenged associated to complex cases could be mitigated through the use of effective professional supervision. The formal process of supervision includes contracted goals [and] agreed protected time to retrospectively reflect on service user care, personal impact of care and debriefing.

Incident reporting — I did not see any evidence of an incident report and was not aware of the processes or expectations of the DHB around when to report and what constitutes an incident.

This report is completed by Carole Schneebeli — Nurse Lead for Auckland Regional Psychiatric Forensics Services."

Names have been removed (except SCDHB and the experts who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.