HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failures in acute mental health care

1. On 5 and 10 March 2021, the Health and Disability Commissioner (HDC) received complaints from Ms B (grandmother) and Mrs A (mother) respectively about the standard of mental health care provided to Mr C at Health New Zealand | Te Whatu Ora (Health NZ) Te Matau a Māui Hawke's Bay before he died. Mr C was aged 26 years at the time. I extend my sincere condolences to Mr C's whānau and friends for their loss.

Information gathered

2. Mr C's General Practitioner (GP), Dr E, made three written referrals to Health NZ Te Matau a Māui Hawke's Bay Mental Health and Addictions Service (MHAS) and one verbal request for psychiatric assessment.

3. The first GP referral, completed in October 2019, requested a psychiatric assessment by MHAS in relation to Mr C's attention deficit hyperactivity disorder[1] (ADHD). The service requested further information from the GP, but there is no record of further information being received, and the referral was not progressed.

4. In March 2020, Mr C presented to MHAS with suicidal ideation and was assessed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 by a psychiatrist. His records showed a history of suicidal ideation and substance use. Following assessment, Mr C was not considered to be suicidal. He was asked to follow up with his GP regarding a referral to 'Addiction Services and Psychology'. Later that month, Mr C's GP sent a second written referral to MHAS. The service called Mr C to discuss the referral, and he stated that he was seeking therapy but denied needing assistance from addiction services as this was not an issue at the time. MHAS recommended that Mr C seek counselling through the Primary Health Organisation (PHO)[2] and noted that if he was seeking addiction support, he could be re-referred. The referral was closed.

5. In May 2020, Mr C's GP made a third written referral to MHAS requesting an assessment for bipolar disorder[3] and consideration of prescribing a mood stabiliser. The referral was declined, noting that Mr C had been assessed by a psychiatrist in March 2020 and bipolar disorder was not indicated. The MHAS again recommended referral to PHO counselling.

6. In June 2020, Mr C's GP called MHAS, reporting that Mr C was experiencing psychotic symptoms (auditory and visual hallucinations) and requesting psychiatric assessment. MHAS staff advised that Mr C's psychotic presentation 'may be a consequence to his ongoing

[1] A neurodevelopmental disorder characterised by persistent patterns of inattention, hyperactivity, and impulsivity.
[2] PHOs are the means by which the government ensures that everyone has access to a GP and a primary care practice. PHOs are made up of several primary care practices that work together to care for patients who are registered with them.
[3] A mental health condition that causes significant fluctuations in mood, energy, activity levels and the ability to think clearly.

substance abuse' and suggested that Mr C self-present to its service. Health NZ told HDC that this was recommended because Mr C would receive a clinical review more promptly by presenting directly to the service, rather than by way of GP referral. MHAS also advised Mr C's GP that 'the most appropriate course would still be for [Mr C] to engage with [addiction] services and address his substance use'. Mr C did not present to the service as suggested by the MHAS clinician. There was no further contact between MHAS and Mr C or his GP until the following year.

7. At 3.45pm on 17 February 2021, Mr C's counsellor, Mr F, made a phone call to refer Mr C to the Health NZ Te Matau a Māui Hawke's Bay Emergency Mental Health Service (EMHS). The call was received by Registered Nurse (RN) G. Mr F told RN G that Mr C had stated that he was planning to take his own life and he had given details of a specific plan to do so. Mr F also told RN G about Mr C's history of attempted self-harm, low mood, and ongoing use of alcohol and cannabis. To ensure Mr C's immediate safety, Mr F was advised to call Police. RN G recorded the plan to '[a]wait further contact from Counsellor [Mr F], Police, or Mr [C]'.

8. Ms B told HDC that she recalled that Mr C's employer had been concerned about Mr C's safety and had called Police to take him to hospital.

9. At approximately 4pm, Mr C presented to the Emergency Department at a public hospital. The ED triage team contacted EMHS to inform staff of Mr C's presentation and that he had stated that he wanted to end his life and had a plan to do so.

10. Mr C was assessed by an EMHS staff member, social worker Ms H, at approximately 5.30pm. Ms H's assessment recorded Mr C's relevant history and presenting issues. It was noted that Mr C was concerned that his history of drug use was a barrier to him accessing mental health support, and it is recorded that Mr C repeated this apprehension to several clinicians over the following days. Ms H noted that Mr C could pose a risk to himself if he felt that his needs were not being addressed appropriately. She discussed Mr C's case with the on-call psychiatrist, Dr I, and it was determined that Mr C did not require inpatient admission to the mental health ward. However, it was considered that 'a more in-depth assessment [was indicated] in light of his history and expressed suicidal ideation'.

11. A plan was made to admit Mr C to the non-government organisation (NGO) respite facility, discuss his case in a multi-disciplinary team meeting (MDTM), plan a psychiatrist review of his diagnosis and medication, and liaise with previous providers regarding his mental health history. Mr C was admitted to the respite facility at approximately 7.30pm on 17 February 2021.

12. On the morning of 18 February 2021, Dr J, an EMHS psychiatrist, wrote to Mr C's GP noting that Mr C was at that point prescribed methylphenidate[4] and diazepam,[5] that he had in the past injected methylphenidate intravenously, and that currently he was using alcohol and cannabis.[6] Dr J stated that the prescribing of methylphenidate is contraindicated[7] in those

[4] A central nervous system stimulant also known as 'Ritalin' or 'Concerta' and used to treat ADHD.
[5] A type of benzodiazepine (a group of depressant drugs used to treat anxiety, insomnia, and seizures).
[6] Mr C was on restricted prescribing, and his GP was his nominated prescriber.
[7] A condition or factor that provides a reason not to use a certain treatment, medication, or procedure.

with active substance misuse. Dr J strongly recommended that Mr C's GP no longer prescribe methylphenidate, benzodiazepines, or any other drug with the potential for abuse.

13. Dr J told HDC that he and his team discussed and considered Mr C's needs holistically when making the recommendation to cease prescribing methylphenidate and diazepam. Dr J said that his aim was harm reduction, and he was aware that Mr C would be seeing his GP that week, where there would be an opportunity for medications to be discussed. Dr J also noted that Mr C's GP, who was more familiar with the patient and his situation, had the option of challenging or rejecting the recommended medication changes.

14. In response to the provisional decision, Mrs A said that the option for someone to dispense medications to Mr C to ensure that he would not abuse them was not considered before his medications were ceased.

15. On 18 February 2021, while still in respite care, Mr C had a phone consultation with his GP. Mr C was upset to learn of the changes to his medication, as per Dr J's recommendation.

16. Following this phone call, Mr C threatened to harm himself. He was seen that evening by RN G. It was agreed that Mr C would remain in respite care and that he would speak to staff if he felt that he was going to harm himself. Mr C was told that his case would be discussed in an MDTM the following morning regarding a potential review by a psychiatrist but that a psychiatric assessment was not guaranteed.

17. In response to the provisional opinion, Mrs A said that Mr C was told by staff to 'stop threatening self-harm or they would kick him out'.

18. Mr C was discharged from the respite facility on 19 February 2021 after a two-night stay. The reasons for discharging Mr C were not recorded at the time. However, a plan was documented, which included contacting Mr C's GP to offer advice on medication, welfare checks each day by phone over the weekend, Mr C being given EMHS contact details, and EMHS contacting Waikato Community Mental Health to gather further information about Mr C's mental health history.

19. Health NZ stated that, although Mr C had been discharged from respite care, he had not been discharged from MHAS. However, it is not documented what further care, if any, MHAS planned for Mr C following the two scheduled welfare phone calls over the weekend, and after clinical notes had been received from Waikato Community Mental Health. Although he was given contact details for EMHS, Mr C was not provided with a written safety plan. Mr C's whānau and friends were not consulted by EMHS during his stay at the respite facility or upon his discharge. There is no record indicating that clinicians discussed with Mr C the option of involving whānau and friends in his care.

20. Health NZ told HDC that EMHS clinicians did not perceive that Mr C was at imminent risk of self-harm when he was reviewed before discharge from the respite facility. Dr J told HDC that psychiatrists are not routinely involved in decision-making regarding discharge from respite care. On this occasion, Mr C, the respite facility, and EMHS clinicians were involved in the decision to discharge.

21. The documentation covering this episode of care records that Mr C requested psychiatric review on four separate occasions. While in respite care, Mr C was assessed four times by nurses and social workers, but he was not reviewed by a psychiatrist. Mr C's case was discussed in MDTMs, although the clinical records do not clearly specify the discussions held in these meetings, or their outcomes.

22. Mr C's clinical records do not contain the reasoning for the decision not to provide him with a psychiatric review. There is also no documentation of the information provided to Dr J that was used to make this decision. Dr J told HDC that it is likely that several high-priority patients were requiring assessment. Mr C was not offered a psychiatric review because he already had established diagnoses, his mental state did not suggest that he required urgent review, and there was no objective evidence of psychotic illness.

23. Mr C saw his GP on the day he was discharged from respite care. During the consultation, Mr C's GP called Dr J, who said that Mr C was 'EUPD[8] and medication [was] not helpful and Mr C [was] at risk of injecting it.' This conversation was not documented by Dr J.

24. Mr C told his GP that he was not seen by a 'psych[iatrist] and feels [he] wasn[']t properly assessed'. Mr C's GP recorded that Mr C was agitated and discussed harming himself. He was reported to have 'calmed down a bit' following discussion about self-harm and consequences. Mr C's GP prescribed diazepam 'to settle him'.

25. Mr C had been in contact with whānau over this period and had expressed concerns about not getting the help he required, clinicians not 'taking [me] seriously', and being labelled by staff as 'drug seeking' in a phone conversation that he had overheard.[9] Health NZ told HDC that it was unable to ascertain whether this was said, and if it was, by whom.

26. Mr C [then] stayed at a friend's house and died not long afterwards. Again, I convey my deepest sympathies to Mr C's whānau and friends for this tragic outcome.

Adverse Event Review

27. An Adverse Event Review (AER) was completed by Health NZ. The review identified the following issues with the care provided to Mr C and other contributing factors:

a) 'Patient factors': Mr C had complex mental health needs with a diagnosis of borderline personality disorder and substance use disorder. He had been referred three times to MHAS but was unable to access early support. This pattern indicated that Mr C was struggling to manage symptoms with existing support and resulted in a crisis presentation.

b) 'Team factors': There was no documentation of MDTM discussions, handover between clinicians, and the information provided to the psychiatrist that supported the clinical

[8] Emotionally unstable personality disorder, also known as borderline personality disorder, is a condition characterised by unstable moods, behaviour, and relationships.
[9] Mr C's whānau provided screenshots of text messages in which Mr C said he had overheard a staff member stating that he was 'drug seeking'.

decision not to assess Mr C. This could have resulted in incomplete information being available to staff.

c) 'Team factors/Task and technology': Mental state examinations and risk assessments did not use a consistent framework. This increased the chance of important information being missed, especially when assessments were completed by consecutive staff members.

d) 'Team factors/Organisation and management factors': There was a lack of communication with family and Mr C's GP about his presentation over the previous months. The standards and policies in place did not support staff to do so.

e) 'Team factors/Organisation and management factors': There was no standard operating procedure (SOP) outlining standards for assessment, no recovery plan documentation, and no follow-up by the crisis team. The lack of an SOP resulted in unclear expectations of staff. No written safety plan was provided to Mr C, which could have initiated more detailed safety planning.

f) 'Institutional context factors': Clinicians could not access health records from other districts and primary health and prescribing records in a timely manner. This affected the clinicians' ability to manage Mr C's clinical presentation and risk appropriately in a timely manner. In addition, staff were uncertain of their roles and responsibilities around patients entering and exiting respite care provided by the respite facility, an NGO.

g) 'Patient factor/Worker factor': Failure to build trust between Mr C and the service. It is evident that Mr C's addiction history impacted decision-making. Earlier efforts to access MHAS resulted in recommendations for addiction services, rather than addressing Mr C's expressed needs. This created a barrier to Mr C accessing mental health care.

28. To address the above identified issues, the AER made the following recommendations:

a) Create a localised ADHD pathway for adults, including considerations for people with a history of substance misuse disorder.

b) Review referral criteria for specialist MHAS to ensure consistent decision-making when accepting and declining referrals.

c) Review the triage process for specialist MHAS and associated standards.

d) Develop an SOP for crisis MHAS assessment and care. This SOP is also to provide standards for MDTMs, handover, escalation, and involvement of whānau in assessment and care planning (unless declined by the patient).

e) Provide training for all MHAS staff in the standard risk assessment framework.

f) Provide training for all MHAS staff on clinical documentation standards.

g) Present a paper to the Health Services Governance group outlining the risk associated with the use of multiple health information platforms.

h) Work in partnership with NGOs providing respite care to clarify responsibilities when patients are entering and exiting care.

i) Improve trauma-informed care education through the inclusion of patient stories.

j) Review audit findings on the provision of information about patient rights.

k) Run a pilot feedback survey on patient views of treatment and care.

29. The AER was provided to HDC on 3 April 2025, more than four years after the events occurred. Health NZ stated that this delay was caused by staff changes, the COVID-19 response, cyclone Gabrielle, unclear processes for disclosing information to whānau, and a lack of correct contact details for Mr C's whānau due to the time that had passed since these events.

Independent clinical advice

30. HDC sought independent clinical advice from a psychiatrist, Dr Caleb Armstrong (Appendix A). Dr Armstrong identified several departures from accepted standards in the care provided to Mr C by Dr J and Health NZ.

31. Dr Armstrong noted that Mr C was not seen by a psychiatrist during his stay at the respite facility. An in-person psychiatric review would have provided the opportunity to reconsider whether Mr C required admission to the inpatient mental health ward. It would also have allowed discussions about changes to medication and supports available to him in the community. Noting Mr C's request for a psychiatric review, and his expressed concern about his history of substance use being a barrier to receiving care, an in-person review would have provided the chance to alleviate this concern. Dr Armstrong considered Mr C not receiving an in-person psychiatric review during his respite stay to be a moderate departure from expected standards of care. I accept this advice.

32. Dr Armstrong considered that it was inappropriate to stop Mr C's methylphenidate and diazepam medications without first reviewing him and assessing his needs holistically. Dr Armstrong noted that the consequences of this decision needed to be weighed against the short-term and long-term risks. While ceasing Mr C's medication was likely clinically appropriate over the longer term, the immediate clinical priority was Mr C's high risk of self-harm. Dr Armstrong considered that ceasing these medications without discussing the changes directly with Mr C and collaboratively formulating an appropriate plan to do so was a moderate departure from accepted standards of care. I accept this advice and note the likely impact this change would have had on Mr C, who was already expressing a high level of distress, which did not seem to be taken into account.

33. Dr Armstrong was highly critical of Health NZ's inadequate consideration of Mr C's self-harm risk. In Dr Armstrong's view, more was done to address Mr C's addiction issues than his present and urgent issue of high risk of self-harm. Dr Armstrong noted that Mr C's initial EMHS assessment appropriately identified his elevated risk of self-harm, but this assessment appears to have been disregarded in subsequent decision-making. Dr Armstrong stated that prior to making a decision regarding discharge, it is important to reassess risk. Dr Armstrong stated that based on the available documentation, he was unable to understand the reasons for Mr C's discharge from the respite facility, as these were not documented clearly. MDTM notes were also not documented clearly, and no other clinical notes providing rationale for the decision-making process regarding discharge were

identified. Dr Armstrong said that it would be expected that clinicians would clearly document any decisions regarding the management of patients with an elevated risk of self-harm. Dr Armstrong considered it a serious departure from expected care for EMHS not to have communicated and documented adequately how Mr C's risk had been recognised and considered. I accept this opinion.

34. Dr Armstrong also considered that the discharge plan and follow-up care arrangements for Mr C were inadequate. Dr Armstrong noted that there was a plan for staff to call Mr C over the weekend to check on his welfare, but the follow-up arrangements were 'vague', and no appointment was made for Mr C to attend. There was also no evidence of contact with the community mental health team for ongoing care arrangements. It would be expected that a management plan to mitigate risk would be formulated with the patient (and whānau if appropriate), risk factors identified and addressed, and care handed over to an appropriate team before Mr C was discharged from respite care. Dr Armstrong considered that the failure to complete appropriate discharge and follow-up care arrangements was a severe departure from accepted standards. I accept this advice.

35. While Dr Armstrong's review focused on the care provided to Mr C from 17 to 19 February 2021 during his respite admission, Dr Armstrong also commented on an instance of care in the previous year. Dr Armstrong noted that in June 2020 Mr C's GP contacted MHAS regarding the emergence of psychotic symptoms. MHAS advised that Mr C could self-present to seek care. Dr Armstrong considered that it would have been more appropriate to request Mr C's GP to make a formal referral to MHAS, which would then result in consideration of an assessment. Dr Armstrong noted that people who are experiencing psychotic symptoms often find it difficult to engage with services. Therefore, a proactive management approach would have been more appropriate in the circumstances, rather than asking Mr C to self-present to MHAS.

Responses to provisional opinion

Ms B

36. Ms B was given the opportunity to comment on the 'Information gathered' section of the provisional opinion. She said that Mr C's addiction was a result of his poor mental health, rather than the other way around, and that he was self-medicating to get through each day. Ms B is very concerned that Mr C was judged by his appearance and that he did not get the help that he needed from mental health services.

37. Ms B's further comments have been incorporated into this report where relevant.

Mrs A and Miss D

38. Mrs A was given the opportunity to comment on the 'Information gathered' section of the provisional opinion. She and her daughter, Miss D (Mr C's younger sister), submitted responses, which have been set out below and incorporated into this report where relevant.

39. Mrs A told HDC that a review of Mr C's diagnosis was required because his original diagnosis had been made approximately a decade earlier, and he had a right to a second opinion, and because EUPD can be confused with bipolar disorder due to overlapping symptoms. Mrs A also noted that a psychiatric assessment was requested by Mr C and his GP.

40. Mrs A said that she encouraged Mr C to trust the mental health system. However, she said that she now deeply regrets this after experiencing inadequate processes and the negative attitudes shown towards people suffering from substance abuse. Mrs A believes that Mr C was not given appropriate mental health care due to his history of substance abuse, and she is concerned that there is a culture of discrimination towards people such as Mr C.

41. Miss D told HDC that Mr C was struggling with the side-effects of sertraline[10] during his admission to the respite facility. Her understanding is that Mr C was trying to get an alternative medication prescribed, due to the negative side-effects. Instead, Mr C's other medications were withdrawn without warning or alternatives being offered.

42. Miss D is concerned that Mr C was discharged from respite care based on the assumption that he was drug-seeking and because staff felt that he 'was not worth treating'.

43. Miss D told HDC that she feels that Health NZ's documentation is inaccurate, noting what she considers to be inconsistent information recorded in Mr C's notes about support offered to travel home following his discharge.

Dr J

44. Dr J was given the opportunity to respond to the provisional opinion. Dr J advised that he had no comment to make.

Health NZ

45. Health NZ was given the opportunity to respond to the provisional decision and advised that it accepts the recommendations made in the report.

46. Health NZ is concerned that this investigation does not take into account the broader context of Mr C's care; namely, the resource constraints and system inadequacies faced by MHAS, and particularly rural health services. Health NZ considers that specific failures in decision-making have been highlighted without exploration of the broader context in which decisions were made. Consequently, Health NZ considers that a lay reader may inappropriately attribute blame to the decisions made by individual staff.

47. Health NZ's further comments have been incorporated into this report where relevant.

Opinion: Dr J — adverse comment

48. Dr Armstrong was critical of the decision not to provide an in-person psychiatric review of Mr C. Dr Armstrong also advised that, given the circumstances, it was inappropriate to make changes to Mr C's medication without reviewing him and assessing his needs holistically. Dr Armstrong considered these to be moderate departures from accepted standards.

49. I acknowledge Dr J's response to Dr Armstrong's criticism, in which he explained that there were competing priorities with multiple patients requiring assessment. Based on Mr C's presentation and established diagnoses, he was not prioritised for an appointment. I

[10] An antidepressant medication.

consider that this response mitigates Dr Armstrong's criticism and acknowledges the need to balance needs within the resources available.

50. Dr J told HDC that the recommendations he made regarding Mr C's medication were balanced against the patient's risk of self-harm and the risk of potential abuse of the prescribed medications. However, I remain concerned that these changes were recommended without adequate consideration of the short-term risks and without direct discussion between Dr J and Mr C to formulate an appropriate plan to cease the medications in question safely. In my view, the suggestion by Dr J that the onus was on Mr C's GP to refute or challenge this recommendation seems ill-founded. As the specialist provider from whom this very information and advice was being sought, it was Dr J's responsibility to provide recommendations for significant changes to medications in consultation with relevant parties and with due regard to the impact of those recommendations.

Opinion: Health NZ Te Matau a Māui Hawke's Bay — breach

51. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to have services provided with reasonable care and skill. Based on the information gathered during the investigation and the advice provided by Dr Armstrong, it is evident that several aspects of the care provided to Mr C did not meet accepted standards.

52. I am concerned that multiple system failings contributed to Mr C's discharge from respite care without adequate consideration of his risk of self-harm and without appropriate discharge planning and follow-up care arrangements being made, and that the rationale for key decisions made about Mr C's care was poorly documented. I am critical of the following systems issues evident in Mr C's care; these align with some of the issues identified in Health NZ's AER:

a) Inadequate standard or framework for the content of each assessment documented in Mr C's clinical records. This meant that when considering risk and making clinical decisions, important information could be overlooked.

b) Inadequate standard operating procedure for acute mental health services to ensure that clear recovery plan documents and follow-up care arrangements were completed by MHAS staff. Clearer procedures would have supported more robust consideration of Mr C's risk and more detailed discharge planning to ensure that appropriate steps were in place to support Mr C's safety and ongoing care.

c) Inadequate standards for ensuring the appropriate recording of MDTM discussions and rationale for key decisions. This information was not recorded clearly in Mr C's clinical notes, potentially leading to incomplete information being available to clinicians.

d) Inadequate policies in place concerning whānau contact and involvement in care. This represented a barrier to whānau participating in Mr C's care.

53. In light of the above systems issues evident at the time of the events, which I consider did not support safe and appropriate decision-making, risk management, discharge planning, and documentation practices, I find that Health NZ Te Matau a Māui Hawke's Bay breached

Right 4(1) of the Code. In response to concerns raised by Health NZ that the rural location and associated resourcing has not been taken into account, it is my view that highlighting these policy and procedural deficits with a view to implementing service improvements supports safer practice for both staff and consumers, irrespective of location. There has been no finding in relation to a lack of appropriate options of care for Mr C.

54. In addition to the criticisms outlined above, I am concerned that Mr C was asked to self-present to services in June 2020 when his GP reported that he was experiencing symptoms of psychosis. I am also concerned that throughout Mr C's care there is a pattern of clinicians being more responsive to his history of substance abuse at the cost of marginalising other significant mental health issues that also required attention.

55. Finally, although cognisant of external events impacting the service, I am critical of the substantial delay in Health NZ completing its AER on this very serious event, which caused a subsequent delay in remedial actions being formulated and implemented.

Changes made since events

56. Dr J told HDC that he has made it his routine practice to ensure that any recommendations for significant changes to medication are first discussed directly with the patient. This includes an explanation of the rationale, potential outcomes of the changes, and support planning.

57. Dr J has reviewed the Australian ADHD Professionals Association's guidance on best practice for the treatment of patients with co-existing substance abuse and ADHD.

58. Dr J has worked with the EMHS team to ensure that when patients experience self-harm (an event and/or ideation), a collaborative safety plan is developed with the person, whānau, and friends. This plan includes actions to limit access to means of self-harm, provides contact information for supports, and sets out any planned contact and treatment through MHAS.

59. Dr J told HDC that, whenever possible, despite workload pressures, he makes a written record of clinically significant discussions with GPs and other clinicians.

60. MHAS is working to monitor the quality of MDTM documentation against the organisation's documentation policy, and all staff have been advised of the need to improve documentation standards and to adhere to the relevant policy.

61. A Patient Safety & Quality Lead has been appointed to work with MHAS to ensure that all significant events are reviewed and reported on comprehensively.

62. MHAS has adopted the 'Safeside Suicide' risk assessment framework that supports staff in documenting risk in each assessment recorded in a patient's clinical notes.

63. In addition to the above changes, I note that Health NZ is in the process of implementing the recommendations set out in the AER.

Recommendations and follow-up actions

64. I recommend that Dr J and Health NZ Te Matau a Māui Hawke's Bay, respectively, provide formal written apologies to Mr C's whānau for the deficiencies identified in this report. The apologies are to be sent to HDC within three weeks of the date of this report for forwarding to Mr C's whānau.

65. I recommend that Health NZ Te Matau a Māui Hawke's Bay provide an update on the progress of each of the changes it has made, or is in the process of implementing, in response to these events (set out above), including details of any training or education provided to staff regarding the changes. The update is to be provided to HDC within six months of the date of this report.

66. I recommend that, as part of the review and update of policies and procedures, consideration be given to referral criteria and pathways for patients experiencing symptoms of psychosis and assessment and treatment of addiction issues alongside existing mental health conditions. A brief report on how these considerations will be (or have already been) incorporated into the existing recommendations is to be provided to HDC within six months of the date of this report.

67. A copy of the sections of this report that relate to Dr J will be sent to the Medical Council of New Zealand.

68. A copy of this report with details identifying the parties removed, except the clinical advisor on this case and Health NZ Te Matau a Māui Hawke's Bay, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Dr Caleb Armstrong:

'**Introduction**

[Mr C] was a young man who died … at the age of 26, shortly after a period of care from the Hawke's Bay District Health Board in 2021. I have been asked by the office of the Health and Disability Commissioner to:

"Please review the enclosed documentation and advise whether you consider the care provided to [Mr C] by Hawke's Bay District was reasonable in the circumstances, and why. In particular, please comment on:

1. The appropriateness of the mental health review conducted in ED on 17 February. In particular, please comment on:
    a. The decision not to provide inpatient admission;
    b. Whether adequate consideration was given to [Mr C's] mental health history; and
    c. Whether adequate consideration was given to [Mr C's] suicidal ideation.
2. Whether [Mr C] received adequate psychiatric review while in respite care. Please comment on the lack of in-person review during his respite stay;
3. Whether appropriate consideration was given to [Mr C's] addiction history when developing his treatment plan. Please comment on how this was balanced with other relevant considerations including [Mr C's] suicidal ideation and mental health diagnoses;
4. The appropriateness of [Mr C's] discharge from [the respite facility] on 19 February, including:
    a. Whether adequate risk assessments were undertaken prior to discharge, and
    b. Whether an appropriate management and follow-up plan were in place following [Mr C's] discharge.
5. Any other matters you wish to comment on.
6. For each question, please advise:
    a. What is the standard of care/accepted practice?
    b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?
    c. How would it be viewed by your peers?
    d. Recommendations for improvement that may help to prevent a similar occurrence in future."

I would like to extend my condolences to [Mr C's] family given their loss under tragic circumstances.

Sources of Information

The following sources of information were available to me for the purposes of compiling this report:

i. Letter of complaint from [Ms B] dated 5 March 2021;

ii. Letter of complaint from [Mrs A] dated 10 March 2021;

iii. Hawke's Bay District's response dated 3 June 2021;

iv. Clinical records from Hawke's Bay District covering the period 1 June 2020 to 20 February 2021;

v. Relevant procedures, policies and guidelines from Hawke's Bay District, including Privacy Policy, Health Record Policy, Mental Health Service Policy, Nursing Clinical Handover — Transfer of Accountability and Responsibility Policy, Medical Officer's on-call Policy, Key worker procedure, Alerts Policy, Open Disclosure Policy, Home-Based Treatment Procedure and Unplanned Substance Detoxification Management.

vi. Clinical records from [general practice] ([Mr C's] General Practitioner) covering the period 20 June 2020 to 20 February 2021.

vii. Document entitled 'Mental Health Service Follow-up after Attempted Suicide'.

In addition to reviewing written sources of information, I have had discussions with many of my colleagues about aspects of this case, whilst protecting the identity of the patient and provider.

Review of Background Information:

<u>General practitioner notes</u>

[Mr C] was a patient of a GP clinic, and notes detailing his contact with this surgery were kept between 2020 and his death.

[Mr C's] general practitioner notes record a variety of different information, including details of accidents for which ACC claims were made and [long-term] diagnoses. Amongst the [long-term] diagnoses were notes of moderate depressive episode, relationship problems, borderline personality disorder, attention deficit hyperactivity disorder, anxiety state NOS, depression NOS.

The daily record information includes notes made by [Mr C's] general practitioner and include information about medications which were prescribed to him and diagnoses made. The notes include referral is made to other services including a referral made by [Dr E] to Hawke's Bay District Health Board mental health services. I also note a previous referral on 17 June 2024 for psychotic symptoms which also included some information about [Mr C's] use of alcohol and cannabis at the time. It is apparent from his medical records that the deceased was subject to a restriction notice under section 25 of the misuse of drugs act. This meant that he was only allowed to collect his prescriptions from a particular pharmacy in Hastings and a request was made that that restriction notice allow for him to collect his medication from a pharmacy closer to his home.

The entries into [Mr C's] clinical record from around 22 December 2020 show that the deceased was struggling with mood but managing to maintain a reasonable degree of control over substance use. Note made on 13 January 2021 detailed depressive symptoms such as self-neglect but no alcohol or other substance use and [Mr C] cited his children as factors protecting him against becoming suicidal. On 26 January he was brought into the surgery by his employer who was concerned about him and reported self-neglect, isolation, anger and agitation. In early February [Mr C's] GP increased his diazepam dose to 5 mg in the morning. [Mr C] contacted his GP via phone on 18 February expressing stress as the "Psychs stopped his Ritalin and diazepam as he has been injecting them". [Mr C] expressed his anger and frustration and the doctor noted "says they are coming back for him tomorrow but thinks he might discharge himself feels nothing left for him if he cannot get his head right". On 19 February 2021 his GP spoke to a psychiatrist [Dr J] who expressed concern "[Mr C] is EUPD [an acronym most likely standing for Emotionally Unstable Personality Disorder] and medication not helpful and [Mr C] at risk of injecting it". The doctor also noted "stressed++ as was discharged from respite".

Review of Hawke's Bay District Health Board Notes

On 17 February 2021, Mr [C] was assessed in the emergency department (ED) and the public hospital. A note was made by [RN G], regarding phone contact from [Mr F], a counsellor … had called and provided some background information. A record was made of [Mr C's] background and current social circumstances. The note states "today [Mr C] has stated that he plans to [self-harm]".

During a mental health assessment conducted by a Social Worker [Ms H] in the emergency department, [Mr C] stated that he had been "doing very well for a few months prior to Christmas and then crashing just before feeling unconnected and beginning to experience suicidal thoughts of varying intensity. Has been managing most of the time at work but has become erratic in mood and goes home and ruminates. [Mr C] says he is unable to focus on anything. Today he had contact with his counsellor and disclosed that he was feeling suicidal".

It was noted that "[Mr C] has been very keen to seek help stating that he wants to be well through the children, he says he does not want them to experience what his father has done to him and his stepsiblings (recent suicide attempt). [Mr C] said that he had expressed suicidal thoughts to his counsellor … He has googled possible options but told writer that he made no preparation and was here to get better".

[Mr C] opined that he did not have "the right diagnosis or the right medication. He was seeking admission in order to receive a full assessment and change in treatment. [Mr C] feels that he has been dismissed by services in the past and is judged on his past addiction."

[Mr C] told the assessor that "he has quit all drugs and not used for 5 years" and that he had reduced his use of alcohol.

With respect to his psychiatric history, his diagnoses of borderline personality disorder, persistent depressive disorder, and ADHD are all noted along with "past suicidal thoughts and planning …". A history of multiple previous admissions to […] (a psychiatric inpatient unit in [Waikato District]) are noted. His family history of mental illness was noted.

A mental state examination was conducted noting multiple symptoms of depression. A risk assessment was recorded, noting that [Mr C] was single with limited family and social support, history of mental illness and associated admissions with suicidal thinking and planning. His history of substance use is noted and it is recorded that he had limited his alcohol use and "not used drugs for a number of years". His medications were recorded. A discussion with […], presumably the on-call psychiatrist, took place. It was noted that [Mr C] lives alone in a remote area which did not lend itself to "home treatment option at this time".

This assessment of [Mr C] appears to be reasonably comprehensive and to cover the issues which would usually be assessed in such a situation. The need for a more in-depth assessment was acknowledged, "in light of his past history and expressed suicidal ideation".

It is recorded that "[Mr C] also has a strong sense that he was labelled an addict and not taken seriously by services which could lead to him acting impulsively if returning home this evening".

[Mr C] was placed in respite care with a plan for review the next day.

[Mr C] was visited by team members on the 18th of February 2021 who assessed his mental state and found his requests for psychiatric review unchanged. Also on that day, it appears that there was a multidisciplinary team meeting about [Mr C] which is undocumented apart from a letter by one team member, a psychiatrist, who wrote a letter to [Mr C's] GP recommending that his methylphenidate and diazepam be stopped. [Mr C] was upset when told of this and this is reflected in the notes.

On the 19th of February it appears that a decision was made to discharge [Mr C], but there is no record of how that decision was made or for what reasons. This decision was communicated to [Mr C] in person, and he was offered transport which he declined.

Planned phone calls from the Psychiatric Emergency Team to [Mr C] [later] went unanswered. The provider was notified of [Mr C's] death by police.

Opinion:

Re: The appropriateness of the mental health review conducted in ED on 17 February.
As above, on 17 February 2021, Mr [C] was assessed in the emergency department (ED) and the public hospital. A note was made by RN G, regarding phone contact from Mr F, a counsellor … had called and provided some background information. A record was made of [Mr C's] background and current social circumstances. The note states "today [Mr C] has stated that he plans to [self-harm]".

During a mental health assessment conducted by Social Worker [Ms H] in the emergency department, [Mr C] stated that he had been "doing very well for a few months prior to Christmas and then crashing just before feeling unconnected and beginning to experience suicidal thoughts of varying intensity. Has been managing most of the time at work but has become erratic in mood and goes home and ruminates. [Mr C] says he is unable to focus on anything. Today he had contact with his counsellor and disclosed that he was feeling suicidal".

It was noted that "[Mr C] has been very keen to seek help stating that he wants to be well through the children, he says he does not want them to experience what his father has done to him and his stepsiblings (recent suicide attempt). [Mr C] said that he had expressed suicidal thoughts to his counsellor … He has googled possible options but told writer that he made no preparation and was here to get better".

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A mental state examination was conducted noting multiple symptoms of depression. A risk assessment was recorded, noting that [Mr C] was single with limited family and social support, history of mental illness and associated admissions with suicidal thinking and planning. His history of substance use is noted, and it is recorded that he had limited his alcohol use and "not used drugs for a number of years". His medications were recorded. A discussion with […], presumably the on-call psychiatrist, took place. It was noted that [Mr C] lives alone in a remote area which did not lend itself to a "home treatment option at this time".

This assessment of [Mr C] appears to be reasonably comprehensive and to cover the issues which would usually be assessed in such a situation. The need for a more in-depth assessment was acknowledged, "in light of his past history and expressed suicidal ideation".

It is recorded that "[Mr C] also has a strong sense that he was labelled an addict and not taken seriously by services which could lead to him acting impulsively if returning home this evening".

In my view, this initial contact between [Mr C] and Hawke's Bay DHB mental health clinicians was appropriate because it recognised that he was unwell, recorded information about his fears of not being taken seriously because of his history of substance abuse, and acknowledges a risk of completed suicide sufficient to recommend against him returning home.

In particular, please comment on:

a. The decision not to provide inpatient admission;

It is difficult to comment much on the decision not to provide inpatient admission. Although it appears that [Mr C's] risk of self-harm was acknowledged by the assessing condition, there is no rational given for why a decision was reached that "whilst an acute admission was not indicated, [Mr C] did require a more in-depth assessment in light of his history and expressed suicidal ideation."

In hindsight it appears that the most efficient way of obtaining a more in-depth assessment of the patient's history and to manage his risk would have been to admit him to the inpatient unit.

It is difficult to know whether there exists a culture of declining acute admission to patients who are requesting it in the Hawke's Bay Mental Health Service. In my view, it is possible that the management and staff working for services in the public sector may come to view ward admission as the preserve of those patients subject to the Mental Health Act who require containment in a hospital, and that other patients who are more cooperative should be managed in a community setting. This approach has face validity, but it is important for the risk of suicide to be taken into account to ensure that regardless of the venue of care (at home, in respite, or in the ward), a similar level of care, including medical input, can be provided.

I note that the plan was for [Mr C] to be taken to a respite facility, where he was provided with his regular medication, and a request was made for "please discuss in the MDT (multidisciplinary team meeting) plan psychiatrist review of diagnosis and medication".

Unfortunately, the result of that meeting is uncertain because it is not documented in the patient's notes. The meeting did not result in a review of the patient by a psychiatrist, but a letter to the patient's GP that certain medications should be discontinued. This appears to have been the only action resulting from this meeting. Whilst it may be clinically appropriate over the longer term, it is not in my view appropriate for a benzodiazepine drug such as diazepam to be discontinued in the setting of high suicidal risk without a discussion of the need for this with the patient and an agreed pathway towards achieving this. My reasoning for this is that it is inappropriate to take actions that might place a patient in withdrawal from a benzodiazepine medication without the doctor knowing what impact that might have on a patient's risk of suicide or self-harm, and without appropriate support having been arranged for the patient to undergo withdrawal. Furthermore, it is not at all the case that patients should simply have prescriptions of benzodiazepines

stopped — there is the alternative of handing over prescribing of benzodiazepines to a drug and alcohol service for them to work with the patient to gradually reduce and stop this medication. A collaborative approach to managing prescribing of these medications to benefit the patient's overall health would require a meeting with the patient; in this case there is the backdrop of [Mr C] expressing concern about being labelled and treated as a drug user. Ignoring this stated fear on the part of the patient may have supported [Mr C's] feeling that his needs would [not] be taken seriously.

Although stopping stimulant medications such as methylphenidate is in itself unlikely to lead to acute withdrawal symptoms likely to worsen a patient's suicidal thinking or to increase agitation, within the context of community care in respite as an alternative to acute admission to the ward for suicidal thinking, this decision should not have been taken without addressing the wider context of his presentation and his acute mental health needs. Citing literature and guidelines to support a decision is a poor substitute for informed, holistic decision-making after a thorough psychiatric review. A recognition of [Mr C's] high risk of completed suicide should have led to that issue becoming the clinical priority, rather than the less urgent issue of a prescription of a stimulant medication and a low dose of a benzodiazepine. However, the reasons for this apparent failure to consider his suicide risk as a priority remains unexplained, as the reasoning for this clinical decision-making is not documented.

The expected standard of care would be for the doctor to review the patient's needs as a whole prior to making a determination about what medications should be stopped and how and that the consequences of such a decision should be weighed against acute and long-term risk. It is a departure from the expected standard of care to do otherwise, and this is of moderate severity. In this context, this would not be viewed as appropriate by my colleagues.

b. <u>Re: Whether adequate consideration was given to [Mr C's] mental health history</u>

It appears that clinicians working with [Mr C] were aware that he had a mental health history and this was sought from Waikato District Health Board. I think that there was a fairly good level of awareness that more detail about his mental health history was yet to come following that request. In my view, it is difficult to know whether the mental health history given by [Mr C] was adequately taken into account. It appears that [Mr C] was concerned that his history of substance use might be held against him in some way, leading to him not being able to access the care he needed. The fact that he had been admitted to hospital in [Waikato District] to manage suicide risk in the past was not unknown to the Hawke's Bay service; a history of serious self-harm or suicide attempts is the most important known risk factor determining suicide risk.

Another issue of relevance is that amongst the few clinical notes existing in the Hawke's Bay system prior to the 17th of February 2021, [Mr C's] GP had contacted the mental health service regarding [Mr C] reporting psychotic symptoms, namely

auditory hallucinations emanating from a heater and from shadows. The possibility that this was due to ongoing substance abuse was raised and a plan made for [Mr C] to self-present to mental health services if he wanted to. In my view, the possibility of an earlier missed diagnosis of a psychotic disorder is another indicator for early psychiatric review.

Whether adequate consideration was given to [Mr C's] suicidal ideation.

In my view adequate consideration was not given to [Mr C's] suicidal ideation. It had been recognised by the first assessing clinician that he represented a higher risk of completed suicide or self-harm and as a result he was not sent home from the emergency department. Instead, a plan was put in place to admit him to a respite facility and have him followed up by the appropriate team. It does appear that on making that decision consideration was given to the fact that he was at high risk of suicide but was cooperative and help seeking.

The only documented result of the multidisciplinary team meeting on Thursday 18th February 2021 was a letter by the team's psychiatrist to [Mr C's] GP regarding discontinuing medications. I think that this shows a lack of awareness of the actual reason for [Mr C's] presentation at that time, and this in turn reflects the fact that he had not been seen by a psychiatrist. I think that one way of demonstrating awareness of his high risk of suicidal behaviour would have been for the team to review him in the morning after his admission to the respite facility, or at least to document the reasons why this could not be achieved within a very brief time frame, with the need for an in-person review acknowledged. This should have been scheduled to occur within 24 hours of admission. I think that this is a generous timeframe for reviewing patients who have identified elevated suicidal risk who are placed in respite.

The lack of documentation of any multidisciplinary team meetings leaves me unable to comment on the reasons why [Mr C's] suicide risk was not considered by the team.

It was of concern to me to note that respite staff who had access to [Mr C's] notes felt that he was presenting with a high risk of completed suicide; however, this risk appears to have been glossed over in their discussions with mental health service staff. They were reassured that he did not in fact have a plan to end his life, whereas his plan to do so was clearly documented. My impression of the conversation recorded in the notes is that the staff at respite were more aware of [Mr C's] suicidal plans than the mental health team members.

[Mr C] was inconsistent in his reporting of his suicidal plan; however, I do not see it as being hugely relevant whether he had scoped out possible sites for ending his life in person or via Google maps. I am sure that there is no literature suggesting that there is a lower risk of completed suicide if a person is "only" checking out possible places to commit suicide online versus in person.

> In my view it is a serious departure from the expected standard of care not to communicate and document how this serious risk of completed suicide was taken into account in his care. My colleagues have unanimously expressed that the standard of care should be that any decisions regarding management of patients with elevated suicide risk should be well documented. The suicide risk should be explicitly recognised in such a case, and a robust, agreed management plan should be reached with the patient (and their family if necessary) prior to discharge from respite or an inpatient service.

3. Re: Whether [Mr C] received adequate psychiatric review while in respite care. Please comment on the lack of in-person review during his respite stay

[Mr C] was not seen by a psychiatrist at all during his respite stay, despite this respite being organised as an alternative to hospitalisation, which in turn was indicated by his assessed elevated risk of completed suicide.

Where respite care is offered as an alternative to acute admission, it is to be expected that the level of clinical input from the mental health team should be similar to that which would occur on the acute inpatient unit; otherwise, it is not sensible to think of it as being an alternative at all. [Mr C] did not receive in-person psychiatric review during his respite stay, and this to me seems a critical failing of his care.

[Mr C] had expressed the wish to be seen by a psychiatrist; he had expressed his suspicion that his previous substance use might be held against him within the context of seeking mental health care, and had such a review occurred it is quite possible that a different outcome might have been reached. For instance, an in-person review would have been an opportunity to reconsider whether he required admission to the acute ward, it would also have been an opportunity to discuss with him the appropriateness or otherwise of continuing his medications, ceasing them, or changing them. It would also have been an opportunity to discuss the other supports available to him in the community and to allay fears that his mental health needs might be ignored or minimised within the context of his history of substance misuse. There is a considerable difference between communicating in person that a medication should ultimately be stopped, and offering support for this to be achieved, and communicating the need to immediately cease certain medications by the person's GP whilst apparently failing to arrange an in-person review to address specific concerns raised by the patient.

[Mr C] was seen in person by team members other than the psychiatrist, and some issues.

As above, I believe that this is a moderately severe departure from the expected standard.

4. Re: Whether appropriate consideration was given to [Mr C's] addiction history when developing his treatment plan. Please comment on how this was balanced with other relevant considerations, including [Mr C's] suicidal ideation and mental health diagnoses

In my view, much more was done to address concerns relating to [Mr C's] addiction history and chronic risk of relapse than to the acute high risk of suicide with which he presented. This is the only aspect of [Mr C's] care that was commented on by a consultant psychiatrist, albeit without this doctor having met [Mr C]. A plan of sorts was made to address the potential for harm arising from [Mr C] [being] prescribed methylphenidate and diazepam, which could indeed do long-term damage to him if continued. However, this was not balanced properly against the more acute issue: that [Mr C] was presenting with depressive symptoms and strong suicidal ideation with a plan to kill himself, as well as very specific concerns about the way that his mental health could be ignored in favour of addressing addiction issues. At one point during his respite admission, respite staff contacted the mental health service to express their concern about [Mr C's] risk and his plans for committing suicide. Unfortunately, this was not taken on board by the mental health team, who instead responded with reassurance that this was not the case, perhaps demonstrating that respite staff were in fact more aware of his suicidal risk than were the team managing his care and respite.

In my discussions with colleagues, I have established that the standard of care is that there should be an assiduous effort to address both mental health and substance abuse conditions and that a psychiatric review is an important component of achieving this. [Mr C] probably needed input from a drug and alcohol service as well as a mental health service but to achieve this, given his expressed views, rapport would have to be created between the patient and the team.

Re: The appropriateness of [Mr C's] discharge from [the respite facility] on 19 February, including:

a. Whether adequate risk assessments were undertaken prior to discharge

In my view, [Mr C] had been assessed adequately at the time of presentation to the Emergency Department, when the first assessor [Ms H] noted that "Due to his history and demographic factors, I believe [Mr C] could present with risk to self if not feeling that his needs are being appropriately assessed." This unfortunately foreshadowed what ultimately did happen.

Therefore, in my view, there was at least one fairly comprehensive assessment of [Mr C's] risk of completed suicide, which accurately indicated an elevated acute risk of suicide, with the pathway towards that possible outcome depending in part on [Mr C's] perception he was being treated as a drug user rather than an individual suffering from a mental illness.

In my view, this assessment of elevated acute suicidal risk was adequate and accurate and seems to have been disregarded.

There is another important point at which risk should be assessed, and that is prior to making a decision about discharge. The question should be whether the risk has reduced, or whether there is at least a concrete plan for the risk to be addressed in another setting. For instance, in this case, [Mr C's] risk of suicide should have been reassessed prior to discharge, with a view to establishing whether the risk had been

reduced, or whether it could be managed in a community setting. On the 17th of February, it was the opinion of team members that the risk [Mr C] presented was too high to be managed in a community setting and that respite was required to facilitate a more in-depth assessment. There is no documentation suggestive of this question being asked, let alone answered. There is no indication of a plan beyond phone calls to check on [Mr C's] welfare over the weekend, and no appointment had been made for [Mr C] to attend. There is no evidence that his care had been discussed with a Community Mental Health Team, who might be reasonably expected to take over his care after his discharge — certainly, following a hospital stay, a discharge plan would need to include consideration of follow-up by a mental health team.

Reviewing [Mr C's] notes, I can see no record of the decision-making process regarding discharge whatsoever. There is no minute from a team meeting, no record of deliberation, and no way to know for what reasons this decision was made. This seems like an extraordinary omission.

The admission to respite began with a clear outcome in mind — to better contain the risk of suicide than it could be contained in the community, and to facilitate a more in-depth assessment of [Mr C].

On the other hand, the reasons for [Mr C] being discharged are unknown, and there is no evidence that his high risk of suicide was a factor taken into account in that decision, nor of who was involved in that decision-making. [Mr C] had been ambivalent about staying, but it is not clear that he was discharging against medical advice, and this does not seem to be the case. No reason is given, it is simply stated in a clinical note that the plan was for discharge. The reason for disregarding the initial goal of an in-depth assessment prior to discharge is not given.

There is no documentation of any discussion of admitting [Mr C] to hospital as an alternative to discharging him, and so no way to know whether this option was even considered.

The documentation of [Mr C's] risk only appears to have been taken into account in decision-making at the very beginning of his contact with the mental health service.

The failure to document the reasoning behind a decision to discharge a patient at high acute risk of suicide without having a psychiatric review falls well below the standard expected of a mental health service in such circumstances. The expected standard of care would be to document clinical decision-making, to involve the patient in decision-making, and to present a plan acknowledging this risk and addressing its various sources. The impact of decisions upon risk in the short and long term ought to be considered and documented during the episode of care but particularly at the point of discharge from respite.

b. <u>Whether an appropriate management and follow-up plan were in place following [Mr C's] discharge.</u>

Beyond a plan for staff to call [Mr C] over the weekend, there was no discharge plan made for [Mr C]. He did not have an appointment with a psychiatrist to reassure him that his issues with his medication would be attended to at some stage. This is inappropriate, particularly in the context of [Mr C's] fears that he would not be taken seriously by services. There does not appear to have been any consideration of admitting [Mr C] to the hospital, at least none that is documented. [Ms H] noted [Mr C's] risk and the circumstances in which he might be most vulnerable to suicidal behaviour; however, this also does not appear to have been taken into account in the team's approach to his care.

Patients with an assessed high risk of suicide should be discharged once a management plan is in place to mitigate this risk, with a specified team nominated to take over the responsibility for the execution of this plan. It is much safer to discharge on a Monday morning than a Friday afternoon, given weekend staffing levels. No responsible team or clinician is named, and there is no documentation of a handover to a team (such as a Community Mental Health Team or Community Alcohol and Drug Service) of [Mr C's] care.

Essentially, having read the documentation provided to me, I am unable to understand the reasons for [Mr C] being discharged as they do not appear to have been documented. The follow-up arrangements were vague. The need for a review by a psychiatrist was noted, and a plan for community mental health follow up is alluded to, however there is no referral to a community mental health team on file. There appears to have been little appreciation by those who discharged [Mr C] that his risk of suicide had been assessed as being high just two days before, and that little assessment, treatment or safety planning had been attended to in the meantime.

This is a severe departure from the expected standard of care. Risk is dynamic and partially dependent on the actions of the treating team and in this case there is little evidence that the risk was recognised in clinical decision-making.

c. Any other matters you wish to comment on.

I hope it will be helpful for me to comment on two further issues — the Provider Response, 2 June 2021, and the policy documents made available to me.

The Provider response sets out [Mr C's] history of contact with the mental health service, including a contact from his GP regarding psychotic symptoms experienced by [Mr C] around that time. The possibility that [Mr C] might be suffering with substance-induced psychotic symptoms was raised. The possibility of a first episode of psychosis was not raised. A plan was suggested for [Mr C] to self-present to the service. In my view, a far more appropriate plan would have been to ask the doctor to send a referral to the relevant community mental health team for [Mr C] to be assessed on a semi-urgent basis, as psychotic symptoms require assessment to determine cause, associated risk, and possible links to other factors such as medical problems, personality disorders, and substance use. I note that [Mr C] told relatives

that he had heard a doctor talking about him during his stay in […] the unplanned respite facility.

[The provider] provided information regarding the arrangement of respite for [Mr C], additional to the information in the health record. It appears that there was some discrepancy between what was said verbally and the written records. My reading of [Ms H]'s assessment of [Mr C] does not leave me with the impression of "low risk" overall; however, under the circumstances where the patient is cooperative and help-seeking, I think that it may be appropriate to assess a patient's acute risk of suicide as low, even if their overall risk of dying by suicide is high. This, however, implies a level of risk that is fluctuating and depends on a range of factors, including the patient's engagement with treatment. In this case, [Mr C] was discharged without that engagement having been established.

Perhaps more important than the issue of communication about risk levels in this instance is [the provider's] statement that "It was agreed that [Mr C] would be reviewed next day". It is likely under such circumstances that a review by a psychiatrist or trainee psychiatrist was anticipated, rather than a review by allied health professionals, as [Mr C] presented with sufficient risk of suicide that it was felt to be unwise for him to return home. It was also very clearly stated by [Mr C] that he needed a psychiatric review due to concerns about his medication.

The Provider response covers the letter written by [Dr J] to the GP because of the MDT[M] on 21 February 2021. It notes the consistency between [Dr J's] advice and that of the New Zealand Formulary. The New Zealand Formulary is available to GPs and frequently used by them. [Dr J's] letter presupposes that [Mr C] had ongoing substance use problems sufficiently severe to warrant suddenly stopping these medications without a plan to manage any resulting changes in risk in the short term, for instance agitation caused by benzodiazepine withdrawal.

The information in [Dr J's] letter to the GP is correct; however, it is never possible to determine whether a healthcare worker's intervention is well-timed and relevant without a more comprehensive assessment in place. To start making changes to the patient's long-term management before meeting him and assessing his needs was inappropriate and would be poor practice in any case. In fact, notes from the respite facility show that [Mr C] was upset by hearing about this advice to his GP and did threaten suicide following this.

It is stated several times in the Provider's response that [Dr J] "never directly met with [Mr C]". However, it does appear that [Dr J] was part of at least one multidisciplinary team meeting and if asked he may have been able to shed light on the reasons why he did not meet with [Mr C].

I am very concerned that [Dr J's] letter to the GP on 21 February 2021 is the only record of the Multidisciplinary Meeting at all. It is impossible to know what the team's discussion or deliberations covered with respect to [Mr C]. The reason for the apparent shift with respect to the perception of the risk of [Mr C] committing

suicide are unknown, because the meetings in which this was likely discussed are simply not documented. It is in fact impossible to know from this documentation whether his risk was recognised or considered at all during the process of deciding to discharge [Mr C].

It is somewhat disappointing that the obvious deficiencies in [Mr C's] care such as the lack of documentation of important meetings or other suggestions for improvements to the service do not appear in the provider response.

[…], on behalf of the provider, concluded that the provider had not found evidence of any negligence by any mental health worker. However, in my view investigations of events such as [Mr C's] death need to go far beyond the question of negligence or blame and should aim to find areas for improvement.

Policies

The provider has given several policies for review in response to your request. Although the Provider's Response lists an "Existing Respite Care. PDF", presumably also a policy, this is missing from the materials provided to me. The Home-Based Treatment (HBT) policy spells out inclusion criteria for that service, noting that rural clients can only receive the service "by negotiation" and that the service is not able to support people "posing imminent and severe risk to self or others that cannot be supported at home or living environment". A referral form is required for entry into the service. Once again, it is unknown whether the additional support of HBT was considered in [Mr C's] case.

There is no document available to me outlining how patients placed in respite should be treated, nor whose responsibility this is. I assume that existing patients of the service are placed in respite and remain under the care of their usual treating team. The mental health unit will have its own policies regarding admission criteria, documentation, and care practices.

The provider's response does not identify any areas for improvement arising from [Mr C's] death, and there is no reflection on the adequacy of the documentation of clinical decision-making.

Recommendations

In my view, it is essential that the provider institute a policy of documenting Multidisciplinary Team Meetings forthwith. This documentation need not be lengthy or detailed but will at least show that a meeting occurred, the attendance to the meeting, issues discussed, and outcomes of the meetings. An alteration to the documentation policy of the provider should be made to this effect.

Furthermore, I note that the documentation when [Mr C] presented to ED was adequate and gave a clinical impression of a person with multiple problems and elevated risk of suicide. However, it may be appropriate to make a document, which might be titled "Respite Admission Summary" which would need to include a risk

assessment and a goal for admission. The team responsible for providing care to the patient during their respite stay should be clearly documented on the form.

The purpose of stating a goal for admission is to clearly state the outcome that should be achieved before discharge. In this case, "short-term stabilisation of suicide risk and arrangement of necessary follow-up care" would have been a good goal — it would have made it much easier for the team to reflect upon whether or not the admission goal has been reached before discharge or transfer to another team. To change the admission goal would be possible via the MDT[M] process, but it should remain as a guide to treatment and discharge planning.

The "Health Record Standards for the Mental Health Service" document sets out that a registration form and a "Comprehensive Assessment" document should be commenced, to be updated during the patient's period of contact with the service. It appears to be a universal requirement; however it is unclear to me whether the assessment conducted by [Ms H] on the 17th of February 2021 is considered to be a "Comprehensive Assessment" in terms of that policy. These are often completed on separate forms rather than being placed between other notes.

It is important also to address [Mr C's] other presentations to the service prior to 17 February 2021. He had been seen in the police cells and assessed as being intoxicated in March of 2020. His GP also contacted the service regarding the first emergence of psychotic symptoms. In my view, it would have been far more appropriate for the service to respond to reports of psychotic symptoms by requesting a formal referral from the GP, which should result in consideration of an outpatient assessment by the community mental health team, at least. One of the reasons for this is that positive psychotic symptoms (such as hallucinations) are often accompanied by negative symptoms such as amotivation and disorganised behaviour, which reduces the ability of people experiencing psychosis to engage with services without some direction and guidance. Put another way, a person who is hearing voices may be experiencing other symptoms that could prevent them from arranging even basic things for themselves, and a proactive approach from a mental health service is far more likely to be useful than leaving it up to the person to present themselves for assessment. Another reason for treating such symptoms seriously is that the risk relating to psychosis is often high, can involve other members of the community, and is difficult for those without experience to assess. Education about the management of initial presentations of psychosis should be conducted for all team members whose job involves responding to referrals and inquiries from GPs, and the organisation as a whole should explicitly express a commitment to responding appropriately to referrals for psychotic symptoms, perhaps in the form of an alteration to relevant policies.

It would also be useful for the provider to conduct its own reflections on this case, with the benefit of the local knowledge of the services and teams involved, focused on creating appropriate safeguards and clarification of the expected management of patients in respite. This reflection should seek explanations of the reasons for why [Mr C] was not assessed by a psychiatrist, and how his risk was communicated

and responded to between the assessing clinician in the Emergency Department and the team who took over his care the next day.

Because of the inadequacy of the documentation in this case with respect to clinical decision-making within the multidisciplinary team, it is difficult to make more specific recommendations in this case.

In my view, it is important for the provider to consider giving an apology to [Mr C's] family for the inadequacies in his care and the documentation thereof.

I trust that this report will be of some assistance to the Commissioner. Please feel free to contact me should you require further information.

Yours sincerely,

Dr Caleb Armstrong, FRANZCP, Cert Child Adol Psych, Cert Adult Psych, Cert Forensic Psych'