A District Health Board

Psychiatrist, Dr F

Registered Nurse, Ms G

Registered Nurse, Ms D

A Residential Home

A Report by the

Health and Disability Commissioner

(Case 05HDC13239)

Parties involved

Mr A (dec)	Consumer
Mrs B	Complainant/Consumer's mother
Mrs C	Consumer's grandmother
Ms D	Provider/Manager of the Home
Mrs E	Managing Director of the Home
Dr F	Provider/Psychiatrist
Ms G	Provider/Psychiatric nurse
Dr H	House officer
Dr I	Psychiatric registrar
Mr J	Psychiatric nurse
Ms K	Registered nurse
Dr M	Psychiatric registrar
Mr L	Dr F's lawyer
The Home	Residential Home/Provider
The District Health Board	District Health Board/Provider
Crisis team	Psychiatric crisis team
Mobile nursing team	Mobile nursing team
The Agency	Needs assessment agency

Complaint

On 12 September 2005, the Commissioner received a complaint from Mrs B about the services provided to her son, Mr A, by a District Health Board a few months earlier. The following issues were identified for investigation:

- *The appropriateness and adequacy of the care and treatment provided by the District Health Board to Mr A.*
- *The appropriateness and adequacy of the assessment, diagnosis and recommended treatment provided by psychiatrist Dr F to Mr A.*
- *The appropriateness and adequacy of the care provided by registered psychiatric nurse Ms G to Mr A.*
- *The appropriateness and adequacy of the care and treatment provided by the Home to Mr A.*
- *The appropriateness and adequacy of the care provided to Mr A by Ms D.*

An investigation was commenced on 10 February 2006. The investigation took nearly two years due to the complexity of the issues and the need for further expert advice.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Information reviewed

Information from:
- Mrs B
- Mrs C
- Dr F
- Ms G
- Ms K, registered nurse
- Mr J, psychiatric nurse
- Ms D, registered nurse
- Mrs E
- The District Health Board
- The Home
- Dr H
- Dr I

Independent expert advice was obtained from psychiatrist Dr Murray Patton and psychiatric nurse Ms Christine Lyall.

Information gathered during investigation

Overview
Mr A, aged 24, was admitted to a hospital psychiatric unit for observation after presenting to the Emergency Department (ED) with symptoms of anxiety which had developed while his grandparents, with whom he lived, were away on holiday.

The following day, psychiatrist Dr F formed the view that Mr A was not suffering from a psychiatric illness, but that his judgement was impaired as a result of his head injury. Mr A was placed under the care of community mental health services and transferred to a rest home (the Home) for respite care as a voluntary patient.[1] The Home is a private rest home that provides long-term residential care and primarily caters for aged care and young people with disabilities, but also has a limited number of beds for mental health respite care.

A day later, Mr A left the premises of the Home but was persuaded to return. On the morning of the next day, Mr A left the Home again. The Home Manager Ms D followed him and tried to persuade him to return. However, Mr A deliberately stepped into oncoming traffic and was killed as a result of being hit by a vehicle.

[1] Mr A was not a compulsory patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

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Mr A's family believe that his symptoms were inappropriately attributed solely to his brain injury rather than the development of a mental disorder.

Mr A's disability

In June 1989, at the age of nine, Mr A was involved in a road traffic accident and suffered a significant head injury. The injury was mainly to the frontal lobe of his brain. The effect of the injury was that it made it difficult for Mr A to form relationships and appreciate the subtleties of non-verbal communication. Mr A was subsequently in accelerated classes at secondary school but at university struggled with group tasks and presentations and left before completing his studies.

Mr A lived with his grandparents from the age of 15. His grandmother, Mrs C, said that Mr A assisted with manual tasks around the house. She described it as a "happy and close arrangement". She stated:

> "The effect from the brain injury for [Mr A] was that he remained gifted intellectually and perfectly fit and healthy in all physical respects. He had difficulty comprehending close relationships. This did not affect his communication abilities on an every day level but would inhibit such situations as making close friends and group working tasks, especially with people he did not know."

Mr A's general practitioner confirmed that other than the brain injury, Mr A was a healthy young man who did not take any regular medications.

Mr A's presentation to Hospital

On Day 1, Mr A rode his bicycle to the psychiatric unit at Hospital. He arrived distressed and anxious, and requested assistance. He had brought with him documentation relating to his medical history. The on-duty nurse instructed Mr A to go to the Emergency Department. The District Health Board (the DHB) informed me that all people requesting psychiatric assistance are initially seen in the Emergency Department for assessment and assistance. The guidelines for admission to the DHB adult mental health services include a "serious mental illness" (or equivalent) and "serious psychiatric illness associated with head injury".

Mr A arrived at the Emergency Department at 7.52am and was seen by the triage nurse. The nurse noted that Mr A had a history of a brain injury and had not been sleeping. His general observations were recorded, with blood pressure of 180/103mmHg and pulse of 140 beats per minute. Mr A told the nurse that he had a history of previous psychotic episodes. Mr A initially settled, but after about an hour he became agitated and more distressed. He asked the nurse for lorazepam to help him settle.

Assessment by Dr H

House Officer Dr H examined Mr A at 8.30am. She recalls that he was dishevelled and tearful. Dr H read the information Mr A had brought with him about his head injury.

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The information included historical information and also recent reports prepared by Mr A's lawyers about his head injury.[2]

Dr H assessed Mr A's behaviour, ability to orientate, appearance, thoughts, speech, affect, and safety. Mr A told Dr H about a movie[3] he had seen where a character with a similar head injury to his own became violent. Mr A was concerned that he would become like that character and hurt his family. Mr A also said he had not slept for four days and seemed to have limitless energy. He was anxious and agitated and was afraid he would hurt himself.

Dr H recorded:

> "He states he is a psychopath. Admits to wanting to hurt himself at present. Denies wanting to hurt others. Denies hearing voices. States he had a psychotic episode in February after taking marijuana for the second time. Denies drug use at present."

Dr H stated:

> "My impression that [Mr A] may be experiencing a psychotic episode was based on the history that he provided of a previous psychotic episode and my observation that he was displaying some features of psychosis such as expressing paranoid thoughts about other patients and displaying a disjointed thought pattern known as flight of ideas. My assessment that [Mr A] may be at risk of self harm was based on his repeated statements that he was afraid of hurting himself.
>
> Having only basic knowledge and experience in psychiatric assessment gained as a medical student I referred [Mr A] to the Mental Health Services for formal assessment and treatment as required."

Dr H requested that a psychiatric registrar review Mr A as soon as possible. She attempted to calm Mr A while waiting for the psychiatrist to arrive.

Assessment in Emergency Department

Psychiatric registrar Dr I reviewed Mr A at 9.30am. Mr A told Dr I that he had concerns that someone was following him because of a note he had posted on the internet. After her assessment, Dr I decided that Mr A's concerns were of an "overvalued nature" and that he was not delusional. She noted that he did have "fleeting" thoughts of hurting himself, but these were not expressed with any intent. Although Mr A was initially agitated, he calmed with discussion and was able to

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[2] A legal process in an overseas country relating to compensation for Mr A's brain injury had been delayed until he reached the age of 20 to allow for calculation of the financial impact of his brain injury on his potential earnings. The information included clinical reports from two neuropsychologists and a vocational assessment by an Associate Professor.

[3] *Saw*, a horror movie directed by James Wan (2004).

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explain his history and that his grandparents were away at present. Dr I also reviewed the written information Mr A had with him.

Dr I explained her perception of Mr A:

> "His behavior did not represent paranoid psychotic behavior; it seemed more in keeping with agitation seen in patients who have suffered a significant head injury and have difficulty with managing stress, emotional liability and self soothing.
>
> …
>
> [Mr A] was distressed with no support at home until his grandparents arrived home from holiday in the next few days. [Mr A] was experiencing a situational crisis. That is, he was struggling to cope with the intensity of his emotional response to the situation at home. His distress impacted negatively on his ability and capacity to cope with the intensity of his distress. [Mr A] was not psychotic, he had fleeting suicidality, he was dysphoric,[4] and his response to stress was compromised by the impact of his past head injury. I believed that he required admission to hospital for the reasons as stated above."

Dr I recorded her impression that Mr A was in "situational crisis" and was "distressed". Dr I prescribed clonazepam, risperidone and zopiclone (Imovane) for Mr A, as required.[5] Dr I documented a plan of admitting Mr A to the acute mental health unit and referring him to community mental health services on discharge. She contacted the mobile nursing team (MNT) to discuss this referral. Their primary role is monitoring patients in the community.[6] The DHB service description for the MNT states:

> "The focus is to provide mostly acute, short term intensive care (7–10 days) for individuals in the community. Visits are generally undertaken in pairs and staff work rostered duties of four days on and two days off. The [MNT] service acts as case manager for the brief period of time and forms part of the sector teams for the purpose of the availability of the multidisciplinary team. The same service and care requirements are expected as from all case managers, with the exception that the contacts occur more often, for example on a daily basis or as required. This service is underpinned by a philosophy of early intervention and recovery. "

The guidelines for referral to the MNT include:

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[4] Dysphoria: an emotional state characterised by depression, anxiety, or unease.

[5] Clonazepam is an anti-convulsant, risperidone an anti-psychotic and Imovane a sedative.

[6] The MNTs operate seven days a week from 8.30am to 7.30pm. Outside these hours the psychiatric crisis team (Crisis Team) is available.

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- Individuals who do not quality for Mental Health Services but who need monitoring to confirm stabilisation, such as after suicide attempts based on relationship break-ups or other reasons than a mental disorder.
- Monitoring of behaviours of risk and doing risk assessments or mental health status assessments as required.

Mr J was the psychiatric nurse on call for the MNT that day. Mr J undertook the role of Mr A's key worker in partnership with Ms G, another psychiatric nurse.[7] Mr J came to the Emergency Department at 12.15pm to meet Mr A. Having spoken to Dr I, Mr J explained the role of the MNT to Mr A, and how they would provide community care for him. Mr A told Mr J that Dr I had given him stimulants. Mr J stated that Mr A was "really worried and suspicious about this". He reassured Mr A that Dr I had not given him stimulants, but clonazepam,[8] which has a sedative effect and would help Mr A to relax. Mr A then told Mr J that he had also taken two Imovane[9] (sleeping tablets), again believing these to be stimulants. Mr J informed Dr I that Mr A had persecutory ideas and was exhibiting anxiety, fear and agitation and poor judgement. Mr J stated:

> "After re-checking with [Mr A] [Dr I] formed and agreed to the same conclusion that [Mr A] required at least a night's admission …"

Mr A was referred to an acute psychiatric inpatient unit (the unit). Dr I commented:

> "[Mr A] was admitted accordingly, giving us the opportunity to assess and treat him, particularly as he was unknown to our mental health services and we needed to gather further collateral history. Admission would give the opportunity for his grandparents [to] return from holiday early in the following week."

Admission to the unit

At 2pm on Day 1, Mr A was formally admitted to the unit by registered nurse (RN) Ms K. She noted that Mr A presented as sedated (having taken clonazepam and Imovane). She encouraged him to have lunch and then sleep. Ms K documented:

> "Fleeting thoughts of risk of harm to self/no plan. Disorganised thinking and [reduced] understanding due to intellectual disability/brain injury. Poor sleep past [4 days]. Agitation and anxiety."

Ms K completed a nursing plan. The objectives were to maintain Mr A's safety, and monitor his mental state, eating and sleep patterns. Ms K placed Mr A on observations

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[7] The "key worker" is the health professional nominated to ensure that all the client's required reviews and referrals take place. This person is also called the "case manager".

[8] Mr A was administered 0.5mg clonazepam at 11am.

[9] Mr A was given two 7.5mg zopiclone tablets.

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every 15 minutes and planned to complete a urine screen to check for the presence of any other drugs that he might have taken.

Throughout the day, the nursing staff noted that Mr A's behaviour was "childlike" and "unsettled". He continued to talk of "conspiracy theories". It was also noted that his grandparents were "back tomorrow".

Overnight the staff documented that Mr A remained "anxious" and displayed "perseveration".[10] He told staff that the water in his room was tainted and he insisted on getting his water from another room. Ms K recalls that Mr A slept "very soundly" that night, probably due to the effect of the sedative medications, and was "quite settled" in the morning.

On the following morning, Day 2, Mr A wanted to leave the unit to buy groceries as he was suspicious about the food provided in the unit. Ms K was again on duty and suggested he stay and see the doctor first. She noted that Mr A maintained good eye contact and reported feeling much better. Ms K documented that Mr A's behaviour was restless, but "directable". She also noted a slight erratic rhythm to his speech, with normal tone and volume, and that he was responding well to frequent contact and reassurance. Later in the morning, Ms K documented that Mr A continued to display perseveration and was asking "frequent questions" with "little apparent understanding of explanations offered". Ms K also noted that Mr A described being "superhuman" before his admission and believed he may have been "manic".

Despite being asked to remain in the unit, Mr A left to go and buy his own fruit, vegetables and water. Mrs C informed me that Mr A ate a lot of health foods, and he preferred to do his own cooking with vegetarian ingredients.

Dr F's assessment

Dr F was a locum MOSS (Medical Officer of Special Scale).[11] He had been employed as a locum at the Hospital since June 2004.[12]

At approximately 11am, Dr F and Dr M (the on-call psychiatric registrar) reviewed Mr A with Ms K present. Prior to seeing Mr A, Dr F reviewed the documents Mr A had brought with him and the clinical notes.

Dr M commenced the assessment at Dr F's request. Dr F undertook the role of documenting the notes. Dr M stated that Dr F took over the assessment, explaining:

[10] Perseveration: the constant repetition of a meaningless word or phrase.

[11] Dr F became vocationally registered in April 2005. He received weekly supervision from a psychiatrist.

[12] Dr F is no longer employed by the District Health Board.

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> "It was difficult to make some sense of the temporal relationship of [Mr A's] symptoms at which point [Dr F] decided to conduct the remainder of the clinical assessment and he also continued to document his findings."

Mr A told Dr F about the issues that concerned him, his occasional bad thoughts, and about his previous head injury. Dr F informed me:

> "During the interview, [Mr A] was not restless, distractible, irritable or threatening. He maintained good eye contact, sat still in his chair, and his speech was fluent and understandable. There were no fluctuations in his level of consciousness. He remained lucid throughout the interview, responding logically and understandably to my questions. Nor was he responding to non-apparent stimuli. I concluded therefore that he was not suffering from any serious mental disorder.
>
> His mood was even; it was neither high nor low. I observed no disorder in thought form, hallucinations, or delusions. There was no evidence of mania or depression. Nor did he seem sluggish or pressured. Accordingly, I concluded that he was not suffering from psychotic symptoms or from a primary mood disorder.
>
> I did notice that he volunteered ideas that were out of the ordinary. This had been noted previously by the ED House Surgeon [Dr H], and by the admitting psychiatric registrar [Dr I]. I probed to ascertain if these were of delusional intensity. I concluded that while he expressed over-valued ideas, these could not be regarded as delusional. For example he explained that in 1995 he had cut off his own hair after teasing his half siblings too much.
>
> In my assessment he was neither suicidal nor homicidal … I concluded therefore that he was not at risk of self-harm or of hurting others."

Dr F recalled that the assessment took "at least" one hour and started some time before midday. Dr F considered that Mr A's documents about his head injury were relatively unhelpful from a psychiatric perspective but "consistent with my observations of the patient's impaired judgment". Dr F considered the clinical observations of the staff had not revealed any indicators of "any mood or psychotic symptoms".

Dr F reviewed the medications prescribed for Mr A by Dr I, but made no changes. He considered that Mr A would continue to improve on the medications prescribed. He recorded:

> "No evidence of psychotic symptoms or primary mood disorder. Over-valued ideas rather than delusions. Not actively suicidal/homicidal.

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> I see no current role for further input from MHS [Mental Health Services]. I think [Mr A's] princi[pal] issues should be referred to [the Agency][13] as [Mr A] seems to have impaired judgment."

RN Ms K further noted (at approximately midday):

> "OK for leave
>
> [Dr F] to meet with Grandparents about current issues
>
> Referral to [the Agency]
>
> For discharge as soon as alternative arranged or grandparents return from holiday
>
> Message left with [Mr J] ([MNT]) who will contact grandparents on their return … Possible respite option in interim."

At 1.30pm Ms K noted that Mr J had ascertained that a bed was available at the Home until the return of Mr A's grandparents.

Dr F stated that the management plan documented by Ms K was the "overall plan". Dr F explained that his reference to "MHS" meant that he considered that there was no further role for acute mental health services. He considered that there was no need for Mr A to remain in the acute ward because of "the lack of any obvious symptoms of a major mental illness". Dr F advised me that he was aware of Dr I's plan for Mr A to be discharged to the Home "once respite could be arranged" with follow-up by the MNT.[14] He stated:

> "[T]hat was a decision made the previous day by the assessing registrar and the plan apparently had always been to send him to respite and he ended up in the acute in-patient unit because it was not logistically possible to arrange on [a public holiday].
>
> …
>
> I understood a plan has been put in place and I saw one of my roles as making sure that plan remained appropriate for [Mr A]. "

Dr F stated that RN Ms K and Dr M were not "merely observers" in the assessment of Mr A. They actively participated in the interview process, and contributed to the management plan. His lawyer, Mr L, advised:

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[13]The Agency provides needs assessments and co-ordinates the provision of disability support services to people with long term disabilities.

[14] Dr I's plan makes no reference to respite care or the Home but refers to support from MNT on discharge.

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> "Consistent with the functioning of a modern multidisciplinary team, all three actively participated in the interview. All three [asked] questions of the patient, especially to clarify aspects which might not have been covered to their satisfaction. As the consultant, [Dr F] led the team, drawing on the experience and insight of the other two. For example, [Dr F] specifically recalls that before he saw [Mr A] he asked R/N [Ms K] whether she had observed any symptoms suggestive of serious mental illness to which she replied that she had not."

Dr F commented that it would have been "extremely unwise" to have discharged Mr A with "zero social support". Dr F decided to place Mr A in a respite care facility, such as the Home, with review when his grandparents returned from holiday. Dr F explained that he has no control of the actual placement, and respite facilities are normally discussed in general terms. He stated:

> "My expectation of [the Home] staff would be that if there are any symptoms that arise, behaviours of concern that they could not reasonably deal with that they will inform the [MNT] or after the [MNT] had finished for the day the crisis team.
>
> …
>
> I see it as a dual role. I anticipate that they would have staff of varying skill levels and some would be, I imagine, easily skilled in interpreting certain phenomena but I would expect them to generally observe and report."

Dr F referred to the principle that patients should be treated in the least restrictive environment, and commented that "respite is a less restrictive environment that an in-patient unit". He stated:

> "[The Home] is staffed by registered nurses[15] and is the subject of monitoring and supervision 24 hours a day 7 days a week … My confidence was reinforced by the availability of [MNT] with after hours back-up from the Crisis Team …"

Dr M explained that the decision to discharge Mr A with referral to the Agency was an "independent decision made by Dr F" and he was "not directly included" in the decision-making process. He also stated:

> "The decision to discharge [Mr A] to [the Home] respite care under the [MNT] was made by [Dr F]. I am unable to comment on the rationale for this decision as [Dr F] made this [decision]."

Ms K had no specific recollection of how the decision to send Mr A to respite care was made, but commented that it was a "doctor's decision". She recalls that one of the unusual things about Mr A's discharge meeting was that there was no support person

[15] The registered nurse and manager (Ms D) is available during working hours Monday to Friday. Outside these hours care staff are present, with Ms D available on call.

or family member input, although MNT was trying to contact his grandmother. She stated that the decision to send Mr A to respite care was probably a "cautionary measure" that was "largely based" on the fact that Mr A had no support people in the area. Ms K also completed a "discharge information form" for Mr A to take with him to the Home which stated, "[Mr J] to liaise with [Dr F] re meeting with grandparents to discuss appropriate referrals and discharge plans."

Mr J's MNT partner, Ms G, recalls events slightly differently. She stated that RN Ms K contacted Mr J and herself in the morning, as the MNT on-call staff, to ask if they would transport Mr A home. Ms G was concerned that Mr A did not have the keys to his home. Consequently, Ms G suggested to Ms K and Dr F that the best course of action would be to find a respite bed for Mr A and wait for his grandparents to return home. Dr F agreed.

Mr J recalls that he received a telephone call from RN Ms K asking if a respite bed was available. He then phoned the Home and arranged for a bed, and advised RN Ms K accordingly. Mr J also understood that Mr A had "lost" his house keys. However, he was "fairly sure" that MNT had no part in the decision to send Mr A to respite care. He cannot comment on whether there had been any variation of the original discharge plan as he was not present at the meeting. He stated:

> "I would have recommended a period of respite also, while [Mr A] was waiting for his grandparents to return home had not [Dr F] requested it."

Ms K has no recollection of Mr A losing his house keys, and commented that she assumed this became apparent after he had been collected by MNT.

Transfer to the Home

Mr J and Ms G took Mr A to the Home at approximately 4pm on Day 2. Mr J recalls that Mr A told them about the movie he had watched *Saw* and how it had "freaked him out". He continued to mutter quietly to himself but appeared responsive when asked questions. Mr J recalls that Mr A had become more settled since the previous day when they had met in the Emergency Department. Mr J added that he did not know what Mr A's normal behaviour was like and it was therefore difficult to assess whether his current behaviour was solely related to his head injury.

Ms G remembers that Mr A talked about a red car that was parked outside his house, believing the occupant to be a threat to him. He appeared to be "paranoid" about the car.

When Mr J and Ms G reached the Home they handed over care of Mr A to Ms D, registered nurse and manager of the facility. The handover was both verbal and written. On the referral document Mr J has recorded that the MNT will follow up Mr A with the following management plan:

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> "Admit to [the Home] till grandparents return home. Not considered a risk to self or others but needs [observations] just the same. Please monitor mental state."

Mr J said he expected the Home to "monitor and assess patients" in respite care. According to Mr J, the staff at the Home had "a lot of experience in that area". A registered nurse was available at all times and if she was concerned about a patient she could alert the MNT or, if out of hours, the mental health crisis team. Mr J stated that the MNT would visit Mr A daily at the Home. However, they would expect to receive appropriate and effective information from the Home. Mr J described Mr A's placement at the Home as a situation of "shared care" with the MNT. The facility would provide a place to relax and not have to worry about shopping or cooking. Mr J felt that the staff were good at putting patients at ease. The MNT had previously placed suicidal patients at the Home after the crisis stage of their illness has passed.

Ms G said that she expected the Home staff to monitor aspects such as eating habits, drinking, sleeping, mood and disposition. Their role was to report any unusual behaviour to the MNT.

Ms D explained that she expected the MNT to manage and regularly review Mr A while he remained in respite care. In her view, the role of the Home was to provide a safe and less stressful environment. Any unusual behaviour would be reported to the mental health team, but there was no expectation that the Home staff would interpret behaviour or make any kind of assessment. Mr A was a voluntary patient and his room was on the ground floor of the facility. The internal and external doors could be locked or left open as he wished.

Mrs E,[16] managing director of the Home,[17] stated:

> "With reference to 'respite care plan' regarding the 'monitoring of mental state' — this is the responsibility of Mental Health Services personnel and is clearly stated in the memorandum of understanding[18] as is the responsibility of MHS for placement decisions/levels of care.
>
> By 'monitoring mental state' it has always been the understanding between the Home and [the] Mental Health service to mean 'observation of behaviour' (not assessment). Any concerns are immediately relayed to the [MNT] who are expected to visit daily and respond to our concerns. In this instance, our concerns were relayed regarding [Mr A] wandering on the road and sexually disinhibited behaviour.

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[16] Mrs E is Ms D's mother.

[17] Mrs E is one of the directors and shareholders of the Company, which trades as the Home.

[18] A copy of a memorandum of understanding between the Home and the District Health Board Mental Health Services was provided. It was marked "draft" and was signed on 15 April 2004 by the Home only. Mrs E advised that this memorandum is currently under review.

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> [The Home], as normal practice, will institute regular observations on all new admissions — these may be informal or formally documented and will relate to their behaviours and whereabouts in the facility. This is clearly understood by [the] Mental Health Service to relate to acceptable behaviour and not psychiatric phenomena.
>
> As [Mr A's] admission was to all intents clearly a social admission there [were] no indications of his risk … at all times his conversation was lucid, coherent and appropriate except regarding his sexuality and his perceived needs in this area."

Day 3

The following day, Mr A began to exhibit inappropriate sexual behaviour. This included repeated showers, masturbation and walking into the dining room naked. An incident form (completed by Ms D) recorded that Mr A "asked female staff to engage in living out his sexual fantasies".

Ms G visited Mr A just before lunch and Ms D discussed Mr A's inappropriate behaviour with her. Ms G then spoke to Mr A (who was in the shower) and asked if he wanted to talk to her. Mr A declined and Ms G left. Afterwards, Ms D spoke to Mr A and he acknowledged his behaviour was inappropriate.

Ms G was not particularly concerned about Mr A's inappropriate behaviour because it was easily deterred and managed without the need for medication. Ms G recorded that Ms D had reported "nil safety issues" and was not concerned that staff or residents were at risk because Mr A was "directable and compliant". Ms D also undertook to contact MNT or the Crisis Team if she became concerned about Mr A. Ms G commented that the primary concern was that Mr A was maintained in a safe environment until he could be reassessed.

Ms G also contacted Mr A's grandmother, Mrs C (who arrived home on Day 3), and informed her about her grandson's admission to the unit and respite care at the Home. Ms G noted that his grandmother was willing to meet with Dr F "ASAP" to discuss Mr A. Mrs C also reported that Mr A's mood had been low and his sleep poor over the last two weeks. Ms G stated that Mrs C talked about Mr A's head injury. It is not clear what information Ms G gathered regarding Mr A's usual mental state and the extent to which recent behaviour was out of character.

Between 1pm and 3pm that afternoon, Mr A informed staff that he was going for a walk. Mrs E found Mr A walking away from the facility along the main road as she returned from shopping. Mr A was initially reluctant to return and told Mrs E he wanted to telephone his grandmother. Mrs E offered Mr A the use of her mobile phone. She explained to Mr A that he could use the telephone at the facility whenever he wished and did not need to find a public telephone. Mrs C recalls receiving a telephone call from Mr A. She told Mr A that she had been worried about him when he was not home when she returned, and that he should go back to the Home where she would come and visit him.

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Eventually, Mr A was collected by Ms D at approximately 4.30pm. After spending some time talking to Mr A, Ms D contacted Ms G at around 5pm. Ms D informed me:

> "I notified the [MNT] that if [Mr A] was to continue to leave the premises by walking along the road [the Home] would not be able to provide further respite care for him."

Ms G asked Ms D to ask Mr A if he was suicidal, and whether he planned to leave the Home again. (This was confirmed by Ms D but not documented.) Ms G explained that she felt that Mr A had been open in the past, and he would disclose any suicidal thoughts. Ms D advised that Mr A's reply was that he did not feel suicidal, and that he would not leave the facility.

It was agreed that Mr A would stay at the Home and be placed on 15 minute observations. If there were any further concerns about Mr A, the psychiatric crisis team (the Crisis Team) was to be notified and Mr A would then be assessed. Ms D completed a second incident report, as follows:

> "Discussed with [Ms G] ([MNT]) if [Mr A] continues to leave [the Home] the [MNT] will pick up [Mr A]. Staff informed to have 15 minute observations on [Mr A] to ensure he is here [the Home]. Any concerns crisis team will be in contact/know [Mr A's] situation."

Ms G recorded:

> "Spoke with [Ms D] who has spent some time with [Mr A] he's not suicidal but was walking into town, he had agreed not to wander off and is aware of their concern. Staff will do 15 minute obs[ervations] over the next little while and will get back to us if there [are] any further concerns. [Ms D] aware that I will ring [the crisis team] and bring them up to date with current status."

Ms G completed a Crisis Team alert form which described Mr A as an "informal and low risk" first presentation with a history of head injury and was written "in case of further contact from [the Home] staff". Ms G also contacted a Crisis Team member who recorded:

> "Call from [MNT] ([Ms G]) re [Mr A] at [the Home] — attempt to walk on road Caregivers took him back to [the Home] — info[rmation] only — if [the Home] call re ongoing concerns with [Mr A] re-admission to Ward to be considered if safety an issue."

The Crisis Team member noted that Mr A was "possibly" at risk. The plan was "Await contact from [the Home]". No further contact was made with MNT or the Crisis Team throughout that night.

Ms D explained that there was not a formal documented process of observation at the Home such as will occur in the hospital in-patient setting. She instructed the carers to

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make themselves aware of Mr A's whereabouts and report any unusual behaviour. There were no further concerns about Mr A's behaviour that afternoon. Ms G recalls that she spoke to Ms D again at around 7pm, and Mr A was reported to be settled.

Mrs C visited that evening and recalls that her grandson looked well. Mrs C recalls discussing his needs and deciding together that he should stay at the Home. Mr A wrote in his diary that he wanted help with his mental health concerns.

Later that evening, the carers documented further examples of inappropriate sexualised behaviour by Mr A. (Mr A was noted to have had three showers and invited female caregivers into his room.) Otherwise, Mr A had a settled night.

Mrs C commented that exhibitive sexualised behaviour, which she was unaware of at the time, was highly out of character for Mr A and should have raised "red flags".

Day 4
Mr A ate a full meal for the first time (he had been eating only fruit and vegetables during his admission up to this point) and appeared relaxed at breakfast. At 8.30am, a carer encountered Mr A and they talked briefly. Mr A reported that he had had a "good sleep" and mentioned going for a walk with another resident. Soon afterwards, an off-duty staff member advised the Home that she had seen Mr A on the main road and he was behaving dangerously with the traffic. Ms D went to look for him and staff telephoned Ms G to alert her to the situation.

Despite Ms D's considerable attempts to prevent him doing so, Mr A stepped out into traffic and crouched down before being hit by a vehicle. Mr A died at the scene. Ms D provided the following vivid account of what occurred:

> "I approached [Mr A] who was distraught and threatening. At this point I made numerous attempts to contact the police however there was no reception. I continued to walk behind [Mr A] encouraging [him] to come and get in the car at the same time flagging down cars for assistance and to avoid them hitting him. On three occasions [Mr A] stepped out into the path of oncoming vehicles with his head lowered and I managed to flag cars around him until the last incident which was uncontrollable. Even with the arrival of a second staff member to assist who was slowing down approaching traffic [Mr A] deliberately stepped in front of a truck approaching from the opposite direction."

Subsequent events
The DHB conducted an investigation into the care provided to Mr A and concluded that the care provided by DHB staff had been appropriate. The serious incident review report noted:

> "[Mr A] seemingly experienced distress while his grandmother was away on holiday. Although he usually seemed to function fairly independently, his distress combined with a history of head injury and impaired judgement resulted in his

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admission to the psychiatric unit and thereafter to crisis respite care awaiting the return of his grandmother, with whom he resided. Before and during his admission to [the Unit], [Mr A] was assessed by registrars and a psychiatrist who found him not to be mentally disordered and with no significant risk. [Mr A] was discharged to [the Home] with [MNT] follow-up with the intent to be discharged when his grandparents returned from their holiday. [Dr F] planned to meet with [Mr A's] grandmother upon her return."

Independent advice to Commissioner

Nursing advice
The following expert advice was obtained from Ms Christine Lyall:

"I have been requested by the Commissioner to provide an opinion on case number 05HDC13239. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am a registered nurse (registration number 069024), gaining registration in 1980 with mental health nursing defined as my scope of practice. I have a Bachelor of Nursing degree (Otago Polytechnic, 1999) and a Master of Arts (Applied) in Nursing (Victoria University of Wellington, 2004).

The majority of my thirty year career has been spent in general adult mental health. The last six of these have been in either senior clinical or managerial positions. My previous position was that of Unit Manger in an acute inpatient mental health unit. Since June 2005 I have been working within a Primary Health Organisation as a specialist mental health nurse. A component of this position is that of liaison with general practitioners, non-government organisations and District Health Board provider arm services.

I have been requested by the Commissioner to provide expert advice on a number of questions. These are:

1. Was the care provided by [Ms G] adequate and appropriate?

[Ms G] has followed policies and procedures relating to the [mobile nursing team]. The focus of this service is to provide mostly acute, short term intensive care (7–10 days) for individuals in the community. The guidelines for referral for care by the [MNT] are comprehensive, this includes individuals who do not qualify for mental health services but who need monitoring to confirm stabilisation.

The rationale for placing [Mr A] in respite care at [the Home] is sound. The twenty minute journey to [the Home] provided opportunity for [Ms G] to assess

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and begin to develop a therapeutic relationship with [Mr A]. He was well informed regarding the treatment plan and visits from the [MNT].

[Mr A] was unavailable (he was in the shower) when [Ms G] visited on [Day 3]. A discussion with the staff there indicated there were no apparent safety concerns.

[Ms G] was able to contact [Mrs C] ([Mr A's] grandmother) in the early afternoon and apprise her of [Mr A's] whereabouts and the plan which was in place for his care.

The decision to place [Mr A] on fifteen minute observations later in the day following [Mr A's] decision to walk into town was reasonable. It is not an uncommon decision to place people on regular observations to ascertain their whereabouts even when there are no immediate safety concerns. Regular observations are often used as part of a treatment plan to assess and monitor behaviour and mental state.

2. Was the care provided by [Ms D] adequate and appropriate?

[The Home] was contracted to [the] District Health Board to provide short term respite care in supervised accommodation. [Ms D's] position as nurse manager was to ensure that the care provided followed the memorandum of understanding by the provision of: a safe, supervised therapeutic environment; daily living skills assessment and assistance if required. It is clear from the supporting information that the respite provider does not provide clinical treatment; they follow the plan from mental health services.

[Ms D] did not hesitate in contacting the [MNT] to discuss concerns, such as [Mr A's] inappropriate disinhibited behaviour on [Day 3] and his plan to walk to [town]. It seems the care provided by [Ms D] was adequate and appropriate.

3. Was the communication between [Ms G] and [Ms D] adequate and appropriate to [Mr A's] needs?

The communication between [Ms G] and [Ms D] seems to be of a high standard. The supporting information provided indicates a clear understanding of the [MNT] and respite roles. There appears to have been no hesitation from either party to contact and discuss any issues which may have arisen.

4. Was the care provided by [the] District Health Board adequate and appropriate?

The District Health Board responded to [Mr A's] presentation seeking assistance on [Day 1] in an appropriate manner. The assessments carried out at the Emergency Department and [the Unit] were completed in a timely manner and were comprehensive. During [Mr A's] time at the hospital he was assessed twice before his admission to the unit. One of these assessments was carried out by the on-call psychiatric registrar. He was seen again in the in-patient unit, two doctors

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undertook this assessment. He was also monitored and assessed by nursing staff during his stay on the ward. At no time were there documented concerns for [Mr A's] safety.

The team responsible for [Mr A] during this time acted responsibly and appropriately in arranging respite care until his living situation could be clarified.

5. Was the care provided by [the Home] adequate and appropriate?

[The Home] provided adequate and appropriate care to [Mr A] by following their memorandum of understanding to provide respite services. Staff were diligent in liaising with [MNT] staff and in their care of [Mr A] who was staying there voluntarily.

6. Is the record keeping of an adequate standard?

The record keeping is overall of an adequate standard. The documentation is clear and concise providing rationale for decisions.

There is no record of the 15 minute observations that [Mr A] was placed on at [the Home]. It is usual practice within in-patient units for these to be recorded. While the role of [the Home] is not the same as an in-patient unit this could be considered if respite recipients in the future were placed on observations. Despite this I am sure that staff at [the Home] undertook these observations appropriately.

7. Were the policies and procedures adhered to?

The policies and procedures were adhered to.

8. Were the policies and procedures appropriate?

The policies and procedures were appropriate.

9. What standards apply in this case?

The rights of patients and the duties of providers [are set out in the] Code of Health and Disability Services Consumers' Rights (1996) …

The providers in this case have taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in the Code.

[Ms G] and [Ms D] as registered nurses working within the mental health context have followed the New Zealand Nursing Council and Te Ao Maramatanga (New Zealand College of Mental Health Nurses Inc. 2004) standards of practice."

Further nursing advice

Ms Lyall subsequently advised that, in practice, a degree of reliance is placed on respite care staff to monitor a patient. The level of contact respite care staff have with patients means that they are well placed to observe changes in a patient's mental state.

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Psychiatric advice
The following expert advice was obtained from psychiatrist Dr Murray Patton:

"I am not aware of any personal or professional conflict in this matter. I do have some prior knowledge of mental health services at [the] Hospital and have been involved in a prior review for the Health and Disability Commissioner. I do not recall those matters having any relationship to the present complaint.

I have also had some professional contact with [Dr F] who was a trainee in psychiatry in Auckland in services for which I had ultimate clinical responsibility as Clinical Director. I do not recall however having had a direct supervisory relationship with [Dr F].

…

You have sought my advice about whether [Dr F] and [the] District Health Board provided services of an appropriate standard of care to [Mr A].

In preparing this report I have read the bundle of documents provided to me with your letter of 29 May 2006 identified by page numbers 1 to 218. Where necessary I shall refer to documents by page number from that bundle of documents.

I have read the Guidelines for Independent Advisors (dated 9 November 2005) supplied with your letter of 29 May 2006.

I am a vocationally registered psychiatrist. I obtained Fellowship of the Royal Australian and New Zealand College of Psychiatrists in 1989. I have subsequently practised in general adult psychiatry in community and inpatient acute settings and have held senior clinical administrative roles in Auckland (Clinical Director roles in central Auckland and South Auckland services) Tasmania (Statewide Director) and most recently in Wellington.

You have provided me with a summary of the events over the period from [Mr A's] presentation to [Hospital] on [Day 1] to the [time of his death].

…

I shall direct my attention to the specific questions identified at page 4 of the document 'Medical/Professional Expert Advice — 05HDC13239 (29 May 2006)'.

1. Was it appropriate not to admit [Mr A] at the psychiatric unit but to send him to the Emergency Department for evaluation?

In general it is reasonably common practice for psychiatric inpatient services in New Zealand to direct people presenting themselves to those units for assessment to another venue for assessment. The venue to which they are directed is largely determined by service arrangements such as the location of the psychiatric crisis

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service and the protocols for assessment. Psychiatric inpatient services typically are not staffed to provide the observation or extra-assistance that might be required by someone pending assessment and may not have suitable dedicated facilities for waiting or for the assessment itself, which may have characteristics different to that required for the ongoing work of the inpatient service.

Although there will be occasional exceptions to this general practice, determined usually by characteristics of the individual presentation, in the circumstances of [Mr A's] presentation it was not unreasonable for him to be directed to the emergency department.

[Mr A] was not known to the mental health services. Although his presenting concerns were suggestive of psychiatric disturbance there was some need for close attention to potential physical causes for his presentation and for some immediate investigations much more satisfactorily managed within the emergency department setting.

There was no notice prior to his arrival at hospital that may have allowed staffing arrangements to be made to assist with observation and to ensure prompt assessment. It was likely that there would be at least a short delay prior to crisis nursing and medical staff availability, during which time some initial physical observations, such as should readily occur in an emergency department setting with well-established triage protocols, was appropriate.

In general, should someone present initially at a psychiatric inpatient facility but be redirected to the emergency department, it is appropriate for the emergency department to be alerted to the imminent arrival of the person. Suitable arrangements should also be made to ensure the person reaches the emergency department.

2. ***Is the policy concerning acute access to the Mental Health Services through the Emergency Department appropriate?***

I could not find in the bundle of documents supplied any specific policy in relation to the locus of assessments undertaken by the psychiatric crisis service, and in particular any policy regarding access through the emergency department.

The Service Type Description for Community Mental Health Service — Crisis Intervention Service identifies that the service will be mobile and will be able to be provided at the location of the crisis.

As I have noted above however, in general it is not unreasonable for people to be directed from a psychiatric inpatient facility to the Emergency Department as the point of contact for mental health crisis service assessment. There are many crisis services throughout New Zealand that use emergency departments as the venue for assessments, all or some of the time.

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The policy 'Referral' (issued September 2003) identifies timeframes for response and the personnel who will be involved but does not specify locations at which assessments will be conducted. This policy does not elaborate upon arrangements for re-directing someone from another location to the Emergency Department for assessment.

This policy refers to another policy 'Assessment' (identified as policy 6.100.21.1) but it is not clear to me whether this other policy identifies the location at which assessments are to be conducted. That policy is not included in the bundle of documents.

I do not have detail regarding the operating procedures of the psychiatric crisis service, particularly with respect to the location at which assessments should be conducted.

I have already commented above however (at my response to question 1) about the use of emergency departments for assessment. In general, in my view, such location is preferable to an acute psychiatric inpatient facility for new, unplanned assessments, unless the psychiatric inpatient facility is designed and staffed for such purpose.

3. Was the care provided by [Dr F] adequate and appropriate?

In addressing this question it is important to identify the time at which [Dr F] became responsible for [Mr A's] care and for decisions about his treatment.

[Dr F] reviewed [Mr A] on [Day 2]. The notes he entered in the clinical file do not reflect the time at which that assessment was conducted but it appears to have been during the course of the morning nursing shift that day. [Mr A] had been in the ward for less than 24 hours up to that time.

Prior to that point the treatment plan had been developed by other staff. I can not find a clear indication that those earlier assessments and plans had been discussed with senior medical staff.

The assessment note completed by [Dr I], psychiatric registrar, on Day 1 documents the conclusion that [Mr A] was suffering from a situational crisis. The treatment plan as documented is minimal identifying only that [Mr A] would be followed up by [MNT] on discharge and that he would be admitted to [the acute psychiatric inpatient unit].

The treatment plan form (page 106 in the bundle of documents) appears to have been completed by the admitting nurse. Although the entry of [Day 1] is not signed (there being no specific space for identification of the writer) the writing appears to be that of the RN who made a note in the clinical file dated and timed at [Day 1] at 1400 hrs.

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This treatment plan record reflects the intention to 'observe/document mental state develop therapeutic rapport/reassure' and to use prn (as required) medication for sleep and agitation. Fifteen minute observations were to be made to ensure safety and decrease risk of 'AWOL'.

An additional note in the body of the file reflects the intention to arrange 'physical and toxicology screen ASAP' and makes reference to some plans with regard to [Mr A's] bike.

Another document referring to elements of a plan is available. This document 'Treatment Plan' (at page 111 of the bundle of documents) appears to have been completed on [Day 1]. It records 'stabilised mental state' as the goal of admission.

One other note in the file records a section headed 'plan'. This entry (at the reverse side of page 112 of the bundle of notes) appears to reflect the entry from the afternoon nursing shift on [Day 1]. It records the plan as:

— *G-parents back tomorrow*
— *Meeting with them*
— *Review mane*

There is no record that [Dr F] had input to those plans prior to his own assessment of [Mr A].

[Dr F] has entered notes following his own assessment. There is some exploration of the history and phenomena described by [Mr A] although there is limited detail of coverage of the full range of symptoms that might be associated with the range of syndromes that might explain the nature of [Mr A's] presentation. There is very limited exploration of the prior elements of the history alluded to in the assessments already undertaken. In particular, there is no reference to the report of 'depression' identified in the emergency department assessment and the account of having had a psychotic episode (in the same notes).

Important positive and negative findings in the history with regard to the possibility of a severe anxiety disorder and the full range of symptoms that might be associated with a major depressive disorder or with a psychotic illness are not elaborated.

I think the coverage of these matters is more limited than would ordinarily be expected of a psychiatrist needing to be clear about someone presenting with unusual symptoms and concerns. The history appears to be sufficiently unclear that much more collateral information and detail was required before being able to reach a definitive conclusion about the presence or absence of mental disorder, particularly in the presence of someone themselves having some limitations in clearly reporting their story. Whilst there appear to have been a number of prior reports available to [Dr F] in respect of [Mr A's] head injury and subsequent difficulties, those reports (at pages 136 to 153 of the bundle of documents) do not

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include prior psychiatric assessments and do not in themselves provide detail of the depressive and paranoid symptoms reported to have been present at times.

[Dr F] concludes however that there was no evidence of psychotic symptoms or primary mood disorder, key matters to assess in light of the odd ideas with which [Mr A] presented and in light of his reported statements about self-harm.

Following his assessment on [Day 2] [Dr F] recorded that he saw no current role for further input from the mental health service. He felt that the main concerns should be dealt with by [the Agency] in light of [Mr A's] impaired judgment. [Dr F] recorded no other specific plan.

In my view this was not adequate. [Mr A] was presenting with a number of somatic and psychological symptoms. There was a history of impairments thought to be related to prior head injury but at the end of [Dr F's] assessment there was not a clear documented understanding of the significance of the prior reports of depression and paranoid features.

[Dr F's] own record following his assessment, particularly with regard to the treatment plan, is in my view extremely limited. In light of the nature of [Mr A's] presentation (with vague symptoms and appearance to the service at a time of some possible stress related to the absence of his family) and in light of the very brief period of oversight as an inpatient during which carers (who could add background information to assist with reaching a definitive view of the problems with which [Mr A] was presenting) were not available, it was appropriate for further contact with [Mr A] and his family by mental health service staff to be arranged.

I do not feel therefore that the view outlined by [Dr F] ('I see no current role for further input from MHS') was appropriate. It seems to me that at least the further stage of discussion with his grandparents was a part of the role of the mental health service, even if only to be sure that a clear understanding of this presentation in the context of [Mr A's] longitudinal history could be conveyed to whichever support agency continued to be involved in contact.

[Dr F] had formed a view that [Mr A] had developed heightened affective responses such as diminished sleep and nervousness following normal stimuli. There appears to me however to have been some need for exploration with his grandparents regarding this possible pattern to confirm this hypothesis, which if supported had implications for the manner in which [Mr A] was supported in the future. It would certainly have implications for future interventions to help reduce that pattern of response.

The nursing note following [Dr F's] assessment entered apparently by the RN who accompanied [Dr F] in this assessment, identifies the plan as:

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- *discontinue 15/60's*
- *OK for leave*
- *[Dr F] to meet with grandparents re current issues*
- *Referral to [the Agency]*
- *For D/C as soon as alternative arranged or grandparents return home from holiday*
- *Possible respite option in interim*
- *The availability of a respite place was then confirmed in the notes.*

This file note apparently made by the RN following [Dr F's] assessment indicates a more satisfactory arrangement for care in that it identifies that further contact with the grandparents was to be arranged. It is not clear how this plan was developed and what [Dr F's] role was in that process. This intention appears to be in accord with the file entry noted in the plan identified in the afternoon shift records of [Day 1], referred to above.

[Dr F] however does refer to ongoing involvement of another agency, [the Agency]. I do not have any information regarding the role and function of this agency.[19] Without that information it is difficult to be clear whether this was a reasonable plan. Whilst it might be argued that another agency could undertake further assessment particularly with regard [to] the needs of [Mr A] and his family for ongoing support, it would also be useful for this agency to have a clear indication of the nature of [Mr A's] presenting problems and for the proposed aetiology of these to be outlined in order for them to be incorporated in to the further approach to his care. It is not clear how such discussion or other communication was to take place, if at all.

The nursing entry following [Dr F's] assessment also refers to discharge once an alternative (presumably referring to alternative accommodation) was arranged and to the possibility of respite care. It appears that it was thought that remaining in hospital pending the return of his grandparents was not preferred to the possibility of some other accommodation. It is not clear why this was so, especially in the knowledge that his grandparents would be returning within a few days. If the assumption made by [Dr F] was correct, that [Mr A's] emotional responses to even ordinary phenomena were heightened, a further change to his situation may have been likely to contribute to increased disturbance.

[19] As noted on page 9, the Agency provides needs assessments and service co-ordination.

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4. Was the decision to transfer [Mr A] to [the Home] care appropriate to his requirements?

The entries in the treatment plan record of [Day 2] identify placement at [the Home] and awaiting return of grandparents.

One of the early plans had been to observe and monitor [Mr A's] mental state. This treatment plan record also reflects the intention to continue to assess mental state and sleep daily through discussion with [the Home] staff and daily visit.

The [MNT] was to continue contact with [Mr A]. Daily (nursing note entry on page 117 of bundle of documents).

There is no record of [Dr F's] view of [Mr A] having been discussed with staff at [the Home]. In particular, there is no evidence of any advice being given to staff at [the Home] regarding how to manage any tendency for [Mr A] to have heightened emotional responses to stimuli. The Respite Plan for Carer (page 124 of the bundle of documents) repeats (at the CRC Management Plan section) '… needs obs just the same' and 'please monitor mental state').

[Ms D], RN Manager at [the Home], in her letter of 15 February 2006 in response to Rae Lamb's letter of 10 February, notes (at page 185 of the bundle of documents) that 'We do not … assess the mental state of any respite in our care we observe and monitor behaviour and if concerned relay information to the [MNT]'.

[Ms D] had however apparently undertaken an assessment of [Mr A's] level of suicidal ideation on [Day 3] following his departure from the premises. This assessment is reported in the [MNT] record of that afternoon (at page 118 of the bundle of documents). I can not find however any corresponding record within the notes of [the Home] …[20]

Despite the view of [Ms D] above, I note that [Mrs E], Director of [the Home], in a letter to [HDC] also dated 15 February (at page 163 of the bundle of documents) identifies that '[Mr A's] care plan was written by [the] Mental Health Services that we adhered to'. This plan includes reference to monitoring mental state.

Although it seems clear from the RN Manager that staff at [the Home] do not see it as their role to assess mental state of their respite residents, monitoring of mental state appears to have been the expectation of the mental health service. Monitoring, in my view, implies assessments repeated over periods of time.

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[20] Ms D made no specific record of her question to Mr A about whether he was suicidal. Ms D relayed this question and Mr A's answer to Ms G.

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[The Home] staff, at least as outlined in the RN Manager's letter, do monitor behaviour, but this is a lesser task than monitoring mental state. Although there is some connection between mental state and behaviour, expressed and observed behaviour is really only a part of the overall mental state of any person.

It appears therefore that there was some mismatch of the expectations of the [MNT] as expressed in the Respite Care Plan and the understanding of [the Home] staff of their role. Whether however [the Home] was appropriate to [Mr A's] requirements in respect of ongoing attention to his mental state would be determined by some specificity regarding what was being sought in relation to his mental state, which degree of detail is not included in the Respite Plan. Overall therefore, if 'monitor mental state' implies (as it suggests) repeated assessments of complete mental state (rather than just observed behaviour), [the Home] does not see itself as having that role and would therefore be inadequate to meet the requirements of the Respite Plan.

Given that it appears that [the Home] intended to adhere to the Respite Plan (according to the Director's letter) including attention to monitoring mental state, the comment by the RN Manager that this is not the role of the staff at that facility is important. There appears to be some internal inconsistency at that facility in relation to this aspect of function.

A question must therefore be asked as to whether staff at [the Home] ought to be able to monitor mental state, rather than just observed behaviour. The documentation supplied to me does not suggest that there is no consistent understanding or application of whether this is a responsibility for [the Home] staff.

If [the Home] staff do not have a role in monitoring mental state, particular responsibility falls to staff with a more clearly defined role in this element of activity. The [MNT] were to have a significant role in that respect, to be exercised through visiting daily and assessing [Mr A]. On [Day 3] however, when they visited, [Mr A] was in the shower and lunch was on the table so he did not wish to talk to the visiting staff. This appears to have been accepted by the [MNT] staff, who noted that he 'appeared settled' despite the reports from [the Home] staff of odd behaviour from [Mr A].

Later that day the [MNT] received information from [the Home] that [Mr A] had left the property. Despite this further unexpected development, direct assessment by [MNT] staff did not occur.

However, even if [the Home] staff were to have an agreed role in monitoring mental state, the clinical responsibility ultimately remained with the [MNT] (in the interim) and the mental health service, who therefore had a responsibility to be sure that the assessment information available to them was of a sound standard. For example, the report 'he's not suicidal' (at page 118 of the bundle of

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documents) appears to have followed 'some time' being spent with [Mr A] by [Ms D], but there is insufficient detail available in the record to know the content of that assessment and what information was conveyed to the [MNT] that assisted the decision whether to accept that assessment from the respite facility.

5. Was [the Home] a suitable facility for [Mr A] at the time of the decision to transfer him there?

The question of suitability relates to the purpose of the plan and the capability of [the Home] in responding to [Mr A's] needs.

If it is accepted that ongoing monitoring of mental state was required (which I believe it was) and that this is not a role that could be expected of [the Home], then it was clearly not a suitable facility for this part of the plan.

I have no detail available to me regarding the skills of staff at the respite facility, nor of the mix of residents at that facility, each of which may also have some bearing on whether this was a suitable facility for [Mr A]. There is no detail recorded of any information provided to [the Home] staff regarding management of any behaviour of concern, such as any tendency to heightened responses to stimuli.

6. Should [Dr F] have consulted his supervisor regarding [Mr A] and the decisions/conclusions made.

As I understand [Dr F's] status with the District Health Board [at that time], he was employed in a locum capacity as a Medical Officer of Specialist Scale.

I note that in [Dr F's] letter of 10 March 2006 to [HDC], he notes that in the period 2000 to 2001 he had been a Senior Trainee in psychiatry.

In accord with the training regulations of the Royal Australian and New Zealand College of Psychiatrists, a Senior Trainee (generally the final 12 months of training in accord with the regulations that pertained at that time) has some further objectives to be completed under supervision. Successful completion of those requirements was usually then followed within several months with the award of Fellowship of that College and eligibility for vocational registration.

A period of nearly three years following the completion of the Senior Trainee year and before the Fellowship is awarded is in my experience unusual. It is not clear to me whether in [Dr F's] circumstances any part of this delay was due to performance or practice concerns and thus whether this delay had any particular implications for the type of oversight he would require in order to maintain what I presume to have been general registration with the Medical Council and to ensure safe practice clinically.

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[Dr F] notes in his letter that he did not have a written job description. There is no reference to any particular requirements or arrangements for supervision or oversight.

[Dr F] reports that by [the end of 2004] he had been awarded Fellowship of the Royal Australian and New Zealand College of Psychiatrists. Generally then, by that time, he was eligible for vocational registration, although that apparently did not occur until April 2005.

Although I do not claim any detailed knowledge of the usual time course of proceeding to vocational registration once an eligible qualification is obtained, my experience has been of this being less than 6 months.

Whilst [Dr F] did not have vocational registration [at that time], having a specialist qualification (the FRANZCP) would generally provide some indication that his practice should be at the level of a specialist medical practitioner.

Unless there were particular concerns about performance it would not usually be required for such a person to have arrangements for close supervision and a reasonable degree of autonomy of practice would be reasonable. Even though the Medical Council requirements for general registration include provision for oversight, these may be tailored to the particular requirements of the individual practitioner.

For [Dr F], assuming no prior performance concerns or particular specification in his job description for supervision it would not be unreasonable for him to make assessments and develop treatment plans without immediate reference to a supervisor or the vocationally registered practitioner identified for oversight purposes.

Although it is not clearly identified in the information available to me, it appears that [Dr F] undertook his assessment on [Day 2] as the senior medical practitioner on call.

He undertook the assessment with [Dr M] (who I understand to be the on-call resident medical officer — RMO). It would be usual and good practice for new admissions to be reviewed within 24 hours by the on-call RMO and Senior Medical Officer.

Ordinarily on-call senior medical staff are expected to perform with a reasonably high level of autonomy. Although there may be a further more senior medical practitioner available to back-up the senior medical officer on-call this would most likely be the Clinical Director of the service who would generally only be called for complex matters including difficult resourcing or Medico legal matters or where there is some significant clinical risk.

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In circumstances such as the assessment of [Mr A] where it appears [Dr F] was in the role of on-call psychiatrist, where he was confident about his assessment and the treatment approach and where there appeared to be no immediate concerns regarding risk, it was reasonable for him not to consult with another medical practitioner.

7. Were the policies and procedures adhered to?

I have been provided with the following documents that outline policies and procedures:

- Description of the [MNT] and [Crisis Team] as required for the Health and Disability Commission Investigation (22 February 2006)
- Service description — [MNT] (1 February 2001)
- Service Description — Crisis Intervention Service (1 February 2001)
- CMHS Treatment Pathway
- CMHS Protocol for Referrals and Waiting Lists
- Guidelines for prioritising of referrals for adult mental health [in this area]
- Referrals to MNT — letter from Acting Clinical Director (20 March 2002)
- Referral policy (September 2003)
- Treatment plan policy (September 2003)
- Crisis Respite care policy (draft 5 distributed for comment 25 November 2004 and apparently confirmed February 2005)
- Memorandum of Understanding — crisis respite — [the Home]
- Transfer of patients policy (March 2004)
- Service description — dual diagnosis with intellectual disability (1 February 2001).

[MNT] description
In general, given that [Mr A] appeared to require further review pending the final determination of follow-up arrangements, it was appropriate for the [MNT] to be involved in care. Efforts were made to contact family, as outlined in the description of the [MNT]. The [MNT] also acted as the point of contact for concerns, also in accord with the description of their role.

In my view, it would have been appropriate for the [MNT] staff to have assessed [Mr A] directly on [Day 3], in accord with the elements of the description of their role in relation to monitoring of people in respite care and in monitoring behaviours indicative of risk.

Crisis Service description:

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This is a standard description of this type of service, apparently extracted from the set of National Service Specifications for mental health services.

In general the service acted in accord with this description, with a reasonably prompt response and assessment within a short period of [Mr A's] presentation at hospital. I have already discussed the venue of the assessment and noted that I am not clear how the arrangement was made to refer [Mr A] to the emergency department.

CMHS Treatment Pathway and CMHS Referral Protocols:
[Mr A] presented over a statutory holiday period. Despite this there was generally adherence to the processes set out in the Treatment Pathway and Referral documents, as such as could be completed in the absence of the full range of staff and services.

Treatment Plan:
This policy (page 46 of the bundle of documents) identifies that a treatment plan will be based upon a comprehensive assessment.

The file reflects that [Mr A] was assessed by at least 3 different doctors in a period of what appears to be just over 24 hours.

None of the assessments, at least as documented, are fully comprehensive.

The triage assessment in the emergency department on [Day 1] appears to suggest that [Mr A] had some problem (the record is not legible but may reflect 'pain') in the abdomen, chest and leg along with diarrhoea. These symptoms were not explored by the emergency department house-officer. There is no record of a physical examination being completed or of any laboratory investigations. Appropriately however in light of some of the symptoms with which [Mr A] was presenting, referral to the psychiatry registrar was arranged.

This subsequent assessment however, at least as evident from the documentation was scanty. There is little exploration of the concerns with which [Mr A] presented with no evidence of exploration of syndromes that might present with similar features.

I do not feel that either of these assessments were adequate.

Referral to the psychiatry registrar was however appropriate, although should have been preceded by some investigation (even if only in the form of documented formal enquiry) of the reports of physical symptoms. The plan as outlined by the registrar really identified only that admission should occur. Whilst admission was probably reasonable in the circumstances, the rationale for inpatient care was not entirely clear nor was the care to be provided in the inpatient setting detailed. The plan was therefore of an inadequate standard and certainly falls short of the criteria

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set out on page 2 of 6 of the policy on Treatment (page 47 of the bundle of documents).

The further plans discussed earlier in this report provide a little more detail regarding the proposed approach to treatment. The focus generally was on further review and monitoring to clarify the nature of [Mr A's] presentation. It does appear that there was some attention to revising elements of the plan following the further assessment conducted by [Dr F].

A risk assessment form was completed initially by [Dr I]. It was added to on [Day 3] following [Mr A] absenting himself from [the Home] but appears not to have included (at least in the records available to me) any reference to the inappropriate sexual behaviour noted at that facility.

Overall, it does not appear to me that a fully comprehensive treatment plan in accord with the policy was developed. In my view, a series of actions were taken in response to individual assessments and particular events.

Whilst each action in itself may have been reasonable, they do not seem to have been under-pinned by a shared understanding of [Mr A's] needs and a systematic approach to addressing what was assessed as the underlying cause.

Crisis Respite Care Policy (and associated respite documentation):

The policy document Crisis Respite Care (policy number 6.100.3.4 dated February 2005) at page 54 of the bundle of documents identifies 'absence of mental illness' as a criterion for not using Crisis Respite care.

[Dr F] appears to have been of the view that [Mr A] did not have a mental illness, or certainly not one that required further input from the mental health service. It is not clear therefore why arrangements were made for crisis respite care that appear incongruent with this exclusion criterion.

8. Were the policies and procedures appropriate?

In general the documents outlining policies and procedures are consistent with documents of this type that are found in many mental health services in New Zealand. In general they are appropriate and reasonable in their purpose and content, with perhaps one exception amongst the set provided to me.

The Memorandum of Understanding between the Mental Health Service and [the Home] in my view lacks clarity regarding notes and responsibilities of the two organisations. At my comments in relation to question 4 I have highlighted what appears to be some confusion regarding whose role it is to undertake assessments of mental state of residents of the respite facility, whether it was that of the Mental Health Service alone or whether the respite service staff also had a role in that activity.

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9. *What standards apply in this case?*

[The Mental Health Service] has established its own set of standards within the documents identified at question 7 above. I have commented already on those.

Additionally, other standards apply. Most notably for Mental Health Services in New Zealand the National Mental Health Sector Standards should apply. Of these standards, perhaps the most relevant to [Mr A] are those related to provision of services that met his needs, to the quality of documentation, and to minimizing the impact and distress of ongoing mental disorder. Standards in relation to the comprehensiveness of assessment are also clearly relevant.

I have commented on aspects of these already. Additionally it is likely that the [the Mental Health Service] will have been formally audited against these standards within a process of accreditation. I do not have any details of the findings of such survey.

One further standard that is of indirect relevance is evident in the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992. Whilst that legislation in itself does not apply to this situation as [Mr A] was not subject to the provisions of that Act, the Act contains provisions that reflect the principle that consultation with carers is of importance in reaching views regarding the assessment and plans for a patient. This provision reflects the more widely important standard of practice whereby such consultation is an important, and often highly necessary, element of providing adequate care. Opportunities should therefore be developed for such consultation before final arrangements for treatment and disposition are confirmed.

Summary

It is my view that there were a number of inadequacies in the assessment of and care provided to [Mr A]. Although assessed on several occasions by medical staff, each single assessment was deficient in exploring the symptoms with which he presented. Even with all the information put together from these assessments, there were still gaps in the information available. Whilst some of these gaps may have been contributed to by difficulties [Mr A] was experiencing that prevented him from giving a full and coherent account, this added particular importance to the gathering of additional information from other people and to repeated observations over a short period of time. In my view, a period of observation in hospital of just over 24 hours was not sufficient for that purpose.

Although it may be argued that there were no clear grounds for acute inpatient care — and I accept that such care may be relatively expensive compared with other service options and should be reserved for the most acutely ill people often with significant risks associated with their disorder — in my view there was a reasonably strong case to be made for [Mr A] remaining in a facility where skilled observation and assessment could continue for the further short period thought to

be needed before his grandparents returned, at which time further history could be obtained and definitive plans made. Certainly in the absence of any other pressures (such as high occupancy or [Mr A] refusing to stay), such [a] course would have been preferred, in my view, particularly in light of the working hypothesis that [Mr A] developed heightened responses to normal stimuli.

In my view, the opinion documented by [Dr F] following his assessment, that there was no further role for the mental health service, is a significant and serious departure from a reasonable standard of care in light of the limited information available at that time.

It is not clear how the decision to transfer to [the Home] respite facility was made.

However, even if it is accepted that transfer to respite was reasonable, it was felt that further monitoring of mental state was required, as evident in the respite care plan. What appears unclear however is whether this was an accepted and agreed role of the respite facility. [MNT] staff, who were to have a role in that monitoring, elected not to see [Mr A] on the day after discharge even in the presence of information about further odd behaviour. Later that day some reliance was placed upon the assessment of the respite service staff member, at least with regard to the presence of suicidal ideation. There appear to be differing views within the respite facility regarding whether they do have a role in monitoring mental state, but it is not clear whether [MNT] staff recognize that this may not be part of the role they can expect respite staff to undertake.

When faced however with behaviour that was difficult to manage, it does appear that [the Home] staff took sensible steps to intervene, but unfortunately were unable to avert the event that led to [Mr A's] death."

Further psychiatric advice
Dr Patton provided the following further expert advice:

"Thank you for your letter dated 14 February 2007 requesting additional advice.

Your letter was accompanied by material forwarded with your original request as well as additional material gathered since my earlier report. Your letter identifies this material as follows:

1. Letter from [Dr H] dated 16 October 2006
2. Letter from [Dr I] dated 29 October 2006
3. Letter from [Dr M] dated 19 December 2006
4. Information from [Mrs E]
5. Information from [Ms D]
6. Documentation of meeting with [Mrs C] dated 26 September 2006

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7. Interview with [Dr F] dated 18 October 2006 (including letter from lawyer [Mr L] dated 11 December 2006)
8. Interview with [Ms K] dated 26 September 2006
9. Interview with [Ms G] dated 26 September 2006
10. Telephone conversation with [Mr J] dated 20 September 2006.

You have asked whether this further information has resulted in any change to my opinion outlined in my report of August 2006.

…

My current opinion in relation to each of the matters in relation to which comment was originally sought in [HDC's] letter of 29 May 2006 follows with reference to how this further material has changed my views as expressed in August 2006.

1. Was it appropriate not to admit [Mr A] at the psychiatric unit but to send him to the Emergency Department for evaluation?

My original opinion stands. No further material supplied addresses this matter.

2. Is the policy concerning access to the Mental Health Services through the Emergency Department appropriate?

My original opinion stands. No further material supplied addresses this matter.

3. Was the care provided to [Mr A] adequate and appropriate?

In my earlier report I comment unfavorably about several aspects of the assessment and the treatment plan documented by [Dr F]. I shall address each of those.

a) *Coverage of the history*:
In the further information provided by [Dr F] in the interview of 18 October 2006, [Dr F] makes no comment regarding the scope of his assessment. My view on this matter has not changed. I noted previously that the coverage of these matters is more limited than would ordinarily be expected of a psychiatrist needing to be clear about someone presenting with unusual symptoms and concerns. Although [Dr F] records his conclusions, there is insufficient information in the record of the assessment to justify or support these conclusions. This is a moderately serious deviation from accepted standards.

b) *Ongoing contact with the Mental Health Service*:
[Dr F] confirms in the interview of 18 October 2006 that [he] noted he saw no role for further input from the Mental Health Service. In my earlier report I expressed the opinion that further contact with Mental Health Services was appropriate.

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[Dr F] clarifies that by 'no further contact with MHS' he meant the acute Mental Health Services. He comments that he expected the [MNT] to be involved, that decision having been made the previous day by the registrar who assessed [Mr A] that day. [Dr F] notes that he did not discuss this with the [MNT].

[Dr F], in his interview of 18 October 2006, comments that he imagined that some staff at [the Home] would be skilled in interpreting certain phenomena. His expectation however appears to have been of a lesser degree of expertise being applied by staff at [the Home], being simply to 'observe and report' (rather than interpret).

This expectation appears congruent with the view that [the Home] senior staff themselves expressed of their role. [Mrs E] in the interview on 26 September 2006 identifies her understanding that respite facilities are required to observe behaviour and report to [the MNT] anything unusual. She similarly states this view in her letter of 23 September 2006.

I have noted already in my earlier report and above my view that [Dr F] did not document a comprehensive history and that the coverage of important negative and positive findings was limited, although I acknowledge that despite this [Dr F] concluded that there was no evidence of psychotic symptoms or primary mood disorder. [Dr F] had formed a view that [Mr A] had developed heightened affective responses such as diminished sleep along with nervousness following normal stimuli (recorded in the 'impression' section of the assessment he recorded in the clinical file).

In my earlier report I note that in my view there was a need to explore this hypothesis or 'impression' with [Mr A's] grandparents. The further information provided by [Dr F] has not changed this opinion.

[Dr F] has confirmed that his expectations of [the Home] staff was just that of observing and reporting. This then appears to suggest that the role of [MNT] staff would be to continue to review [Mr A's] mental state. [Dr F], in his letter of 10 March 2006 (at page 191 of the original bundle of documents) identifies that [MNT] staff were to be 'available' to [the Home] staff. Neither that letter nor the clinical records reflect for what specific purpose the [MNT] would be available. [Dr F] does not expand on that in the interview of 18 October, other than to identify that the [MNT] would make the referral to [the Agency].

In my view, ongoing contact with the Mental Health Service was appropriate. [Dr F's] entry in the 'plan' section of his entry in the clinical record appears to suggest that the main purpose of such contact would be to arrange the referral to [the Agency], this being exercised through the involvement of the [MNT]. The [MNT] were also to be available (along with the crisis service after hours) to [the Home].

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There was however no direction given to [MNT] staff by [Dr F]. In my view, given the impression [Dr F] had reached and in the face of features of [Mr A's] presentation that should have been explored further with people who knew him well, it would have been appropriate for [Dr F] to make clear what further information should be sought. It would have been appropriate for him to have had direct contact with the [MNT] about this, but contact with the [MNT] was left to the nurse who also attended the interview with [Dr F]. There is no record of any specific instructions regarding information to be obtained from [Mr A's] grandparents.

It is unclear how the plan as recorded by this nurse with respect to [Dr F] meeting with [Mr A's] grandparents was developed. [Dr F] makes no reference to this in his own entry in the clinical file or in his letter to [HDC] of 10 March 2006. In his interview on 18 October 2006 he refers to his understanding that there was to be a discussion with his grandparents although it is not specified whether that was to involve the [MNT] alone or [Dr F].

In summary, I remain of the view that ongoing contact with the Mental Health Service was necessary to clarify matters of history and phenomenology, with [Mr A's] grandparents having an important role in that. The plan documented in the file ('no current role for further input from MHS') is inadequate, however if it is accepted that [Dr F] intended that the [MNT] would continue to have contact, this is more reasonable. It would still however have been appropriate for there to be some specificity to the [MNT] about the purpose of their 'availability' to [the Home] and of the information to be gathered from [Mr A's] grandparents.

The proposed management plan set out on the second page of [Dr F's] letter of 10 March 2006 is in itself reasonable, except for 2 key issues. The conclusion that [Mr A] was not suffering from a serious mental disorder, psychotic symptoms nor primary mood disorder was based upon one interview and a cross-sectional assessment that in my view does not adequately explain the odd features noted on assessment the day before. I do not believe a firm conclusion could be drawn with respect to presence or absence of mental disorder. I accept however there was no indication of risk of harm, even though this assessment is scantily documented in the file.

Secondly, this plan does not identify the need to gather more detail from grandparents to assist with clarification of [Mr A's] presentation and needs, and to test out the hypothesis regarding heightened responses to stimuli by exploring prior patterns of behaviour.

Overall, in my view, these several deficiencies amount to a major departure from acceptable standards.

4. Was the decision to transfer [Mr A] to [the Home] care appropriate to his requirements?

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In my earlier opinion I noted that there appeared to be some mismatch between the expectations of the [MNT] as expressed in the care plan and the understanding of [the Home] staff of their role.

As I note above, the overall plan as identified by [Dr F] in his letter of 10 March 2006 and broadly as identified in the respite care plan was based upon a view that [Mr A] did not require inpatient care but did appear to need additional support pending return of his grandparents. A respite facility would generally be appropriate for such purpose. However, I do not accept that in [Mr A's] circumstances and with the conclusion that had been reached about his presentation, these otherwise ordinarily applicable arrangements were suitable.

In my view, some ongoing monitoring of his behaviour and presence or absence of symptoms was necessary. [Dr F] appears not to have had the expectation that such skilled observation was the specific responsibility of [the Home] staff, recognising that staff there would be of varying skill levels at that facility.

[Mrs E] and [Ms D] have confirmed the role of [the Home] as being observation of behaviour, rather than more formal assessment of mental state.

In general therefore the expectations of [the Home] staff and of [Dr F], that the facility was to provide social support and observation of behaviour, were in accord with each other and generally [the Home] seems a suitable environment for such purpose. The responsibility for the key element however with respect to ongoing assessment of mental state and to clarify history fell to the [MNT], but they were not specifically directed to focus on particular phenomena or details.

The decision to transfer [Mr A] to respite care was initially made, according to [Dr F] in the interview on 18 October 2006, by the assessing registrar on the day [Mr A] presented to the service. [Dr F] saw his role as to confirm whether that decision was appropriate.

[Dr I], the assessing registrar, makes no specific reference to respite care in her letter to [HDC] of 29 October 2006. Her file note of [Day 1] does not refer specifically to respite being required.

The first reference to respite appears to be on [Day 2], where an entry in the clinical file identifies '… to stay at [the Home] 4 days' (page 105 of original bundle of documents) and another entry records 'possible respite option in interim' (pages 115 of original bundle of documents).

The notes of the interview of 26 September with [Ms K] do not reveal how the decision regarding respite was made, but [Ms K] suggests such decisions are a medical responsibility, although sometimes such suggestions for respite care are made by nurses.

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[Ms G] in the interview of 26 September could not clarify with certainty how the decision for respite was made, although seems to suggest that the decision was made on [Day 2] when faced with the prospect of [Mr A] being returned to his own home, alone.

[Mr J] in his telephone interview of 20 September notes that [he recalled] the decision for [Mr A] to go to [the Home] was made by [Dr F] after his assessment, having initially decided that there was to be no more input from the [MNT].[21]

In summary therefore it is unclear who made this decision.

Of importance however is the question of why transfer to respite was necessary. [Dr F] has stated in his letter of 10 March that the arrangement for respite did not arise from pressure on acute beds. [Mr A's] grandparents were expected to return in the near future. A conversation was necessary with them to help clarify the nature of his presentation. [Dr F] has stated through his lawyer (in the letter from [his lawyer] [Mr L] of 11 December) that patients should be treated in the least restrictive environment. [Dr F] has previously stated however (in his letter of 10 March) that [the Home] and the acute psychiatric in-patient unit both offered a similar level of security, both being unlocked.

There appears to have been no compelling need for space to be created in the psychiatric ward by transferring [Mr A] to respite. Whilst respite care may have been appropriate to care for someone presenting as of no particular risk, as [Mr A] was judged to be, and whilst monitoring of mental state could be facilitated by ongoing contact with the [MNT] staff, I do not believe it to have been appropriate in this circumstance. [Mr A] had been assessed by [Dr F] as having heightened affective responses to normal stimuli. To subject [Mr A] to yet another change in his social circumstances and environment when there was already evidence of poor adjustment to such stress, in the absence of any competing priority for the in-patient bed, was not appropriate and could even be argued as contraindicated, especially when the duration of either inpatient or respite care was anticipated as being brief pending return of his grandparents.

The matter of least restrictive environment raised by [Dr F] through [Mr L] is not a valid consideration in [Mr A's] care at [the Home], in my view. This is however a matter sometimes raised by clinical staff, without proper attention to the often unspoken element of the full range of matters to be considered, being the least restrictive environment <u>appropriate to the person's needs</u>. For the reasons I have outlined, ongoing care for a short period at the acute inpatient setting would have met the need for further observation of [Mr A's] presentation, as well as meeting [Mr A's] need for support pending the return of his grandparents.

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[21] In fact, Mr J was not present at the meeting and was unable to comment on whether there had been any change of plan. See page 10 above.

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In my view, confirming (or making) the decision to transfer [Mr A] to respite represents a failure to fully consider the implications of treatment decisions and thus represents a major departure from acceptable standards.

5. Was [the Home] a suitable facility for [Mr A] at the time of his transfer there?

The information provided since my earlier report makes clear that monitoring of mental state, more than simply observing and reporting on behaviour, is not a role for [the Home]. [Dr F] appears not to have expected this to have been their responsibility and such monitoring would be the responsibility of the [MNT] staff.

The additional information provided to me is that [the Home] is predominantly an aged-care facility, although with an identified number of beds available for mental health respite care.

Ideally the mix of mental health crisis respite beds with longer-term residential facilities, for aged-care should be avoided, although this arrangement is not unique to [the Home]. Other District Health Boards however have negotiated agreements with providers to develop stand-alone respite facilities, or respite beds associated with Mental Health residential rehabilitation services.

It is not clear to me whether other respite options were available to [Mr A] at the time the respite care at [the Home] was arranged. In the absence however of a facility with a younger mix of residents, [the Home] was a suitable facility if respite care was necessary.

6. Should [Dr F] have consulted his supervisor regarding [Mr A] and the decisions/conclusions made?

[Dr F] has clarified that what appeared to me to be a delay in obtaining the fellowship of the Royal Australian and New Zealand College of Psychiatrists (which I comment upon in my earlier report) was due to it taking a long time to put together his dissertation. [Dr F] has confirmed that he was employed as a MOSS and has identified his supervisor.

In the absence of any particular concerns about employment and performance it was not unreasonable for [Dr F] as MOSS and as the on-call senior medical staff member, to make his own determination regarding plans for [Mr A] without reference to another senior medical practitioner or his supervisor.

7. Were the policies and procedures adhered to?

Largely my earlier views with regard to policies and procedures remain as noted in my earlier report.

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The further information provided to me however suggests that there is some considerable lack of certainty with regard to who made the decision regarding respite care and how it was determined that this be provided at [the Home].

Additionally, no clear direction seems to have been provided to the [MNT] regarding their role with [Mr A] while at [the Home].

In my view, ongoing monitoring of [Mr A's] mental state was necessary. This role appears to have been the [MNT] staff responsibility, but no explicit direction was provided to the [MNT] about this, perhaps contributing to the relative lack of assertiveness in their efforts to see [Mr A] at [the Home]. Clear direction may have resulted in them insisting on seeing [Mr A] each day and in reviewing closely with him and with staff the reasons for his apparently disinhibited behaviour at the respite facility.

8. Were the policies and procedures appropriate?

The further information supplied clarifies that [the Home] staff have a role in observing and reporting on behaviour, rather than in more comprehensive assessment of mental state. This further material identifies that the memorandum of understanding between [the Home] and [the DHB] was being reviewed. It is not clear how this revised document will reflect responsibilities for observing behaviour and monitoring mental state.

9. What standards apply in this case.

No further information has been supplied that clearly identifies additional standards that apply in these circumstances.

I have however noted already some comments regarding [Dr F's] remarks reported through his lawyer, regarding the least restrictive environment.

Summary
Broadly I remain of the view expressed in my earlier report, although the additional material provided has heightened some concerns.

I remain of the view that the assessment of [Mr A], as documented, was inadequate. There is no documented evidence of key positive and negative findings that support the overall conclusion made by [Dr F]. It is now less clear to me who made the decision for [Mr A] to be transferred to [the Home] and it is evident that there were no clear instructions provided to the [MNT] with respect to their role while [Mr A] was at that facility. Such instruction from [Dr F] was important, given his apparent understanding that [the Home] staff were of mixed skills and predominantly only observe behaviour.

In my earlier report I was critical of the [MNT] in electing not to see [Mr A] on the occasions he was not immediately available or when informed of behaviour that was of some concern. Whilst I remain concerned that there should have been

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a more assertive approach taken by the [MNT] to reviewing [Mr A] and that these staff should have exercised greater professional judgement independent of any assessment by [Dr F], their failure to act in such manner appears in part to have been caused by transmission to them of a view that only social support was necessary for [Mr A].

In my earlier report I expressed concern about the opinion expressed by [Dr F] following his assessment.

The additional information received has caused me to adjust my view with regard to [Dr F].

[Dr F] clarified that he saw no further role for the acute mental health service. He did however expect the [MNT] to have ongoing involvement and he anticipated that the [MNT] would make a referral to [the Agency].

In my view [Dr F] did not meet his responsibility to ensure that the treatment plan was clearly understood by the people to be involved in ongoing care.

[Dr F] has confirmed that in the absence of [Mr A's] usual social supports, discharge home was not a good idea. The decision to discharge to respite care however, another change for [Mr A], when assessment had been made that [Mr A] coped poorly with change and in the absence of any other pressures on occupancy, was not in [Mr A's] best interests and was not appropriate.

As noted through the body of this report, these various deficiencies amount, in my view, to moderate to major departures from acceptable standards."

Responses to Provisional Opinion

Ms G

Ms G emphasised that she had been advised that Mr A had been assessed as not suffering from a mental disorder. The care plan was to provide supervised accommodation, with ongoing monitoring by the MNT, with a priority to contact Mr A's grandparents to obtain collateral history. She stated:

> "[Mr A] was supported in respite accommodation in the absence of an identified mental disorder, but possible cognitive impairment secondary to previous head injury, because he had lost his keys to his house and his primary social supports were away. The intent was to facilitate a family interview at the earliest instance to obtain collateral information and monitor his condition meantime. He was discharged from hospital on no medication and [Ms G] maintained consistent contact with the respite provider."

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Ms G submitted that the care she provided was consistent with therapeutic plan and satisfied the requirements of Standard III of the *Standards of Practice for Mental Health Nursing in New Zealand*. Ms G drew particular attention to the rationale for Standard III, which states:

> "Critical thinking and clinical judgement are used in conjunction with a collaborative and consultative approach with the intention of providing integrated and individualised nursing care. Integrated care is directed towards meeting the holistic health care needs of the consumer within the context of their life situation, including their family or whanau and community."

Ms G informed me that she has reflected deeply on this case and considers her nursing care was appropriately collaborative, consultative and consistent with Mr A's known situation. At the time, his behaviour was not rated as an indicator of suicidal ideas or self-harm by Ms D or herself. Mr A himself, on direct questioning, denied ideation or intent to self-harm. Ms G stated:

> "Following [Ms G's] phone call with [Ms D] later that afternoon, when [Mr A] had left [the Home] to walk into town, [Ms G] completed an alert form for the crisis team and amended the care plan. The crisis team were instructed to facilitate re-admission to the in-patient unit if [the Home] staff contacted MHS again citing safety concerns … she was available to [Ms D] and … [Ms G] responded to all calls from [Ms D]. Her actions reflect attention to part b. IX of Mental Health Nursing Standard III by attending to a limitation in the nursing care plan to include an option to readmit [Mr A] to the in-patient unit.[22]
>
> [Ms G] recalls contacting [Mrs C] and that [Mrs C] was concerned with [Mr A's] past head injury and thought that the recent contact with MHS [mental health services] would add some weight towards obtaining assessment and head injury support services for [Mr A] and for that reason was content to have [Mr A] stay at [the Home]. A care plan objective was to arrange an interview with [Dr F] and [Ms G] actively engaged with meeting this goal. [Mrs C] preferred to meet as soon as she could confirm when [her friend] who works with IHC would be available. [Ms G] did not disclose the incident of disinhibited behaviour to [Mrs C] because, in her judgement, [Mrs C] seemed somewhat overwhelmed by recent events. [Ms G] has reflected over this action and considers that sensitivity to the experience of family members was valid and consistent with the intent of Mental Health Nursing Standard III.
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> …

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[22] Part b. IX of Standard III states that part of the skill of a mental health nurse is to "[i]nitiate steps to address deficiencies/limitations in the nursing and therapeutic plan".

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> [T]he relationship with [the Home] is characterised by a high degree of collaboration and cooperation and strengthened by interpersonal connections. [Ms G] acted as preceptor to [Ms D] when she was a nursing student about five years ago. Moreover, [the Home] is a family business and all are mental health professionals and have worked previously with MHS at the DHB."

Ms G also noted that she was not working independently in relation to Mr A's care, and ample opportunity existed to critique nursing actions and the care plan. A further opportunity to critique the existing care plan occurred when the alert form was presented to the crisis team. Within the context of that working day, given the assessment completed by Dr F, and the information that was shared "by and with" Ms D, it is significant that none of her colleagues perceived the need to progress a further assessment of Mr A as a matter of urgency.

Ms G's response was endorsed by the District Health Board's senior clinical mental health staff.

Dr F

Dr F's lawyer, Mr L, submitted that Dr F's clinical assessment of Mr A, assisted by RN Ms K and Dr M, was both adequate and reasonable. The diagnosis was appropriate and supported by clinical indicators although would need to be reviewed once further information had been obtained from Mr A's grandparents. There is a "division of labour" within the multidisciplinary team — Dr F wrote up the interview findings, while RN Ms K prepared the transfer of care and contacted the MNT. Mr L stated:

> "[Dr F] states that he documented [Mr A's] daily routine, which is where he would elicit information about neuro-vegetative symptoms such as sleep pattern, energy levels, appetite, any anhedonia etc. [Dr F] acknowledges that the notes might be regarded as 'clumsy' but he did probe into [Mr A's] unusual ideas at least three separate times within the interview, to ascertain how rigidly held they might be. On every occasion [Dr F] found that they were not fixed at all, but very variable."

Mr L emphasised that Dr F did not consider that Mr A required no more Mental Health Service input — although he acknowledges the "ambiguity" of what he wrote. Dr F's belief was that no further *acute inpatient care* was necessary. If Dr F had concluded that no further Mental Health Service input was required, Mr A would have simply been discharged back home, with no MNT input at all. Furthermore, there was no variation to the treatment plan, and referral to respite care was always the plan. Mr L also commented that the Mental Health Services use an "integrated" approach to treatment and Dr F therefore expected that he would remain responsible for Mr A after his discharge from the Ward:

> "In hindsight, [Dr F] acknowledges that his own notes of the treatment plan were not as detailed as they might have been, however in a multidisciplinary team context, it was reasonable for him to expect that the detail would be supplied by R/N [Ms K]. This is what happened."

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Mr L submitted that the decision not to retain Mr A in acute inpatient care and refer him to respite care subject to MNT input and oversight was reasonable. Dr F believed that, on balance, retaining Mr A in an environment with acutely mentally unwell people was not in his best interests. He commented that inpatient care is used only if other options are untenable and also does not provide a higher level of security for voluntary patients than respite care. In addition, Dr F had no information about when Mr A's grandparents were returning. It is not practical to retain patients on the sole basis of outstanding corroborative information. Mr L stated:

> "In view of the low levels of risk identified with [Mr A] and appreciating that at the time there were still information gaps, [Dr F] believed that respite care was a reasonable and safe alternative. In his experience, this approach is commonly used in [this area] for people with clinical profiles similar to that of [Mr A]. As [Dr F] had had ongoing professional contact with [MNT] staff over the previous six months, he had a sound knowledge of their operations and confidence in their skills. Consistent with that experience, his expectation was that if there should be any significant post-discharge issue as to the patient's mental state, he or the duty doctor would be alerted immediately."

Mr L submitted that the MNT are experienced professionals who do not require detailed oversight or instructions. The MNT was aware that its role included monitoring Mr A's mental state and was not told that "only social support" was required for Mr A. The MNT was not told what further specific information was required as Dr F expected to meet with Mr A's family himself.

Mr L included the following report which he obtained from Professor Graham Mellsop:[23]

> "The major points made by the [HDC] reviewers, and which I would endorse are:
>
> 1. Documentation by the clinical treating team falls short of the optimal.
>
> 2. The logic of the management plan, and the clinical logic, were probably not well thought through, and have not been comprehensively documented.
>
> 3. The written view of [Dr F] that [Mr A] required no more mental health service attention was inappropriate, unless it meant no further acute inpatient care.
>
> In giving an opinion on the contributions of [Dr F] to the above, as they might reflect on his compliance with standards and level of skills and care, it is my view that several relevant issues have not been raised in the report of Dr Patton, comprehensive as it otherwise is.

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[23] Professor Mellsop has been Director of Clinical Services (or the equivalent position) in major psychiatric services in Australia and New Zealand. He is currently Professor of Psychiatry at Auckland University.

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1. [Dr F's] entry in the clinical file, being of four pages, is at the upper limit of common New Zealand practice, where an on-call psychiatrist is reviewing for someone for whom the comprehensive history has already been recorded. [Dr F's] handwriting leaves a lot to be desired, but his account appears to concentrate on reporting what the patient said, from the patient's perspective, rather than being of a more interrogative style, which favours Dr Patton's opinion. I do not share that view. The end point of [Dr F's] account would ideally be a comprehensively written out management plan. In his own writing that plan is very brief, and subject to some ambiguity in interpretation. The next case note entry however is understood to have been written by a nursing staff member present at [Dr F's] interview with [Mr A] and would appear to me to be likely to represent a reasonable summary of what was determined in that interview. That another team member has written that more comprehensive account, rather than [Dr F], falls short of a good standard of practice, but only to a mild degree since it is not uncommon practice within New Zealand and Australian services.

2. In modern psychiatric services, with the multidisciplinary team approach and the clinical sophistication of frontline nursing staff, in standard clinical practice who makes final and definitive decisions is not always easy to specify, and nor should it be. Any degree of confusion as to the contributions of the different staff to the decision to transfer [Mr A] to [the Home] is therefore not surprising. [Dr F's] role in this, being unclear, would be a very unreliable indication of competence and compliance with standards.

3. Adult acute mental health services almost always try to resist having people admitted who had previous organic brain damage. Frontline staff have to determine who occupies acute beds on a priority system, rather than on being able to provide to each person ideal, well-resourced care. It would be extremely unlikely that such contextual influences would not have influenced this management plan. And I note that in the guidelines for prioritising submitted by [the DHB] not[ing] the requirement for a serious mental illness, it does list serious psychiatric disorder associated with serious head injury. Of note is that the two diagnostic groups associated with high suicide rates, schizophrenia and depression, [are] not applicable to [Mr A]. Two things are to be noted here. Firstly, this is for <u>admission to the service,</u> not for inpatient care. And secondly, the assessment of [Dr F], and others from the Mental Health Services at the time, did not appear to support the idea of serious psychiatric disorder.

4. Taking the mental status observation of [Dr F], and his diagnostic conclusions, as consequences of an imperfectly recorded but possibly adequate assessment, then the discharge of [Mr A] to respite (community based) care would be entirely consistent with much New Zealand practice; practices which are advocated for by many pressure groups (notwithstanding that in my personal view I fail to see exactly what it is supposed to deal with and contribute).

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5. As it turned out, the behaviour of all staff in relation to [Mr A's] care, once he went to [the Home], appears to have vindicated the decision to send him there. This includes the view expressed by [Mrs C] on her visit on the evening prior to the tragedy, and the messages that [Mr A] himself was giving to [the Home] staff. This renders the specifics of the tragedy unpredictable in advance.

6. I specifically disagree with the HDC … view, and the view of Dr Patton which it quotes, that [Mr A] should have been kept as an inpatient for further observation. I accept that doing so would have prevented the tragedy, and have allowed a more leisurely and thorough assessment and management of the difficulties of [Mr A]. The reason why I disagree with it as a conclusion is that the same logic could be applied to the care of hundreds of New Zealanders each year who are discharged from inpatient care to community based care of one form or another, making way for the inpatient care of those whose needs are greater, or for whom no alternatives can be found or [who] are assessed as at greater risk.

So in conclusion, I hold the view that [Dr F's] contribution to the care of [Mr A] amounts to a moderate departure from an optimal standard of care, but only a minor departure from the standard of care currently available in New Zealand and therefore to be reasonably expected."

Further advice from Dr Murray Patton
Dr Patton provided the following further expert advice, having reviewed Professor Mellsop's advice and Mr L's submissions on behalf of Dr F:

"I have forwarded my further comments on several key areas:

- The content of the clinical record by [Dr F]
- Communication regarding ongoing care
- Appropriateness of respite care

1. The clinical record

Ordinarily a psychiatric assessment attempts to encompass a range of specific areas of inquiry in order to ascertain the significance or otherwise of features presented by a patient. Sometimes a patient will spontaneously provide information in sufficient detail that all potential avenues for inquiry are covered. More commonly however specific prompts by the assessor will be required.

It is not unusual that a psychiatrist will make his or her assessment after other clinicians have conducted some elements of assessment and gathering of information. In such circumstances some detail of matters that might otherwise have been addressed by the psychiatrist may already be outlined. Sometimes

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however such preliminary assessment may raise issues that themselves require further exploration or analysis.

Undertaking and documenting a full psychiatric assessment is a time-consuming activity. I accept that many psychiatrists will not routinely complete a comprehensive review of all potential psychiatric phenomena, nor necessarily document a full mental status examination, on each occasion that they see a patient. The early assessments in the course of care however, in my view, require a much greater degree of attention to key phenomena (including key negative findings) which underpin the conclusions reached, no matter how the information is obtained, because of the importance of this assessment in determining the course of future care.

I remain of the view that the documentation available with regard to the assessment by [Dr F] is not optimal. Professor Mellsop comments that [Dr F] appears to have concentrated on reporting what [Mr A] said rather than following a more interrogative style (which I understand to mean seeking clarification of features through specific questions), and appears to suggest that not following an interrogative style was reasonable.

I do not agree, especially at a point early in the process of assessment. Seeking elaboration of concerns and symptoms is especially important to gain a full understanding. Although an assumption, I think it is likely that [Dr F] did make specific prompts, in some areas. He notes a number of odd ideas presented by [Mr A] and concludes these are not delusions but are over-valued ideas. To draw this conclusion requires more investigation than is documented. Additionally, [Mr A] is also noted to have a discursive style of speech. For an assessor to make the conclusions reached by [Dr F] within the time span of the interview would usually require some prompting and direction.

Nonetheless while Professor Mellsop and I appear both to agree that the standard of documentation falls short of a good standard, the diagnostic conclusion reached at the end of the assessment is congruent with the observations recorded. There is however insufficient detail to be fully confident about other possible causes for [Mr A's] presentation, some of which detail may only have become available with discussion with other people.

I accept that it appears there was an intention for [Dr F] to meet with [Mr A's] grandparents. The plan as recorded by [Dr F] is at best cursory. Submissions received since my first report have however clarified the apparently contradictory comments regarding there being no further role for the mental health service and the events as they took place. Most recently, through [Mr L], [Dr F] has clarified the 'integrated treatment' approach at [the] Mental Health Services, by which approach [Dr F] expected to remain responsible for [Mr A's] care.

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It is presumably this integrated approach that underpins [Dr F's] expectation, outlined in [Mr L's] letter, that if there were any significant post-discharge issue [Dr F] (or the duty doctor) would be alerted immediately. It perhaps also explains the absence of [Dr F] making any reference himself in the record to seeing [Mr A's] grandparents, as that integrated system would place such responsibility on him anyway. This explains too the reference made by another staff member about [Dr F] seeing the grandparents, when [Dr F's] own entry gave no suggestion of that direction.

2. Communication regarding care

Professor Mellsop quite reasonably identifies that in a multidisciplinary team approach to care and in a context where there are highly developed skills of front line nursing staff, who makes final and definitive decisions is not always easy to specify.

Effective care in the context of a team-based approach requires agreed goals and effective communication between team members, amongst other things.

I agree that in the context of a team-based approach to care, performance of various tasks will be distributed amongst team members. I accept [Mr L's] assertion that the consultant performing all tasks personally is impracticable.

My earlier comment however (to which [Mr L] is apparently responding), that no direction was given to [MNT] staff by [Dr F], should not be read to imply that I meant that [Dr F] should have performed tasks that were the role of the [MNT]. My intention was to suggest that [Dr F], as the psychiatrist and thus with a particular professionally based perspective on what ongoing assessment and observation and intervention was required, had a role in ensuring that what he expected was communicated to the front-line staff who would then exercise their own judgment in accord with their professional roles and who would conduct such further assessments in accord with their own professional standards.

It seems that there were differing expectations of what would happen while [Mr A] was at [the Home]. [Dr F] has noted that he did not expect [the Home] staff to assess [Mr A's] mental state, but to observe and report. In these circumstances, given that the role of further assessment and monitoring of mental state would fall to the [MNT], it would have been helpful for [Dr F] to identify those particular aspects of [Mr A's] presentation that warranted further attention by the [MNT].

This is not to suggest that [Dr F] should have undertaken the further assessment directly himself, nor to suggest that [MNT] staff were not skilled professionals and required direction in how to monitor mental state. What I am suggesting is that without prompts to focus on particular areas of concern, a more general instruction to monitor may not lead to inquiry into or review of particular phenomena. If for example [Dr F] wanted further focus on the significance of the feature of [Mr A's]

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account of having a lot of energy and [Mr A's] thought he might have been manic, and the question of impaired judgement noted by [Dr F] (all of which features might suggest an affective disorder), directing the [MNT] to focus on these and other elements suggestive of mood disorder would have been helpful. How the [MNT] then did that however would be for the [MNT] to determine. Focus on these specific matters may have facilitated for example a different response when an example of what may have been disinhibited behaviour (which could possibly also be due to an affective disorder) at [the Home] was reported to the [MNT].

Ruling out various other conditions in the process of reaching a diagnostic conclusion is a particular role of a psychiatrist. Relying on another staff member to clearly transmit to another service the focus of further assessment in clarifying diagnostic matters risks the intention being diluted or missed completely, especially in the absence of clear discussion and documentation of that intention. I accept that it may not always be possible for the psychiatrist to speak directly to the staff who will be involved in ongoing review, but clear documentation of areas for attention then becomes valuable. If it is clear that the communication with the staff involved in ongoing care will be through another staff member, discussion between the psychiatrist and the referring staff member must be explicit with regard to expectations to be transmitted to the ongoing care staff. [Ms K's] record following the joint assessment with [Dr F], and the record in the treatment plan, do not contain any specificity regarding any focus of the ongoing review of mental state.

Further assessment, especially in the face of [Mr A] having presented acutely and with only brief opportunity to assess him closely in hospital and in the absence of corroborative history, was appropriate and appears to have been the plan as is evident from the treatment plan form. In my view, the importance of this and the particular focus for attention should have been much more clearly communicated between members of the mental health team involved in [Mr A's] care. If reliance is placed upon team-based care, such good communication is of great importance.

3. Appropriateness of respite care

I accept the assertion that many mental health services expect that inpatient care is used only if other options are untenable. I accept also that no specific risks, other than heightened affective responses to normal stimuli, were identified in [Mr A].

I remain unclear as to how the plan for respite care was actually developed, having noted previously that there is no reference to it in [Dr I's] note and that in [Ms K's] plan as documented on [Day 2] 'possible respite option in interim' is noted.

Whether or not a plan for respite was in place prior to [Dr F's] assessment and despite respite being a common arrangement for people not requiring acute inpatient care, a critical judgment must be made for each person about what impact may follow a decision to remain in the current location or to undergo a change.

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Factors that might be included in this consideration include what evidence there is of discomfort or distress in the current setting, the likely period of further care in whichever setting was chosen, how the person has coped with other charges, and what the person's own view is of a preferred setting. Another critical factor will generally be any occupancy pressures in acute inpatient services, although I understand that was not a particular pressure on this occasion.

I remain concerned that there is little evidence of considering [Mr A's] particular circumstances and his adaptation to change in reaching (or confirming) the decision to proceed with respite care. Having concluded that [Mr A] developed heightened affective responses to normal stimuli, I believe that [Dr F] had a particular responsibility to consider whether the practice of arranging respite was appropriate for [Mr A], and if respite was to proceed how any potentially adverse effects of this further change might be mitigated. The potential for heightened affective response to the stimulus of a new setting should have been one of the things clearly communicated to staff who would be involved in further care.

Summary

I remain concerned that these aspects of care fall short of optimal or even good practice. Professor Mellsop has commented that [Dr F's] contribution amounts to a moderate departure from an optimal standard of care.

I have previously expressed a view that deficiencies in [Dr F's] proposed management plan combined with inadequacies in the assessment documentation amounted to a major departure from accepted standards.

[Dr F] has now made further comment clarifying the 'integrated' nature of the service in [the area] and how the various separately documented elements of the treatment plan were developed and documented.

With this further information I am happy to modify my previously expressed opinion about the overall role of [Dr F]. When seen in totality and accepting [Dr F's] comments that he was an active participant in developing the overall plan (rather than that element simply outlined by him) and that he himself intended to meet with [Mr A's] grandparents, the overall intention was reasonable.

I remain concerned that documentation was poor.

I remain concerned too about the adequacy of communication as noted.

You have sought my view about what approach might be most appropriate with respect to any concerns.

Whilst these shortfalls in these aspects of care are significant, I do not feel that a disciplinary approach is appropriate when the overall context and plans for [Mr A] are considered.

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I note Professor Mellsop's comment that implies the overall standard of care in New Zealand may not be far different from the care provided by [Dr F]. I think this view could be debated. However, even if this statement was to be accepted, it does not in my view take away from the individual practitioner the need to improve their own practice if found to be deficient and not in accord with optimal standards, even if those standards are commonly breached.

My preference therefore would be for an approach to be taken that encourages [Dr F] to develop his practice with regard to documentation and communication, particularly focusing on those aspects that enhance the understanding of the foundation of diagnostic conclusions and which enhance understanding of the psychiatrist's view of the contribution to be made by the various members of a multidisciplinary team involved in care of any one person."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

Other relevant standards

The New Zealand College of Mental Health Nurses Incorporated's *Standards of Practice for Mental Health Nursing in New Zealand*:

"Standard III

The Mental Health Nurse provides nursing care that reflects contemporary nursing practice and is consistent with therapeutic plan."

Opinion: Breach — Dr F

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Introduction
Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), Mr A was entitled to services provided with reasonable care and skill. In my view, Dr F failed to provide an appropriately thorough assessment of Mr A. The decisions Dr F made in relation to Mr A's care and treatment were not well considered or properly documented. Although Dr F did plan to consult with Mr A's family, this could have occurred prior to his discharge from the ward since his grandmother was due back shortly. No specific information was provided to the MNT about Mr A other than the need to monitor him, or about the importance of consulting with his grandmother to clarify the diagnosis. This omission may have contributed to the lack of reassessment of Mr A following his transfer to the Home. In all the circumstances, I consider that Dr F breached Right 4(1). The detailed reasons for my view are set out below.

Assessment
Dr F assessed Mr A on Day 2. Dr F had had no previous input into Mr A's care but had access to his medical records since his admission the previous day. Also present were psychiatric registrar Dr M and registered nurse Ms K (who had admitted Mr A to the ward). Dr F also had available to him written information about Mr A's head injury (which Mr A had brought with him). Dr F commented that he found the information about Mr A's head injury relatively unhelpful from a psychiatric perspective but his observations of Mr A were consistent with impaired judgement due to frontal lobe damage.

Dr M advised that Dr F took over responsibility for the interview as it was difficult to make sense of the "temporal relationship" of Mr A's symptoms. Dr F concluded that Mr A exhibited ideas that were "over-valued" rather than delusional but displayed no evidence of psychotic symptoms or primary mood disorder. He considered that Mr A was "not actively" suicidal or homicidal. Dr F also considered that the previously documented observations did not indicate any psychotic symptoms.

Dr F emphasised that there was a "division of labour" within the multidisciplinary team and both RN Ms K and Dr M actively contributed to Mr A's assessment. In particular, RN Ms K was consulted about whether Mr A had exhibited any serious signs of mental illness during his time as an inpatient. His assessment, and that of other staff from mental health services, did not indicate the presence of a serious mental illness which, under the DHB's guidelines, is a criterion for admission to the mental health services.

However, my expert psychiatric advisor, Dr Murray Patton, considered that Dr F's assessment of Mr A was inadequate and there was insufficient information documented to support or justify his conclusion that there was no evidence of psychotic symptoms or a primary mood disorder. Dr Patton noted that there was very little exploration of prior elements in Mr A's history. There was no elaboration of important positive and negative findings in Mr A's history with regard to the possibility of a severe anxiety disorder and the full range of symptoms that might be associated with a major depressive disorder or psychotic illness. Dr Patton advised:

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> "I think the coverage of these matters is more limited than would ordinarily be expected of a psychiatrist needing to be clear about someone presenting with unusual symptoms and concerns. The history appears to be sufficiently unclear that much more collateral information and detail was required before being able to reach a definitive conclusion about the presence or absence of mental disorder, particularly in the presence of someone themselves having some limitations in clearly reporting their story. Whilst there appear to have been a number of prior reports available to [Dr F] in respect of [Mr A's] head injury and subsequent difficulties, those reports … do not include prior psychiatric assessments and do not in themselves provide detail of the depressive and paranoid symptoms reported to have been present at times."

Professor Graham Mellsop noted that Dr F's clinical record (although, at four pages, relatively long) concentrates primarily on what the patient reported, and does not include a comprehensive treatment plan. He stated that the clinical logic and treatment plan were "probably not well thought through".

Dr F submitted that, overall, his assessment of Mr A was adequate. His lawyer, Mr L, stated:

> "[Dr F] acknowledges that the notes might be regarded as 'clumsy' but he did probe into [Mr A's] unusual ideas at least three separate times within the interview, to ascertain how rigidly held they might be. On every occasion [Dr F] found that they were not fixed at all, but very variable."

Dr Patton accepts that it is likely [Dr F] made some attempts to clarify certain areas of concern — although this was not well documented — and that the diagnostic conclusions were consistent with the observations recorded. However, he stated:

> "There is however insufficient detail to be fully confident about other possible causes for [Mr A's] presentation, some of which detail may only have become available with discussion with other people."

Documented treatment plan
The treatment plan, as documented by Dr F and RN Ms K, did not specify that the MNT was to monitor Mr A during his time at the Home.

Dr F made no change to the medications charted by Dr I. His written treatment plan constituted a referral to an agency that provides needs assessment and co-ordinates disability services. Dr F recorded that there was "no further role" for mental health services. He informed me that his intention was for no further role for "acute mental health services", not that there be no further support provided to Mr A.

Nurse Ms K documented that Dr F was to meet with Mr A's grandparents and that Mr A could be discharged "as soon as alternative arranged" or his grandparents returned. It was noted that a "message" had been left with the MNT, who were to be

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responsible for contacting Mr A's grandparents. A subsequent note by Ms K confirms the availability of a bed at the Home following MNT member Mr J's enquiry. Ms K also completed a discharge information form for Mr A, noting that Mr J was to liaise with Dr F about meeting with Mr A's grandparents.

Dr F acknowledged that his documented treatment plan was not detailed but submitted that in the context of multidisciplinary care, it was reasonable for him to expect that RN Ms K would record the plan in detail. Dr F acknowledged that it would have been "extremely unwise" to discharge Mr A home without support from the MNT. Dr F explained that Nurse Ms K was responsible for contacting the MNT and arranging Mr A's discharge to the Home, and had documented the "overall plan".

Dr Patton advised me that the file note by Nurse Ms K documented a better management plan in that it identified further contact with Mr A's grandparents (and referred to the need for interim accommodation). Professor Mellsop commented that, given the multidisciplinary context, Ms K's documented treatment plan was "likely to represent a reasonable summary of what was determined in that interview".

Consultation with Mr A's family

Dr Patton considered that a conversation with Mr A's grandparents was an important aspect of the assessment process "to help clarify the nature of [Mr A's] presentation" and explore his view that Mr A had developed heightened affective responses such as diminished sleep and nervousness. Dr Patton stated that appropriate consultation with a patient's family is important before final arrangements for "treatment and disposition" are made. Mr A's historical head injury appears to have influenced the assessments made of him and the views reached as to the cause of his behaviour. In this context it was particularly important to obtain information from Mr A's grandparents about his normal behaviour and mental state.

Dr F acknowledges that further information was required from Mr A's grandparents — and Ms K documented that Dr F was "to meet with grandparents about current issues". Dr F advised me that he had no information about the grandparents' return, and believed there was no reason to retain Mr A as an inpatient in the interim. In addition, Mr A's grandparents were unable to be contacted during his admission.

Involvement of the MNT

Psychiatric Registrar, Dr M recalls that the decision for respite care with follow-up from the MNT was made by Dr F. Nurse Ms K commented that it was a "doctor's decision". In contrast, Ms G recalls that Mr A was transferred to the Home on her suggestion as he did not have the keys to his house. Her MNT partner, Mr J, was not aware that there had been any variation in the discharge plan.

Dr F considered that it was sufficient that the MNT was made aware that Mr A required monitoring, and that further instructions were not necessary as he intended to meet with Mr A's grandparents himself.

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Dr Patton noted that an integrated approach to Mr A's care may have resulted in Dr F being responsible for Mr A's post-discharge care, without there being specific documentation. However, if the ongoing involvement of the MNT was indeed intentional, the role of the MNT should have been specified. In effect, the MNT was responsible for the further assessment of Mr A's mental state but was not "specifically directed to focus on particular phenomena or details". Furthermore, specific instructions should have been given regarding information to be obtained from Mr A's grandparents. Clearer direction to the MNT may have resulted in a more proactive and closer assessment of Mr A's mental state. Dr Patton stated:

> "This is not to suggest that [Dr F] should have undertaken the further assessment directly himself, nor to suggest that [MNT] staff were not skilled professionals and required direction in how to monitor mental state. What I am suggesting is that without prompts to focus on particular areas of concern, a more general instruction to monitor may not lead to inquiry into or review of particular phenomena."

Transfer to respite care
Dr F submitted that, notwithstanding the need to gather further information, respite care was a reasonable and safe alternative given the "low levels of risk identified with [Mr A]". If any significant issues of concern with Mr A did develop, he expected to be immediately notified. Dr F stated that inpatient care is an option of last resort, and keeping Mr A in an environment with acutely mentally unwell people was not in his best interests.

In all the circumstances, Professor Mellsop considered that it was appropriate to discharge Mr A to the Home. Professor Mellsop stated:

> "Taking the mental status observation of [Dr F], and his diagnostic conclusions, as consequences of an imperfectly recorded but possibly adequate assessment, then the discharge of [Mr A] to respite (community based) care would be entirely consistent with much New Zealand practice;
>
> …
>
> As it turned out, the behaviour of all staff in relation to [Mr A's] care, once he went to [the Home], appears to have vindicated the decision to send him there. This includes the view expressed by [Mrs C] on her visit on the evening prior to the tragedy, and the messages that [Mr A] himself was giving to [the Home] staff. This renders the specifics of the tragedy unpredictable in advance."
>
> Dr Patton considered that the Home would generally be considered an appropriate facility for respite care, but the role of the Home is confined to the observation of behaviour, rather than more formal assessment of mental state. Essentially, Dr Patton believes Mr A required a higher degree of monitoring than Dr F could have reasonably expected to occur at the Home. Dr Patton stated:

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> "Having concluded that [Mr A] developed heightened affective responses to normal stimuli, I believe that [Dr F] had a particular responsibility to consider whether the practice of arranging respite was appropriate for [Mr A], and if respite was to proceed how any potentially adverse effects of this further change might be mitigated. The potential for heightened affective response to the stimulus of a new setting should have been one of the things clearly communicated to staff who would be involved in further care."

Conclusion

In summary, Dr Patton considers that there was insufficient information documented in Dr F's assessment to justify his conclusion that there was no evidence of psychotic symptoms. Professor Mellsop agrees that there were deficiencies with Dr F's assessment and treatment plan. Dr F accepts that his assessment notes were "clumsy" but states that he questioned Mr A about his unusual ideas, and found them to "variable", rather than "fixed". Dr Patton agrees that Dr F may have made some attempt to probe and question Mr A although there is no documentation to show that this occurred in any substantial manner. Dr Patton emphasises the importance of fully exploring key phenomena in assessment interviews, owing to the significance of the assessment in determining future treatment.

Overall, I conclude that Dr F's assessment of Mr A on Day 2 was limited. Dr F's role was to undertake a thorough assessment of Mr A. While Mr A may not have been overtly suffering from a "serious" mental illness, and Dr F's diagnostic conclusions were consistent with the recorded behaviour, the lack of detail documented in Dr F's assessment has resulted in considerable doubt about whether Mr A was adequately assessed. I acknowledge that no other member of the multidisciplinary team caring for Mr A was alerted to signs that he was at increased risk of self-harm. However, Dr F was the senior clinician within the multidisciplinary team and was ultimately responsible for decisions about admission, discharge, and the overall direction of treatment. It is most unfortunate, given the circumstances of his subsequent suicide, that it cannot be said that Mr A received an appropriately thorough psychiatric assessment prior to his discharge from the unit.

Quite clearly, the treatment plan, as documented by Dr F, was inadequate, and suggested that Mr A's discharge care was arranged at the initiative of nursing staff. I consider it likely that Dr F did in fact contribute to the discharge planning process. However, the decision to transfer Mr A to the Home, and to have the MNT monitor him was not properly documented. The treatment plan, even as documented in more detail by Nurse Ms K, does not specifically refer to the monitoring of Mr A by the MNT. It was acceptable for nursing staff such as Ms K to document further details, particularly as they arose, but Dr F should have documented his overall plan. Without such documentation by the responsible clinician it is possible that patients will fall between the cracks, despite an understanding having been reached amongst the multidisciplinary team.

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I share Dr Patton's view that much more information was required (from Mr A and from his grandmother) before reaching a final determination about Mr A's care. Mrs C's later advice that her grandson's disinhibited behaviours were highly unusual further emphasises the importance of consulting carers before making a final decision about treatment options. Furthermore, there was no information to suggest that Mr A's grandparents would not return shortly (on Day 1 nursing staff documented that they were "back tomorrow"). In these circumstances, it would have been prudent to make further enquiries about the grandparents' return. Optimally, Mr A would not have been transferred to respite care without some form of consultation with his grandmother.

Dr F was entitled to rely on the MNT, as experienced health professionals, to monitor Mr A. I also acknowledge that Dr F intended to meet with Mr A's grandmother himself. However, in my view, Dr F should have provided further information to the MNT about Mr A, including specific instructions about what further aspects of Mr A's presentation warranted particular attention.

Dr Patton and Dr Mellsop have expressed different views about whether Mr A should have been kept as an inpatient for further observation before decisions were made about his diagnosis and future treatment options. It is questionable whether transferring Mr A to the Home was in Mr A's best interests given the additional stress created by a further change in environment, and the fact that his grandmother was due to return home shortly. If he was to be discharged, there should have been clear instructions given to those responsible for assessing his mental state to be alert to any signs of psychosis, anxiety disorder or any tendency to self-harm.

I appreciate the risk of hindsight and outcome bias in a case like this. I also acknowledge that Mr A was not exhibiting symptoms of a serious mental illness**.** However, in my view Dr F failed his patient at a crucial time when a more careful and cautious assessment could have made all the difference in a young man's life.

In these circumstances Dr F breached Right 4(1) of the Code.

No Breach — Ms G

The service specification documentation provided by the DHB states that the philosophy of the MNT is of early intervention. Therefore, a proactive approach to care and risk prevention is required. Under standard III of the *Standards of Practice for Mental Health Nursing in New Zealand*, Ms G was required to provide collaborative and consultative nursing care that was consistent with therapeutic plan. At the time of his discharge, Mr A was regarded as a low risk of self-harm and had not been diagnosed with a mental illness.

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Registered psychiatric nurse Ms G accompanied Mr A to the Home on Day 2, together with her colleague, Mr J. Ms G and Mr J were staff members of the DHB's mobile nursing team. In this instance, the role of the MNT was essentially to monitor Mr A's behaviour and reassess him if required, particularly if it appeared he was at an increased risk of harm to himself.

Mr J recalls that Mr A appeared more settled than the previous day but continued to "mutter to himself", and (again) expressed concern about the movie *Saw.*[24] Ms G understood that the decision to transfer Mr A to respite care had primarily been made because Mr A did not have his house keys. She recalls Mr A expressing paranoid thoughts. My psychiatric nursing advisor, Ms Lyall, observed:

> "The rationale for placing [Mr A] in respite care at [the Home] [was] sound. The twenty minute journey to [the Home] provided opportunity for [Ms G] to assess and begin to develop a therapeutic relationship with [Mr A]. He was well informed regarding the treatment plan and visits from the [MNT]."

The care of Mr A was handed over to the Home Manager RN Ms D at approximately 3pm. The Home was contracted to the DHB to provide short-term respite care. The handover instructions included Mr J's written advice to "please monitor mental state". Mr J indicated that he regarded it as a situation of "shared care". However, the Home's responsibilities did not extend to the interpretation or assessment of mental state. The Home was to report any unusual behaviour on Mr A's part, but staff were not qualified or expected to undertake a formal role in assessing his mental state.

Ms Lyall explained that in practice, a degree of reliance must be placed on respite care staff to assess a patient's mental state, and they are well placed to do so. This seems logical, but careful consideration must be given to whether a resident's behaviour warrants reassessment after consultation with respite care staff.

The MNT planned to assess Mr A daily. Ms G visited Mr A on Day 3. Ms D informed her of Mr A's inappropriate sexual behaviour but explained that it was easily managed, and there were no apparent safety concerns. Ms G left without properly speaking to Mr A as he was in the shower and apparently did not want to talk to her. Ms G contacted Mr A's grandmother in the early afternoon and informed her of Mr A's whereabouts and the care plan. Ms G did not inform Mrs C of Mr A's disinhibited behaviour (apparently because of her concern not to upset Mrs C further). Later in the day, Ms G obtained a verbal assurance from Ms D that Mr A was not suicidal and did not plan to leave the Home again. It was then agreed that 15-minute observations of Mr A would be undertaken, and if there were any further concerns after Ms G had finished her shift, Ms D would contact the crisis team. Ms G alerted the crisis team to possible concerns about Mr A, and readmission to the unit was to be considered if Mr A's safety became an issue.

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[24] See page 4 above.

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Ms Lyall considered that the communication between Ms G and Ms D was of a high standard with no apparent hesitation on the part of either party to contact each other.

Dr Patton, in contrast, expressed concern at the level of reliance Ms G placed on Ms D, rather than assessing Mr A in person. However, he also noted that the MNT was given no specific instructions by Dr F about Mr A. Dr Patton stated:

> "In my view, ongoing monitoring of [Mr A's] mental state was necessary. This role appears to have been [MNT] staff responsibility, but no explicit direction was provided to the [MNT] about this, perhaps contributing to the relative lack of assertiveness in their efforts to see [Mr A] at [the Home]. Clear direction may have resulted in them insisting on seeing [Mr A] each day and in reviewing closely with him and with staff the reasons for his apparently disinhibited behaviour at the respite facility.
>
> …
>
> Whilst I remain concerned that there should have been a more assertive approach taken by the [MNT] to reviewing [Mr A] and that these staff should have exercised greater professional judgement independent of any assessment by [Dr F], their failure to act in such manner appears in part to have been caused by transmission to them of a view that only social support was necessary for [Mr A]."

I have been left with some disquiet about whether Ms G was sufficiently proactive in her care of Mr A. In particular, the development of sexualised behaviour was a new symptom that required consideration and may have been a sign of increased risk of self-harm. Optimally, Ms G should have assessed Mr A in person on Day 3 rather than relying on Ms D — although I note that this would not necessarily have resulted in Mr A's readmission to the unit. I also query Ms G's decision not to inform Mrs C about Mr A's disinhibited behaviour. One of the key failings in Mr A's care was the lack of consultation with his family, particularly *prior* to his discharge from the unit. However, Ms G did take steps to initiate a meeting between Mrs C and Dr F, which would have provided the opportunity for a more in-depth consultation. Ms G remained in close contact with Ms D throughout the day and was fully informed of developments. Ms G amended the care plan and notified the Crisis Team of possible concern about Mr A's safety. In addition, Ms G had received no information from Dr F to alert herself to any particular concerns about Mr A's safety. Overall, I consider that the care provided to Mr A by Ms G was adequate and consistent with therapeutic plan.

Accordingly, in my opinion Ms G did not breach Right 4(2) the Code.

No breach — Ms D and the Home

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As noted above, the role of the Home was to provide Mr A with interim supported

accommodation prior to the return of his grandparents. This included the observation of Mr A's behaviour, but not assessment of his mental state. Manager and registered nurse Ms D had primary responsibility for Mr A's care. My nursing advisor, Ms Lyall, commented:

> "[Ms D's] position as nurse manger was to ensure that the care provided followed the memorandum of understanding by the provision of: a safe, supervised therapeutic environment; daily living skills assessment and assistance if required. It is clear from the supporting information that the respite provider does not provide clinical treatment; they follow the plan from mental health services."

Ms D completed two incidents reports concerning Mr A on Day 3. The first concerned his inappropriate disinhibited sexualised behaviour. The second concerned Mr A leaving the Home. Both these incidents were reported to Ms G. Ms D also spent some time in discussions with Mr A and was reassured by Mr A that his behaviour would improve, and that he would not continue to leave the premises.

Ms Lyall noted that Ms D did not hesitate in contacting the MNT to discuss her concerns about Mr A as they arose. Overall, Ms Lyall considered that the care provided by Ms D was "adequate and appropriate".

Ms Lyall commented:

> "[The Home] provided adequate and appropriate care to [Mr A] by following their memorandum of understanding to provide respite services. Staff were diligent in liaising with [MNT] staff and in their care of [Mr A] who was staying there voluntarily."

I am satisfied that Ms D and the Home provided appropriate care to Mr A. Ms D managed Mr A's inappropriate behaviour appropriately, and reported her concerns to Ms G in accordance with the memorandum of understanding.

Accordingly, Ms D and the Home did not breach the Code. Ms D is to be commended for her courageous attempts to assist Mr A prior to his death.

No breach — The District Health Board

On Day 1 Mr A presented in a distressed state to the psychiatric unit at Hospital. In accordance with the DHB policy, he was told to attend the Emergency Department (ED) for assessment.

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My expert psychiatric advisor, Dr Patton, considered Mr A's referral to ED was appropriate, although he noted that it was unclear whether any arrangements were made to facilitate Mr A's transfer to ED. He explained:

> "Psychiatric inpatient services typically are not staffed to provide the observation or extra-assistance that might be required by someone pending assessment and may not have suitable dedicated facilities for waiting or for the assessment itself, which may have characteristics different to that required for the ongoing work of the inpatient service."

On Day 1 Mr A was seen by Emergency Department house officer Dr H, who considered that due to Mr A's paranoid and disjointed thought patterns he might be experiencing a psychotic episode. Dr H also noted that Mr A was afraid he would hurt himself.

Mr A was then reviewed by psychiatric registrar Dr I, who considered that Mr A was not paranoid or delusional but was experiencing a "situation crisis" while his grandparents were away on holiday, and his ability to copy with stress was compromised by his head injury. Dr I thought that Mr A's "fleeting" suicidal thoughts were not expressed with any intention, but that he did require hospital admission. She documented a plan of admitting Mr A to the acute mental health unit and referring him to the mobile nursing team on discharge.

Mr A was seen by [MNT] psychiatric nurse Mr J, before his admission to the acute mental health unit. Mr J considered that Mr A was exhibiting persecutory ideas, poor judgment and anxiety. (According to Mr J, the decision to admit Mr A was made after he spoke further to Dr I.) That afternoon and overnight on the ward, Mr A was noted to have "fleeting" thoughts of self-harm, disorganised thinking, anxiety and a degree of paranoia.

Dr Patton advised that the relevant policy and procedure documentation was appropriate, and there was general adherence to the relevant procedures. However, he was somewhat critical of the level of detail in Mr A's treatment plan. Dr Patton noted that the policy documentation requires that a treatment plan will be based upon a "comprehensive assessment". He considered that there may have been an inadequate assessment of Mr A's report of physical symptoms in ED, and the rationale for inpatient care was not clearly documented. He stated:

> "It is my view that there were a number of inadequacies in the assessment of and care provided to [Mr A]. Although assessed on several occasions by medical staff, each single assessment was deficient in exploring the symptoms with which he presented. Even with all the information put together from these assessments, there were still gaps in the information available. Whilst some of these gaps may have been contributed to by difficulties [Mr A] was experiencing that prevented him from giving a full and coherent account, this added particular importance to the gathering of additional information from other people and to repeated

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observations over a short period of time. In my view, a period of observation in hospital of just over 24 hours was not sufficient for that purpose."

My nursing advisor, Ms Lyall, considered that the care provided to Mr A by the DHB was appropriate. She stated:

> "The assessments carried out at the Emergency Department and [the Unit] were completed in a timely manner and were comprehensive. During [Mr A's] time at the hospital he was assessed twice before his admission to the unit. One of these assessments was carried out by the on-call psychiatric registrar. He was seen again in the in-patient unit, two doctors undertook this assessment. He was also monitored and assessed by nursing staff during his stay on the ward. At no time were there documented concerns for [Mr A's] safety.
>
> The team responsible for [Mr A] during this time acted responsibly and appropriately in arranging respite care until his living situation could be clarified."

In some respects there was a lack of detail in Mr A's assessments and treatment plans. The information deficits may have contributed to a minor degree to Dr F's assessment that no mental disorder was present. However, the purpose of Mr A's admission was to allow for a more detailed assessment of his needs. Unfortunately, Mr A was not admitted for long enough for a full assessment of his needs to occur. Although the assessment of a patient involves a multidisciplinary approach, Dr F was primarily responsible for the treatment decisions in relation to Mr A.

Overall, I consider that the DHB provided appropriate care to Mr A, and did not breach the Code.

Vicarious liability

In addition to any direct liability for a breach of the Code, an employing authority may be vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for any breach of the Code by an employee. Section 72(5) affords a defence for an employing authority if it took such steps as reasonably practicable to prevent the act or omission in question. Dr F was an employee of the DHB, and therefore the issue of vicarious liability must be considered.

The DHB had policies in place regarding treatment plans, referrals and crisis respite care. Dr Patton advised that, with the exception of the memorandum of understanding with the Home, the policies are "appropriate and reasonable in their purpose and content". Having considered the policies in place and the nature of Dr F's breach of the Code, I conclude that the DHB took reasonable steps to prevent the acts and omissions in question. Overall I consider that the DHB is not vicariously liable for Dr F's breach of the Code.

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Other comment

Ms Lyall considered that the documentation of Mr A's care at the Home was of an adequate standard. She stated that it provided a "clear and concise rationale" for the treatment decisions made. However, she noted that there was no record of the 15-minute observations that Mr A was placed on at the Home.

I acknowledge that the system of observation at the Home was relatively informal. However, without any corresponding documentation, it is unclear precisely what occurred. There was also no record made of Ms D's conversation with Mr A (on Ms G's instruction) about whether Mr A felt suicidal. This was significant clinical information that should have been recorded. I recommend that Ms D review her documentation practice and ensure that all significant clinical information is recorded.

Actions taken

The Home has reviewed its procedures in relation to accepting respite care referrals. The referring practitioner now completes an admission form before respite care is agreed to. Previously, these forms were completed by the MNT at the time of arrival and after discussion. The form requests details about a person's history, behaviour and risk assessment. Only after reviewing the written referral information will the Home then accept the referral.

Recommendations

I recommend that Dr F take the following actions:

- review his practice in light of my report with a particular focus on improving his clinical judgement skills. Dr F should also ensure that he fully documents the rationale for his clinical decisions, and that a clear management plan is recorded; and
- apologise to Mr A's family for his breach of the Code.

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Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand with a recommendation that it undertake a review of Dr F's competence to practise psychiatry.
- A copy of this report will be sent to the Nursing Council of New Zealand.
- A copy of this report will be sent to the Director of Mental Health and the Royal Australian and New Zealand College of Psychiatrists.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.