West Coast District Health Board

A Report by the
Mental Health Commissioner

(Case 18HDC01087)

Contents

Executive summary

1. This report highlights concerns about the care provided to a voluntary patient at a mental health inpatient unit (the inpatient unit) in 2018.

2. The man had a complex clinical background including a history of mental illness. When his condition deteriorated, he was admitted to the inpatient unit for diagnostic clarification. He was considered to be a moderate to high suicide risk.

3. The man was monitored over the weekend and no new concerns were noted until Sunday evening, when he became agitated and refused his medication. During the night, he barricaded himself in his room and began slamming the door repeatedly. He expressed a desire to leave the inpatient unit and to speak to the District Inspector,[1] and rang his sister and a friend for support.

4. Nursing staff undertook visual observations of the man during the night, but from 6.30am to 9.30am on Monday morning, no visual observations were undertaken. A multidisciplinary meeting took place at 9am, during which the man's sister's concerns were conveyed and the man's presentation was discussed.

5. At 9.30am, the man was found in his room following what was suspected to be an attempted suicide. He died four days later.

Findings

6. The Mental Health Commissioner found West Coast District Health Board (DHB) in breach of Right 4(1) of the Code[2] for failing to (a) transcribe possible diagnoses onto the admission form accurately; (b) fully document a medical plan for care; (c) document a nursing plan for care; (d) ensure that the man's room was checked for risk points; (e) complete hourly observations after 6.30am; (f) escalate the man's care when his condition deteriorated from 11pm given that he was known to be a moderate to high risk of suicide; and (g) develop an appropriate observations policy and a policy for the escalation of care.

Recommendations

7. In addition to the actions already undertaken by West Cost DHB, the Mental Health Commissioner recommended that the DHB assess where communication and teamwork skills could be strengthened within the team and undertake appropriate training; review the individual treatment and recovery plan template; audit the efficacy of new handover and admission forms to ensure that the relevant information is being captured; finalise an escalation pathway policy and provide evidence of recent training on the policy; provide evidence of recent training on care plans and documentation; conduct an audit of staff compliance with a selection of recent hourly observation plans; conduct a review of risk assessments; and provide a written apology to the man's family.

[1] Mental Health District Inspectors are lawyers appointed by the Minister of Health to protect the rights of people under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Mr A was not a patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992.
[2] The Code of Health and Disability Services Consumers' Rights.

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8. The Mental Health Commissioner referred West Coast DHB to the Director of Proceedings.

Complaint and investigation

9. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided to her brother, Mr A, by West Coast DHB. The following issue was identified for investigation:

- *The appropriateness of the care provided to Mr A by West Coast District Health Board in 2018.*

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

11. The parties directly involved in the investigation were:

Mrs B	Mr A's sister/complainant
West Coast DHB	

12. Further information was received from:

The Office of the Coroner	
Dr D	Psychiatrist
Dr C	Psychiatrist

Also mentioned in this report:

RN E	Registered nurse
RN F	Registered nurse

13. Independent expert advice was obtained from a psychiatrist, Dr Murray Patton (Appendix A), and from a registered psychiatric nurse, Dr Anthony O'Brien (Appendix B).

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Information gathered during investigation

Background

14. Mr A had a history of severe back pain, low mood, and long-term cannabis use. He had been diagnosed with cluster B personality disorder[3] and had attempted suicide or self-harm on several occasions. At the time of these events he was in his sixties.

15. On Day 1[4] and Day 6, Mr A harmed himself.

16. On Day 1, Mr A harmed himself. He was seen by TACT[5] and sent to the Emergency Department for medical treatment. He declined admission to the inpatient unit and was discharged to the community.

17. During this period, Mr A was under the care of the Community Mental Health Service (CMH) and he was seen by a psychiatrist on Day 7, Day 9, Day 13, Day 15, and Day 16.

18. On Day 15, Mr A was reviewed by a community psychiatrist, Dr C, who recorded that Mr A's mood was elevated and that he appeared in a hypomanic state with delusional thoughts.

Discharge/transfer from Community Mental Health Service (CMH) on Day 16

19. By Day 16, Mr A had become acutely unwell and was reviewed by Dr C, who recorded that Mr A's mental state had deteriorated and that he was expressing delusional ideation. Dr C recorded: "? Serotonergic syndrome,[6] ? Mania — elevated mood and psychosis."

20. Dr C told HDC:

> "[Mr A's] admission [to the inpatient unit] was for diagnostic clarification given the clinical complexity. [Mr A] was also admitted due to concerns about his safety. I considered him to be a moderate to high suicide risk, particularly due to the development of psychotic symptoms along with two recent suicide attempts."

21. The Comprehensive Psychiatric Assessment Form completed by the CMH case manager on Day 16 recorded the provisional diagnosis of "Possible serotonergic syndrome, Possible Mania — elevated mood and psychosis". The CMH case manager also completed the Mental Health Services Discharge/Transfer Summary of Care form (the Discharge/ Transfer form) and recorded the following diagnoses:

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[3] A grouping of personality disorders sharing traits of attention seeking, highly excitable emotional states, and unpredictable behaviour. This group includes antisocial, borderline, narcissistic, and histrionic personality disorders.

[4] Relevant dates are referred to as Days 1-23 to protect privacy.

[5] The community Triage Assessment Crisis Treatment team, which provides a mental health and addictions service.

[6] Serotonin is a chemical produced by the brain. Serotonin syndrome occurs when the level of serotonin becomes too high, which may be caused by the use of serotonergic medications, and can produce a range of symptoms that may include agitation, confusion, and hallucination.

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"• ? Serotonergic syndrome ? Bipolar
- Personality Disorder NOS [PD-NOS[7]]
- Chronic back pain
- Cannabis withdrawal"

22. The Discharge/Transfer form recorded that Mr A had been prescribed the following medication:

- Olanzapine nocte[8] (used to treat psychotic disorder/paranoia and mania/hypomania mood symptoms)
- Temazepam nocte (a benzodiazepine used to treat insomnia)
- Tramadol (an opioid medication used to treat pain)
- Paracetamol (used to treat pain and inflammation)
- Gabapentin (used to treat neuropathic pain).

23. The Discharge/Transfer form recorded that the following medications had been stopped because they were deemed to be affecting Mr A's health negatively:

- Citalopram (a selective serotonin reuptake inhibitor (SSRI) anti-depressant)
- Prednisone (a corticosteroid)
- Chlorpromazine (an anti-psychotic)

Admission to the inpatient unit on Thursday Day 16

24. On Day 16, Mr A was admitted to the inpatient unit. He signed a form that recorded his consent to an "informal" admission, which meant that he was admitted as a voluntary patient.

25. The admission form, completed at 11.15am, recorded that the diagnosis on admission was: "Personality Disorder NOS". It is unclear who completed the form and why serotonin syndrome was not recorded.

26. West Coast DHB noted[9] that "[t]his discrepancy may have affected the interpretation of [Mr A's] clinical behaviours by staff".

27. The Comprehensive Psychiatric Assessment Form recorded that Mr A's medications had not changed from those prescribed by Dr C on 4 and Day 16, and were the same as those detailed in the transfer form.

[7] Personality Disorder Not Otherwise Specified — meaning that a person has characteristics of a personality disorder but does not fully meet the criteria for any specific one.
[8] At night.
[9] This was noted in West Coast DHB's Serious Event Report, which is discussed in more detail later in this report.

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28. At 3pm, Mr A was reviewed by a resident medical officer who recorded that Mr A was "admitted with personality disorder and suicidal intent". She also documented:

> "[Mr A] stated his current admission stems from difficulty with lower back pain. Irritability, low mood and suicide attempts due to above. Easily irritable and becoming frustrated during consultation."

29. In addition to the medication prescribed by Dr C, the medical officer prescribed the following PRN[10] medication:

- Temazepam (for insomnia)
- Olanzapine (for psychosis and psychomotor agitation)
- Clonazepam (for agitation and for cannabis withdrawal)
- Ibuprofen (for pain).

30. A registered nurse (RN) recorded in the nursing notes:[11] "Working diagnosis is Personality Disorder."

31. Dr D was Mr A's treating psychiatrist at the inpatient unit from Day 16. Dr D said that he received a direct verbal handover from Dr C. Dr D told HDC:

> "The emergence of the manic/hypomanic and the psychotic symptoms which led to the admission, the possibilities of (corticosteroid[12] related) mania/hypomania and psychosis, possibility of a serotonin toxicity syndrome [serotonergic syndrome], and the possibility of substance withdrawals were discussed, and [Dr C] also advised me on the medication changes that had been made in the previous 1–2 days and at the point of admission with regards these diagnostic possibilities."

32. Dr D stated that the default level for nursing observations was hourly, and that this was applied to Mr A at the time of admission.

33. The written nursing observations policy at the inpatient unit, "Observations in the IPU [Inpatient Unit] Procedure",[13] required "intermittent observation as part of planned care where there is concern that an individual may be deteriorating", but did not indicate the frequency of observation.

34. Mr A was placed on "ward limits", which meant that he needed to be accompanied in order to leave the inpatient unit for any length of time.

[10] PRN medication is medication that is given "as required".
[11] This entry is dated Day 20. West Coast DHB noted that the entry was possibly dated incorrectly, and that it "should be [Day 16]".
[12] For example, prednisone.
[13] Dated July 2002, last reviewed August 2011.

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35. Dr D did not see Mr A on Day 16, nor did he record his discussion with Dr C or make any other notes.

36. There is no record of a risk check of Mr A's room before he was admitted.

Friday Day 17

Nursing care

37. The nursing notes for Friday Day 17 record that Mr A slept throughout the night, and also:

> "[Mr A] has spent his time in communal areas and in his room resting. Bright and engaging on interaction. Talkative ++ however able to take direction when asked to stop or listen. Mood appearing slightly elevated and variable/sensitive. One period of irritability when he did not get the correct meal causing him disappointment. Apologetic following this. Appropriately tearful when discussing [a family matter] … Accepting of medications. Risks: unpredictable due to changing mood."

38. At 6.31pm, the nursing notes record:

> "Visited by sister after tea … Remains polite and friendly. Still very over inclusive in conversation but seems slightly less elevated this [afternoon] than yesterday. Adherent with all medications."

Medical care

39. On Friday Day 17, the medical officer reviewed Mr A at 9.50am. She examined the lacerations to his left wrist and prescribed an antibiotic.

Psychiatric care

40. Dr D told HDC that he attended a multi-disciplinary team (MDT) meeting on Friday Day 17 at 9am and discussed Mr A's presentation overnight. He stated:

> "[Overnight] [t]here had been no significant findings on his mental state, no evidence of mania or psychosis driven behaviours since his admission …
>
> I also discussed his psychiatric medications and their rationale at the MDT, including the fact that all the serotonergic medications had been stopped in the previous 1–3 days by the admitting psychiatrist [Dr C] and the [resident medical officer], and mood elevating medications had been stopped in the previous 2–3 days by the admitting psychiatrist. I did not have any intentions of starting or restarting any such psychotropic medications. The RMO, as handed over by the admitting psychiatrist, had been careful to chart [Mr A] only non-opiate analgesics (some opiate analgesics can be serotonergic). I remember discussing these medication changes at the MDT handover, the rationale behind the changes, and the overall verbal handover that I had received from the community psychiatrist."

41. There is no written record of the MDT meeting.

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42. At 3.30pm, Dr D met with Mr A for the first time. Dr D told HDC that he introduced himself and reviewed Mr A's mental and physical state. Dr D discussed with Mr A the losses Mr A had experienced in his life, his decision to give up cannabis and tobacco, his medication, and his suicide attempts. Dr D concluded:

> "I found [Mr A's] mental state to be settling down. My overall impression of [Mr A's] presentation at that time was of a likely manic episode with psychotic features on the background of cannabis dependence and a personality disorder of cluster B type (encompassing emotional instability, affective instability, impulsivity, suicidality, histrionicity, and narcissism). The mania may have been triggered by corticosteroid treatment (which I considered most likely); there may have been a possible contribution of an elevated serotonergic state (which I considered unlikely based on [Mr A's] presentation during my interview with him and based on his progress over the last 24 hours), and even of cannabis withdrawal (for which I had ensured that PRN medications were available). The fact that Prednisone in the future might produce such psychiatric reactions was noted down on his medication chart. This presentation, of the manic/hypomanic symptoms and psychotic symptoms, was of a relatively short duration and was showing signs of early remission, and responding well to the medication treatment."

43. Dr D told HDC that he did not make any changes to the treatment and management plan suggested by Dr C, and that Mr A's admission continued on a voluntary basis. Dr D stated that there was no clinical reason to change the nursing observations from hourly, or his physical check-ups from daily.

44. Dr D did not record all these details in the clinical notes, or the rationale for his clinical management, but summarised the information he gathered as follows:

> "• settled on [the inpatient unit]
>
> • no ideas of [self-harm or suicidal ideation] etc
>
> • no aggression etc
>
> Plan — as per treating psychiatrist in community"

45. Dr D stated:

> "When I wrote the plan 'as per treating psychiatrist in community' it was a considered endorsement of a management plan that was working sufficiently, and an attempt to maintain clarity, consistency, and to refer the reader to the previous piece which all in all contained a lot more detail than my summary."

Saturday Day 18

46. Mr A was awake for a period overnight and arose early in the morning. He told staff that he had "the sweats", which he thought was a withdrawal symptom. He had last smoked

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cannabis three days earlier. Mr A was interacting with others on the ward and his mood was slightly elevated. Mr A's wound was redressed, and he accepted his medications.

47. It appears from the nursing notes that Mr A was being monitored by nursing staff, but the observations were not recorded on an hourly basis.

Sunday Day 19

48. Mr A slept poorly overnight and arose early. His mood was slightly elevated during the day, but generally he was settled.

49. At 9pm, the nursing notes record:

> "More settled evening for [Mr A] today. Nil episodes of histrionics this duty. Alternating between spending time alone in his room, and in communal areas watching TV."

Evening of Sunday Day 19 and morning of Monday Day 20

50. On Sunday evening, the nursing notes record that Mr A was being observed at least hourly.

51. At 9.30pm, Mr A's friend called the inpatient unit to say that Mr A had contacted him to ask him to contact the District Inspector.

52. At 9.50pm, a nurse recorded:

> "Went to give [Mr A] his [evening] medication. He was on the phone and told me to 'go away, not now, come back in half an hour'. Then followed me back into the corridor and said he would take them … He made out that he took the medications, but I am suspicious that he has not taken them."

53. At 10.20pm, the nurse recorded:

> "Knocked on his bedroom door to offer him the rest of his medication and he stated 'not now, sorry'."

54. RN E recorded[14] that at 11pm she:

> "Went to give [Mr A] his tablets and check him. He had locked the door and pushed the bed up against it so I said that I would come back later. Phone call [received] just after [11.30pm] from [Mr A's] sister saying things to the effect that he needs to 'get out of here' and he hates it here. Reassured her that the only thing adverse that happened was that he didn't want to take his tablets. She indicated that he often behaves like this and she will be up [tomorrow] morning and to tell him this."

55. At 11.40pm, RN E recorded that Mr A still had his bed up against the door and that the door was locked. She stated that Mr A asked to see Dr C, and he was advised that he could

[14] In the clinical notes.

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see another psychiatrist in the morning. RN E said that Mr A told her: "I don't want to be here." She recorded: "I left him to settle then."

56. At 12.30am on the morning of Monday Day 20, RN E recorded:

> "[Mr A] was still sitting in a chair by his bed which had been moved back to its usual position. He was holding up a piece of paper with [the District Inspector's] name and phone number. He seemed more settled and less angry. Offers of help, medications, turning off main bedroom light were all declined."

57. At 1.30am, RN E recorded:

> "[Mr A] was sitting in the chair bedside his bed holding the previously described piece of paper with [the District Inspector's] name on. Stating 'No the damage has been done and can't be undone'. I closed the door and walked away."

58. At 2.20am, RN E recorded:

> "[Mr A] was still awake on check. He flashed the [the District Inspector] piece of paper at me when he realised that I was at the door. The rest of his medications were offered but [Mr A] declined them."

59. At 3.20am, RN E recorded: "Checked carefully (quietly) to see if he was asleep. Was still awake abusive. Reluctant to engage."

60. At 3.30am, RN E recorded: "Deliberately slamming door every minute to wake everyone up. Left alone to calm as it seems trying to be nice exacerbates behaviour."

61. West Coast DHB told HDC that at 4am a clinical decision was made not to enter the room, with the expectation that this would help him to settle. West Coast DHB was unable to provide any information about who made the decision.

62. At 4.30am, RN E recorded: "Room not entered. Bedlight on. Quiet in room."

63. At 5.20am, RN E recorded: "[Mr A] was awake he was pulling his curtains open to close his windows no social interaction at this time."

64. At 6.30am, RN E recorded: "Room checked with minimal invasiveness. Night light still on, but room quiet."

65. It is unclear from the nursing notes whether RN E observed Mr A at 6.30am. However, West Coast DHB told HDC that the last documented sighting of Mr A was at 6.30am. There is no record in the nursing notes that any observations were undertaken after 6.30am.

66. The on-call psychiatrist was not advised of the clinical situation as it developed overnight, and nor were the Duty Nurse Manager, the RMO, or the police.

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67. West Coast DHB told HDC that at the time of these events there was no written policy for escalating the care of a patient who deteriorated overnight. However, the unwritten policy was that Mr A's care should have been escalated to the Duty Nurse Manager or the on-call consultant psychiatrist.

68. West Coast DHB told HDC that Mr A's room did not have an observation window, but that all rooms have now been fitted with observation windows.

Events of Monday Day 20

69. At 7am, the night staff handed over Mr A's care to the morning nursing staff. The morning staff were concerned about their ability to restrain Mr A if that became necessary. West Coast DHB told HDC that a clinical decision was made to wait for more staff to arrive before Mr A was checked, for safety reasons. West Coast DHB was unable to provide any information about who made the decision.

70. At 8am, the Clinical Nurse Manager arrived and agreed with the decision. She decided to wait for the MDT meeting scheduled for 9am to discuss Mr A's situation.

71. At 8.50am, RN F, a TACT nurse, arrived on the ward. RN F later recorded in the nursing notes[15] that she had received a telephone call from Mr A's sister at approximately 8.30am. RN F recorded:

> "[Mr A's sister] stated that [Mr A] had been texting her last night with angry and paranoid texts which she did not see until [11.30pm] when she looked at her phone. He was asking her to get the Police and break him out of the ward, she stated. She then stated that he began texting her this morning around [6.30am]. The texts became angrier and he was swearing at her — which she asked him not to do. [She] then rang TACT to inform us what he was doing, stating that she was concerned for the safety of the ward staff. I went to the ward to let them know this and stayed for the [9am] meeting (MDT) so that I could let all the staff know."

72. West Coast DHB told HDC that there was no mention of self-harm or suicidal ideation in the text messages.

73. The MDT meeting commenced at approximately 9am and was attended by RN F, Dr D, and all of the staff on the ward. West Coast DHB stated[16] that Mr A was not under regular observation at this time.

74. Dr D told HDC:

> "My next update regarding [Mr A's] presentation was at [the inpatient unit] daily handover meeting on Monday [Day 20] at 9am. I remember that events of the preceding evening/night were discussed by [inpatient unit] staff. I also remember it was agreed that I would review him immediately after the meeting with his

[15] At 12.20pm.
[16] In the Serious Event Report.

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> Community Case Manager (who was at the meeting), with the aim to review his presentation, re-negotiate his continued admission, and failing that, I was intending to consider whether a period of assessment and treatment under the Mental Health Act was indicated."

75. A nurse recorded in the nursing notes[17] that at approximately 9.30am a visitor to the inpatient unit advised her of her concerns about what she could see through Mr A's outside window. The nurse went to Mr A's room and found him following what was suspected to be an attempted suicide. She commenced CPR and called for assistance.

76. Mr A was transferred to a main centre hospital where he subsequently died.

77. West Coast DHB stated:

> "The West Coast DHB wishes to extend its sincere condolences to [Mr A's] family following this tragic event. We wish to acknowledge his family's extensive care and support that they provided [Mr A] during this difficult period of his life."

Further information from West Coast DHB

West Coast DHB's Serious Event Report (SER) findings

78. Following these events, West Coast DHB undertook a Serious Event investigation. The SER found the following:

> "• That an error of the documented clinical diagnosis occurred in the transcription from the referring service to the admitting service.
>
> • The change in the clinical presentation at [11pm] (Day 19) indicated that a psychiatric clinical review was warranted. Escalation to the [Duty Nurse Manager] would have been appropriate at this time.
>
> • The following were missed opportunities to reassess in detail [Mr A's] mental state and risk:
>
> o escalation to the on-call psychiatrist for immediate review overnight
> o [6.45am] handover between the two shifts when four staff were present
> o [8am] when nursing management were on site
> o when the MDT gathered and prior to the discussion of the patient
>
> • There was no physical interaction with [Mr A] from [3.30am] and no visual sighting of [Mr A] from [5.20am]. Given the change in mental state, appropriate clinical assessment should have included visual sighting and physical engagement.
>
> • There was no documentation of the rationale for clinical management.
>
> • There is a lack of critical assessment and management of the deteriorating mental health patient commencing the evening of [Day 19]."

[17] At 10.30am.

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Other issues raised in the SER

79. The SER stated:

> "There is one RMO on duty covering all inpatient services at the West Coast DHB during weekend shifts. The expectation is that the RMO would be called to assess and treat any deterioration of any patient within inpatient services. The Senior Medical Officer does not routinely round on patients in the Mental Health inpatient service, but is on call to attend if requested.
>
> …
>
> There was limited ability to undertake unobtrusive observation of [Mr A] [while he was in his room]. There was no history of a […] check process prior to the event."

80. There is no written escalation policy in place for situations where a patient is deteriorating overnight. However, the SER stated that the inpatient unit staff generally escalate directly to a consultant or the police, and do not follow the protocols of advising the RMO or Duty Nurse Manager.

81. The SER stated:

> "Two nurses described a lack of confidence to escalate to the DNM as from experience, there was lack of clinical knowledge and understanding of managing escalating problems within the mental health setting and therefore the DNM was not advised of this clinical situation on the night of [Day 19]."

SER recommendations

82. The SER made the following recommendations:

- Develop an escalation pathway, including guidance to staff indicating availability of the out-of-hours Duty Nurse Manager, on-call psychiatrist, and police.
- Refresh the Observation Policy and include the necessity of face-to-face observations and engagement of individuals under observation.
- Review the guidelines for handover and include verbal handover between the outpatient and inpatient team when admitting, and include the diagnosis, provisional diagnosis, and purpose of the admission.

Changes made by West Coast DHB

83. Since these events, West Coast DHB has made a number of changes to its practice, including the following:

<u>Observations</u>

- A new "Fireboard" is used to record observations and ensure that all consumers are sighted at least hourly.
- The "Leave [Status] Form/Observation [Level] Form" and the "Recording Observation Form" have been updated.

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- The "Observation in the inpatient unit Inpatient Unit Procedure" has been reviewed, and now requires that "consumers must be sighted at least every hour (including overnight) and recorded on the IPU [Inpatient Unit] Fireboard".
- Observation windows have been inserted into all bedroom doors.
- A "[Safety Review]" was completed and remedial action was implemented.

Admission and handover forms

- Admission, Post-Admission, and Discharge Checklists have been reviewed and updated.
- An "ISBAR[18] Handover Sheet" has been introduced to improve the handover of information between shifts. The handover sheet is in addition to the verbal handover between staff.
- A "Pending Admission Form" has been introduced to improve communication between the inpatient unit and other services for pending admissions. Risks, an admission plan, goals for admission, and physical health are recorded.
- The "MDT Review Form" has been updated to include more detailed information.
    - A new "Clinical Hard File Audit Tool" has been developed and is being used regularly.
    - The "Unexpected Death of an Inpatient Procedure" has been reviewed and updated.

Escalation

- Primary Nursing[19] has been introduced within the Inpatient Unit.
- An "Escalation Pathway" is being developed to assist staff when a consumer's physical and/or mental state begins to deteriorate.

Responses to provisional opinion

Mrs B

84. Mrs B was given an opportunity to comment on the "information gathered" section of the provisional opinion. Where relevant her response has been incorporated into the "information gathered" section above.

85. In addition, Mrs B stated:

> "We are shocked and upset at the lack of monitoring and the lack of care that was provided before he [harmed] himself. We feel the service let him and those around him down. There was evidence that his care should have been escalated and there

[18] ISBAR (Identify, Situation, Background, Assessment, and Recommendation) is a mnemonic created to improve safety in the transfer of critical information.

[19] Where one primary nurse provides direct care to a patient and is responsible for directing and supervising the patient's care in collaboration with other healthcare team members.

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> was more than sufficient indicators and time to have undertaken this, which likely would have saved his life. As a family it is expected that patients will be safe while in an inpatient environment however as care was well below what is acceptable, the outcome was the worst that anyone can imagine."

West Coast DHB

86. West Coast DHB was given an opportunity to comment on the provisional opinion. West Coast DHB advised HDC that it accepts the findings and the recommendations made in the provisional report.

Dr D

87. Dr D was given an opportunity to comment on the provisional opinion. He advised HDC that he did not wish to make any further submissions.

Opinion: West Coast District Health Board — breach

Introduction

88. West Coast DHB had the ultimate responsibility to ensure that the overall care provided to Mr A was of an appropriate standard. During the course of his five-day admission, a range of individual health providers at West Coast DHB provided care, and I am concerned about a number of aspects of the care Mr A received.

Transcription error at admission

89. All of the documents relating to Mr A's discharge from the Community Mental Health Service refer to the possible diagnoses of serotonin syndrome, mania, and PD-NOS. However, the admission form to the inpatient unit recorded only that Mr A had been diagnosed with PD-NOS.

90. West Coast DHB accepted that there was an error in the transcription of the clinical diagnoses from the Community Mental Health Service to the inpatient unit.

91. My expert advisor, psychiatrist Dr Patton, advised:

> "This difference [between serotonin syndrome and PD-NOS] is important. Personality disorders are often long-standing in nature. Although subject to some fluctuation in acute disturbance associated with the disorder, treatment approaches are typically long-term and better carried out in outpatient settings rather than inpatient wards. Serotonin syndrome and/or acute episodes of bipolar illness do commonly require inpatient care, with close monitoring and often high levels of observation of mental state and, particularly in the case of serotonin syndrome, close attention to physiological parameters."

92. The admission form is one of the documents that forms the basis for a patient's ongoing management, and it is essential that the information contained in the document is

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complete and accurate. In this case, material information regarding a possible diagnosis of serotonin syndrome was not included in the admission document. It is unclear whether the reason for this was a lack of understanding by the admitting nurse, or some other reason. I am critical that the diagnoses were not recorded on the admission form.

Documentation of psychiatric care

93. Dr D provided HDC with a detailed account of his clinical decision-making and his interactions with Mr A and other clinicians. He said that he discussed Mr A's presentation with Mr A's community psychiatrist, and was aware of the possible diagnoses of serotonin syndrome and personality disorder, and that Mr A may have been withdrawing from cannabis use. Dr D stated that he assessed Mr A, developed a plan for his ongoing care, and discussed the plan with the other health providers involved in Mr A's care. However, Dr D did not document this information fully in his notes and, as a result, the rationale for his decision-making and his instructions for Mr A's ongoing care were not recorded.

94. Dr Patton advised:

> "In my view, given a key function of the clinical record is to communicate the understanding of current clinical state and to communicate plans to others who may need to be involved in care, it would have been helpful for the record to outline these conclusions.
>
> …
>
> [T]here were discussions between [Dr D] and inpatient staff regarding the background to admission, risk factors and the treatment approach to be taken. There seems to have been appropriate consideration by [Dr D] of indications of progress over the first 24 hours of admission and the implications of this for further care.
>
> Although I am reassured by this consideration, it is my view that these elements should have been more clearly evident in the clinical record."

95. Following consideration of my expert's advice, I am satisfied that Dr D's clinical decision-making was appropriate and that he understood Mr A's presentation and had a clear plan for his management. I am also satisfied that Dr D communicated these matters to other staff verbally. However, I am critical that not all these matters were represented fully in the clinical notes.

Nursing care plan

96. The default level for nursing observations was hourly, and this was applied to Mr A at the time of admission. The nursing notes show that over the weekend, nurses monitored Mr A's mental state and were aware of his whereabouts and activities, and were engaging with him. However, the nursing observations were not recorded hourly, and no plan for his nursing care was documented.

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97. My expert nursing advisor, Dr O'Brien, advised that the lack of a "documented plan of nursing care or observations for Mr A covering any period of his admission from [Day 16] to [Day 20] … is a significant omission".

98. I accept this advice. I am mindful that a medical plan for Mr A's care had been developed, albeit poorly documented, and discussed by staff, but I am critical that there was no documented nursing care plan, and that there is no evidence that observations of Mr A were undertaken on an hourly basis over the weekend.

Risk check

99. There is no record of a risk check of Mr A's room before he was admitted.

100. Following these events, a review was undertaken by West Coast DHB and remedial action was implemented. Dr Patton advised that the scope of the review was reasonably broad, and there was a good attempt to cover the relevant areas of the ward. He offered some observations on how the risk assessment could be improved.

101. I am concerned that there appears to have been no risk assessment prior to Mr A's admission, and that remedial action was undertaken only after Mr A died. I note Dr Patton's comments, and consider this to be an opportunity for West Coast DHB to reflect on and improve its risk assessments.

Escalation of care

102. Mr A had a complex clinical background and was acutely unwell at admission. In the days following his admission, Mr A interacted with the nurses, no new concerns were noted, and he appeared to improve. On Sunday evening, Mr A became agitated and refused some of his medication. During the night, Mr A barricaded himself in his room and later began slamming his door repeatedly. He expressed a desire to leave the inpatient unit and to speak to the District Inspector, and he rang his sister and a friend for support. Both Mr A's sister and his friend were sufficiently concerned that they contacted the inpatient unit.

103. The deterioration in Mr A's condition did not prompt any appreciable response from the nursing staff. The hourly observations continued as usual, and Mr A's care was not escalated to the Duty Nurse Manager or the on-call medical staff.

104. West Coast DHB told HDC that at the time of these events there was no formal written policy for the escalation of care. However, there was an unwritten policy that required the Duty Nurse Manager or the on-call psychiatrist to be contacted if a patient deteriorated. It is unclear why the nursing staff did not do this. West Coast DHB has suggested that it may have been a lack of confidence in the ability of the Duty Nurse Manager, or because the practice at the inpatient unit at the time was to call a consultant or the police directly if there were any concerns.

105. In any event, the nursing staff took no action to escalate Mr A's care as his condition began to deteriorate overnight.

106. Dr O'Brien advised:

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> "The result seems to be that there is no clear escalation pathway available to the mental health unit. Duty Nurse Managers are also not given a handover from the mental health unit at the commencement of each shift, as they are for other areas of the hospital. Mental health deterioration is also not referred to the [Resident] Medical Officer, but it is not clear why. The lack, or non-use, of an escalation pathway also seems to leave a gap in which there is no opportunity to call on further expertise in managing difficult clinical issues."

107. Dr O'Brien also advised:

> "Despite [Mr A's] evident deterioration there was no referral to an on-call doctor to review [Mr A's] mental state and treatment. This is a usual practice for deteriorating consumers in any health setting."

108. Dr O'Brien concluded that the failure to escalate Mr A's care to more senior clinicians was a moderate departure from the accepted standard of care.

109. Dr Patton also commented on the response to Mr A overnight, and advised:

> "I also remain of the view that there was insufficient response to what subsequently appears to have been deterioration in [Mr A's] condition. It remains my opinion that the level of expertise and rigour of critical thinking that should have been applied was absent. It concerns me greatly that there was no escalation of concern to on-call medical staff or to other senior nursing staff within other parts of the hospital, when [Mr A] barricaded himself in his room and could not be observed."

110. As outlined above, several events over the course of Sunday evening should have triggered the escalation of Mr A's care to the Duty Nurse Manager or medical staff, including Mr A's refusal to take his medication, his decision to barricade himself in his room, and his expressed desire to speak to the District Inspector. Mr A also contacted his sister and a friend, who conveyed their concerns to staff. I am critical that there was no written policy for the escalation of care. I accept that there was an informal policy, but it appears that this was not followed. I would be very concerned if the reason that care was not escalated was because of a lack of confidence in the competence of other staff members, or because the policy was circumvented routinely, which would indicate a culture of poor communication within West Coast DHB. In my view, it is unacceptable that Mr A's care was not escalated to the Duty Nurse Manager or medical staff from 11pm, when Mr A barricaded himself in his room.

Observations after 5.20am on Monday Day 20

111. The last recorded sighting of Mr A was at 5.20am. The nursing note recorded at 6.30am states: "Room checked with minimal invasiveness. Night light still on, but room quiet." It is unclear from this entry whether Mr A was in fact seen by RN E at 6.30am, but I accept that there were no sightings or observations of Mr A after 6.30am.

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112. Dr O'Brien noted that there was no observation window in Mr A's room, and that staff expressed concern about their safety. However, Dr O'Brien stated that Mr A still should have been observed after 6.30am, and that "there is no safety reason that would prevent this".

113. Dr O'Brien advised:

> "The lack of observations after [6.30am] is unusual and concerning for a consumer in an acute inpatient unit, with the recent history of suicide attempts and given his deterioration over the previous eight hours. Adding to this concern [Mr A] had received no medication that might have helped relieve his distress. In these circumstances I would expect to see evidence of a written plan of frequent observations along with continued attempts at engagement. It is very concerning that the record of nursing intervention stops at [6.30am]."

114. At 8.30am, Mr A's sister rang RN F, a TACT nurse, to discuss the events of the previous evening and her concerns for the safety of the staff. RN F stated that they discussed Mr A's increasingly angry and paranoid texts, and that he had asked his sister to call the police to break him out of the inpatient unit. RN F said that she arrived at the inpatient unit at 8.50am and advised staff of the discussion, then stayed for the MDT meeting so that she could brief all staff.

115. Mr A remained in his room, and the information provided by RN F did not prompt an immediate visual check by any staff member.

116. Dr O'Brien advised:

> "Taken together with the well documented deterioration in [Mr A's] mental state overnight, this information from [RN F] should have been enough to trigger at least a brief face to face assessment by the nursing staff on duty after 6.30am on [Day 20]."

117. Dr O'Brien advised that the lack of any visual observation of Mr A from 6.30am to 9.30am was a severe departure from the accepted standard of care.

118. I accept this advice and am critical of the observations undertaken at the inpatient unit for three reasons. First, in my view, the observations policy was inadequate, and did not outline clearly the requirement for hourly observations or specify how frequent the general observations should be. The default policy, which specified hourly observations, appears not to have been considered mandatory and, in any event, was not followed by staff.

119. Secondly, even though the policy was inadequate, staff should have instigated regular and ongoing observations. Mr A was a high-risk patient whose condition was deteriorating. As outlined above, a number of events during the evening and the following morning were cause for concern. This did not trigger an increase in the frequency of observations and, after 6.30am, there were no observations at all. This suggests a lack of critical thinking by staff.

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120. Finally, I am also concerned that no clinical staff were on the ward while the MDT meeting was taking place at 9am. The meeting appears to have taken up to 30 minutes and, in my view, it is unacceptable that no staff members were responsible for patients during that time.

Conclusion

121. Mr A was admitted to the inpatient unit following a transfer of care by the Community Mental Health Service when he became acutely unwell. The community psychiatrist identified him as being at a moderate to high risk of suicide and sought admission for diagnostic clarification given Mr A's clinical complexity.

122. Given that context I am concerned that, following admission, a nursing care plan was not developed for Mr A, and that the documentation of his medical care plan was incomplete. In addition, several staff at West Coast DHB demonstrated a lack of critical thinking about the care that Mr A required overnight on Day 19, and a lack of initiative in addressing his deteriorating condition. I am also concerned that the policies were not adequate. In particular, West Coast DHB failed to:

- Transcribe possible diagnoses onto the admission form accurately;
- Fully document a medical plan for care;
- Document a nursing plan for care;
- Ensure that Mr A's room was checked for risk points;
- Complete hourly observations after 6.30am;
- Escalate Mr A's care when his condition deteriorated from 11pm given that he was known to be a moderate to high risk of suicide; and
- Develop an appropriate observations policy and a policy for the escalation of care.

123. As a result, West Coast DHB failed to provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[20]

Policies

124. West Coast DHB provided HDC with a range of policies and templates that have been developed or updated since these events. These documents were reviewed by my experts.

125. Dr Patton advised: "There does appear to have been appropriate consideration by the DHB of some relevant policies and procedures."

126. Dr O'Brien was particularly concerned about the policies relating to the escalation of care and observations. He advised that the new observation policy outlines the level and frequency of observations that are needed and the requirements for escalating observations if needed, and said that this meets the requirements for such a policy.

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

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127. Dr O'Brien recommended that an escalation of care pathway be developed to guide staff, so that senior clinicians are advised immediately if there is increased level of concern. I note that West Coast DHB has now developed a draft escalation policy.

128. Dr O'Brien reviewed the individual treatment and recovery plan template and advised that further development was required, particularly on matters such as mental state, physical health, and levels of observation.

129. I accept this advice. As outlined above, I am concerned that West Coast DHB did not have effective escalation and observation policies, and I note my expert's comments about the individual treatment and recovery plan template.

Recommendations

130. I note the actions already taken by West Coast DHB, and recommend that West Coast DHB:

a) Assess, with input from the inpatient unit staff, where communication and teamwork skills can be strengthened within the team, and with the DNM and other key nursing and medical staff, and undertake appropriate training and/or development initiatives to address the findings from that assessment;
b) Review the individual treatment and recovery plan template with reference to my expert's advice;
c) Audit the efficacy of new handover and admission forms to ensure that the relevant information is being captured;
d) Finalise an escalation pathway policy and provide evidence of recent training on the policy;
e) Provide evidence of recent training on care plans and documentation;
f) Conduct an audit of staff compliance with a selection of recent hourly observation plans; and
g) Conduct a review of risk assessments, taking account of the issues raised in this report.

West Coast DHB is to report back to HDC on the outcome of these actions within four months of the date of this report.

131. I also recommend that West Coast DHB provide a written apology to Mr A's family for the breach of the Code identified in this report. The apology should be provided to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

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Follow-up actions

132. West Coast DHB will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

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

134. A copy of this report with details identifying the parties removed, except West Coast DHB and the experts who advised on this case, will be sent to the Director of Mental Health, the Health Quality & Safety Commission, Te Ao Maramatanga New Zealand College of Mental Health Nurses, and the Royal Australian and New Zealand College of Psychiatrists, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

135. The outcome of the referral to the Director of Proceedings was a restorative settlement by way of negotiated agreement. No formal proceedings were taken by the Director

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Dr Murray Patton on 28 May 2019:

> "My name is Murray Patton. I hold vocational registration as a psychiatrist with the New Zealand Medical Council. I also have registration as a psychiatrist with the Australian Health Practitioners Regulation Agency. I obtained Fellowship of the Royal Australian and New Zealand College of Psychiatrists in 1989. I have held a variety of leadership roles in public sector mental health and addiction services in New Zealand and in Australia and have undertaken clinical roles in both countries, including in the last two years providing consultant psychiatrist cover to an acute adult inpatient unit in a mid-size District Health Board (DHB) in New Zealand.
>
> I presently have a leadership role and a clinical role in a crisis service of another DHB.
>
> I have been asked to provide expert opinion on many occasions including for the Health and Disability Commissioner, to DHBs and to Coroners.
>
> I am not aware of any conflict of opinion in providing an opinion on this occasion.
>
> In a letter dated 7 March 2019 you have asked for my assistance with an opinion regarding the care of [Mr A]. Your letter arrived by courier on 12 March. I sought clarification of a detail within the correspondence and received a response to that on 15 March.
>
> You provided me with the following material:
>
> — the complaint from Mrs B dated […]
> — record of a phone note of a call dated [2018]
> — West Coast District Health Board letter dated [2018]
> — report for the Coroner completed by [Dr D] dated [2018]
> — copies of clinical records related to mental health care that appear to date from [Day 15], although also including record of ED attendance on [Day 7] and aspects of care in the general hospital following transfer from the psychiatric inpatient service on [Day 20].
>
> I subsequently sought some additional information to assist me in formulating a view on the care. The copies of the medical records initially provided to me were poorly copied and some dates were cut off and some records appeared out of sequence. Clarification of some dates along with a request for some additional material was sought by me in an email on 20 March 2019 as follows:
>
> *Can you arrange for me to get:*
>
> — *Detail of the observation policy for the service*
> — *Detail of what the intended plan was for observing [Mr A]*

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— *Detail of the observations made (many services record these in separate observation records)*

— *What time [Mr A] was admitted*

— *How many other people were admitted that day, overnight, and the following morning*

— *What the bed numbers are*

— *What the expectation is with regard to medical staff ward rounds/attendance at weekends*

— *records of nursing handover information regarding [Mr A] for the period of the admission*

— *if the service uses Trendcare, the Trendcare reports related to [Mr A] for the period of the admission*

On 21 May I received a response with some additional material from the DHB. Most of the extra information I sought was not amongst that additional material. I received a redacted copy of the Serious Event Review report completed for the DHB (the sections 'Compliance with regulations' and 'Findings' having been masked) as well as two documents, one titled 'Observations in the IPU procedure' identified as an 'uncontrolled document' and due for review by August 2013, the other titled 'Observations in the inpatient unit Inpatient Unit procedure', undated. I also received a table that identifies the number of patients on the ward in the period from [Day 16] to [Day 20], including the number of admissions over that period.

I sought clarification of the status of the two policy documents on 22 May. That clarification is still awaited.

My views therefore are based upon less information than I would have ordinarily found helpful. I shall do my best with what is available to me, but I must note some frustration and disappointment that the DHB has been so slow in providing material that seems to me should be readily available, or has failed to confirm that the detail I am seeking is not available.

You have asked me to comment on a number of issues related to the care of [Mr A] in the period from [Day 16] to [Day 20]. I shall address these in turn in each of the sections below.

The adequacy of the psychiatric care provided to [Mr A] from [Day 16] to [Day 20]

[Mr A] had been under the care of the community mental health team before his admission. In a period of some two weeks before admission he had attempted to harm himself on several occasions. The ED record of [Day 7] documents two episodes of [self harm].

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He presented again on [Day 7] having [harmed] himself again, apparently with suicidal intent.

What appears to be an outpatient note dated [Day 16] identifies the decision to admit [Mr A]. Much of this record is hard to decipher clearly but it appears to identify persecutory and self-referential delusions. [Mr A] agreed to voluntary admission, signing a document to that effect on Thursday [Day 16]. A record of such agreement to admission is good practice.

A 'Discharge/Transfer summary of care' document was completed, dated [Day 16]. This form identifies, with question marks presumably indicating some uncertainty, that the diagnosis was of a serotonergic syndrome or a bipolar disorder as the axis 1 (principle) diagnosis, noting the presence also of an unspecified personality disorder.

The handwritten admission form notes that the diagnosis is of 'Personality Disorder NOS'. This form does not identify the particular concern (the possibility of serotonergic syndrome) that appears to have prompted admission and that seemed likely to be the main focus for further assessment and treatment, as recorded in the transfer summary of care document.

This difference is important. Personality disorders are often long-standing in nature. Although subject to some fluctuation in acute disturbance associated with the disorder, treatment approaches are typically long-term and better carried out in outpatient settings rather than inpatient wards. Serotonin syndrome and/or acute episodes of bipolar illness do commonly require inpatient care, with close monitoring and often high levels of observation of mental state and, particularly in the case of serotonin syndrome, close attention to physiological parameters.

It is concerning that there seems to have been a change in the understanding of the reason for the admission amongst nursing staff at this very early stage of inpatient care. The need to pay attention to the very real risk of harm associated with the potentially serious consequences of a serotonin syndrome appears to have been completely lost in what seems to have been poor communication of the reason for admission. This is further compounded by the inadequate treatment plan, about which I comment further below.

There was a risk assessment completed on [Day 16] documented in the 'Risk Assessment Form' of that date. This identifies a long history of [self harm] and identifies a number of internal and situational factors that contribute to [Mr A's] increased risk of self harm. Although reasonably thorough and with identification of these dynamic factors that appear relevant to increased risk of self-harm, there is no detail of any specific precipitants for any of the self-harm events in recent days, nor is this elaborated in the typed comprehensive psychiatric assessment documented that same day by his community case manager. There was a lost opportunity to more closely consider the dynamic factors in the formulation of risk, which may have been

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possible had the context for and precipitants of these recent self harm attempts been explored in more detail.

That comprehensive assessment document is otherwise quite thorough. There is reasonable outline of symptoms and the chronology of their development and there is a useful summary of his background. The relationship between the risk of him harming himself and his fluctuating mental state is clearly identified.

The plan in this document stops at the decision to admit. There is no reference to what other elements of a treatment plan should be addressed, nor is there reference to what issues should be resolved in order for him to be discharged.

The handwritten record dated [Day 16] that appears to be part of the community mental health team record has a little more substance. It notes:

> Admit voluntarily. If wants to leave then assess re MHA
>
> No leave until review by psychiatrist tomorrow
>
> Stop tramadol and chart other pain relief prn
>
> Bloods including TFTs
>
> Needs physical — elevated BP
>
> To remain off citalopram and prednisone
>
> Olanzapine 10mg nocte.

This does not appear to have taken account of some key matters of risk. In that same record [Mr A] was identified as being at moderate to high risk of self-harm given his changeable mental state. It was noted he was giving up marijuana. Psychotic symptoms were identified.

Given the concern regarding the possibility of a serotonin syndrome, something which does not occur commonly but which has potentially serious consequences, direction to staff about what to look for and what action to take should signs become apparent would have been appropriate.

There is no reference to what observation level should be applied in respect of [Mr A's] whereabouts and mental state. The note records 'needs physical — elevated BP' but there is no guidance regarding ongoing monitoring of the physiological markers that may be associated with excessively elevated levels of serotonin that occur in a serotonin syndrome.

Serotonin syndrome symptoms may include high body temperature, agitation, increased reflexes, tremor, sweating, dilated pupils, and diarrhea. Heart rate and blood pressure may rise. Symptoms may consist of increased heart rate, elevated blood pressure, shivering, sweating, dilated pupils, myoclonus (intermittent jerking or twitching), as well as overresponsive reflexes.

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Some of these features may be observed without 'hands-on' examination of a person, but many require direct measurement.

There is no specific test to diagnose serotonin syndrome. Diagnosis is by symptom observation and investigation of the person's history. Complications may include seizures and extensive muscle breakdown. It is important therefore that appropriate monitoring is set in place.

In these circumstances, it would have been good practice for staff to be directed to observe for particular features of affective or other psychotic illness. It would have been helpful for attention to be paid to signs of a withdrawal syndrome, even aside from any requirement for monitoring for evidence of a serotonin syndrome.

The directions in respect of medication management, oriented to reducing medications which contribute to serotonin release, were appropriate in the circumstances where there was suspicion that elevated levels of serotonin may have been contributing to [Mr A's] disturbed mental state. Such measures would usually be sufficient to resolve the crisis associated with this problem, although sometimes other medication may be required to assist with complications or to more rapidly reduce serotonin levels.

Similarly, ceasing prednisone, a medication with known propensity to adversely affect mental state, was also appropriate.

A file entry prefixed 'NURSING' has an ambiguous date that looks like [Day 20]. This would be unlikely however as this is the day [Mr A] was found dead, yet the note makes no reference to such an event. It seems most likely to be [Day 16] (as it discusses recent outpatient events and outlines the prescribing of the outpatient psychiatrist and discusses the admission presentation, and in the original bundle of documents provided to me it appeared before any of the other nursing records related to the inpatient care) and notes a working diagnosis of personality disorder. It makes no reference at all to the possibility of a manic episode in the context of a bipolar disorder nor does it consider the serotonin syndrome. This record makes no reference to the observation level to be applied nor any physiological monitoring to be implemented.

A file entry by the RMO on [Day 16] records temperature, blood pressure, respiratory rate and heart rate. No indication is given of any requirement for further observations or recordings.

Late in the afternoon of [Day 17] record is made by the inpatient psychiatrist of his review of [Mr A]. A very very brief summary of history is noted. In the circumstances, given that [Mr A] had been reasonably thoroughly assessed the previous day a comprehensive review of the history was not required.

Given however the diagnostic possibilities considered as the reasons for the acute admission, I would ordinarily expect an assessment focussed on confirming or

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discounting those diagnoses. Such a focus is not evident in the documentation of this assessment. I note that [Mr A] would not discuss the persecutory ideation previously reported, but there is no suggestion that he would not discuss other phenomena.

[Mr A] was apparently asked about and denied that ideas of self harm were present. There was no exploration of the context in which these had recently been present nor what had contributed to them resolving. There is no reference to what the goals of the admission were nor what [Mr A] was wanting from admission.

There is no statement in the file about how this doctor understood [Mr A's] presentation. The inpatient psychiatrist in his letter to the Coronial Case Manager dated [2018] confirms the possibility that [Mr A's] presentation may have been related to recent changes in or interactions between his medications. He also notes that cannabis misuse and withdrawal could have been a contributing factor to his presentation.

No direction was provided to other staff about what this doctor thought of the presentation or the implications for ongoing care.

The plan is simply noted as 'as per treating psych in community'.

In my view this was quite inadequate. There was no direction to nursing staff about monitoring of [Mr A's] mental state or physical condition. No guidance was given to how matters that [Mr A] was reluctant to discuss might be further assessed by other staff. The outpatient psychiatrist had delegated to his inpatient colleague the consideration of any leave. This is not referred to by the inpatient psychiatrist.

On [Day 18] a nursing file note apparently at the end of the night shift records that he had been sweaty overnight and notes that [Mr A] thought he was going through some sort of withdrawal. This resulted in an offer of 'medication' (unspecified) but did not result in any plan to more systematically monitor for withdrawal features, nor did it even explore whether there were other withdrawal features being experienced at the time.

Difficulty sleeping the previous night is also reflected in the note made at the end of the day shift that day. This is not explored. This same note also identifies withdrawal symptoms, apparently from ceasing smoking. There was no exploration of other substance use withdrawal, nor even what substance he had been smoking. The assessment was that he was at low risk while on the ward. There seems to have been no consideration whether withdrawal symptoms might exacerbate risk of any sort nor how his persisting elevated and irritable mood might contribute to risk.

Later that day there was clear evidence of an exaggerated response to a meal that was not to his satisfaction. He later said that he was ruminating on the events of the day.

The following day ([Day 19]) he was told that if withdrawals were to set in severely then a benzodiazepine medication was available. There appears to have been a

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reliance on [Mr A] to self-report, rather than him being systematically monitored for withdrawal symptoms.

Later that day a call was received from a friend of [Mr A] who noted that [Mr A] had indicated by text message that he wanted to contact a District Inspector. Rather than this nurse following up with [Mr A] how he could make contact directly with the District Inspector, the nurse told the friend to message [Mr A] about how that might take place. There appears to have been no consideration of discussing directly with [Mr A] what he was concerned about and whether any other help could be given.

As noted above, there are a number of what in my view are deficiencies in the rigour of assessment and in the comprehensiveness of the approach to [Mr A's] care in hospital. There seems to have been a lack of clinical curiosity and of proactive attention to matters that should have been of concern.

An acute inpatient psychiatric setting is an environment where skilled medical, nursing and allied health care should be available to the most acutely ill people in the service. Attention should be sharply focussed on assessment to develop a close understanding of the basis of what may at times be a complex and confusing clinical picture, with care plans directed to furthering the assessment and providing expert treatment to help resolve the clinical problems and the risk associated with these.

I find it hard to see this in practice with [Mr A's] inpatient care, on the basis of the records available to me.

Although there are no clear national standards in respect of this, commonly accepted best practice for anyone, regardless of the clinical problem, includes:

- clear documentation of the factors behind decision to admit
- clear identification of goals for the admission
- clear care plans to guide the inpatient care, including attention to observation levels
- clear processes for considering the legal status of any person admitted voluntarily who subsequently wishes to leave
- clear processes to ensure continuity of understanding of the focus of care and of the treatment plan.

More readily available are nationally agreed guidelines for risk assessment and management. These guidelines suggest that risk formulation is helpful, and that rather than cross sectional consideration of risk as somewhere on a scale of low to high, it is helpful to consider the context in which harms of various sorts may be at increased or decreased risk of occurring. There should be consideration of factors known to have an association with increased risk of harms of various sorts (such as gender; age; history of harm; etc) and factors which when present mitigate or increase the possibility of harm occurring (such as substance use; psychiatric symptoms; social

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supports or isolation; etc). In assessing an episode of harm, teasing out factors which contributed to the event taking place can be helpful in guiding the formulation, which should then be developed into a plan focussed on minimising the possibility of harm occurring and which pays attention to the contextual factors which for this person are known to be associated with a greater possibility of an adverse event taking place (and thus when present, require strategies to be implemented to try to lower the risk of the event occurring).

There had been a good attempt at documenting the focus of care and the possible concern regarding a physiologic syndrome arising from the combination of medications he had received prior to admission. The fact that the risk of harm was increased due to his changeable mental state was documented at the time of admission. Rather than active ongoing exploration and consideration of these matters however, the records appear simply to identify passive observation of behaviour, sometimes couched in perjorative terms ('Nil episodes of histrionics' — in the file note of [Day 19] at 2100 hrs) more suggesting that the primary issue was related to personality structure rather than exploring the possibility of phenomena related to a major affective disorder or adverse reaction to medication.

Through the evening of [Day 19] into the morning of [Day 20] a number of occasions of interaction with [Mr A] are recorded, some noting that he had barricaded himself in his room. It is not clear that this behaviour in a man who was regarded on admission, just 3 days previously, as being at moderate to high risk because of a changeable mental state and whose behaviour still appeared to be quite disturbed, led to any active consideration about how best to proceed. From possibly as early as 2220hrs on [Day 19] when he would not take his medication when a knock was made on his door (it is not clear whether he opened the door and was seen at this time), but certainly from 2300 when he had pushed his bed against the door through to 0030 on [Day 20], there appears not to have been any action to gain access to someone recently thought to be at some risk to himself.

In addition to these general aspects of care, consideration must also be given to the particular clinical features of each person's presentation. I comment further on this below.

Overall, with respect to these general aspects of care, it is my clear impression that the level of expertise and the rigour that should be evident in critical thinking about the basis of what is being observed was markedly absent. [Mr A] seems simply to have been, in large part, simply (and not even very consistently) observed without much evidence of any attempt to understand what was being seen or to address it in a way that might expedite his recovery.

The adequacy of the assessments undertaken, particularly with regard to [Mr A's] level of risk

I have commented already on some aspects of the assessment of [Mr A]. I shall here address this more specifically in relation to several aspects of his presentation. [Mr A]

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appeared to have several key risks associated with this admission. He recently had a history of several attempts at harming himself, apparently with the intention of ending his life on at least some of these occasions.

As noted already, there was the risk of harm associated with a serotonin syndrome, one of the problems considered possibly present at the time of admission. There is no evidence of ongoing physical monitoring to assess whether harm might develop.

There was also a risk of a withdrawal syndrome.

[Mr A] reported that he had not used alcohol since age 25. An alcohol withdrawal syndrome was therefore unlikely, although attention should always be paid to the possibility if mis-reporting any substance use.

He was open about marijuana use, described as 'heavy' and for more than 40 years. He was at clear risk of developing withdrawal symptoms from that. Symptoms of withdrawing from marijuana vary according to an individual's level of dependency: Mild dependence on marijuana, when use ceases, may result in minor physical and psychological discomfort, such as headaches or restlessness. Cessation of more severe marijuana addiction may result in more intense withdrawal symptoms, including sweating, fever, chills and hallucinations. In general, the longer the individual has used marijuana, the more severe their symptoms will be.

The most common symptoms include:

- Anxiety
- Depression
- Mood changes
- Agitation
- Irritability
- Headaches
- Restlessness
- Stomach pains
- Appetite loss/weight loss
- Nausea
- Insomnia or fatigue.

He was also described as smoking tobacco. Nicotine withdrawal may be experienced following abruptly ceasing use of tobacco. This is typically a group of symptoms that occur in the first few weeks. Symptoms include intense cravings for nicotine, anger/irritability, anxiety, depression, impatience, trouble sleeping, restlessness, hunger or weight gain, and difficulty concentrating.

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There seems to have been no systematic attempt to understand the symptoms with which [Mr A] was presenting and to differentiate them from the possible problems of serotonin syndrome or an acute episode of mania associated with a bipolar disorder. The approach to managing nicotine withdrawal (typically by replacement of the nicotine in some form) is different from the management of cannabis withdrawal.

A withdrawal syndrome could of course occur concurrently with the other possible acute problems. It should not be beyond the expertise of an acute admission setting to be able to at least pay attention to these various factors, making observations and assessments to help differentiate the possible causes and to offer appropriate interventions for each. I see little evidence of this having taken place for [Mr A].

There was a further risk associated with his behaviour and what appeared to have been psychotic symptoms evident before admission. There is no evidence of further efforts to explore these symptoms after the first day.

The appropriateness of any treatment plans put in place

I have commented already on the treatment plan. Although the elements set out are in themselves appropriate they are not sufficient to fully address the matters requiring attention through the period of inpatient care. Even within the first 24 hours of admission, some attention to physiologic monitoring would have been appropriate and directions set out in the initial treatment plan. This should have been further reviewed and direction given on the further psychiatric assessment the following day. This did not occur.

There was no reference to any other observation levels nor how ongoing nursing interactions with [Mr A] might contribute to an understanding of his presentation. This was not evident in the medical plan nor is there a nursing plan that addresses these aspects of care.

In the absence of a response for clarification from the DHB about the status of the 2 documents (referred to above) relating to observation levels, I shall assume the undated one replaces the document due for review in 2013. This document identifies that a minimum standard for all consumers is that they are seen at least every hour and recorded on the IPU fireboard. The document notes that level 4 observations, each 15–30 minutes, may be implemented when risk factors indicate that therapeutic interaction is required at an increased level from standard ward observations. Even more frequent observations are set out in circumstances of deteriorating mental state.

No records available to me, as far as I have been able to identify, reflect what level of observation was to be applied to [Mr A's] care. I think that for at least some of the time, given the explicit concern regarding a moderate to high level of risk of self harm, it would have been appropriate for level 4 observations (each 15–30 minutes) to have been applied.

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Despite my request, I have not been supplied with any documentation recording what observations actually were applied over the course of the admission. From the evidence available in the clinical record however, it is clear that no observation of him was possible on the night of [Day 19] when he had barricaded himself in his room for a period of at least an hour, and where it in fact seems likely he had not been directly observed for a much longer period since 2220 that night. This is a significant failing at a time when his behaviour should ordinarily have prompted more concern, resulting in a higher level of observation and associated efforts to more actively engage with him and respond to the deterioration in mental state. Even if I was to accept that it was reasonable that night, despite the deteriorated behaviour, to have been seen at the minimum frequency of hourly, it seems clear too that no attempt at observation was made on the morning of [Day 20] between 0630 and 0930 when he was found.

Any other matters that I consider amount to a departure from accepted standards of care

As noted already, the admission form identifies the diagnosis on admission as personality disorder. This is repeated as the 'working diagnosis' in a nursing note with an ambiguous date commencing '[Mr A] is a [man in his sixties] readmitted by CMHT…'. I assume this to be a nursing note made on his admission to the ward as it contains reference to medication prescribed by the outpatient psychiatrist, and to medication he had taken the night before, which was the same as outlined in the typed comprehensive assessment form.

Personality disorder was not the provisional diagnosis identified in the comprehensive assessment form. It was however repeated again in the notes made by the RMO on [Day 16].

The notes from the review by the psychiatrist on [Day 17] are silent with regard to diagnosis although there is a brief sentence in the body of that record outlining the possibility that recent prednisone prescription may have affected [Mr A's] mood. There is no concluding statement regarding how the presentation was understood.

[Mr A] is reported in this same record as having been reluctant to discuss the previously reported paranoid ideas. In this circumstance, where such ideas had been present in recent days and where understanding their persistence may be an important element of considering the diagnosis and treatment, some guidance to staff about what to look for in further efforts to engage [Mr A] would have been appropriate.

I believe there to have been a failure in communication regarding diagnosis and the focus of care, as evident in these examples.

On the evening of [Day 19] [Mr A] was apparently wishing to make contact with the District Inspector (DI). There was no proactive effort by the staff member who received this information to either determine at that time from [Mr A] himself why he

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wanted to contact the DI, nor any evidence of an offer to assist him in contacting the DI sooner than the following day.

Later that same evening [Mr A] was more clearly not cooperating with staff. His sister had apparently called and [Mr A] is described as saying that he 'needs to get out of here and he hates it here'. He repeated later to the staff member 'I don't want to be here'.

These statements appear significant for two reasons, neither of which seem to have been considered by the staff member.

[Mr A] was in hospital voluntarily. Any expression of concern that he did not want to remain in hospital should have prompted consideration of whether remaining voluntarily was appropriate.

Secondly, 'here' may have meant in hospital, but it could also have been interpreted as a signal that once again [Mr A] was possibly unhappy with his existence. Given the recent number of attempts on his life, or at least what could have been seen as expressions of his distress manifesting in self-harm, this statement should have prompted consideration of whether [Mr A] was at greater risk of further action to harm himself.

These examples appear to point to a lack of critical enquiry amongst the staff. Various elements of [Mr A's] presentation were not typical of any particular problem. He was becoming poorly engaged in the treatment process, or at least poorly cooperative with it by [Day 19]. He had had recent self-harm attempts and there were still features of disturbed mental state which may have contributed to higher risk of self-harm.

Although not explicit in the notes, this concern may have led to the apparent increase in recorded observations that night. The records show a number of file entries that identify contact with or sighting of [Mr A] at intervals between 10 minutes and just over an hour apart.

An increased level of observation in these circumstances was appropriate. The variation in frequency though, especially with intervals apparently as far as an hour apart, would typically not be regarded as satisfactory for someone about whom there was a heightened level of concern. In most inpatient settings, observation frequency for someone regarded as at higher risk of harm or who is more acutely ill would be at irregular intervals of between 10 and 20 minutes.

If this increased level of observation was a result of this increased concern, it is not reflected in a nursing plan. There is no record to suggest this was to be carried on through the following shift, or at least formally reviewed to agree what level of observation should continue.

There appears to have been no attempt made to see [Mr A] again between the last night shift record at 0630 (although the note is silent as to whether he was actually

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seen at that time) and the finding, soon after staff had their attention drawn to something odd at 0930, that [Mr A's] door was locked and when his room entered, the finding that he had [harmed] himself.

It is not clear why no attempt had been made to see [Mr A] before that time. Even without the heightened concern overnight, good practice for staff coming on to a shift is to familiarise themselves with the current state and physical location of people allocated to their care that shift. Although I have not been provided with medication records, it seems also likely that [Mr A] was prescribed medication to be taken in the morning (other records refer to a particular antibiotic, flucloxacillin, which is best taken an hour before meals, as well as to gabapentin taken in the morning). Why those medications had not been administered before 0930 is not clear.

I note that the DHB has already taken action to address the […] risk associated with […] in the ward. It is not clear to me whether the scope of review of potential […].

Overall conclusions

It appears clear, at least as evident in his letter to the Coroner, that the inpatient psychiatrist had a reasonable sense of what the clinical concerns were when [Mr A] was admitted. This did not translate to any direction regarding care. Even in the absence of such direction from the medical staff, nursing staff should still be able to develop their own understanding of the clinical issues, as is evident in the assessment of the community nurse, but appears strikingly absent from the inpatient nursing team.

It should be clear from my comments above that I believe there to have been significant shortfalls in a number of aspects of care. These can be summarised into several broad headings, as follows:

— Failure to ensure consistent understanding of the presenting problems and focus for the admission

— Failure to develop and implement a management plan addressing the core concerns prompting admission

— Failure of clinical curiosity or enquiry

— Failure to respond appropriately to ensure adequate access to [Mr A] in the face of deterioration in his mental state.

There are no clear guidelines against which these practices can be measured, other than in respect of risk assessment and management and the general guidance set out in documents such as the Code of Rights, as well as the DHB's own policy and procedure documents. Of these latter, it seems clear that the DHB's own expectations of observation and interaction and these increasing when mental state was deteriorating were not achieved.

Despite the absence of clear standards or guidelines, it is my view based upon substantial clinical experience in inpatient settings that each of these areas I identify

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as failings are significant and would be similarly regarded by my medical peers and by nursing colleagues.

Recommendations

Although the failures seem obvious, the cause for these is less clear from the file review alone. Somehow the understanding of the community team of the nature of the problems and the reasons for admission was not grasped by the inpatient nursing staff, presumably despite the community records being available.

It is not clear to me what conversation took place to support the written material and to ensure handover of relevant information.

I suggest the DHB closely consider the way in which community and inpatient teams communicate verbally to discuss admissions, and how documentation is completed and made available, to ensure consistent understanding of reasons for admission. This review of communication to ensure consistent care should also include how concerns are conveyed from shift to shift within the inpatient setting.

There are a number of checklists that appear in the record that apparently should be completed on admission, although it is evident that some are only partially completed and many elements are not specifically directed toward guiding clinical care. I suggest the DHB reviews this range of checklist material to ensure that staff time is most efficiently directed toward a shared understanding of the nature of the clinical presentation and what nursing and other plans are to be implemented to address the range of identified clinical needs. I further suggest that senior staff should ensure these processes are audited regularly to ensure that a number of matters are clear, including, as a minimum:

— diagnosis

— priorities for immediate care, including further investigations and nursing interventions

— observation levels to be applied and how the observations and associated interactions should contribute to the assessment and to the treatment process

— leave permission

— medication management

— risk formulation that guides staff in responding to situations in which a risk of harm appears to be increased, and which guides them in developing strategies to mitigate these risks.

As I have indicated, I do not get any sense that the inpatient service was responding in a way that demonstrates the high level of expertise required in such an acute setting.

I accept that a single example of care may not be a good indicator of general standards but I am sufficiently concerned that the very poor responsiveness of the

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DHB to requests for additional information (at least as evident from the material provided and the timing of its availability to me) to wonder about how seriously the responsibility to provide expert care or to demonstrate their ability to do so is taken, or whether core systems are in place to provide this care. These would include handover processes; care planning processes (medical and nursing); systems to elevate concern should clinical presentations deteriorate and arrangements for out-of-hours access to medical advice. At the very least I would suggest that senior DHB staff look closely at the culture of the inpatient service, with a focus on this issue of providing expert care for the most acutely and seriously mentally ill people in the district, to consider whether this example of care is more broadly representative of care within this setting.

Yours sincerely

M D Patton"

The following further expert advice was obtained from Dr Patton on 20 October 2019:

"You have asked me to review some further documentation provided by West Coast DHB and to consider whether this changes my opinion set out in my report of 28 May 2019.

You have provided me with the following:

- Letter to [HDC] dated 25 July 2019 from [Dr C]
- Report dated 26 August 2019 prepared by [Dr D]
- Letter to [HDC] dated 1 August 2019 from [West Coast DHB].

plus a variety of other documents:

- IPU Mental Health Level 3 and Level 4 observation form
- IPU pending admission form
- Observations in the inpatient unit Inpatient Unit procedure (WCDHB-MHealth#23 Version 8 Reviewed May 2019)
- Unexpected death of an inpatient procedure (date not specified)
- Unexpected death of an inpatient procedure (WCDHB-MHS-0058 Version 5, reviewed April 2010 and due for review April 2012)
- Ward period shift variance report for [the inpatient unit] [2018]
- Serious event review report
- Sample (blank) IPU ISBAR handover sheet
- Mental Health Services MDT review (note I was provided with 2 versions of this, one slightly expanded compared with the other)
- IPU Fire Board template WCDHB-MHealth 10 Version 1, Reviewed May 2019)

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- Mental Health Services IPU inpatient discharge/transfer checklist (WCDHB-MHealth 15 Version 1, Reviewed May 2019)
- IPU inpatient post admission checklist (developed April 2019)
- Prompts for leave status (WCDHB MHealth8 Version 1, Reviewed May 2019)
- Mental Health 15 minute observation form
- List of [risk] points identified in review [2018]
- Floor plan of Community Mental Health/[the inpatient unit]
- Hospital shift notes reports for day shift [Day 20] and evening and night shifts of same day
- Staff lists by day for [Days 17-20]
- Mental Health Risk Assessment and Management Procedure (WCDHB-MHS-0005 reviewed November 2009, due for review November 2010)
- Clinical hard file audit template — the inpatient unit IPU

I note that several of the documents have been developed earlier this year. It is not clear for some whether these are new documents or updated versions of previous documents. Overall these each appear to be reasonably thorough although it is difficult to know from a review of this nature, based simply on documentation, to know how they fit the overall scheme of care and the systems that are applied.

A key issue, however, no matter how thorough the documentation that sets out the description of how work should occur (as these procedure documents are presumably intended to do), is actually how the work is performed. For example, the 'Observations in the inpatient unit Inpatient Unit' looks very thorough and is an updated version of an existing document. My previous comments note though that no matter what the earlier written document may have set out, there appears to have been a flaw in how an agreed policy was actually applied. It is evident that no matter what level of observation was to be applied, there was a substantial period of time when no observations took place.

Policy and procedure documents are only as good as their actual application. Systems should be in place to monitor 'work as performed', rather than to assume that 'work as described' (in policy and procedure) will actually be what takes place.

In my earlier comments I noted concern at the apparent different understanding of the reason for admission amongst the inpatient nursing staff, as least as evident in some of the initial inpatient nursing documentation. I note the 'IPU Pending Admission Form' which includes reference to current presentation and reason for admission. It is not immediately clear to me how this document is to be completed, although it looks as though it is intended to be completed by an inpatient unit staff member on receiving information from another service. It includes reference to the current presentation and reason for admission.

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This does appear to represent an attempt to ensure that the view of the referring team and their intentions for the admission are represented clearly to the inpatient service. If this has not existed previously, this may be a useful document to minimize the risk of different views of the purpose of admission.

I previously expressed concern regarding the lack of guidance from the medical staff with respect to the level of observation to be applied and nature of any recordings of physiologic measures. [Dr C] does not address this in his letter to [HDC]. [Dr D], in his report of 26 August, discusses the range of diagnostic considerations that seemed relevant. He notes that [Mr A] would be subject to at least the default hourly observations. He also notes that the RMO doctor undertook a physical examination and that 'no pressing or significant findings were drawn to my attention', although it is not clear whether there was explicit discussion with this RMO about the possibility of the serotonin syndrome (something not commonly encountered and therefore possibly not seen before or familiar to the RMO) and what should be the focus of attention. That discussion did take place however the following afternoon.

[Dr D] discusses in his report the physiologic measures that were available to him when he reviewed [Mr A] on [Day 17]. He took these as well as other aspects of [Mr A's] presentation into account and reached a conclusion that [Mr A] appeared to be improving.

This set of observations outlined in the report is more comprehensive than the clinical record. In my view, given a key function of the clinical record is to communicate the understanding of current clinical state and to communicate plans to others who may need to be involved in care, it would have been helpful for the record to outline these conclusions.

In the circumstances as outlined in his report, it seems reasonable for [Dr D] to have concluded [Mr A] was improving. I remain of the view however that it would have been good practice for there to be greater clarity in the records about the assessment and treatment plan [Dr D] describes discussing with staff. Withdrawal syndromes typically are not immediately evident once substance use ceases. Remaining vigilant to this possibility through the first 3–5 days of admission, sometimes even longer depending upon the substance involved, is important. Although [Dr D] advises he discussed the use of prn medication with [Mr A] and with staff, the possibility of withdrawal does not appear to have been subject to vigilant monitoring, even when [Mr A] himself identified that he thought he might be suffering withdrawal symptoms (nursing note on [Day 18]). Specific reference to the instructions in his clinical note would reduce the risk that the information [Dr D] had discussed with some staff may not be accurately handed on to staff on subsequent shifts.

I have not been provided with handover documents related to the period of [Mr A's] care but have seen the template used for handover documentation. Any template of this nature with only limited space for documentation potentially runs the risk that only information that the particular staff member making the record feels is most

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important to fit into the space available. There is no evidence of a structured handover format of the type increasingly used in health care settings, based upon the SBAR (Situation, Background, Assessment, Recommendation) format or a further adaptation of it. These SBAR-based handover processes allow for short, organized and predictable flow of information, prompting attention to current key issues, the context of their development, the conclusions drawn from the assessment of the staff member(s) involved, and a proposed recommended course of action.

It is not clear to me how the template is used and whether staff involved in a shift are directly involved in the face-to-face discussion of their observations with staff of the incoming shift. Such direct involvement provides the opportunity for expansion of clinical impressions and elaboration of material that may not have been fully captured in summary documentation, whereas the simple reading of a summary by a staff member who may not actually have been involved in care misses the opportunity for a more rich and clinically meaningful discussion.

I was provided with a copy of a [risk assessment] of the inpatient setting. In my earlier report I commented that the scope of the [risk review] that had been carried out was not clear. This further document makes it evident that the scope has been reasonably broad, paying attention to a range of areas within the ward. Unfortunately the floor plan provided is of poor quality visually and I find it difficult to reconcile each of the areas in the risk assessment with the actual locations within the ward. It does appear however that there has been a good attempt to cover relevant areas of the ward.

I have two comments though. Firstly, there exist some useful frameworks for objectively considering […] risk. One such example is the […] risk assessment. An approach using this tool takes account of patient risk profile as well as […] risk rating as well as 'compensating factors', these being elements of design or observation or other continually present factors which mitigate risk in a particular location on a ward. Considering all these factors enables locations to be ranked by risk, further enabling appropriate controls to be implemented. It is not clear whether the list provided to me has used such an approach.

Secondly, I note in the document many elements where the recommended action is 'staff awareness'. Others note 'Assess' as the recommended action.

I am concerned that staff awareness itself may not be sufficient. [Mr A] for example had prior episodes of self harm. According to [Dr D], this was a matter discussed with a nursing staff member present in this interview. This account of prior episodes of self-harm, some recently, might ordinarily suggest heightened awareness of ongoing risk in the context of an acute episode of illness is necessary, yet was insufficient to translate into such concern that access to [Mr A] was attempted during a period in which he had barricaded himself in his room.

Some items with 'assess' as the recommended action have a further entry that indicates further assessment has taken place. One […] has no further indication of any

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outcome of the assessment. It is difficult therefore to be sure how adequate the […] risk assessment process has been.

I was also provided with a copy of a template used for clinical hard file audit. I comment elsewhere on the potential gap between work as prescribed in policy and procedure documents and the work actually performed, at least as evident in clinical documentation (bearing in mind that sometimes what is documented may itself only be a partial representation of the work actually carried out). It is good therefore to see the attention to audit, although it is not clear to me how this takes place.

Overall, the further information provided provides some greater reassurance that despite some evidence of poor understanding by the admitting nurse of the reason for admission, as documented in the handwritten admission form, there were discussions between [Dr D] and inpatient staff regarding the background to admission, risk factors and the treatment approach to be taken. There seems to have been appropriate consideration by [Dr D] of indications of progress over the first 24 hours of admission and the implications of this for further care.

Although I am reassured by this consideration, it is my view that these elements should have been more clearly evident in the clinical record.

I also remain of the view that there was insufficient response to what subsequently appears to have been deterioration in [Mr A's] condition. It remains my opinion that the level of expertise and rigour of critical thinking that should have been applied was absent. It concerns me greatly that there was no escalation of concern to on-call medical staff or to other senior nursing staff within other parts of the hospital, when [Mr A] barricaded himself in his room and could not be observed.

There does appear to have been appropriate consideration by the DHB of some relevant policies and procedures. I remain of the opinion that the recommendations I made in my initial report remain relevant.

M D Patton"

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Appendix B: Independent advice to the Commissioner

The following expert advice was obtained from Dr Anthony O'Brien:

"29 March 2019

Report prepared by Anthony O'Brien, RN, PhD, FANZCMHN

Preamble

I have been asked by the Commissioner to provide expert advice on case number C18HDC01087. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications

I qualified as a registered male nurse in in 1977 and as a registered psychiatric nurse in 1982. I hold a Bachelor of Arts (Education) (Massey, 1996), a Master of Philosophy (Nursing) (Massey, 2003) and a Doctor of Philosophy in Psychiatry (Auckland, 2014). I am a past President and current Fellow and board member of Te Ao Maramatanga, the New Zealand College of Mental Health Nurses. I am currently employed as Nurse Specialist (Liaison Psychiatry) with the Auckland District Health Board and a Senior Lecturer in Mental Health Nursing with the University of Auckland. My current clinical role involves assessment and care of people in acute mental health crisis, including suicidality, and advising on care of people with mental health or behavioural issues in the general hospital. I am a duly authorised officer under the Mental Health (Compulsory Assessment and Treatment) Act (1992). My academic role involves teaching postgraduate mental health nurses, supervision of research projects, and research into mental health issues. In the course of my career as a mental health nurse I have been closely involved with professional development issues, including development of the College of Mental Health Nurses *Standards of Practice*. I have previously acted as an external advisor to mental health services following critical incidents and as advisor to the Health and Disability Commissioner.

The purpose of this report is to provide independent expert advice about matters related to the care provided to [Mr A] by West Coast District Health Board (DHB) mental health service between [Day 16] and [Day 20]. I do not have any personal or professional conflict of interest in this case.

An initial report was written on 29 March 2019. Some additional comments are provided following this initial report. Despite requests, I have not seen [Mr A's] medication chart or medication record.

Instructions from the Commissioner are:

Please review the enclosed documentation and advise whether you consider the care provided to [Mr A] at [the DHB] was reasonable in the circumstances, and why.

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In particular please comment on:

1. The adequacy of the nursing care provided to [Mr A] from [Day 16] to [Day 20], particularly with regard to the level of monitoring and observation; and
2. Any other matters that you consider to amount to a departure from accepted standards of care.

In relation to the above issues I have been asked to advise on:

a. What the standard of care/accepted practice is;

b. If there has been a departure from the standard of care or accepted practice, how significant a departure it is.

c. How the care provided would be viewed by your peers?

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

I have had the following documents available to me for the purpose of writing this report:

(Note: documents are recorded in the order provided; there were duplicate copies of many documents. All dates are 2018.)

1. Copy of complaint to HDC dated [2018].
2. Record of phone call from [HDC] to [Mrs B].
3. Letter from [West Coast DHB], to the Office of the Health and Disability Commissioner [2018].
4. Letter from [Dr D], Consultant Psychiatrist, to [Coronial Services Unit], [2018].
5. Record of [Mr A's] presentation to [the Emergency Department] [Day 7].
6. Clinical coding printout, West Coast DHB, [Day 20]
7. Discharge summary, West Coast DHB Critical Care Unit, [Day 20].
8. Undated Adult Patient Observation Chart
9. Copy of clinical notes for the afternoon (1446–1611) of [Day 20].
10. Copy of medical clinical notes from 0930 [Day 20].
11. Copy of nursing clinical notes from the afternoon of [Day 20].
12. ECG records from [Day 20].
13. Resuscitation Status and Advance Directive Form, West Coast DHB [Day 20].
14. CVAD + CLAB insertion form, West Coast DHB, [Day 20].
15. Clinical Care Unit observation records, [Day 20].
16. Further ECG records, [Day 20].

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17. Two results of blood analysis, [Day 20] (0935 and 0955).
18. Photocopy of [Mr A's] driver's license
19. Emergency Department Trauma form, West Coast DHB (dated [Day 21] but would actually have been [Day 20]).
20. Clinical Emergency Record/Drug Treatment Form West Coast DHB [Day 20].
21. Behaviour and Safety Management Form recording [Mr A's] discovery after [self harming], completed [Day 20].
22. Inpatient Episode of Care document recording [Mr A's] personal details, completed [Day 16].
23. Mental Health Services Consent to Treatment form.
24. [The inpatient unit's] Acute Mental Health Inpatient Unit Admission Form (an administrative checklist) completed [Day 16].
25. Mental Health Services Discharge/Transfer summary of care [Day 16] documenting transfer of care from [Community Mental Health] to inpatient care.
26. Mental Health Services Risk Assessment Form completed on [Day 16] by [Mr A's] community mental health nurse, on [Mr A's] transfer to inpatient care.
27. Comprehensive Psychiatric Assessment Form completed on [Day 16] by [Mr A's] community mental health nurse, on [Mr A's] transfer to inpatient care.
28. An undated guideline for an 8 point case management plan.
29. Clinical notes documenting [Mr A's] admission to inpatient care, and subsequent care in the inpatient unit, from [Day 16] to [Day 20].
30. Discharge summary, Adult Mental Health Service, West Coast DHB, [Day 23].
31. Discharge form, Acute Mental Health Unit, West Coast DHB, [Day 20].
32. Mental Health Services Transfer Checklist, [Day 23].
33. Prescribing record [dates]
34. Further ECG readings, date not evident.
35. Nursing physical examination form, undated, source not clear.
36. Mental health limitations of movement form [Day 16].
37. Outpatient episode of care form, undated.
38. Mental Health Services Consent to Treatment Form (not completed).
39. Comprehensive Psychiatric Assessment Form [Day 7]
40. Mental Health Services Risk Assessment form [Day 9].
41. Clinical note by [Dr D].
42. Nursing and medical physical examination forms.

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43. Clinical notes from the West Coast DHB community mental health service from [Day 9] to [Day 16].
44. A printout of drugs prescribed, [2017] to [Day 9].
45. Record of appointment at AOD service, [Day 7].
46. Task completion form, [Day 16].
47. Standard Measures for Adults and Older Adults form dated [Day 16].
48. HoNOS form dated [Day 7].
49. Hospital prescription form date and content unclear.
50. Rata Alcohol and Drug Service Referral form
51. Clinical letter from [Dr C] to [the] Medical Centre, [Mr A's] primary care provider, [Day 15].
52. Clinical letter from [Dr C] to [the] Medical Centre, [Mr A's] primary care provider, [Day 9].

Documents provided subsequent to writing initial report.

1. Mental Health Services Individual Treatment & Recovery Plan
2. Serious Event Review, [2018]
3. Observations in the IPU Procedure

Outline of events

[Mr A] was a [man in his sixties] who at the time of the events under consideration in this report, was a voluntary inpatient in the [the public hospital] mental health inpatient unit. [Mr A] had a life history of trauma, severe back pain, low mood and long term cannabis use. He had a diagnosis of cluster B personality disorder. He had experienced [family-related trauma]. [Mr A] had been unemployed for […] years. He had a supportive sister. He had made several previous suicide attempts, and at the time of his admission to [the public hospital] on [Day 16], he had become acutely unwell with changes in his mental state including low mood over the past year, elevated mood on admission, confusion, paranoid thoughts, and irritability. In the week prior to his admission he had [harmed himself]. It is also evident from the clinical notes that [Mr A] was possibly withdrawing from prednisone, cannabis, and nicotine, and may have had discontinuation symptoms from having recently stopped citalopram. His clinical picture was therefore complex. It is significant that it was thought necessary to consider detention under the Mental Health (Community Assessment and Treatment) Act (1992) if [Mr A] expressed an intention to leave the inpatient unit.

In the days following his admission [Mr A's] mental state appeared to have improved. The nursing notes comment several times on his interactions with nurses, and do not indicate any new acute concern until the evening of Sunday [Day 19] and the early

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morning (2400–0630) of [Day 20]. During the evening of [Day 19] [Mr A] appears to have become agitated, irritable and distrustful of nursing staff. He refused some of his evening medication, and the nurse on the evening shift expressed doubt that he had taken any medication at all. It appears from the nursing notes of [Days 19-20] (2300–0630) that [Mr A] did not sleep at all overnight. On two occasions he locked his door. He also pushed his bed against the door of his room (perhaps to prevent the door being opened). He expressed a wish to leave the hospital, and refused further offers of his prescribed medication. Over this period [Mr A] appears to have been agitated and acutely distressed. He expressed in a phone call to his sister that he needed to get out of hospital, he locked the door to his room for a period of time, and requested to see his community psychiatrist [Dr C], and later [the District Inspector]. He appears to have been experiencing paranoid ideas similar to those he had reported in the days prior to his admission. At 0930 am, following a report from a visitor, a nurse entered [Mr A's] room to find [he had harmed himself]. Despite attempts to resuscitate him, [Mr A] died later that day in [the public] hospital.

The following section of this report responds to the Commissioner's questions.

Question 1. The adequacy of the nursing care provided to [Mr A] from [Day 16] to [Day 20], particularly with regard to the level of monitoring and observation.

As my summary above shows, [Mr A] was acutely unwell at the time of his admission. His diagnostic picture is not entirely clear, something that is not unusual in consumers with complex issues that include drug withdrawal and other changes in mental state that may or may not be related to withdrawal. [Mr A] was prescribed a variety of medication, most notably olanzapine and clonazepam which would be expected to relieve withdrawal symptoms. Nevertheless, [Mr A] was in the early days of admission for an acute mental health crisis, and it could be expected that his mental state, and therefore risk, would fluctuate over that time. The documents from the community mental health service refer to the possibility of his fluctuation in risk, especially if [Mr A] were to become distressed.

The inpatient nursing notes from [Day 16] until [Day 20] show that nurses were monitoring [Mr A's] mental state, were aware of his whereabouts and activities, and were making reasonable attempts to engage with him. He accepted all prescribed regular medication (although he refused medication offered in the morning of [Day 20]). From the notes available it is not possible to understand if [Mr A] had required any PRN clonazepam or olanzapine over the period of his admission. There are several examples of nursing records that show that [Mr A] was being closely observed as would be expected for a consumer in an acute crisis. In particular there is a series of notes written in the period from 2400–0630 on [Day 20] that show that [Mr A] was observed hourly over that time. He was offered, but refused, medication (although it is not stated what medication he was offered). It could have been his night time dose of 10mg olanzapine or his night time dose of 10mg temazepam, each of which would have helped his sleep (I have not seen his medication chart).

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There is no record of any sighting of [Mr A] after 0630 am. (The final overnight note of 0630am does not mention that [Mr A] was actually sighted, which it should do, but I have assumed, based on the content of the earlier notes that he was physically sighted). The lack of observations after 0630 is unusual and concerning for a consumer in an acute inpatient unit, with the recent history of suicide attempts and given his deterioration over the previous eight hours. Adding to this concern [Mr A] had received no medication that might have helped relieve his distress. In these circumstances I would expect to see evidence of a written plan of frequent observations along with continued attempts at engagement. It is very concerning that the record of nursing intervention stops at 0630.

An additional concern is about actions taken after community mental health nurse [RN F] attended the ward some time before 0900 on [Day 20] to pass on concerns of [Mr A's sister]. It is not clear exactly what time this information was communicated to staff on the ward, but the note states that after passing the information on, [[RN F]] stayed for the 0900 team meeting. [Mr A] had texted [his sister] expressing angry and paranoid ideas, asking for Police to be called. Taken together with the well documented deterioration in [Mr A's] mental state overnight, this information from [RN F] should have been enough to trigger at least a brief face to face assessment by the nursing staff on duty after 6.30am on [Day 20].

Despite [Mr A's] evident deterioration there was no referral to an on call doctor to review [Mr A's] mental state and treatment. This is a usual practice for deteriorating consumers in any health setting.

There is no documented plan of nursing care or observations for [Mr A] covering any period of his admission from [Day 16] to [Day 20]. This is a significant omission.

The standard of care/accepted practice

In my opinion [Mr A] was generally offered an acceptable standard of care over the period of his hospitalisation, with the exception of the crucial period from 0630–0930 hrs. From his admission on [Day 16] until 0630 on [Day 20], nursing staff appear to have been aware of [Mr A's] whereabouts, and made many references to his mental state and behaviour. He was given and accepted medication as prescribed. Overnight on [Day 20] [Mr A] was observed hourly, with attempts made to engage with his concerns. This is in line with the accepted standard of care. Although regular hourly observations were made and documented, there was no evident review of the level of observations. Given that [Mr A] had become agitated overnight I would have expected to see observations continued after 0630 and documented regularly.

In an acute setting such as an inpatient mental health unit it is usual to review the frequency of observations if there is an acute change in a consumer's presentation as there was in this case. There is no record of implementation of regular observations or other actions taken after 0630 in the morning of [Day 20] and this is below the expected standard. It is accepted practice that all consumers have a documented plan

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of care, and that that plan is reviewed in case of a significant change in the consumer's mental state.

I understand from [the record] of a phone discussion with [Mrs B] that early in the morning of [Day 20] (until 0930am) all unit staff were involved in a multidisciplinary team meeting. Such meetings are a standard part of inpatient care, although there would normally be provision made for at least one nurse to remain out of the meeting to attend to any immediate consumer needs, particularly those on frequent observations. This would especially apply to [Mr A] whose mental state appears had deteriorated over the evening of [Day 19] and morning of [Day 20].

Review of the condition of a consumer showing significant deterioration is an expected standard of care. It is evident that [Mr A's] mental state began to deteriorate on the evening of [Day 19], but especially in the early hours of [Day 20]. Although there were regular observations of [Mr A] over this time, there was no review requested by an on call doctor. It may be that a review was planned following the team meeting at 0900, but an earlier review might have led to an increase in the level of observations, and to ensuring they were maintained after 0630hrs.

How the care provided would be viewed by your peers?

In my opinion the apparent lack of any sighting of [Mr A] from 0630 to 0930 would be viewed by my peers as a serious breach of standards.

In my opinion the apparent lack of a documented plan of care for [Mr A] would be regarded as a moderate breach of standards.

In my opinion the apparent lack of assessment for level of observations for [Mr A] would be regarded as a moderate breach of standards.

In my opinion the lack of any review of [Mr A] either on the evening of [Day 19] or in the early hours of [Day 20] would be regarded by my peers as a moderate breach of standards.

Recommendations for improvement that may help to prevent a similar occurrence in future.

If it is not already in place, West Coast DHB should adopt a standard template for planning the nursing care of consumers in the inpatient unit. Such a document does not need to be complex, but should include review of the level of observation and engagement maintained in the event of an acute deterioration in a consumer's mental state.

If it is not already in place, West Coast DHB should adopt a guideline for levels of observation and engagement for consumers in the acute inpatient unit. Such a guideline should stipulate the frequency and type of observation to be made for each level of observation. A guideline should also cover regular documentation of observations made.

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I recommend that West Coast DHB review its policies and protocols for its inpatient mental health service to ensure there are no other system issues or aspects of the physical environment that could be improved to reduce the likelihood of further incidents of inpatient suicide.

I recommend that the DHB review its policies for seeking a review of a consumer whose mental state shows significant deterioration.

Any other matters in this case you consider amount to a departure from expected practice.

There are no other matters I feel I need to comment on."

The following further advice was received from Dr O'Brien on 29 May 2019:

"The Serious Event Review notes that there is a lack of understanding of the process of escalating concerns to the DNM (Duty Nurse Manager) with the suggestion that there is a lack of clinical knowledge (presumably on the DNM's part) relating to the mental health setting. The result seems to be that there is no clear escalation pathway available to the mental health unit. DNMs are also not given a handover from the mental health unit at the commencement of each shift, as they are for other areas of the hospital. Mental health deterioration is also not referred to the Registered Medical Officer, but it is not clear why. The lack, or non-use, of an escalation pathway also seems to leave a gap in which there is no opportunity to call on further expertise in managing difficult clinical issues.

My recommendation is that this issue is addressed by the development of an escalation pathway, and if necessary, staff training in use of that pathway. If it is not thought useful to escalate to the DNM, consideration could be given to having an on call senior mental health nurse as a first level of escalation. The big advantage of such a system is that the clinician called is immediately aware that there is an increased level of concern and would review measures such as medication used, levels of observations, and mental state.

The 'Observations in the IPU Procedure' document meets the requirement of my second recommendation above. The document is ideal for the purpose of defining the level and frequency of observations needed, and for escalating observations if necessary. The definitions of levels of observation are very specific and there is reference to various observation forms (not seen) that would help in the process of documentation. If it has not already been done the use of this form should be promoted, even made mandatory for patients showing significant deterioration.

The individual treatment and recovery plan template is fairly minimal, and doesn't provide guidance on issues like mental state, physical health, or levels of observation. If used it would at least provide some structure for nursing care, but in my opinion it needs to be further developed.

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Document consulted

Te Ao Māramatanga, New Zealand College of Mental Health Nurses (2012). *Standards of practice for mental health nursing in Aotearoa New Zealand* (3rd Edition) Auckland, Te Ao Māramatanga."

The following further advice was received from Dr O'Brien on 10 October 2019:

"Additional report prepared by Anthony O'Brien, RN, PhD, FANZCMHN

I have been asked by the Commissioner to provide further advice on case number C18HDC01087. I have reviewed my previous report, and the documents provided, including statements by [Dr C] and [Dr D]. I have also reviewed the various policy and recording documents provided. I have been asked whether this documentation changes my opinion of 29 March 2019.

The Serious Event Review is a systematic review of the events surrounding the death of [Mr A], and highlights numerous relevant factors, especially in relation to the escalation process, the relative isolation in which the IPU functioned over the weekend, and the lack of a psychiatrist review of [Mr A's] legal status. The measures adopted to respond to these issues seem sound and reasonable and will go some way to preventing further such events in the future. I note that there was a decision made on the morning of [Day 20] to wait until sufficient staff were available at 0900 to restrain [Mr A]. While I appreciate that restraint is a potentially risky practice and needs sufficient trained staff, this should not have prevented [Mr A] being observed through the window of his room as had happened overnight. I also note there are differences in the diagnoses recorded. However nursing practice in inpatient mental health settings is not driven by diagnosis alone; it is about responding to consumers' presenting behaviours, and these were clearly documented overnight by [RN E] to show escalation and agitation. The notes by [a nurse] also show increasing agitation the previous evening. There was also a very good clinical assessment provided by […] on [Day 16], which records provisional diagnoses of serotonergic syndrome, mania and psychosis.

Reviewing this case again, I would add that clinical practice occurs in an organisational context, and in this case there are clearly some system issues that contributed to [Mr A's] case not being escalated to either the Duty Nurse Manager or the on call psychiatrist. However it remains that there was a lack of observation of [Mr A] for several hours, at a time when he was most in need of a more intensive nursing response. I do not wish to change my original opinion.

Anthony O'Brien RN, PhD, FNZCMHN"

The following further advice was received from Dr O'Brien on 21 May 2020:

"I obviously made an assumption that there would be a window. The absence of an observation window does not change my opinion. There should have been some observation of [Mr A] after 6.30am. There is no safety reason that would prevent this."

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