HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Decision by the Deputy Health and Disability Commissioner

(Case 20HDC01354)

Contents

Introduction

1. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to the late Mr A by Health New Zealand|Te Whatu Ora (Health NZ),[1] a rehabilitation service provider, and a medical centre.

3. The following issues were identified for investigation:

- *Whether Health New Zealand|Te Whatu Ora provided [Mr A] with an appropriate standard of care from [Month1 2019 to Month7 2020] (inclusive).*

[1] Formerly known as Te Whatu Ora|Health New Zealand. On 1 July 2022 the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Health New Zealand.

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

- *Whether [the medical centre] provided [Mr A] with an appropriate standard of care from [Month1 2019 to Month7 2020] (inclusive).*

4. The parties directly involved in the investigation were:

Mrs A's wife	Complainant
Mr A's son	
Health NZ	
The medical centre[2]	

5. Further information was received from:

Dr B	Neurologist
Dr D	General practitioner (GP)/Public Hospital 2[3]
Rehabilitation service provider[4]	
Ambulance service provider	
Mrs A's counsellor	
A psychiatrist	
The New Zealand Police	
The Coroner	
ACC	

6. Also mentioned in this report:

Mr A	Consumer
Dr C[5]	GP
RN E	Registered nurse
Dr F[6]	GP
Duly authorised officer	

7. In-house clinical advice was received from GP Dr Fiona Whitworth (Appendix A).

[2] This medical centre is the sole practice providing primary care services in the region.
[3] At the time, the public hospital was staffed by GPs from separate practices.
[4] The rehabilitation service provider was contracted by ACC to provide post-concussion rehabilitation services to Mr A. The concussion service provides early access and timely assessment for people who have sustained a mild (concussion) or moderate traumatic brain injury or have post-concussion syndrome.
[5] Dr C also provides medical services to other hospitals within the region and saw Mr A when he was admitted to the public hospital.
[6] Dr F also provides medical services to other hospitals within the region and saw Mr A when he was admitted to the public hospital.

Background

Introduction

8. Mr A, aged in his fifties at the time of the events, had a history of rheumatoid arthritis,[7] which had been diagnosed in October 2018. In Month1 Mr A had an incident while surfing, and over the next six months he developed complex symptoms that initially were thought to have occurred due to a combination of post-concussion syndrome[8] and mental illness.

9. Mr A presented repeatedly to various healthcare providers between Month1 and Month7 for treatment. He had five hospitalisations within rural and regional public hospitals in the region, multiple presentations to his primary care provider, mental health service follow-up in the community, and follow-up with a rehabilitation service provider who provided post-concussion services.

10. In Month7 Mr A deteriorated and passed away. The post-mortem report identified the cause of his death as 'severe meningoencephalitis[9] with features most in keeping with rheumatoid meningoencephalitis' (a manifestation of Mr A's arthritis). Mr A had not received a diagnosis of meningoencephalitis before his death and thus was not treated for it.

11. Mrs A complained to this Office about the care provided to Mr A by various healthcare providers. Mrs A told HDC that Mr A received an incorrect diagnosis, at a time when Mr A's whānau had placed 'unconditional trust' on providers within the region. Mrs A said that Mr A's misdiagnosis occurred from 'ill informed, biased decision making' resulting in 'inadequate action and lack of critical support', which brought about 'unwarranted suffering' for their whānau and community.

12. Adverse event reports (AERs) completed by Health NZ and the rehabilitation service provider noted systems failures in the care provided to Mr A.

13. This report focuses on the key issues that impacted Mr A's standard of care. At the outset, I note that HDC received differing information from each provider about their engagement with Mr A and with each other. To simplify this information, a timeline of Mr A's care is attached as Appendix B.

Surfing accident and hospital admission

14. Clinical records show that on 28 Month1, while surfing at a beach, Mr A was found 'dumped on the beach', agitated and experiencing seizure activity. This incident marked the start of Mr A's complex symptoms and repeated presentations to healthcare providers.

15. An ambulance service was called for support, and Mr A was transferred to Public Hospital 1 for further management. During the hospital admission, Mr A was reviewed by a

[7] An autoimmune disease in which the immune system attacks healthy cells within the body, causing inflammation (painful swelling), mainly of the joints but also of other areas of the body.
[8] Post-concussion syndrome occurs when a patient experiences persistent symptoms three months or more after a head injury.
[9] Infection and inflammation of the brain and layers of the thin tissue that covers the brain (meninges).

neurologist, Dr B, who noted an impression of 'provoked seizure secondary to concussion' and a secondary impression of poor sleep related to prednisone.[10] A CT scan of the head was completed and reported '[n]o acute abnormality'.

16. Mr A was discharged on 30 Month1 after no further seizure activity had been noted. Health NZ's AER states that 'seizures within 24 hours after a traumatic brain injury are not indicative of further seizure activity'. Dr B told HDC that Mr A did not have features of encephalitis,[11] and Dr B would have expected Mr A to have had further seizures if he had meningoencephalitis.

17. Mr A's discharge letter for his 28 Month1 presentation recorded a follow-up plan for an electroencephalogram (EEG)[12] to assess for epilepsy,[13] and an outpatient neurology appointment with Dr B after the EEG had been completed.

18. Neither the outpatient neurology appointment nor the EEG occurred prior to Mr A's death, and there is no documentation to show that Health NZ followed up on these when they did not occur. Health NZ's AER indicates that neither task was completed owing to an administration issue within Health NZ's systems.

19. The only documented follow-up was by Dr C, Mr A's GP from the medical centre, who wrote to Dr B on 14 Month7 and advised to expedite the EEG. In response to the provisional report, the medical centre told HDC that it was the norm for EEGs, including those marked as 'urgent', to have significant waiting times in the region and in an outpatient clinic. Therefore, the prolonged delay in completing the EEG did not raise any alarm bells.

Concussion assessment and ACC

20. Dr C filed an ACC treatment injury for Mr A's concussion on 30 Month2 and sought a referral to the concussion service. In addition, on 2 Month3 Dr C wrote directly to the rehabilitation service provider, asking for a complete concussion assessment. The rehabilitation service provider confirmed that it received this referral.

21. The rehabilitation service provider told HDC that the usual process following a referral involves an initial assessment of the consumer and subsequent triaging with interdisciplinary team input, which determines the diagnosis, intervention, and a tailored rehabilitation programme for the consumer. The rehabilitation plan is then forwarded to ACC for approval. ACC's records show that approval was given for the post-concussion assessment to be undertaken on 13 Month3. Health NZ's AER states that the usual wait time from referral to the first appointment is three months.

[10] A steroid used to treat arthritis.
[11] Inflammation of the brain.
[12] A test that measures electrical activity in the brain.
[13] A disorder in which nerve cell activity in the brain is disturbed, causing seizures. Epilepsy may occur as a result of a genetic disorder or an acquired brain injury, such as trauma or a stroke. During a seizure, a person experiences abnormal behaviour, symptoms, and sensations, sometimes including loss of consciousness.

22. Mr A required an occupational therapy (OT) assessment, physiotherapist assessment, medical review, and a neuropsychology screen. The rehabilitation service provider told HDC that these assessments were required to better understand Mr A's aetiology[14] and the severity of symptoms, and to determine the influence of neurogenic[15] and/or psychogenic[16] factors affecting Mr A's cognitive and emotional functioning.

23. Initial assessment was completed by the rehabilitation service provider's OT on 20 Month3. On 6 Month6 the rehabilitation service provider completed Mr A's physiotherapy screen. A neuropsychology case review occurred on 11 Month6, and a medical case review occurred on 17 Month6.

24. The rehabilitation service provider told HDC that there was no delay in completing the OT screen. However, it acknowledged that there was a delay in completing the physiotherapy and neuropsychology case reviews. The rehabilitation service provider's AER and its statement to HDC indicate that the delays occurred for numerous reasons, including, but not limited to, a lack of engagement from Mr A, the inability to access Mr A's full medical notes, planned staff leave, and difficulties visiting Mr A due to the remote location of his residence.[17] Health NZ's AER and the medical centre's statement to HDC also notes the delayed assessments by the rehabilitation service provider.

25. The lack of engagement from Mr A was evident in the clinical records provided by the rehabilitation service provider. These show that efforts were made to contact Mr A via Mrs A, and the rehabilitation service provider advised ACC of these difficulties. There is no documented response from ACC as to how to manage the difficulties.

26. The rehabilitation service provider's AER indicates that the medical centre did not always appear to receive the rehabilitation service provider's phone calls and messages, including those about Mr A's engagement. Likewise, clinical records show that the medical centre tried to contact the rehabilitation service provider directly to expedite the rehabilitation service provider's assessments, but this was not always successful.[18] In addition, the rehabilitation service provider's AER shows that the medical centre asked Mrs A to contact the rehabilitation service provider regarding an assessment on several occasions.[19]

Assessments and specialist input

Health NZ assessments

27. Between Month1 and Month7, Mr A experienced symptoms including mood swings, amnesia, headaches, urinary incontinence, balance issues, impulsive and abusive behaviour, and discoordination of thoughts and actions.

[14] The causes or manner of causation of a disease.
[15] Caused or controlled by the nervous system.
[16] Attributable to psychological or emotional factors.
[17] A 1.5-hour drive according to the rehabilitation service provider's AER.
[18] As per Health NZ's AER and the rehabilitation service provider's AER. This occurred on 18 Month4 and 4 Month5.
[19] On 15 Month5 and 21 Month5.

28. Clinical notes indicate that many of these symptoms were attributed to either post-concussion syndrome or mental health/behavioural issues. However, Health NZ's AER, which received input from a psychiatrist and a neurologist, states that these were neurological in origin. The neurological nature of Mr A's symptoms was also indicated in Mr A's clinical records from 2019 when a house officer noted cerebellar[20] signs, and in a consultant review two days later, which queried encephalitis.[21]

29. Health NZ's AER notes issues in the standard of assessments completed by clinicians and the clinical descriptors of Mr A's care and symptoms. The AER states that this was driven by clinical bias, diagnostic momentum,[22] and the nature of the information available to clinicians.

30. Mr A began to present with psychiatric and behavioural symptoms in Month4, in addition to symptoms that were atypical for a mental health disorder.[23] Health NZ stated that organic causes needed to be ruled out before a psychiatric diagnosis could be established, and specialist psychiatric and neurology input should have been requested. Health NZ's AER indicates various stages of Mr A's care where organic causes were not considered, including the various assessments completed by the community mental health team, the medical consultant's assessment on 15 Month5, which followed a psychological pathway, and the decision to admit Mr A to the mental health unit on 15 Month7.

31. The clinical records note that on 23 Month4 Mrs A expressed concerns about Mr A's behavioural changes. He was assessed by the Mental Health and Addictions Service (MH&A), and it is noted that a 'neuropsychology assessment [was] pending'. It is documented that Mr A did not want to see a psychiatrist and did not meet the threshold for further assessment under the Mental Health Compulsory Assessment and Treatment Act 1992 (the Mental Health Act).

32. Mental health nurses from the MH&A team completed four assessments between 23 and 31 Month4. Health NZ's AER notes that although the MH&A team's assessments were comprehensive, organic components still needed to be ruled out first before a psychiatric diagnosis could be established.

33. Health NZ's AER states that a multidisciplinary meeting with the MH&A team was held in Month4, but it is not known whether a psychiatrist or neurologist attended the meeting.

34. On 15 Month7, following a home visit from Dr D, a Health NZ doctor and GP from the medical centre, a decision was made to admit Mr A directly to the mental health unit at a public hospital. Health NZ told HDC that this did not follow the usual admission pathway, where normally a consumer is admitted to the ED first. A duly authorised officer (DAO) for Health

[20] Refers to issues within the cerebellum, which is the part of the brain that controls motor coordination, balance, and cognitive and emotional functions.
[21] The consultant stated that while the previous focus had been on the psychiatric aspects of Mr A's illness, it was clear on this occasion that Mr A was extremely unwell with evidence of significant neurological pathology.
[22] Ruling in a particular diagnosis without adequate evidence.
[23] Impaired balance, amnesia, urinary incontinence.

NZ[24] said that this was because Mr A 'had been thoroughly assessed on the … medical ward …'. Therefore, a plan was made to transfer Mr A directly to the mental health unit, which was a quicker pathway than waiting in ED.

35. Health NZ's AER states that the admission of Mr A to the mental health unit delayed Mr A's medical assessment, as his case should have been discussed with a psychiatrist and neurologist sooner. The AER states that as Mr A was admitted to the mental health unit rather than the ED, medical interventions and investigations were not prioritised, reducing the opportunity to rule out organic causes for Mr A's symptoms.

Medical centre assessments

36. Between Month1 and Month7,[25] Mr A presented repeatedly to the medical centre with worsening symptoms, including headaches, photophobia, nausea, and changes in mood, and he was seen by multiple clinicians.

37. The clinical record indicates that there was limited neurological assessment and documentation of red flags and negative findings. There was also no documented neurological examination or fundoscopy[26] completed when Mr A reported photophobia and an increase in headaches on 4 Month5. Minimal history was taken regarding Mr A's headaches.

38. In addition to the lack of documented assessments, it does not appear from the clinical record that Mr A was provided with any safety-netting advice following his appointments. This included Mr A's presentation on 17 Month4 where he was advised by Dr C to restart an increased dose of amitriptyline[27] to treat his headaches.

39. On 4 Month5 Mr A was seen by Dr D at the medical centre. Dr D noted that Mr A had ongoing photophobia, migraines, and vomiting and that Mr A had had two collapses at home. Dr D recorded a plan to seek neurologist input, but Health NZ's AER states that the referral to the neurologist did not occur because reportedly Mr A's headaches had improved.

40. On 22 Month5 Mr A was seen by a different GP at the medical centre, Dr F, for the ongoing headaches and photophobia. Dr F documented that the rehabilitation service provider had been in touch with Mr A, and a neuropsychiatrist referral had been planned. Dr F advised the MH&A team that Mr A would be seen by the rehabilitation service provider and asked the team to 'please disregard previous request for assessment'. Health NZ's AER states that it is unclear why this referral was withdrawn.

[24] DAOs are health professionals designated and authorised by a Director of Area Mental Health Services (DAMHS) to perform certain functions and use certain powers under the Mental Health Act.
[25] On 8 Month2, 2 Month3, 13 Month3, 30 Month3, 17 Month4, 4 Month5, and 11 Month5.
[26] A visual examination of the retina and the optic disc.
[27] An antidepressant that is also used to treat migraines.

Complexity and rarity of illness

41. As noted above, between Month1 and Month7 Mr A experienced a variety of symptoms, and he did not receive a diagnosis of, or treatment for, meningoencephalitis prior to his death.

42. Health NZ's AER notes that rheumatoid encephalitis is a 'very rare condition' and that usually, prognosis is poor. The AER states that the diagnosis would have been difficult to make because of this, as well as the absence of overt symptoms of infection, as Mr A's arthritis was under control and several medical investigations had proved to be normal. The AER concluded that Mr A's diagnosis would have been delayed, even if it had been identified prior to his death.

43. Similar to Health NZ's AER, the rehabilitation service provider's clinical notes record:

> '[Mr A] ha[d] demonstrated an unusual and unexpected symptom trajectory. Symptoms have been inconsistent, ranging in functionality from adequately independent … to unusually high impairment.'

44. The rehabilitation service provider's AER indicates that clinicians had difficulty understanding Mr A's symptoms. The AER states that the rehabilitation service provider's physiotherapist did not understand some of the 'red flags' in Mr A's conditions or what to do about them, while other clinicians were concerned that this was not concussion related. On 14 Month7 the rehabilitation service provider wrote to ACC stating that Mr A's symptoms did not 'necessarily [relate to] a concussion anymore' and that multidisciplinary team (MDT) input was required to problem solve.

Information sharing between providers

45. HDC received conflicting information from parties about what was shared and when. Health NZ's AER notes that there was poor communication and a lack of coordinated care across the treating teams. This meant that providers were giving advice, re-referring to each other, and waiting for reports, updates, or tests without follow-up, consultation, or clear oversight over Mr A's care. The lack of liaison meant that providers were not able to get a full picture of Mr A's complex symptoms, some of which were fleeting and appeared to self-resolve.

46. The medical centre's statement to HDC and Health NZ's AER indicate that the rehabilitation service provider did not share the findings of its initial assessments with the medical centre. The medical centre contacted the rehabilitation service provider multiple times[28] to complete its initial assessment, as Dr C was unsure 'how much' was concussion and/or migraine related. Despite multiple attempts by the medical centre, the rehabilitation service provider did not appear to return their contact. The clinical record notes one instance in Month5 where the rehabilitation service provider told the medical centre of the difficulties in contacting Mr A. The rehabilitation service provider's response to HDC states that this was because it was unable to provide information to non-ACC entities at the time without

[28] This occurred on 2, 17, and 18 Month4, by phone and email.

ACC's permission.[29] In contrast to this, ACC told HDC that it expects all suppliers to proactively share information with clients' GPs and other providers in accordance with good professional practice, although it also said that there was a lack of consistency in ACC's expectations of its suppliers.[30]

47. In response to the provisional opinion, the medical centre told HDC that as Mr A had been referred by its practice, it expected feedback on assessments and treatments. It stated that when assessments are completed by other providers, GPs are typically provided with written notification of such assessments and if there is significant concern, a phone call is often initiated.

48. ACC's records show that the rehabilitation service provider had been advising ACC on its difficulties in engaging with Mr A and that he appeared to be 'acutely unwell' requiring hospital/medical assistance. Further, the rehabilitation service provider provided a report outlining a set of recommendations, including an MRI scan, neurology review, and neuropsychology assessment, explicitly requesting that ACC forward these recommendations to the medical centre. ACC did not forward the recommendations to the medical centre until 24 Month7. Dr D stated: '[I]f we had [had] access to this report (which strongly suggested a neurologist referral) we would have referred him to a neurologist.' In response to the provisional opinion, ACC said that this was because the report sent to it on 23 Month6 was a draft and, while it contained useful information, there was no express request for it to be provided to Mr A's GP. The final report was not sent to ACC until 22 Month7.

49. The rehabilitation service provider's AER states that it had asked for GP clinic notes from ACC multiple times and that ACC did not provide clinical notes in a timely manner. However, ACC's records show that there was evidence of only one occasion where the rehabilitation service provider requested medical information (on 13 Month7). In addition, the rehabilitation service provider's AER states that the medical centre did not inform the rehabilitation service provider of the significant changes in Mr A's personality and behaviour during GP consultations. The rehabilitation service provider said that its staff repeatedly tried to get information from the medical centre without success. In contrast, the clinical records show that in Month4, Dr C advised the rehabilitation service provider that Mr A's ongoing headaches were now 'very problematic' and required hospitalisation and cancellation of his overseas trip.

50. The rehabilitation service provider said that its staff noted that Mr A was not suitable for its service, with their staff repeatedly referring him back to the GP or ED, only for them to re-refer Mr A back to the rehabilitation service provider. However, there is no evidence of

[29] In response to the provisional report, the rehabilitation service provider told HDC that this was not the current view held by the business.

[30] ACC said that it does not consider that its role is to set standards of practice for the provision of contracted services. Rather, ACC requires suppliers and providers to act in accordance with professional standards and guidance established by the relevant professional and regulatory bodies.

the rehabilitation service provider advising the medical centre that Mr A was not suitable for its service.

51. Mrs A also contacted the rehabilitation service provider's staff on two occasions, on 21 Month4 and 15 Month5, for continuation of services, which resulted in the rehabilitation service provider referring Mr A to the GP or the emergency department.

Communication between Health NZ staff and Mr A

52. Mrs A's complaint indicated several concerns relating to the communication provided to Mr A by Health NZ staff.

53. On 15 Month7, Dr D and RN E completed a home visit (as part of Health NZ's mental health service) due to concerns that Mr A was in a distressed state.

54. Mrs A said that RN E 'proceeded to berate and belittle [Mr A]', asking him to 'sort himself out'. Mrs A said that this was 'repeated … over and over' and that Dr D 'backed [RN E] up'. Mrs A stated that Dr D advised to 'ignore [Mr A's] behaviour as he was putting it all on and only ramping up his manipulation' of [RN E].

55. Dr D acknowledged stating that Mr A's behaviour seemed to be manipulative. Dr D said that the comments relating to Mr A's manipulative behaviour were based on the previous observations of Mr A, and the advice given to Mr A's family regarding the management of Mr A's behaviour was based on many sources.

56. Dr D considers that the communication between Dr D and RN E with Mrs A and her whānau was not disrespectful or belittling to Mrs A. However, Dr D expressed sincere apologies if the engagement was perceived in this way.

Documentation issues

57. It is clear from my own review of the clinical records that there are significant gaps. Health NZ's AER also shows concern about the standard of documentation by Health NZ, the rehabilitation service provider, and the medical centre clinicians.

58. The rehabilitation service provider's AER states that 70% of Mr A's clinical notes were not completed. In particular, the rehabilitation service provider's AER notes that further appointments occurred with the OT and Mr A over Month4 and Month5,[31] but there is no documentation of what the appointments involved. In addition, keyworker reports did not always indicate whether Mr A was seen on his own or how he got to their clinic.

59. On 16 Month7 Mr A was reviewed by a house officer in the mental health unit. The house officer completed a full examination and noted clear cerebellar signs, mild weakness, and stilted eye movements. An MRI scan was requested, and a referral was made for Mr A to be seen in Neurology on 17 Month7. However, Health NZ's AER documents that this neurology

[31] The appointments occurred on 1, 7, 21, 23 Month4, and 21, 26 Month5. Appointments on 23 and 31 Month6 were also not recorded.

review was deferred to an outpatient appointment without reviewing Mr A in person, and the reasons for the change are unclear and are not recorded.

60. Clinical records for the medical centre also demonstrate a lack of compliance with documentation standards. There is minimal recording of the symptoms experienced by Mr A, the assessments undertaken, the advice given, and when Mr A was due for a follow-up, particularly when he experienced repeated headaches. In response to the provisional report, the medical centre stated that at times Dr C's clinic notes were brief because it was apparent that Mr A was distressed, and neurological examination had been deferred until the headache and vomiting was better controlled. However, the medical centre acknowledged that Dr C did not complete detailed documentation.

61. In addition, when Mr A was referred to Public Hospital 2's ED on 30 Month3, the referral did not document differential diagnoses and information about the assessments completed on Mr A. In response to the provisional report, the medical centre told HDC that if a patient belonging to a medical practice presented to the hospital, then the GP from the medical practice was responsible for admission and the initial management (unless it was after hours). In non-acute situations, it was usual practice to send the patient to the public hospital with a drug chart and for the GP to go to the hospital to complete the admission paperwork afterwards. The medical centre said that on 30 Month3, Dr C went to the public hospital to complete the admission paperwork. Therefore, the referral was just a brief note to the nurses outlining the reason for admission and treatment instructions.

Further information

62. Health NZ provided Mrs A with a copy of its AER and invited Mr A's whānau to a hui to discuss the AER. Mr A's son stated that his whānau accepted the AER findings, provided that the recommendations were followed through.

Relevant standards

63. The Medical Council of New Zealand's Good Medical Practice standards (dated November 2021) state that doctors must:

- '[P]rovide a good standard of clinical care. This includes:
  - adequately assessing the patient's condition, taking account of the patient's history and their views, reading the patient's notes and examining the patient as appropriate
  - providing or arranging investigations or treatment when needed
  - taking suitable and prompt action when needed and referring the patient to another practitioner or service when this is in the patient's best interests.'
- '[K]eep clear and accurate patient records that report:
  - relevant clinical information
  - options discussed
  - decisions made and the reasons for them.'

Responses to provisional report

Health NZ

64. Relevant portions of the provisional report were provided to Health NZ for comment. Health NZ told HDC that it accepted the findings and recommendations. Other comments have been integrated elsewhere in this report where relevant.

Rehabilitation service provider

65. Relevant portions of the provisional report were provided to the rehabilitation service provider for comment. The rehabilitation service provider told HDC that the business has changed hands since the events, and the new owners thanked HDC for its thorough review and consideration of this case. It acknowledged the tragic outcome for Mr A and his whānau, and the multifaceted system failures that cumulatively led to Mr A receiving a poor standard of care. Other comments have been integrated elsewhere in this report where relevant.

Medical centre

66. Relevant portions of the provisional report were provided to the medical centre for comment. The medical centre extended its sincere condolences to Mr A's whānau for their loss. Other comments have been integrated elsewhere in this report where relevant.

Mr A's whānau

67. Mr A's whānau was provided with the 'facts gathered' section of the provisional report and given the opportunity to comment on this. A hui was held with the whānau to give them an opportunity to ask questions and provide comments.

68. In summary, this experience has caused significant trauma for the whānau. The whānau expressed that they placed significant trust in the healthcare providers in the region to look after Mr A, but this trust was not reciprocated when the whānau advocated for Mr A's welfare. In particular, the whānau expressed disappointment over the care provided by the medical centre — they criticised the practice's lack of documentation, its refusal to believe that Mr A was unwell, its refusal to provide care to Mr A when he presented to the practice multiple times, its lack of ordering of an MRI, its lack of communication, and its lack of response when concerns were raised. This resulted in a significant loss of dignity for Mr A and his whānau.

69. The whānau accepted that many changes have been made by Health NZ and the rehabilitation service provider and feel more reassured by this. However, they expressed discontent over the lack of changes made by the medical centre and feel that the practice has not taken any accountability. They would like to see more changes in the medical practice, particularly in the context of the medical centre being the only medical practice available in the region and there being a lack of other options to seek primary-care services for the residents.

Opinion: Introduction

70. In Month1 Mr A was thought to have suffered a head injury following an unwitnessed accident while surfing, due to the observed seizure activity at the beach. Over the next six

months Mr A developed complex symptoms, including severe migraines, photophobia, behavioural and personality changes, urinary incontinence, amnesia, and balance issues. Mr A presented to various providers repeatedly from Month1 to Month7 due to these issues. Sadly, in Month7 Mr A passed away and the post mortem identified the cause of death as severe meningoencephalitis with features in keeping with rheumatoid meningoencephalitis, linked to Mr A's rheumatoid arthritis, which had been diagnosed in 2018.

71. At the outset, I reiterate my deepest sympathies to Mr A's whānau for their loss. Mrs A and her whānau were very involved in Mr A's care, and this was a tragic outcome. I also acknowledge the complexity and rarity of Mr A's illness. Mr A's presentation was unusual for rheumatoid meningoencephalitis, as evidenced by his evolving and confusing cluster of symptoms. This has been acknowledged by both Health NZ's and the rehabilitation service provider's AERs. Given the poor prognosis of rheumatoid meningoencephalitis, I note that even had a more timely diagnosis been made, this may not have changed the outcome.

72. However, the fact remains that several systems failures cumulatively led to Mr A receiving a poor standard of care. These failures deprived Mr A of the opportunity for earlier investigations and interventions, an understanding of what was causing his symptoms, and an opportunity for him and his whānau to prepare for the prognosis.

Opinion: Health NZ — breach

73. This opinion considers the care provided to Mr A by Health NZ. As a healthcare provider, Health NZ has a responsibility to ensure that it provides care in accordance with the Code of Health and Disability Services Consumers' Rights (the Code). After carefully reviewing all the information on file, including the clinical notes, provider responses to the complaint, and Health NZ's comprehensive AER, I consider that Health NZ did not provide a reasonable standard of care to Mr A. In forming this decision, I have also considered the care provided by Dr D at Public Hospital 2.

74. Between Month1 and Month7 (inclusive), Mr A presented repeatedly to the three public hospitals and received care from multiple clinicians, including a neurologist, a psychiatrist, registered nurses, doctors, and mental health clinicians. In addition, Mr A was followed up by MH&A services in the community and was reviewed by his rheumatologist. Yet the diagnosis of meningoencephalitis was not queried as a potential cause for Mr A's symptoms, apart from in Month7, when 'encephalitis' was queried (but not confirmed).

75. I acknowledge that individual providers played a part in Mr A's care and hold some responsibility for the failings. However, overall, I consider this to be a system failing because of the consistent pattern of poor care over a six-month period, the multiple clinicians involved with Mr A, and the inadequate structures to support staff in providing effective clinical care. I agree with the outcome of Health NZ's AER, and it is apparent that Health NZ's system failed Mr A.

76. I proposed that HDC find Health NZ in breach of Right 4(1)[32] of the Code, by way of adopting the findings of Health NZ's comprehensive AER, which had been accepted by Mrs A and her whānau. I proposed this option given the clear and accepted position that the care provided to Mr A was not of a reasonable standard. I highlighted the following issues within Health NZ's systems:

- Insufficient assessment of Mr A's symptoms due to a lack of critical thinking;
- The failure to seek specialist input from a neurologist and a psychiatrist, leading to missed opportunities in diagnosing Mr A's condition;
- Poor communication amongst Health NZ providers;
- Poor documentation practices, including the inconsistent use of medical terminology, the failure to document a follow-up plan, and the failure to document accurate observations;
- The failure to recognise deteriorating symptoms, leading to Mr A being initiated on the wrong treatment pathway and missing opportunities to have his care escalated to the appropriate services;
- Poor administrative systems, in particular the lack of electronic referral systems, resulting in a failure to follow up with the EEG referral; and
- The failure to follow Health NZ's admission procedures, leading to Mr A bypassing the emergency department and not being prioritised for medical interventions.

77. The above system-level failures cumulatively meant that Mr A did not receive the care he needed. This proposal was accepted by Health NZ. Health NZ also stated that it was 'happy for the HDC to adopt the findings of [Health NZ]'s [AER] of this case'.

78. I am pleased that Health NZ has accepted this approach and the steps towards promoting change. In doing so, the focus can now shift to ensuring that these failures are not repeated.

79. Accordingly, I find that Health NZ failed to provide services to Mr A with reasonable care and skill, and, as such, breached Right 4(1) of the Code. I acknowledge the steps Health NZ has already taken to remedy these deficits, including holding open conversations with Mrs A and her whānau. Mr A's son told HDC that his whānau accepted the findings within the AER and were satisfied with its recommendations. I address this further under the 'changes made' and 'recommendations' sections below.

80. I now consider whether the care delivered by other providers was appropriate.

Opinion: The medical centre — breach

Introduction

81. Mr A was an enrolled patient at the medical centre, where multiple clinicians, including Dr C, Dr D, RN E, and Dr F delivered primary-care services to Mr A. After carefully reviewing all the information on file, including the responses from the medical centre, I consider that

[32] The right to services of a reasonable standard.

the medical centre failed to provide Mr A with an appropriate standard of care. In forming this decision, I have considered the clinical advice provided by my in-house clinical advisor, GP Dr Fiona Whitworth, and have noted the remote location of the practice, including the associated challenges. I set out my decision and the reasons for this below.

Failure to complete appropriate clinical assessments

82. I note several areas of concern in relation to the clinical assessments completed by the medical centre.

83. Dr Whitworth advised that there was minimal history-taking in relation to the nature of Mr A's headaches when he presented repeatedly with worsening headaches. This included a lack of assessment regarding whether Mr A experienced other symptoms in conjunction with the headaches, and whether there were any red flags.

84. Dr Whitworth cited the Best Practice Advocacy Centre (bpac^{nz}) guidelines for diagnosing and managing headaches,[33] which recommended a systematic approach to assessing headaches. This included assessing the onset, character, radiation, associated symptoms, timing, exacerbating and reliving factors, and severity of the headaches. While clinical notes written by the GPs made reference to some of these factors, such as the onset of pain and relieving factors, this appeared to be inconsistent, and very brief across the various times Mr A presented to the medical centre.

85. Secondly, Dr Whitworth was critical that there was no documentation regarding salient negative findings following clinical assessments, such as comments on seizure activity, presence of nausea, energy levels, balance, or mood during the 8 Month2 presentation. This is supported by a lack of clinical documentation of such findings within the 8 Month2 clinical notes.

86. Dr Whitworth was also critical of the lack of neurological examination and fundoscopy. Dr Whitworth advised that there were numerous contacts when a neurological examination should have been undertaken, particularly when Mr A presented with an increase in headaches and when he reported photophobia during the 4 Month5 appointment. The neurological examination may have assisted in ruling in/out organic causes of Mr A's symptoms. However, the clinical notes do not document the completion of a neurological examination and fundoscopy over the affected period.

87. In response to the provisional report, the medical centre said that neurological examinations were incomplete because Mr A had been distressed, and it waited for his symptoms to resolve before completing its assessment. I acknowledge that in situations where the patient is distressed, it may be inappropriate to proceed with a full examination, and this must be weighed carefully against the patient's symptoms and comfort. However, based on my review of the clinical notes, there appears to have been a consistent failure to complete

[33] Diagnosing and managing headache in adults in primary care - bpacnz

neurological assessments on multiple occasions even when Mr A appeared to be less distressed, of which I remain critical.

88. Dr Whitworth noted multiple mild to moderate departures from the accepted standards of care in relation to the assessments completed by the medical centre. Specifically, Dr Whitworth noted the following:

a) 8 Month2: The lack of a neurological examination — mild departure;

b) 13 Month3: The lack of detail regarding headache history — mild departure;

c) 13 & 30 Month3: The lack of examination — mild to moderate departure;

d) 4 Month5: The lack of differential diagnosis, and lack of fundoscopy and neurological examination — mild to moderate departures; and

e) Month7: The lack of thorough history-taking and clinical examination — moderate departure.

89. I accept this advice. In my opinion, there were several missed opportunities to complete a thorough clinical assessment and neurological examination, including fundoscopy. Although it was reasonable that clinicians considered Mr A's initial presentations to be related to a concussion, there was a need for increased precaution and careful assessment as Mr A failed to improve and indeed when some symptoms became worse. In addition, assessments undertaken on some occasions did not meet the Medical Council of New Zealand's Good Medical Practice standards, which stipulate that doctors must assess the patient's condition adequately, taking into account the patient's history and their views, and examine the patient as appropriate.

Failure to complete neurologist referral and decision to seek mental health assessments

90. Based on the response from the medical centre and my review of the clinical records, I note that a referral to mental health services was made, rather than to a neurologist. The failure to seek neurology advice was noted in Health NZ's AER, which received input from the medical centre.

91. I have carefully reviewed the medical centre's clinical records and have found no evidence of a referral being made to a neurologist. I note that on 4 Month5 Dr D planned to telephone Neurology regarding headache control — however, this never occurred. Health NZ's AER states that this was because reportedly Mr A's headaches had improved, although this was not documented within Mr A's clinical notes. Instead, I note that clinicians at the medical centre completed a referral to mental health services in Month4, following reports of concern from Mrs A and Mr A's family and friends.

92. Although Mr A experienced behavioural challenges, there is also evidence of Mr A experiencing impaired balance, amnesia, and incontinence, which Health NZ's AER states are atypical symptoms for a mental health disorder. In addition, Health NZ's AER notes that the onset of new psychiatric symptoms in middle age is atypical, and that organic causes needed to be ruled out before considering a psychiatric diagnosis. Therefore, the

appropriateness of the referral for mental health assessments due to behavioural challenges is in question.

93. In contrast, Dr Whitworth advised that a referral to Neurology would have been expected given Mr A's ongoing headaches with increasing severity, vomiting, and nausea, alongside a fluctuating level of concentration and fatigue. However, as stated above, a referral to a neurologist was never completed.

94. In my opinion, a referral to a neurologist was necessary given the totality of Mr A's symptoms and noting that a plan for a neurology review had been documented by Dr B earlier in the year. The absence of a referral to a neurologist likely resulted from a lack of appropriate assessment, which I have discussed above.

95. I consider that the failure to refer Mr A to a neurologist is in conflict with the Good Medical Practice standards, which stipulate that doctors must take suitable and prompt action when needed and refer the patient to another practitioner or service when this is in the patient's best interests. Given Mr A's increasing headaches with vomiting, a fluctuating level of concentration, and fatigue, Mr A should have been referred to a neurologist for advice or a review.

Lack of follow-up regarding discharge plan

96. In Month1 Mr A was discharged from Health NZ following his unwitnessed surfing accident, with the discharge plan stating that Mr A required an EEG and then an outpatient neurology appointment once the EEG had been completed. However, clinical notes show that the medical centre did not follow up with Health NZ to see whether this had been completed, apart from in Month7, shortly before Mr A passed away. The medical centre told HDC that it believed that Health NZ was arranging for follow-up of the EEG, but it did not explain the reason for this.

97. Whilst I acknowledge that the EEG should have been arranged by Health NZ, I consider that the medical centre could have followed up the referral, particularly in Month5 when several months had passed since the plan had been made and Mr A had exhibited worsening neurological symptoms.

98. A key role of the GP is to monitor and coordinate the delivery of care to the consumer. It is imperative for a primary-care service to have proper processes to engage with other healthcare providers, foster good working relationships, and be proactive in connecting patients with other community-based services. For most people, primary care is the first point of contact with health services and is a 'front door' to the rest of the health system. Therefore, robust primary-care structures are key to ensuring that people receive timely and effective care.

Absence of safety-netting advice and follow-up plan

99. Dr Whitworth had concerns about the safety-netting advice provided to Mr A by the medical centre.

100. Following Mr A's presentation of 17 Month4 for a frontal headache and nausea, Dr C advised Mr A to restart amitriptyline for his migraine and increased the dose. Dr Whitworth advised that no safety-netting advice was provided, and she was mildly critical that no time frame was documented for the changes in Mr A's medications to be reviewed. Likewise, Dr Whitworth noted that no follow-up appointment was made after the appointment with RN E on 1 Month5.

101. I agree that no safety-netting advice was provided at the 17 Month4 appointment, and my review of the clinical notes also found that limited safety-netting advice was provided at other appointments. I also agree that there appears to have been no plan for follow-up after the 17 Month4 and 1 Month5 appointments. This is particularly concerning given Mr A's unresolved symptoms.

102. I am concerned about the lack of safety-netting advice and scheduled follow-up. Safety-netting advice helps patients with unresolved or worsening symptoms to know when and how to escalate their concerns. Likewise, planned follow-up is essential to monitor symptom progression, assess treatment efficacy, manage any adverse effects, and prevent care gaps. Safety-netting advice and planned follow-up reduces clinical risk.

Insufficient documentation

103. I note that on several occasions the documentation could have been improved.

104. First, as noted above, there were multiple instances where GPs did not fully document the nature of their examinations and clinical assessments. This included the nature of Mr A's headaches, and documentation regarding salient negative findings following clinical assessments, such as comments on seizure activity, the presence of nausea, energy levels, balance, and mood.

105. Secondly, Dr Whitworth advised that on 30 Month3, the referral provided to the public hospital ED was 'brief', with no documentation of diagnoses other than a headache being considered as a differential diagnosis. In response to the provisional report, the medical centre said that Dr C completed admission paperwork for Mr A after he was referred to the public hospital, which was the reason for the lack of a detailed referral. I accept this explanation, but, as the medical centre had acknowledged, there was a lack of detailed documentation, and I remain concerned about this.

106. Lastly, Dr Whitworth advised that on 17 Month4 no rationale was documented for the amitriptyline prescription or a time frame for a review of the changes made to Mr A's medications.

107. Dr Whitworth advised that cumulatively, the documentation-related deficiencies represent mild to moderate departures from the accepted standard of care. The documentation is inconsistent with the standards set out by Good Medical Practice standards, which stipulate that doctors must keep clear and accurate patient records that report relevant clinical information, the decisions made, and the reasons for them.

108. I accept this advice. The multiple examples of inadequate documentation reflect poorly on the systems in place at the medical centre. Clinical records reflect a clinician's reasoning and are an important source of information regarding the patient's care. Documentation is also a key component of ensuring continuity of care, and in ensuring that the next clinician is able to understand the rationale behind previous clinical decisions. Clinical documentation is therefore a cornerstone of good care, and a required standard of professional practice. In addition, poor clinical notes hamper later inquiry into what happened, thereby compromising the opportunity to address issues raised by or on behalf of a consumer, as well as quality improvement measures that may flow from such inquiry.

Conclusion

109. I consider that the care provided to Mr A by the medical centre did not meet accepted standards. Therefore, I find that the medical centre breached Right 4(1) of the Code for the following reasons:

- The failure to complete appropriate clinical assessments, including the lack of comprehensive history-taking regarding Mr A's headache presentations, and the lack of a neurological examination and fundoscopy;
- The failure to complete a neurologist referral;
- The failure to follow up Mr A's discharge plan, including completion of an EEG and referral to a neurologist; and
- The failure to complete documentation to accepted standards.

110. In addition, I find that the medical centre breached Right 4(2)[34] of the Code for the following reason:

- The failure to follow the Medical Council of New Zealand's Good Medical Practice guidelines.

Opinion: The rehabilitation service provider — adverse comment

Introduction

111. The rehabilitation service provider was contracted by ACC to provide post-concussion rehabilitation services to Mr A. As a healthcare provider, the rehabilitation service provider has a responsibility to ensure that it provides care in accordance with the Code.

Delay in assessment — other comment

112. Based on my review of clinical notes and responses from the rehabilitation service provider, it is clear that there was a delay by the rehabilitation service provider in completing Mr A's initial assessments. I note that Health NZ's AER and the medical centre's statement to HDC noted similar findings.

[34] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

113. Clinical records show that a referral was first completed to the rehabilitation service provider on 3 Month3. ACC's records show that an approval was given for the post-concussion assessment to be undertaken on 13 Month3. While the OT assessment had been completed in a timely manner, there were delays in completing the physiotherapy assessment and the neuropsychology case review, which was not completed until 23 Month6, that is, three and a half months after the initial referral had been made. I also note that while there were delays in completing assessments, Mr A continued to receive follow-up care by the rehabilitation service provider.

114. The rehabilitation service provider said that its usual process involves an initial assessment and a subsequent triaging process with its interdisciplinary team, which determines the pathway for appropriate diagnosis and intervention for the consumer.

115. The rehabilitation service provider stated that the OT completed the initial assessment on 20 Month3, and this was not delayed. However, it acknowledged that the physiotherapy and neuropsychology input was delayed. The rehabilitation service provider cited staffing issues as a reason, and it also appears that Mr A's limited ability to engage with its service contributed to the delay. This was evident within clinical notes provided by the rehabilitation service provider, which show multiple attempts by the rehabilitation service provider to engage with Mr A. This meant that subsequently there was a delay in determining what level of support Mr A required, and the understanding that the rehabilitation service provider could not support him.

116. Once the rehabilitation service provider learnt that it could not support Mr A, there was a further delay in communicating this to other providers. I acknowledge the rehabilitation service provider's response, which indicated that it was not allowed to share information with other service providers without ACC's permission. The consequence of this meant that providers were working in siloes, without a full appreciation of Mr A's symptoms or diagnostic formulations and queries. In addition, other providers did not realise that the rehabilitation service provider was unable to support Mr A, which resulted in Mr A being re-referred to the rehabilitation service provider inappropriately, and consequently he did not receive appropriate or timely interventions.

117. The rehabilitation service provider informed ACC of the challenges in contacting Mr A, but ACC did not provide any guidance on how to manage the situation. ACC agreed that there was an opportunity for ACC to attempt to assist with liaising with Mr A's GP. In addition, the rehabilitation service provider attempted to communicate with Mr A through his whānau, and it attempted to contact the medical centre, although there is limited documentation to show this.

118. In my view, if one provider is able to make a direct referral to another service (in this case the rehabilitation service provider), it would be reasonable and appropriate to have a process by which the referring agent is advised directly if the referral is accepted or declined and the reason why. The lack of clear communication between the services and ACC contributed significantly to the ability of any one provider to have sufficient information to provide an accurate diagnosis for Mr A before he passed. The rehabilitation service provider

said that it fully supports this view because it represents good practice and aligns with accepted standards of care.

Lack of documentation — adverse comment

119. I am concerned about the lack of documentation by the rehabilitation service provider staff on several occasions. My review of the clinical notes indicates that there were significant gaps in the rehabilitation service provider's documentation. I also note the rehabilitation service provider's AER finding that 70% of Mr A's clinical notes were incomplete.

120. First, as discussed above, there is limited documentation of the rehabilitation service provider's attempts to contact the medical centre. The rehabilitation service provider said that it contacted Mr A's GP repeatedly and that voice messages were left. However, the rehabilitation service provider could not provide evidence for this and acknowledged that the missed phone calls/voicemails needed to be followed up with a written request for information from the GP.

121. Secondly, the rehabilitation service provider said that it made repeated requests for clinical information from ACC. However, ACC disputed this and provided records that showed no indication that it had received repeated requests from the rehabilitation service provider for information. The records demonstrated only one occasion on which the rehabilitation service provider requested clinical information (13 Month7).

122. Thirdly, the rehabilitation service provider's AER demonstrates that the rehabilitation service provider providers did not complete documentation on at least seven occasions. This includes documentation of appointment visits, including how and where Mr A was seen, and the nature of the appointment.

123. The multiple examples of inadequate documentation reflect poorly on the system at the rehabilitation service. Clinical records reflect a clinician's reasoning and are an important source of information regarding the patient's care. Documentation is also a key component of ensuring continuity of care, and in ensuring that the next clinician is able to understand the rationale behind previous clinical decisions. Clinical documentation is therefore a cornerstone of good care, and a required standard of professional practice. In addition, poor clinical notes hamper later inquiry into what happened — thereby compromising the opportunity to address issues raised by or on behalf of a consumer, as well as quality improvement measures that may flow from such inquiry.

Changes made

Health NZ

124. Health NZ told HDC that it has undertaken the following changes:

a) The Neurology booker at Health NZ is now copied into all discharge summaries after the Neurology team has reviewed a patient. These discharge summaries are treated as referrals and triaged by one of the neurologists. This helps to ensure that the requested neurological investigations and follow-up visits are arranged and followed through.

b) MH&A and ED staff will be advised that patients with an unclear diagnosis who require further medical investigation are to be assessed in the ED before admission to the mental health unit.

c) MH&A's multidisciplinary team meetings will now include representation from all disciplines, including a psychiatrist.

d) Work with the public hospital and the medical centre has been undertaken to develop a process for ensuring that any requested follow-up for services, referrals, and tests is not lost in the system.

e) It outlines its expectations to contracted service providers (and ACC if appropriate) regarding timeliness of sharing clinical information with clinical staff to ensure patient safety.

f) It will investigate, process map, and potentially redesign current pathways for ensuring that requested tests are booked and checked to see that this has been done.

g) The Radiology Department has established an agreement for work with a private radiology service provider when an urgent result is required.

h) The review of Mr A's care has been shared with the relevant clinical teams to help reinforce the need for thorough medical review of patients to exclude potential organic causes before transfer to the MH&A services.

i) The importance of good communication and thorough clinician-to-clinician handover, including documentation, has been reinforced to clinical teams.

j) It will discuss with the medical centre and the public hospital how frequent attenders can be flagged for a peer review of the patient concerned. This will stop confirmation bias occurring.

k) It has escalated several digital priorities to Health NZ's National Digital and Data team, including the implementation of e-referrals.

The medical centre

125. The medical centre told HDC that it has developed a process where complex caseloads can be coordinated by a nominated clinician to avoid disjointed care. The medical centre has developed a handover sheet, which is generated when one doctor hands over to another doctor prior to the start and end of shifts. In addition, this list contains patients who are not necessarily on the ward but have important results to be followed up.

126. The medical centre also said that if a GP is concerned about a patient and further follow-up in the practice is needed, that GP takes responsibility to discuss the patient with one of their GP colleagues to ensure that handover and follow-up is completed. The GP now documents in the clinical notes who is the responsible GP for the follow-up.

127. There is now a computer in the public hospital where GPs can access the medical centre's practice management system to look up results and previous history or write notes about a ward patient in the practice management system and generate alerts to GPs.

The rehabilitation service provider

128. The rehabilitation service provider told HDC that it has undertaken the following changes:

a) It provided training with local GPs to help them better understand the difference between a mild to moderate concussion, emergency situations, and red-flag type brain condition situations, and how consumers should be managed in each situation.

b) It worked with its team to ensure that written referrals are sent with patients when being sent to the ED or their GP.

c) It implemented an internal 'medical red-flag support' system to identify requirements for consumers that are beyond what the concussion service by ACC can provide. The rehabilitation service provider said that these systems are intended to strengthen the support for their allied health staff, assist in communications with medical staff and, where able, accelerate access to medical imaging.

d) It has planned to develop a red-flag flow chart for clinicians regarding what to do with red flags, including referral to MH&A as needed. This will be added to the Concussion Operations Guidelines and distributed to local GPs.

e) It has planned to develop a template letter to the GP with the reasons why a client is being sent back to them and the limitations of the scope of the concussion service, so that concerns are taken seriously.

f) It provided a company reminder regarding clinical note standards and best practice requirements.

g) It provided a company reminder regarding informed consent standards and consent forms.

h) It updated training material and provided reminders for clinicians on necessary administration processes, including custom forms, duplicating reports, and naming reports.

i) It plans to address issues in obtaining previous medical notes with ACC.

j) It is providing specific feedback to clinicians who have been involved with clients, including documentation standards.

k) It completed a debrief with its team and asked for feedback on how to strengthen its internal processes.

129. In response to the provisional report, the rehabilitation service provider said that the business now has new owners and a new management team. The rehabilitation service provider said that the new team is focused on ensuring that the business has the necessary structures, systems, and processes in place to provide services to a good standard of care consistently.

130. The rehabilitation service provider said that sharing of information with GPs is an expectation of standard practice, and it will be auditing this for patients with a named GP or general practice.

ACC

131. ACC told HDC that it made the following changes:

a) It has considered how communication between providers can be improved across ACC-funded services. ACC said that it expects its suppliers to proactively share information with GPs and other providers. To ensure that these expectations are met, ACC intends to review ACC's individual health service contracts. These will be amended if necessary to include specific requirements to share reports and/or other clinical information with GPs where appropriate, subject to client consent.

b) It has reviewed its Concussion Services contract[35] and has amended the Service Schedule to contain the following requirement:

> '5.13.5 With the Client's written consent, the Supplier will forward the Client Summary Report, medical reports and Neuropsychological Screen (where this has been conducted) to the Client's general practitioner or primary health care provider within the relevant timeframe stipulated in Part B: Table 3[36] of th[e] Service Schedule.'

Recommendations

Health NZ — National

132. I recommend that Health NZ consider progressing the implementation of a national electronic referral system across its services that provides referral tracking data. An update on this consideration is to be provided to HDC within six months of the date of this report.

Health NZ

133. I recommend that Health NZ:

a) Complete an audit of 20 randomly selected discharge letters over the last three months (which contain referrals to outpatient tests) to determine the number of occurrences where referrals were not followed through. Health NZ is to provide HDC with a summary of the audit findings, along with recommendations, within six months of the date of this report.

b) Complete an audit of 20 MDT meetings within the MH&A service to determine the number of occurrences where a psychiatrist did not attend the meeting. Health NZ is to provide HDC with a summary of the audit findings, along with recommendations, within six months of the date of this report.

c) Provide HDC with an update on Health NZ's discussion with the public hospital and the medical centre in relation to its process development for follow-up of tests and

[35] ACC has also similarly reviewed its pain management service contract, which requires suppliers to share information with the client's GP with consent.

[36] The service schedule provides that the client summary report must be submitted to ACC and the client's primary healthcare provider within five or ten working days, and the medical assessment or neurological screen consultation notes, report, letter or summaries must be submitted immediately following the medical assessment or neurological screen.

referrals. This update is to be provided to HDC within six months of the date of this report.

d) Complete a file review of 20 randomly selected patients who were admitted to the inpatient mental health unit over the last year to assess the adequacy of the medical assessments undertaken during the admission and whether organic causes were ruled out before a psychiatric diagnosis was considered. A summary of this file review, along with recommendations, is to be provided to HDC within six months of the date of this report.

e) Provide HDC with an update on its development of a process for flagging frequent attenders and peer reviewing such consumers, within six months of the date of this report.

The medical centre

134. I acknowledge the changes made by the medical centre. In addition, I recommend that the medical centre:

a) Provide a formal written apology to Mrs A and her whānau for the deficiencies identified within this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A and her whānau.

b) Consider developing a memorandum of understanding with the rehabilitation service provider, outlining its expectations and responsibilities relating to referrals. An update on this consideration is to be provided to HDC within three months of the date of this report.

c) Ask its clinicians to review Best Practice Advocacy Centre New Zealand's guidelines on diagnosing and managing headaches in adults in primary care. Confirmation that its clinicians have completed this review is to be provided to HDC within three months of the date of this report.

The rehabilitation service provider

135. I acknowledge the changes made by the rehabilitation service provider. In addition, I recommend that the rehabilitation service provider:

a) Report back on the findings of its internal audit, to ensure that relevant information is being shared with GPs. As part of this recommendation, the report should also outline any corrective actions. This information is to be provided to HDC within three months of the date of this report.

b) Communicate with its staff on the importance of documenting requests for information with other providers, within the consumer's clinical records. Evidence of this communication is to be provided to HDC within three months of the date of this report.

Follow-up actions

136. A copy of this report with details identifying the parties removed, except Health NZ and the clinical advisor on this case, will be sent to ACC and Health NZ and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was received from GP Dr Fiona Whitworth:

'My name is Fiona Whitworth. I am a graduate of Oxford University Medical School and I am a practising general practitioner. My qualifications are: MA 1991,BM BCh 1994, DCH 1996, DCRCOG 1996, MRCGP 1999, PGCMed Ed 2011, FRNZCGP 2013, PGDip GP 2016, FAEG 2020. Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs A] about the care provided by [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

1. **Documents reviewed**

… Complaint
… Autopsy report
… S14 [the medical centre]
… Clinical Notes [the medical centre]

2. **Complaint**

Concerns re ill-informed and biased decision-making from the rehabilitation service providers involved in his care, inadequate action and lack of critical support provided to him.

Following a surfing accident [in Month 1] he was taken to [Public Hospital 3]. It is reported that he had 3 fits and then complained of headaches, loss of balance, vomiting and mood swings. He was initially diagnosed with post-concussion syndrome.

Subsequent to this he exhibited abnormal behaviours. He was given antidepressants. His wife reports him having ECG and CT scan but no MRI. She states she requested for him to be sectioned under the Mental Health Act but that this did not occur.

In [Month7] due to his deteriorating condition she again asked for him to be assessed under the Mental Health Act. He was assessed by 2 doctors at home and then sent to [Public Hospital 3] where he was diagnosed with meningoencephalitis probable of rheumatoid origin. He died in ICU on …

3. **Provider response(s)**

[The medical centre] states that after his surfing accident he was referred to [the rehabilitation provider] Concussion Services in [the region].

It is stated that it was thought that [Public Hospital 3] was arranging an EEG (as per discharge letter).

He was admitted [Month3–Month4] to hospital and treated for migraine.

In [Month5] he had a CT head scan undertaken.

The response also notes other factors taken into account when treating him — *'abrupt withdrawal from marijuana and other substances and past childhood abuse'*.

It is noted that whilst his presentations and symptoms were partially treated as behavioural, a physical review with blood tests and 2 CT head scans were also undertaken. A neuropsychological assessment was awaited.

[Dr C] has reflected on [Dr C's] care, … notes [the referral] for specialist care and for investigations.

[Dr C] states [Mr A was] admitted [by Dr C] to hospital in [Month3] with severe headache. [Dr C] has noted [being] aware of the impact of not being able [to] surf and drum on [Mr A]. It is noted that [Dr C] was aware that [Mrs A] had informed … of concerns [about] his behaviour towards her. [Dr C] states that "*I informed her that she needed to set firm boundaries and not tolerate any abuse … I cannot recall ever describing [Mr A] as 'extremely manipulative'.*"

It is stated that the practice did not receive any requests to have [Mr A] admitted under the Mental Health Act.

[Dr D] was involved in his admission under the Mental Health Act in [Month7].

4. **Review of clinical records**

PMH
2018 RF/CCP positive rheumatoid arthritis
On Lefluonmide 20mg od (previous SE Methotrexate and salazopyrin)
DH
Amitriptyline 20mg nocte
Leflunomide 20mg od
Ibuprofen 800mg od
Ondancetron 4mg qds
Quetiapine 50mg bd
Topamax 25mg 1 bd
Paracetamol 500mg 2qds
Prednisone 5mg od (last script [Month1])

Clinical Timeline
[Prior to Month1] Rheumatology OPD …
Disease under control. For regular blood tests and review in clinic in 4 months. For a slow taper of prednisone 1mg ever 3–4 weeks from 10mg to 5mg
[20 Month1]

[28 Month1] [Public Hospital 1]
Transferred from … with seizure — was surfing prior. When surfing reports that he was "not quite right" in wave when paddling to shore he was dumped by a wave — as came to shore had a 1 min generalised tonic clonic seizure and then post ictal.

No specific history of head injury but had been dumped by wave just before. Presenting with headache and no recollection of the day.

Diagnosis — Provoked seizure secondary to concussion

Seen by [Dr B] Neurology. No anti epileptics given.

Out patient clinic and EEG arranged

[29 Month1] Ward Round [Dr B]. Neurologist

"*he had a head injury, concussion with symptomatic seizures after this."*
For EEG and GP review at 6 months to review driving.

[28 Month1] CT Head with contrast — referred … [Public Hospital 3]
Indications — odd behaviour near drowning seizure.
Reported as normal.
[28 Month1] CXR normal
[30 Month1] Request from wife for prednisone 10mg
[2 Month2] Request to transfer care to [Dr C]

[8 Month2] GP Consultation [Dr C]
Notes document a discussion re recovery from head injury. Advised that can now start graduated activity. It is noted that headaches were improving.
No examination is documented to having been undertaken.

Comment
The notes are brief and do not document salient negative findings eg comment on seizures, nausea, energy, balance, mood.

I am mildly critical that there has not been a neurological examination.

[30 Month2] GP Consultation [Dr C]
Notes state that [Mr A's] wife has come in and reported "*on going severe headaches, poor memory. Clumsiness."*
Requesting ACC claim and referral to concussion service.

[2 Month3] GP Consultation [Dr C]
Notes report increased fatigue and daily headaches. Poor concentration — hard to focus on a conversation, very poor memory, emotional lability. A number of previous concussions also noted.
There is no documented neurological examination. His BP is 100/75.
Amitriptyline 20mg nocte started to help with headaches alongside ibuprofen prn.

Comment
It would be standard practice to review a patient in person prior to referral to the concussion service which has been done. The referral is appropriate given the

symptoms persisting 1 month. I note that newer guidelines have come in since 2019 that have changed how referrals to concussion services are used.

[13 Month3] GP Consultation [Dr C]
Notes state that sleep is improved with amitriptyline. Headaches are worse in the day.

Comment
I am mildly critical at the lack of detail in the notes with regard to headache history. There is no documentation surrounding red flags. Additionally I am mildly to moderately critical that given the increase in headaches no appropriate examination was undertaken.[37]

[30 Month3] GP Consultation [Dr C]
Notes document he developed a severe migraine at the airport the previous Tuesday. It is noted that symptoms have been on going — headache, photophobia.

It is noted he had a history of migraine when younger. A trigger of anxiety re [an overseas trip] was noted. It was also noted that he had seen the head injury team but there was no letter yet.

Examination note he was photophobic and dehydrated.

A plan was made to admit to hospital for iv fluids and medication for migraine with blood tests to [Public Hospital 2's] ED.

Comment
I am mild to moderately critical at the lack of examination undertaken, the brevity of the history documented and the brief hand over referral to the hospital. It appears that no differential other than migraine has been considered.

30 [Month3] Hospital Admission until 1 [Month4]
FBC and Renal function normal
6/7 headache vomiting and photophobia
He was apyrexial with a normal BP. He was given iv fluids and iv chlorpromazine (anti nausea). Headache improved to 6/10 and he was discharged with advice for GP to consider a repeat CT head and follow up with GP.
The discharge letter also states "*no focal neurological signs*".

Comment
The discharge letter is not detailed however it does appear that the headaches resolved with treatment and that a neurological examination has been completed and is normal. However the discharge letter does not detail what level of neurological examination was undertaken.

[37] https://bpac.org.nz/2017/headache.aspx

I am mild to moderately critical at the level of documentation.

4 [Month4] GP Consultation [Dr C]
[Mr A's] wife consulted on his behalf — notes *"has been in bed all day with headache. ondansetron was helping but has run out"*

Email from [the rehabilitation service provider] given to his wife to complete some information and a script issued.

Comment
Given his history and recent admission I would commonly see a GP ask a patient in this situation to come in for review again. There is no documentation around any other symptoms that he could have been experiencing.

15 [Month4] Blood tests
FBC, LFTS normal

17 [Month4] GP Consultation [Dr C]
Notes state that he continued to have a frontal headache and nausea. Not helped by ibuprofen. He had stopped all medication.

It is noted *"some altered personality traits since migraine"*

The diagnosis was noted to be unclear ? migraine ? concussion.

He was advised to restart amitriptyline and ondancetron.

A script for Topamax up titrating to 50mg bd was given.

Comment
Examination has not been undertaken Neurological or BP.

It is not clear whether he had stopped his medication for rheumatoid arthritis (prednisone and lefluonide).

I presume that Topamax has been started for migraine prophylaxis — however this is not stated in the notes.

There is no safety netting.

I am mildly critical that no time frame is documented for review of these changes in medication.

18 [Month4] Letter from [Dr C] to [the rehabilitation service provider] to expedite contact.

21 [Month4] Email from [the rehabilitation service provider]
Unable to contact [Mr A] — despite texting, phoning and visiting his house.

23 [Month4] notes [RN E]
Call 1

From 22 [Month4] Concerns from [Mrs A] that he had behavioural changes, grandiose ideas, was out of control and had a complete change of character. It was noted that [Mrs A] had left the family home for fear of harm.

[Mrs A] advised to call Mental health line.

23 [Month4] Phone call received from Mental health nurse …
It is stated that [the nurse] had offered to visit [Mr A] at home on 22 [Month4] with police escort due to concerns of possible harms. [Mrs A] had declined this offer. No visit made.

23 [Month4] notes [RN E]
Police had contact [with the mental health nurse] with a report of potential harm to [Mr A] — a call from a community person who was concerned re his behaviour.

A phone call to [Dr D] was made to inform … of a possible MH Assessment at [Public Hospital 2].

24 [Month4] [Dr C] left message on phone re email from [the rehabilitation service provider].

30 [Month4] CT head referral — personality change, aggression, poor balance, lack of concentration. Sent by [Dr D].

1 [Month5] Consultation [RN E]
This appears to have been a consultation with [Mr and Mrs A]. Issues stated as anxiety/concussion syndrome. Still photophobia. Discussion around relationship and advice given re how to improve communication regarding the challenges in their relationship.

No planned follow up made.

Comment
It is unclear if this was a nursing appointment or health improvement practitioner appointment. However, the ongoing photophobia should have been escalated to a GP.

4 [Month5] GP Consultation [Dr D]
Notes state there have been ongoing migraines, photophobia, 2 collapses at home where falls to the ground. Occasional vomiting with migraines. He had stopped Topiramate as gave side effects.

Noted that a CT scan has been booked in. GP has phoned the concussion service to get them to make an appointment.

It is documented that at start of consult he could not tolerate light but by the end he could tolerate the light which led the GP to consider an emotional element to his symptoms.

It was planned to phone neurology regarding his headache control.

Comment
It is not clear if any examination was undertaken. If no examination has been done, I am mildly to moderately critical that with on going headache symptoms and reported photophobia that he has not had a neurological examination and fundoscopy.

5 [Month5] DNA GP appointment.
6 [Month5] Offered several review appointments today but these were declined.
7 [Month5] DNA appoint [RN E]
8 [Month5] [RN E] Phone call from [Mrs A]
Concerns regarding behaviour changes documented (screaming, demanding, abusiveness). Noted [Mr A] wishes to engage with help for this — an appointment made for the following week.

11 [Month5] Blood tests [Dr C]
Biochemistry, renal normal. Sl raised neutrophils (point of care)

11 [Month5] ED referral from [Dr C] — 11–16 [Month5] [Public Hospital 2]
Presented with labile bizarre behaviour and headaches post-concussion.

He was noted to have possible confusional episodes, more sleepy than usual and more aggressive than usual with a new history of urinary incontinence.

Headaches detailed left sided fronto temporal most days, which were debilitating with photophobia and nausea with vomiting.

Examination showed no fever, normal BP, GCS 15 (normal) cranial nerve examination and Neurological examination normal. Planters down going. Other examination normal. No meningism.

Some incoordination on testing only found.

A diagnosis of post-concussion syndrome was made.

It was advised to see GP for referral to psychiatry services, to see a counsellor. It was noted [Mrs A] had contacted [the rehabilitation service provider].

Quetiapine was started and prednisone reduced to 9mg (some concern over this contributing to clinical picture).

Comment
A detailed and thorough assessment has been undertaken. This is well documented.

It is possible for psychotic symptoms to be related to prednisone; however his dose was not high and he had not altered this.

I am mildly concerned that the incoordination symptoms do not have an identified cause other than post-concussion syndrome. I am mildly critical that at this point his symptoms appear to be deteriorating rather than improving which would be unusual for post-concussion syndrome[38].

12 [Month5] Consultation [RN E] Seen in hospital.
Reviewed mindfulness and DBT. Noted "*sense episodic anxiety bouts of catastrophic behaviour"*

Discussion re trip to … for CT scan on 13 [Month5].

Noted that on going care will be dictated by CT …

13 [Month5] DNA review appointment with [RN E]

13 [Month5] CT head
No interval changes noted. No abnormality documented.

15 [Month5] Bloods …
FBC, LFTS, normal

20 [Month5] Referral from [Dr F] to …
Referred re Personality disorder assessment.

20 [Month5] Rheumatology review OPD
No concerns from rheumatoid arthritis disease quirt. Advised to continue to decrease his prednisone.

22 [Month5] Mental Health Program — [Dr F]
Seen with Wife [Mrs A].

PHQ9 score 21 (high)

Still complaining of daily headache — noted he wakes then headache comes on. Had stopped marijuana use.

Visual acuity tested.

It is noted he has had contact with [the rehabilitation service provider] and they have referred him to neuropsychiatry.

[38] https://bpac.org.nz/2022/concussion.aspx

A diagnosis of depression and anxiety has been documented.

22 [Month5] Acceptance letter from [the region's] mental health [team] …

23 [Month5] Referral from [Dr F] to [the region's] mental health …
Asking team to disregard previous referral as going to be seen by Traumatic brain injury service in [the region].

3 [Month6] DNA GP appointment [Dr D]

11 [Month7] Admission referred by [Dr C] to [Dr D] General Medicine. 11–13 [Month7]
Presented after a collapse/fall

His previous history of head injury and concussion is noted. The mental health assessments have been reviewed. Noted that he had been seen by Traumatic Brain injury service on 2 occasions. His wife reported that the second visit was the preceding day and that they have found no ongoing TBI issues and that his symptoms are now behavioural.

It is noted that other doctors including [Dr D] have identified his symptoms as to being due to a behavioural cause.

It is reported that some days he is normal and talkative, on others he refuses to speak and on occasions urinates on the floor. It is noted he is falling a lot. It is reported he has a fluctuating level of memory.

It is noted that a full examination was not possible as he was curled up and not cooperative.

He was admitted overnight, at times he was incontinent and was thought to be about to fall.

He was diagnosed as having a somatisation disorder.

On discharge he was referred back to the mental health services, his GP was asked to chase neurology with regard to the EEG and for follow up with counselling service.

Bloods
FBC, biochemistry renal normal

14 [Month 7] [Dr C] wrote to neurology to chase EEG.

15 [Month 7] Admission to [Public Hospital 2] prior to transfer

[Mr A] had been in bed all day and had episode urinary incontinence. The ambulance was called — subsequently [RN E] and [Dr D] visited him at home. Taken to ED where observations were normal, no temperature or tachycardia. GCS 15.

Bloods were abnormal with sodium 183, low calcium. FBC normal

Assessment — significant depression and lacks capacity to care for himself.

He was sectioned under the Mental Health Act and admitted … to the Mental Health Unit.

17 [Month7] Transfer of care from mental health unit to Medical Team due to funny turn and hypertension.

MRI — abnormal
CT head no significant changes from last study.
Discharge letter states *"probable viral encephalitis, Reactivation of slow virus in context of immunosuppression."*

Transferred to ICU with possible seizure activity. Underwent a rapid deterioration and diagnosed brain death on ….

5. **Comments**

This is a very complex case with a very rare diagnosis.

I have been asked to comment on the treatment provided by [the medical centre].

The initial treatment was in the context of a head injury and ensuing post concussion syndrome. This was a plausible diagnosis and the appropriate referral to Traumatic Brain Injury Service was made. There was then a period of time when contact with [Mr A] and the service was difficult. [Dr C] attempted to facilitate the provision of care from this service.

I note [Dr C] also admitted him to hospital with severe headache, ordered CT scans and bloods. [Dr C] additionally chased up the neurological services for his EEG.

It is unclear why there was a delay in getting the EEG.

However, I am moderately critical at the lack of thorough history and examination documentation. There were numerous contacts when a neurological examination should have been undertaken — as documented above.

Additionally, [Mr A] was reporting headaches with increasing severity, vomiting and nausea alongside a fluctuating level of concentration and fatigue. I would commonly see a GP undertake a thorough neurological examination and refer to neurology for review and or advice.

I note that he was seen on the medical ward where blood testing, neurological examination and imaging were normal — apart from a change in coordination.

His symptoms appear to have been thought to be psychiatric in nature.'

Appendix B: Timeline

Date	Event/s
… 2018	Consumer is diagnosed with rheumatoid arthritis.
28 [Month1]	Consumer suffered head injury whilst surfing. Taken to [Public Hospital 1] by ambulance.
30 [Month1]	Consumer is discharged from [Public Hospital 1].
30 [Month2]	[Dr C] at [the medical centre] (GP) completes ACC documentation requesting referral to concussion services ([the rehabilitation service provider]).
2 [Month3]	[Dr C] assesses the consumer and refers him to [the rehabilitation service provider].
13 [Month3]	Referred to [the rehabilitation service provider] concussion services by ACC for neuropsychological screening assessment.
	[The rehabilitation service provider] receives the referral and tries to contact consumer without success.
16 [Month3]	[The rehabilitation service provider] tries to contact the consumer without success.
20 [Month3]	[The rehabilitation service provider] Occupational Therapist assessment.
30 [Month3]	Consumer presents to [Dr C] with a migraine and is referred to [Public Hospital 2's] Emergency Department (ED).
2 [Month4]	[Dr C] contacts [the rehabilitation service provider] to obtain their initial assessment findings.
4 [Month4]	[Mrs A] presented to [the medical centre] and was given [the rehabilitation service provider's] contact information to arrange an assessment for the consumer.
8 [Month4]	[The rehabilitation service provider] tries to contact the consumer.
	[Dr C] contacts [the rehabilitation service provider] about receiving their initial assessment findings.
	Consumer presents to [the medical centre] for headaches.
17 [Month4]	Consumer presents to [the medical centre] for headaches.
18 [Month4]	[The rehabilitation service provider] completes a home visit but consumer was not home.

	[The rehabilitation service provider] advises ACC of the issues with contacting the consumer.
	[The medical centre] contacts [the rehabilitation service provider] to expedite their assessments, noting the consumer's headaches are 'very problematic'.
21 [Month4]	[Mrs A] contacts [the rehabilitation service provider] about continuation of services. Consumer was referred to the GP or ED.
	[The rehabilitation service provider] advises [the medical centre] of issues contacting the consumer.
22 [Month4]	[The rehabilitation service provider] advises ACC of issues contacting the consumer.
	[The medical centre] and Health NZ become aware of mental health concerns following family reports.
23 [Month4]	Consumer undergoes a mental health assessment at [the medical centre] with [RN E] for behavioural changes.
24 [Month4]	ACC record notes [Dr C] had tried to contact the consumer to get him to engage with [the rehabilitation service provider], and voicemail was left.
	Mental Health services conduct home visit for the consumer.
30 [Month4]	Mental Health services assessment of the consumer.
31 [Month4]	Mental Health services assessment of the consumer.
[Month5]	[The rehabilitation service provider] relayed to [the medical centre] the difficulty contacting the consumer.
	Discussions were had between the community MH team and [the medical centre] about the consumer's health.
	Mental Health case discussion.
1 [Month5]	Consumer seen by [RN E] at [the medical centre] for photophobia.
4 [Month5]	[The medical centre] contacts [the rehabilitation service provider] to expedite assessments.
	Mental Health Services GP, [Dr D], assesses consumer. Records intended neurology follow-up for headache control.
	Consumer presents to [the medical centre] with photophobia and ongoing headaches.

8 [Month5]	Mental Health service complete a home visit for the consumer.
11 [Month5]	Consumer is taken to [Public Hospital 2] by ambulance due to collapsing at home.
14 [Month5]	[The rehabilitation service provider] advises ACC of issues contacting consumer.
	Consumer assessed in [Public Hospital 2] ED under psychological pathway.
	[The rehabilitation service provider] advises ACC of issues contacting consumer.
15 [Month5]	Consumer seen by [Dr F], Mental Health team GP, while in [Public Hospital 2]. Consumer is discharged.
21 [Month5]	[The medical centre] asks consumer's partner to contact [the rehabilitation service provider].
	Mental Health team review requested for personality disorder.
22 [Month5]	Seen at [the medical centre] for ongoing headaches and photophobia.
6 [Month6]	[The rehabilitation service provider] physiotherapy screen is completed.
11 [Month6]	[The rehabilitation service provider] neuropsychology case review is completed.
17 [Month6]	[The rehabilitation service provider] medical case review is completed.
20 [Month6]	[The rehabilitation service provider] tries to contact the consumer.
21 [Month6]	[Mrs A] advises [the rehabilitation service provider] that [Mr A] is overwhelmed and 'tries to hide from everyone'.
23 [Month6]	[The rehabilitation service provider] provided ACC with a set of recommendations including MRI, neurology review, and neuropsychologist review. [The rehabilitation service provider] asked that these were passed on to [the medical centre].
Month7	[The rehabilitation service provider] advises ACC the consumer's symptoms were not necessarily related to his concussion.
10 Month7	[The rehabilitation service provider] neuropsychology case review is completed.
11 Month7	Consumer is admitted to [Public Hospital 2] by ambulance after collapsing at home.

12 Month7	Consumer is reviewed by Mental Health team GP, [Dr D].
13 Month7	ACC records show that [the rehabilitation service provider] asked for [the medical centre] clinic notes.
	[Dr C] assesses the consumer while on ward. Discharged home.
14 Month7	[Dr C] wrote to [Dr B] at [Public Hospital 1] to expedite an EEG.
	[The rehabilitation service provider] wrote to ACC that the symptoms did not necessarily relate to a concussion anymore and multi-disciplinary team input was required.
15 Month7	Health NZ records consumer had been seen by multiple neurologists. He had only had neurological exams, rather than assessments by a neurologist.
	Home visit by [RN E] and [Dr D] after a call from [Mrs A]. Decided to admit the consumer to Mental Health Unit.
	Assessed by Psychiatrist … at [Public Hospital 1].
16 Month7	Consumer is reviewed … Neurology appt made … (not completed).
18 Month7	Consultant review which queried encephalopathic cause.
	Transferred to ICU with probable seizure activity.
Month7	Consumer passes away
24 Month7	[The rehabilitation service provider's] recommendations are forwarded from ACC to [the medical centre].