Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Shortcomings in care of man suffering mental distress

19HDC02030

Te Whatu Ora Capital, Coast and Hutt Valley and a psychiatrist at the Community Mental Health Team (CMHT) breached the Code of Health and Disability Services Consumers' Rights in their care of a man aged in his sixties.

The man, who had been under the care of CMHT for a number of years, died in hospital after harming himself, following a period during which his parents noted concerns over his deteriorating mental state, which included agitation, panic attacks, depression and suicidal ideation.

The man received care from two psychiatrists and the crisis contact centre, all of which were part of the CMHT run by the Mental Health, Addiction and Intellectual Disability Service (MHAID). The man was also receiving care from his general practitioner (who was not subject to the investigation).

Throughout this period there was increased contact with the CMHT by both the man and his parents due to concerns about the man's mental state, including frequent phone calls with the crisis contact centre and appointments with two psychiatrists. However, there were a number of shortcomings in the documentation kept by staff in the CMHT, and in the communication from one of the psychiatrists to the man's general practitioner, resulting in inconsistent approaches to the man's care.

Additionally, the whānau meeting – arranged to discuss ongoing management of the man's care – left the man feeling distressed about being discharged from the care of the CMHT.

Deputy Health and Disability Commissioner Dr Vanessa Caldwell, found Te Whatu Ora Capital, Coast and Hutt Valley in breach of Right 4(5) of the Code, which gives consumers the right to cooperation among providers to ensure quality and continuity of services.

Dr Caldwell noted that on a number of occasions staff at CMHT and the contact centre kept poor records of the man's contact with the services.

"In my view, the inadequate documentation kept by the contact centre and CMHT contributed to a distinct lack of clarity and action amongst teams about changes in the man's care, treatment plans, and expectations, including the possibility of the re-emergence of symptoms. This culminated in the collective failure by several clinicians at various points of crisis contact and at the whānau meeting to offer appropriate support to the man following his increasing distress which was entirely predictable."

Dr Caldwell also found the psychiatrist breached Right 4(5) of the Code for the lack of co-operation with the man's general practitioner to ensure quality and continuity of care.

"I am concerned about the psychiatrist's lack of engagement with the man's GP, particularly regarding changes in the man's treatment and the reduction of antipsychotic medication," she said.

Dr Caldwell's recommendations for Te Whatu Ora Capital Coast and Hutt Valley include providing a written apology to the man's whānau for the failings identified in the report.

Te Whatu Ora have made a number of changes in response to this report. This includes confirming that MHAIDS have implemented two of the recommendations, including reviewing the Whānau/Family Participation policy to ensure care, transition planning and exit processes incorporate practices that support collaborative planning and outcomes.

Dr Caldwell made several recommendations for one psychiatrist but noted that they have since retired from practice. The other psychiatrist was found not to have breached the Code and has made a number of changes in response to the report.

June 26, 2023

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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