District Health Board

A Report by the
Mental Health Commissioner

(18HDC00903)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the mental health services provided to a teenager by the youth mental health service (the Service) at a district health board (the DHB) in 2016.

2. The young man had a history of mental health issues, including suicidal ideation. The Police found him in a situation where he appeared to be at risk of self-harming. They took him to the public hospital, where he was admitted under Section 11 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

3. The following day, a child and adolescent psychiatrist assessed the man. The man told the psychiatrist that he was not willing to take medication but was willing to receive other help from the Service.

4. The next day, the psychiatrist discharged the man from hospital without medication, and with the plan that he would have a follow-up appointment with a Service nurse. The psychiatrist told HDC that she briefly discussed this discharge with the man's mother; contrary to this, the man's mother stated that the psychiatrist did not directly give her any information about the discharge or follow-up care.

5. Over the next two months, the man met with a Service nurse several times to discuss his mental health; the man decided that he no longer wanted support from the Service, so the meetings with the Service nurse were discontinued. At no point was the man's case discussed at a multidisciplinary team review.

6. Tragically, the man died by suspected suicide in 2017.

Findings

7. The Mental Health Commissioner was critical that the man did not have a further psychiatric review after his discharge from hospital, and that there was no multidisciplinary team involvement in his care. The Mental Health Commissioner was also critical of the DHB for not involving the man's mother more closely in his care. The Mental Health Commissioner found the DHB in breach of Right 4(1) of the Code.

Recommendations

8. The Mental Health Commissioner recommended that the DHB arrange training for the Service's staff on communication with patients and their families, and on clinical assessment (particularly risk assessment); review all patients seen and discharged by the Service during a one-month period to assess whether risk assessments have been assigned appropriately and multidisciplinary meetings have been undertaken; and apologise to the family.

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Complaint and investigation

9. The Commissioner received a complaint from Ms B about the care provided to her son, Mr A (dec), by the district health board. The following issue was identified for investigation:

- *Whether the DHB provided Mr A with an appropriate standard of care between Month1[1] and Month4 (inclusive) 2016.*

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

11. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's mother
DHB	Provider
Dr C	Provider/psychiatrist
Dr D	Provider/general practitioner (GP)
RN E	Provider/registered nurse (RN)

12. Also mentioned in this report:

RN F	Registered nurse

13. Further information was received from the Coroner.

14. Independent expert advice was obtained from a psychiatrist, Dr Tonya Dudson (Appendix A).

Information gathered during investigation

Introduction

15. This report relates to the care provided to teenager Mr A by the DHB's youth mental health service (the Service) between Month1 and Month4.

16. Mr A's mother, Ms B, considers that the family were not involved in Mr A's care sufficiently or supported adequately, and that the psychiatrist who cared for Mr A, Dr C, failed to share her conclusions, diagnosis, and treatment plan regarding Mr A. Ms B told HDC that she was not provided with a copy of Mr A's discharge letter, and the Service failed to inform her of how best to support Mr A. She said that Mr A was taken off his antidepressants without explanation and was discharged from the Service after three months, without a proper assessment.

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

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17. Ms B also said that neither Dr C nor her nurse completed a whānau/family-based assessment or took any medical/mental history from Ms B, and that Dr C did not assess Mr A's relationship issues with his girlfriend appropriately.

18. Tragically, Mr A died by suspected suicide in 2017.

Background

19. Mr A lived at home with his mother and a sibling. The clinical records note that he had a good relationship with them.

20. Mr A appears to have been at intermittent risk of suicide from 2015.

21. In 2016 Mr A was referred to the Service because of changes in his behaviour. He was assessed by an intake worker, RN F, in the presence of his mother and another nurse. The screening assessment conducted by RN F notes that Mr A's baseline mood was 5/10 and he voiced no concerns about risk to himself. The assessment states: "[Mr A] is not impaired across any domains, thus plan is to discharge from the Service."

22. RN F reported to GP Dr D that Mr A had been discussed at the multidisciplinary team (MDT) meeting and the team agreed that he was not presenting with symptoms of a moderate to severe mental health disorder at that time.

23. Previously Mr A had been treated with venlafaxine[2] 37.5mg daily, prescribed by Dr D for depression, but Mr A told RN F that he stopped taking the medication because it made him feel like a "zombie".

24. At the beginning of 2016, Mr A changed schools because he wished to engage in a particular sport. He returned to his first school shortly before his admission to the public hospital in Month1. Two of Mr A's peer group had recently committed suicide, although he did not know them well.

Admission Month1

25. On 28 Month1, the Police contacted the DHB's mental health emergency team because Mr A had been threatening in text messages to self-harm. The Police located him. When asked by the Police about his intentions, Mr A could not guarantee his safety that night.

26. Prior to going to sport, Mr A had dropped some favourite items at his ex-girlfriend's residence. Ms B told the Police that Mr A's relationship with the ex-girlfriend had been "on and off".

27. The Police took Mr A to the public hospital. He was admitted to an adult inpatient ward under Section 11 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA), and initially he was reviewed by the on-call psychiatrist.

[2] Venlafaxine is a selective serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressant used to treat major depressive disorder, anxiety, and panic disorder.

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28. The admission note completed by the psychiatrist relates Mr A's history and states that during the interview Mr A presented as being awkward and uncomfortable with the situation, and that he did not appreciate that his actions would lead to an assessment under the MHA. His attitude was that he did not care, was unhappy, and did not see a reason to live.

29. Mr A was admitted under level three observations (to be within sight 1:1), with no leave to be allowed.

30. On 28 Month1, Mr A signed a "Consent to Liaise" form in which he authorised his information to be shared with his mother.

31. At 11.30am on 29 Month1, Mr A's case manager, RN E,[3] reviewed Mr A. She noted that he was easily engaged in conversation and showed good levels of eye contact. Mr A reported that his mood had fluctuated over the previous few months depending on his relationship with his girlfriend, who had been the trigger for the events that had occurred the previous day.

32. Mr A was then reviewed by a child and adolescent psychiatrist, Dr C.[4] Dr C told HDC that prior to the assessment she had had a telephone conversation with the psychiatrist. She said that her assessment of Mr A was performed without Ms B being present because Ms B was not in the ward at that time. Dr C stated: "In line with my regular clinical practice, if she had been present I would have included her for at least part of the assessment."

33. In response to the provisional report, Ms B told HDC that she had been in Mr A's room when Dr C arrived, that Dr C asked her to leave the room, and that when she returned to the room Dr C had already left.

34. Dr C told HDC that Mr A complained about the side effects of his medication, as it affected his sleep. She said that he told her that he was not taking the medication and was not willing to take it. Dr C noted in the progress notes that Mr A was willing to see RN E for assistance with coping strategies. Dr C recorded that Mr A's mother was to take him out to have dinner at home that evening.

35. Dr C recorded that she was to meet with Ms B the following day at 8.40am prior to Mr A's discharge. In response to the provisional report, Ms B told HDC that this time was not communicated to her.

36. The DHB said that a thorough and detailed assessment of Mr A was completed on admission to the inpatient mental health unit on 28 Month1, and the assessment included Mr A's past mental health history. The DHB stated that the nursing staff performed ongoing mental state assessments based on their observations and, in addition, RN E and Dr C performed their own mental health assessments.

[3] At the time of these events, RN E was working as a nurse specialist at the Service.
[4] At that time, Dr C worked 0.6 FTE, and the service was able to contact her outside her working hours for urgent advice.

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37. On 30 Month1, Dr C noted in the progress notes: "Assessment in ward with mother." Dr C told HDC that she assessed Mr A, then spoke to Ms B alone outside Mr A's room. Dr C recorded that Ms B told her that the home leave had gone well.

38. Dr C stated that a discharge meeting was scheduled to take place with Mr A and his mother on 30 Month1 at 8.40am. She said that Ms B arrived late, so as she (Dr C) was exiting the room she discussed with Ms B that Mr A was guaranteeing his safety, and wanted to return to school. Dr C said that Mr A was aware that he would be able to contact Ms B or his sibling, or contact the mental health emergency team as per the existing safety plan that he followed prior to admission. Dr C stated that Ms B did not object to the plan. In response to the provisional report, Ms B told HDC that she does not recall this meeting.

39. Dr C stated: "I had clinical work scheduled as from 9 am after the discharge meeting for the rest of the day and could not stay longer to meet with his mother as well after the discharge meeting." Dr C said that she left the scheduling of Mr A's follow-up outpatient appointment to RN E.

40. Dr C told HDC that she remembers mentioning to Ms B that she "had stopped [Mr A's] medication at that point in time", but does not remember Ms B asking why Mr A's medication had been stopped. Dr C apologised for "some miscommunication" between herself and Ms B that "was not recognised at the time" of their meeting.

41. Ms B told HDC that if Dr C had taken the time to talk to her, she would have received a more comprehensive history regarding Mr A. Ms B stated that if she had been asked about Mr A's medication, she would have said that he was taking the venlafaxine every day, as she personally gave the medication to him each morning. She said that they had noticed that the medication was causing insomnia, and that with the guidance of Mr A's GP, they had recently changed the administration of the venlafaxine from evening to morning, to see whether that helped with the insomnia. Ms B pointed out that the nursing notes state that she had been giving Mr A his venlafaxine every day, and Dr C should have been aware of that.

42. Dr C recorded that Mr A was to be discharged without medication, and was to return to school the following day. An appointment was made for him to have follow-up with RN E on 2 Month2.

43. Dr C wrote a discharge letter and sent it to Mr A's GP. However, she did not send a copy to Mr A or to Ms B.

44. With regard to discharge information, the DHB said that Mr A was provided with the nursing discharge plan, which stated that his medication had been discontinued, an appointment with RN E had been scheduled, and a safety plan had been discussed.

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Events following discharge

45. Ms B said that Mr A continued to take venlafaxine after he was discharged because she had been given no information as to how to wean him off the medication.

46. RN E saw Mr A on 2 Month2. Ms B was present, and RN E provided feedback to Ms B about what she had discussed with Mr A during the session. Mr A had denied any problems with his mood, sleep, or appetite, and denied that he had any suicidal thoughts, plan, or intent. Mr A was ambivalent about having to attend appointments at the Service, and did not identify anything with which he needed help that could be the basis of an individualised treatment plan. Ms B discussed Mr A's medication, and RN E told Ms B that Dr C had stopped it and that Ms B should monitor Mr A's mood for any signs of deterioration, and schedule an appointment with Dr C if required.

47. On 13 Month2, RN E met Mr A without his mother being present. He described his mood as stable, and said that he had no suicidal ideation and was looking forward to being with friends at the weekend.

48. On 20 Month2, RN E met with Mr A on his own. She noted that Mr A said that he had issues with decreased focus and concentration. Mr A again said that he did not require the Service's involvement.

49. On 11 Month3, RN E telephoned Ms B and recorded that Ms B said that Mr A had been doing well, apart from issues with his schoolwork, but he had not seen his friends over the school holidays as frequently as usual. RN E offered an appointment for Ms B and Mr A to discuss this further.

50. RN E met with Ms B and Mr A on 21 Month3. Mr A denied any concerns regarding his mood or risk, and said that he was considering career options. He refused support from the Service, but agreed for RN E to set up an appointment with the careers counsellor at his school.

51. RN E stated that she then had a period of unplanned leave, and after she returned from leave she contacted Ms B on 16 Month4 to review Mr A's progress further. Ms B said that Mr A was feeling very positive about the plan for school, and that he had been socialising more. RN E stated that Ms B told her that she had no concerns for Mr A's mental health. RN E said that they discussed relapse prevention strategies, and they also discussed RN E's intention to close Mr A's file with the Service. RN E said that she told Ms B that she should contact the Service if there were concerns about Mr A's mental health in the future.

52. RN E stated that she discussed with Ms B the closing of Mr A's file because he had continued to progress well and had stated that he no longer wanted contact with the Service.

53. On 29 Month4, RN E wrote to Dr D stating that Mr A's file at the Service had been closed as he was unwilling to engage with the Service further.

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54. The DHB said that RN E attempted to support Mr A to develop coping strategies, but he was reluctant to accept any treatment. The DHB apologised that there was no opportunity for Ms B to talk alone with RN E during Mr A's appointments. The DHB said that all the Service's staff have been reminded to ensure that best practice of including families is followed.

55. RN E's discharge letter from the Service was sent to Mr A's GP but not to Mr A or his family.

56. The DHB stated that the failure to schedule a psychiatrist appointment following Mr A's discharge from the inpatient mental health unit has been highlighted as an action for improvement for the Service.

No multidisciplinary team review

57. The DHB told HDC that the Service had policies in place that required regular review of clients at MDT meetings, but in Mr A's case the MDT review was missed. The DHB stated: "We apologise that [Mr A's] case was not presented for a multidisciplinary team review; this was an oversight that the service sincerely regrets."

58. The DHB said that when a key worker presented a client at an MDT meeting, the purpose was to provide the team with the formulation of a treatment plan. However, RN E had not been able to obtain sufficient informed consent from Mr A to develop a treatment plan that could then be presented to an MDT.

Further information — the DHB

59. The DHB said that on 21 Month3 Mr A stated that he did not want further support from the Service. RN E then went on leave unexpectedly for two weeks, returning for half days for another week. The DHB stated that when a staff member is on unplanned leave, any crisis or concerns with clients are managed by the intake worker.

60. The DHB said that on 16 Month4, during a telephone call Ms B confirmed that there was "no further role" for the mental health service.

61. The DHB stated that in August 2019 it undertook an audit of client review status reports. The clinical team manager completed an audit of 20 random client discharge files to measure staff compliance with MDT reviews. The outcome revealed 100% compliance.

62. The DHB told HDC that since these events, the mental health information systems and outcomes coordinator has developed a mental health information and outcomes caseload report for staff, which ensures that staff have reminders regarding data entry requirements as well as the clinical review status of their clients. The report enables clinical staff to identify when the client is due for three-monthly MDT reviews. It also identifies that the psychiatric diagnosis has been entered into the information patient management system, and that the transition plans have been completed.

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63. The DHB told HDC that the Service's staff are required to complete the "SafeSide/risk assessment" training, which includes regular refresher training.

64. The DHB said that in June 2020, it reviewed the records of 13 Service clients, and that "[a]ll files showed evidence of discussion at the Multi-Disciplinary Clinical Review, meeting, including discussion in relation to risk", and "[a]ll clients had a 'transition/just in case' plan that identified signs of deterioration of mental state to be aware of, and who to refer back to after discharge if further support was required".

Further information — Dr C

65. Dr C said that if concerns had continued about Mr A's risk or low mood, it was regular practice for case managers to bring up patients for discussion at an MDT meeting even if a psychiatrist was providing clinical oversight.

66. Dr C stated that she "apologises that [Ms B] did not get a copy of [Mr A's] discharge letter", and that she "was under the impression that a copy of the Doctor's discharge letter was routinely sent to the General Practitioner as well as to the patient". Dr C said that she is "certainly aware of making sure that does happen now".

Further information — RN E

67. RN E stated that she first met Mr A on 28 Month1 in the inpatient mental health unit. She said that Mr A was easily engaged and appeared to speak freely of events leading to his suicidal gesture and the struggles he was currently facing. He agreed to further contact with her at the Service on discharge, and they discussed what they planned to achieve during the sessions.

68. RN E stated that the first appointment at the Service was on 2 Month2 and, at that meeting, Mr A was not as easily engaged. She said:

> "He freely spoke about social events and plans with friends but was not interested in focusing on goal setting or completing a My Plan.[5] This pattern continued over the next two appointments at [the Service] on 13 [Month2] and 20 [Month2]."

69. RN E stated that as Mr A was unwilling to engage other than on a superficial level, she tried to keep the sessions as light as possible, focusing on rapport building and gaining enough information to gauge his current symptoms and level of risk. She said that although there was no specific therapeutic input during the sessions at the Service, Mr A's symptoms seemed to be improving, and that was supported by the conversation she had with Ms B by telephone. RN E stated: "During my last face-to-face appointment with [Mr A] on 21 [Month3], he clearly stated he did not want further support from [the Service]."

Further information — Ms B

70. Ms B stated that had RN E had a one-on-one discussion with her, she would have been able to provide information about Mr A's situation and history. Ms B said that she was

[5] A personal plan to maintain well-being.

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solely responsible for Mr A's health and well-being, but did not receive support and understanding from the Service, or information to enable her to help her son. Ms B stated that as Mr A had signed a consent form allowing her to be informed, his diagnosis and information about how to help him should have been shared with her.

71. Ms B stated that there was no visual or verbal assessment of Mr A before his file was closed, and that after Mr A's file was closed, no contact was made with him, his family, his school, or his GP to find out whether he had ongoing concerns or problems.

72. Ms B said that as far as she is aware, neither the Service nor Dr C gave Mr A information or guidelines as to when he should seek further help. Ms B believes he was not told that continued thoughts of death should not persist, and that he should reach out to someone if he continued to have such thoughts. Ms B stated:

> "I feel that [Dr C] failed to involve [Mr A's] family and [Dr C] failed to inform [Mr A] of the medical risks or warning signs of his condition and what to do in those situations. I feel my right as [Mr A's] mother to provide him with help, support, encouragement and a safe and loving environment was taken from me by being 100% excluded from any pre-, current or post care."

73. Ms B considers that the Service needs to include the family in its assessment of young people, and provide support for the family.

Responses to provisional opinion

74. Ms B was given an opportunity to respond to the "information gathered" section of the provisional report. Her responses have been incorporated above as appropriate.

75. In addition, Ms B stated that in her dealings with the DHB, "there has been no separate individual support or teaching given, or offered, to me". She further stated:

> "It puts both the child and family at a distinct disadvantage when we, the families, are given no information or guidance on how to help and engage with our child, and the child is trying to initiate change in a home environment that isn't aware of what they can do to help, or what they can change within their approach in support of the child. I feel this is a big missing piece of the services offered by [the Service]."

76. Ms B told HDC that she hoped the Service would "change their approach and become the family service their title says they are. That they ensure their clients are supported by both the services [the Service] gives them personally, and their families who have been given the right tools, resources and encouragement by [the Service]."

77. The DHB was given an opportunity to respond to the provisional report. Its responses have been incorporated above as appropriate. The DHB noted that neither Dr C nor RN E wished

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to make comment on the provisional report. The Chief Medical Officer of the DHB stated: "It is my opinion that as Chief Medical Officer I have failed to ensure a safe service to this young man resulting in his death."

Opinion: District health board — breach

Introduction

78. At the outset I would like to express my condolences to Ms B and Mr A's family. It is understandable and appropriate that they want an independent assessment of the care provided to Mr A prior to his tragic and untimely death.

79. Mr A appears to have been at intermittent risk of suicide from December 2015. His mother had a good relationship with him and was caring and supportive. She sought assistance for him from the GP and the Service.

80. This investigation has not considered the circumstances surrounding Mr A's death in 2017; it has focused on the events in 2016 during Mr A's admission to the public hospital and his outpatient care over the following months.

Risk assessment

81. Mr A's clinical records do not contain a completed risk assessment/formulation. My expert advisor, psychiatrist Dr Tonya Dudson, advised that the risk assessment could have been completed while Mr A was in the inpatient unit or by the community service. She stated: "This may have been a useful intervention; given [Mr A] did not want to engage in learning coping skills."

82. Dr Dudson advised that there were frequent assessments of cross-sectional risk for suicide, but the area for improvement was the lack of comprehensive formulation of risk over time, and guidelines for risk management to be used once Mr A was discharged. She stated that this was a departure from accepted practice. I accept this advice.

Discharge from hospital

83. Mr A was admitted to the public hospital on 28 Month1 under the MHA, and discharged after two days. Dr Dudson advised that lengthy hospital admissions for youth without severe mental illness are frequently aversive, as they increase the risk of suicidal behaviour. Furthermore, there were other risks for Mr A, as he was in an adult mental health unit. She stated: "It was good judgement to discharge [Mr A] after a short duration." I accept this advice and consider that the discharge was appropriate.

Medication

84. Mr A had been prescribed venlafaxine by his GP. Mr A told Dr C that he was not taking the medication because of the side effects. However, Ms B said that this is incorrect, as she

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gave it to Mr A each day. In my view, it is unfortunate that Dr C did not discuss the medication with Ms B.

85. Dr C decided to discontinue the medication. Dr Dudson advised that this was an appropriate decision because Mr A had said that he was not taking the medication; he did not have a history of pervasive and severe mood disturbance that might respond to medication; the dosage was unlikely to be therapeutic; and medication would not be recommended to treat an adjustment disorder. Furthermore, Dr Dudson advised that if a psychiatrist were to treat a youth with an antidepressant medication, venlafaxine would seldom be utilised.

86. I accept this advice. I note that Ms B stated that Mr A continued to take venlafaxine after his discharge from the public hospital because she had been given no advice about how to wean him off it. She considers that the medication was one issue that Dr C should have discussed with her. I agree with Ms B's concerns, and consider that the level of family involvement in Mr A's care was poor, as discussed below.

Family involvement

During hospital admission

87. Ms B was Mr A's primary caregiver and she had a good relationship with him, as is shown by Mr A having signed a consent for his information to be shared with his mother, his mother frequently being present while he was in hospital, and her having supported him during his leave from the ward. However, she was not present for either of the psychiatry assessments.

88. Dr Dudson advised that it would be usual practice to have a parent or caregiver contribute to the psychiatric assessment of a young person aged 16 years, as this would be useful for gathering collateral information and expanding the risk assessment. Dr Dudson stated: "On the ward it is common practice for nursing staff to make a time so that family can meet with the psychiatrist and contribute to the assessment process." Dr Dudson considered that the failure to involve Ms B was a departure from accepted practice.

89. Ms B and Mr A were not copied into the discharge information, and Ms B was given minimal information and support to enable her and Mr A to know when further assistance was required. This was not a case where a young person did not want a parent involved, and it was important that the lines of communication with Ms B be kept open. It was understandable that Ms B felt unsupported. However, I accept that Ms B was not present when Dr C reviewed Mr A, and that pressures of work impaired Dr C's ability to meet with Ms B on 29 Month1.

During community care

90. Over three months, RN E met with Ms B and Mr A together on one occasion, and telephoned Ms B twice. Dr Dudson advised that the level of communication between RN E and Ms B was within accepted practice.

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Psychiatric review

91. Mr A was not reviewed again by a psychiatrist after his discharge from the public hospital. Dr Dudson advised that an assessment by a psychiatrist in the community setting would have been indicated, particularly following Mr A's admission to the inpatient unit under the MHA. Dr Dudson stated that it would be common to arrange such a review within two weeks after discharge from hospital. I accept this advice, and I am critical of the lack of psychiatric follow-up.

MDT review

92. There was no MDT review of Mr A's progress prior to his discharge from community care. The DHB said that the service had policies in place that required regular MDT reviews, but that in Mr A's case this did not take place. The DHB stated that when a key worker presented a client at the MDT meeting, the purpose was to provide the team with the treatment plan. However, RN E had not been able to obtain sufficient informed consent from Mr A to develop a treatment plan that could then be presented to an MDT meeting.

93. Dr Dudson stated that regular MDT reviews offer an opportunity for team members to discuss the case assessment, diagnosis and risk, and treatment progress, and have support from the wider team members with respect to treatment. Dr Dudson advised: "A discussion within MDT review process may have identified [that] a treatment review with the psychiatrist [would] be helpful."

94. Dr Dudson advised that the lack of a documented MDT discussion of Mr A's case over the three months following his discharge was a serious departure from accepted practice. I agree. Despite RN E not having been able to develop a treatment plan with Mr A's informed consent, she should have considered discussing Mr A's presentation with the MDT meeting.

Conclusions

95. Dr Dudson's advice is that overall the care provided to Mr A was of a reasonable standard. I agree that certain aspects of the care were appropriate, but I consider that Mr A had been demonstrating concerning behaviours. There was a lack of comprehensive formulation of risk over a period of time, and a lack of guidelines for risk management to be used once Mr A was discharged. Mr A's mother was not involved in his psychiatric assessment while he was an inpatient, and so Dr C was unable to gather background information about his circumstances in order to expand the risk assessment.

96. Neither Dr C nor RN E copied Mr A or his mother into the discharge documentation. In addition, I am critical that Mr A did not have a further psychiatric review after his discharge from hospital, and that there was no MDT involvement in his care.

97. The failings by the DHB clinicians resulted in Mr A's risk not being appreciated, and Mr A and his family feeling unsupported. DHBs are responsible for the services they provide. Accordingly, I find that the DHB failed to provide services to Mr A with reasonable care and

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skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.[6]

Recommendations

98. I recommend that the DHB:

a) Provide a written apology to Mr A's family for the breach of the Code identified in this report. The apology should be sent to HDC within one month of the date of this report, for forwarding to Mr A's family.

b) Arrange for the Service's staff to undertake further training on communication with patients and their families. The DHB should provide evidence of staff attendance at an appropriate workshop/seminar within three months of the date of this report.

c) Arrange for the Service's staff to undertake further professional development focused on clinical assessment and, in particular, risk assessment, and provide a report to this Office on the activities it has arranged, within three months of the date of this report.

d) Undertake a review of all patients seen and discharged by the Service during a one-month period, looking at short-term outcomes to assess whether risk assessments have been assigned appropriately and MDT meetings have been undertaken, and provide a report to this Office within three months of the date of this report.

Follow-up actions

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

100. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Director of Mental Health, who will be advised of the DHB's name.

101. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Health Quality & Safety Commission and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Dr Tonya Dudson:

"**Complaint: [Dr C]/[Public hospital]**

Reference: C18HDC00903

I, Dr Tonya Dudson, have been asked to provide an opinion to the Commissioner on case number C18HDC00903, and I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.

My qualifications include:

— MbCHB, University of Auckland, New Zealand, 1993

— Fellow of the Royal Australian & New Zealand College of Psychiatrists, 2002

— Certificate of Advanced Training in Child and Adolescent Psychiatry, Royal Australian & New Zealand College of Psychiatrists, 2007

I have worked as a Consultant Psychiatrist, in District Health Board funded Mental Health Clinics since 2002. These were/are similarly structured to the teams providing care in the case to be reviewed. A significant part of my work would involve the management of patients who engage in repetitive risk behaviour, both in an Inpatient Unit, and Community Services.

I have been asked to review documents and provide an opinion on the standard of care provided by [Dr C].

Included in this report:

Background
Expert Advice Requested
1. The appropriateness of [Mr A's] Discharge.
2. The appropriateness of [Dr C's] discontinuation of [Mr A's] anti-depressant medication.
3. Concerns for level of involvement of family in assessment and treatment decisions.
4. Treatment Review
5. Risk Assessment

Background:

[Mr A] was admitted to the Inpatient Mental Health Unit under the Mental Health Act for assessment and treatment of concerns for suicidal behaviour. During a hospital stay he was assessed by nursing and medical staff, both in terms of diagnosis, and treatment. After two days he was discharged from hospital and followed up voluntarily by the community team, with contact over the following 3 months.

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Expert Advice Requested:

1. The appropriateness of [Mr A's] Discharge.

[Mr A] had a reasonable assessment of his diagnosis, broader contextual factors and risk while in hospital. Ongoing assessment by the nursing staff, assessments by one medical doctor and two psychiatrists, concluded that [Mr A] was not suffering from a severe mental illness needing treatment within a hospital setting. Through the course of the stay his risk for imminent suicide settled considerably. A diagnosis of Adjustment Disorder was made, and the recommended treatment for [Mr A] to learn coping skills was appropriate. A trial period of leave from hospital was assessed by [Dr C] to have gone well prior to discharge being decided.

Lengthy hospital admissions for youth without severe mental illness are frequently aversive, as they frequently increase risk for suicidal behaviour. There are also other risks for youth within an Adult Mental Health Unit, hence the need for [Mr A] to need a 1:1 level of care. This in itself can be aversive. It was good judgement to discharge [Mr A] after a short duration.

The discharge from hospital after two days was accepted practice.

2. The appropriateness of [Dr C's] discontinuation of [Mr A's] anti-depressant medication.

[Mr A] had been prescribed venlafaxine 37.5mg by his general practitioner, after a previous trial of sertraline. [Dr C] made the decision alongside [Mr A] to stop the medication. The notes suggest several reasons for this to be an appropriate decision:

— [Mr A] said he was not taking the medication

— Nursing and medical notes do not report a history of pervasive and severe mood disturbance that might respond to medication

— The dosage of the medication was unlikely to be therapeutic (usual dose required 75–300mg).

Medication would not be recommended to treat an Adjustment Disorder. This diagnosis appears reasonable. Counselling would be the recommended treatment and [Dr C] suggested this.

If a psychiatrist were to treat a youth with an anti-depressant medication, venlafaxine would seldom be utilised.

The discontinuation of [Mr A's] anti-depressant medication was accepted practice.

3. Concerns for level of involvement in family in assessment and treatment decisions.

[Mr A's] mother was his primary caregiver and he was living with her. Prior to hospital admission she had expressed concern for her son over several months and initiated a previous referral to [the Service] as well as General Practice treatment for her son.

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During the hospital admission [Mr A's] mother was present for long periods of time and supported him during leave from the ward. However it does not appear as though she was present for either of the psychiatry assessments. She was consulted by [Dr C] as to the progress of leave from the ward, and treatment recommendations.

It would be usual practice to have a parent/caregiver to contribute toward the psychiatric assessment of a young person aged 16. This would be useful in gathering collateral information and expanding risk assessment. On the ward it is common practice for nursing staff to make a time so that family can meet with the psychiatrist and contribute to the assessment process.

The lack of involvement of [Mr A's] mother in psychiatric assessment was below standard for a young person age 16.

During the three month follow up by [the Service], [RN E] (nurse specialist), met with [Mr A's] mother alongside him on one occasion, and phoned for feedback from his mother on two occasions. His mother was advised and agreed to discharge from the community service.

The level of communication between [RN E] and [Mr A's] mother was within accepted level of practice.

4. Treatment Review:

[RN E] offered conscientious follow-up where she assessed ongoing symptoms, stressors, and current suicidal ideation. She also provided sensible and patient-centered supports. Despite her best efforts, [Mr A] continued to minimise concerns and did not want to engage in more active therapeutic treatment.

[RN E's] assessment indicated that it was unlikely that [Mr A] had an ongoing psychiatric diagnosis, however a psychiatrist had not reviewed this.

There was no documented evidence of multi-disciplinary team (MDT) review of progress for [Mr A], either when he was not engaging in treatment, or prior to discharge. A discussion within a MDT review process may have identified a treatment review with a psychiatrist to be helpful.

The aim of a more thorough psychiatric assessment would have been a review of diagnosis, formulation and risk assessment. This may have informed a different therapeutic direction, or it may have supported discharge from the service.

An assessment by a psychiatrist during the three months of treatment in the community would have been indicated. This is particularly the case following admission to an Inpatient Unit under the Mental Health Act. Other community services I have worked in prioritise this to occur within two weeks of discharge from the hospital. This would be planned within MDT review process; both on discharge from the hospital, and prior to discharge from the Community team.

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The absence of occurrence of MDT review, and absence of psychiatric assessment during the treatment within the Community Team was below the level of accepted practice.

4. Risk Assessment:

There were several indicators to suggest intermittent high risk for suicide over time, despite [Mr A] minimising all symptoms and saying he was fine. He was associated to two other young people whom had completed suicide over the year, he had presented to the service two times during 2016 with a lethal method and plan for suicide in the context of relationship stressors which were ongoing and erratic, he had been assessed as risky enough to warrant admission to the Inpatient Unit under the Mental Health Act and he was not insightful as to his behaviour nor appropriately help seeking.

There was no evidence in the notes of completed risk assessment/formulation. Included in the notes is a risk assessment toolkit; both tool 2 (Risk formulation/pattern recognition) and tool 3 (Information Sharing/Pathways to safety) were not attempted. This may have been completed both in the Inpatient Unit, or the Community Service. This may have been a useful intervention; given [Mr A] did not want to engage in learning coping skills.

Given his acute risk for suicide on presentation was the primary indication for treatment, the absence of comprehensive risk assessment was below standard of care.

In Summary:

Some improvements in service provision have been identified, namely improved parental involvement in psychiatric assessment, prioritisation of risk formulation/ intervention, and the use of the multi-disciplinary team more effectively.

Treatment of a young person who does not recognize the need for treatment is always difficult for both family and professionals alike.

Dr Tonya Dudson
Child and Adolescent Psychiatrist
2 March 2019"

Addendum

"In general the care provided to the patient was of a reasonable standard.

The lack of family involvement in the psychiatric assessment for a young person age 16.

It would be the norm for a young person to have a parent give information to aid an initial assessment. In this case the mother had given information during a previous

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assessment, if not during the admission process. The admission assessment was completed in an adult inpatient ward, and thus a different culture is likely. The mother was consulted on several occasions over time. I would say that the departure from practice was mild.

Absence of an MDT review and the absence of a psychiatric assessment during the 3 month period of community treatment

Regular MDT reviews offer a place for team members to discuss case assessment, diagnosis and risk, with treatment progress; and have the support from the wider team members with respect to treatment. The lack of documentation of this case being discussed in an MDT over the 3 months following discharge is a serious departure from practice.

The absence of a psychiatric assessment during this time is less clear, as the ongoing nursing assessment did not indicate a severe mental health disorder and the prioritisation of medical intervention. However the psychiatrist has a role in responsibility for risk assessment. The access to a psychiatrist as a resource is likely to have significant implications in some CAMHS settings.

The departure from practice in this case could be thought of as moderate.

Absence of comprehensive risk assessment

There were frequent assessments of cross-sectional risk for suicide completed over the contact time with the service, and I believe his risk was assessed and managed well at the time. The area for improvement is the more comprehensive formulation of risk over time, and some guidelines for risk management to be used once discharged. From my practice, this would not be uncommon. Thus the departure from practice would be mild."

Addendum

"I have reviewed the responses to my previous advice, and do not wish to make any changes to this.

I have confidentially discussed my concerns with three other Child and Adolescent Psychiatrists. The consensus is that any discharge planning from an inpatient unit needs to occur *collaboratively* with family members. The clinical importance of this is family are considered essential in managing risk of teens with suicidal intent. The sharing of an understood formulation as to risk and then a means to manage this needs time and effort. It is particularly important when a young person is minimising distress and the seriousness of their behaviour. The clinical notes in this instance suggest the mother was informed of a plan made, rather than having active input into the plan.

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I believe the role of a psychiatrist, as responsible clinician, requires active follow up of identified high-risk patients. It is positive to see that the service has put some processes in place for this to occur.

I suggest that there is some shared responsibility for the departures observed. However the practice of any clinician is dependent on the culture of the workplace they work in. It is difficult to make a reasonable comment on this, as the notes I have reviewed tell me nothing about work place culture, work-load and resourcing capacity. Most Child and Adolescent Mental Health Services in Auckland are seriously depleted in terms of staffing. This means the capacity to assess and treat high numbers of referrals is difficult despite staff's best intentions and efforts. It is here that safe processes are important. I do not have knowledge as to this service's capacity at the time."

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