MidCentral District Health Board

Registered Nurse, RN D

Registered Nurse, RN E

Registered Nurse, RN F

District Health Board

A Report by the

Mental Health Commissioner

(Case 18HDC00301)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report considers the care provided to a man by a number of clinicians across two district health boards (DHBs). A number of deficiencies in the care provided to the man meant that he did not receive the comprehensive mental health assessment that he required, and multiple opportunities were lost to identify the extent of his illness and access timely, appropriate treatment.

2. The man became unwell while working in a remote location and was taken to be seen by MidCentral DHB's Acute Care Team (ACT). He was assessed by mental health nurses RN D and RN F. The man then returned home to his family. His mother was concerned about his well-being and rang the Crisis Assessment and Treatment Team (CATT) (based in another town in a different DHB (DHB2)) and spoke with mental health nurse RN E. The man's mother took him to the Emergency Department (ED) that evening, and ED clinicians referred him to CATT. RN E spoke with the man's mother, but did not speak with the man directly. A plan was made for the man to return home with a sleeping tablet and to be seen by CATT in the morning.

3. Tragically, early the next morning, the man died of suspected suicide.

Findings

MidCentral DHB

4. The Mental Health Commissioner considered that ACT clinicians did not ensure that the man received an adequate mental health assessment, and that the subsequent management plan was inadequate. In the Mental Health Commissioner's view, MidCentral DHB was responsible for these failures, and MidCentral DHB was found to have breached Right 4(1) of the Code.

RN D and RN F

5. The Mental Health Commissioner was critical that both RN D and RN F did not ensure that the man received a comprehensive assessment of his mental health.

RN E

6. The Mental Health Commissioner had serious concerns about RN E's clinical decision-making. Specifically, she did not seek to assess the man's mental health status when she first spoke to his mother; she did not assess or speak with the man at any stage; her safety plan was developed in the absence of an adequate assessment of the man's mental health, in the context of a known suicide risk; she did not consider herself responsible for the safety plan she developed; and she dismissed concerns from a colleague. The Mental Health Commissioner found that RN E breached Rights 4(1) and 4(2) of the Code.

DHB2

7. The Mental Health Commissioner was critical that the mother's initial telephone call to CATT was not documented, and that at the time of these events the DHB was insufficiently equipped to respond appropriately to acute mental health presentations to ED overnight.

Recommendations

MidCentral DHB

8. The Mental Health Commissioner recommended that MidCentral DHB provide HDC with an update on the results of its review of both its documentation and the training and development needs of the clinicians who work with the ACT; provide training to ACT staff on mental health assessments of out-of-area consumers who are unknown to the service; and provide an apology to the family with input from RN D and RN F.

RN E

9. The Mental Health Commissioner recommended that RN E provide a reflective statement on the changes to her practice as a result of these events; provide evidence of her training on the assessment, management, and care of a consumer who presents with suicidal ideation; and provide an apology to the family.

10. The Mental Health Commissioner also recommended that the Nursing Council of New Zealand consider whether a review of RN E's competency, fitness to practise, and/or conduct is warranted.

DHB2

11. The Mental Health Commissioner recommended that DHB2 undertake a review of the effectiveness of its structural changes to CATT; review its policy on suicidal presentations to ED; use this report as a basis for training and reflection for CATT staff; and provide an apology to the man's family.

Complaint and investigation

12. The Health and Disability Commissioner received a complaint from Mrs B about the services provided by MidCentral District Health Board and by DHB2 to her son, Mr A. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr A by MidCentral District Health Board in 2018*
- *The appropriateness of the care provided to Mr A by RN D in 2018.*
- *The appropriateness of the care provided to Mr A by RN F in 2018.*
- *The appropriateness of the care provided to Mr A by RN E in 2018.*
- *The* appropriateness *of the care provided to Mr A by DHB2 in 2018.*

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

14. The parties directly involved in the investigation were:

Mrs B	Complainant/consumer's mother
Mr B	Complainant/consumer's father
Ms C	Complainant/consumer's sister
MidCentral District Health Board	Provider
DHB2	Provider
RN E	Registered nurse/provider
RN D	Registered nurse/provider
RN F	Registered nurse/provider

15. Further information was received from:

RN G	Registered nurse
RN H	Registered nurse
Dr I	Emergency Department consultant
Ms J	Social worker
The Coroner	

16. Also mentioned in this report:

Mr K	Mr A's supervisor
Mr L	RN G's mentor
Mr M	Clinical Nurse Director

17. Independent expert advice was obtained from a registered nurse, Dr Anthony O'Brien (Appendix A).

Information gathered during investigation

Background

18. Mr A, aged in his forties at the time of events, had been previously diagnosed with Asperger syndrome[1] and had taken antidepressants in the past. Mr A's GP stated that at the time of events, Mr A had no recent history of mental health issues or depression. He worked on a ten days away, five days at home shift pattern. Mr A lived with his parents.

[1] Asperger syndrome is an autism spectrum disorder that is characterised by impaired social interaction, by repetitive patterns of behaviour and restricted interests, by normal language and cognitive development but poor conversational skills and difficulty with nonverbal communication, and often by above average performance in a narrow field against a general background of impaired functioning.

Morning of Day 1[2]

19. On the morning of Day 1, Mr A was out of town for work. The trip had been terminated early because of concerns that Mr A was unwell. Mr A's supervisor, Mr K, met Mr A at their employer's office. They returned to Mr K's house for several hours, during which time Mr A told Mr K that he was suicidal. It was then decided that Mr K would take Mr A to Hospital 1 for a mental health assessment.

Assessment by MidCentral DHB

20. At approximately 1.30pm, Mr A presented with Mr K at Hospital 1 to be seen by MidCentral DHB's Acute Care Team (ACT). Mr A was given a mental health self-assessment form to complete. Mr A wrote in the form that he had suicidal ideation, muddled thoughts, and anxiety/panic attacks, and that he felt sad, was stressed, and was not coping with daily tasks. He wrote that he had been feeling this way for the past ten days. He also confirmed that he had thought that life was not worth living and of harming himself. Mr A did not respond to the question in the form about whether he was then currently thinking of suicide.

21. Mr A was seen by two ACT registered nurses, RN F and RN D, along with a student nurse. RN D told HDC that the day had been very busy and demanding, and ACT had no prior notice that Mr A would be presenting for an assessment. RN F also noted that RN D, the Clinical Coordinator of ACT, was assisting the team that day in his capacity as psychiatric nurse to meet the demand for crisis intervention.

22. During his assessment with RN F and RN D, Mr A reported feeling stressed and having intrusive thoughts in that he was looking at women in an objectifying manner. Mr A also said that he had been having fleeting thoughts of suicide. He mentioned having considered various means of suicide but denied suicidal intent. RN F documented that Mr A's mood was euthymic[3] with congruent affect.[4]

23. RN F noted that Mr A reported strong protective factors, including his family, pets, and work. She also noted that Mr A's eyes remained closed for most of the assessment, and she questioned whether this was linked to his reported tiredness. She told HDC that Mr A was not able to identify any previous incidents that may have led to his belief that he was objectifying women, and also noted that Mr A did not appear to be distressed or preoccupied by this belief during the assessment.

24. MidCentral DHB told HDC that Mr K said that he was not aware of Mr A having any previous psychiatric history, and that a nationwide search did not reveal any previous contact by Mr A with mental health services in New Zealand. In response to the provisional opinion, RN D and RN F told HDC that the fact that Mr A had been diagnosed with Asperger syndrome previously and had taken antidepressants in the past (as noted in

[2] Relevant dates are referred to as Days 1–4 to protect privacy.
[3] A normal, tranquil mental state or mood.
[4] The mood or emotional state is congruent or in agreement with the situation.

paragraph 18 above) was not available to them at the time. They stated that Mr A denied, and Mr K did not know of, any mental health history.

25. RN D and RN F also told HDC, in response to the provisional opinion, that they were not aware that Mr A's work trip had been terminated early because of concerns that Mr A was unwell. They stated that Mr K told them that the reason they had presented to Hospital 1 was because "he wanted [Mr A] seen, to see if everything was alright for the trip home".

26. RN F told HDC that Mr A denied current thoughts of suicide. She said that they confirmed this with him at least three times, noting that he had reported suicidal ideation in the self-assessment form. She added:

> "[Mr A] also stated that he would not act on his suicidal thoughts due to how it would affect his family, and identified that returning [home] to his family would be most helpful at this time."

27. RN D told HDC that Mr A presented well and engaged readily with the assessment. RN D noted that Mr A had experienced suicidal ideas previously and had "coped with them" and had never carried out any attempts. RN D further stated:

> "As the suicidal ideas experienced before the two weeks working away, included method and planning, it was felt that the more passive ideas during the two weeks [working away from home] indicated less of a risk."

28. RN D told HDC that the context of his and RN F's involvement with Mr A was a brief assessment supporting him to return to his home, which he had identified as the safest place for him and where he wanted to go. RN D stated that it was not intended to be a full assessment.

29. RN F told HDC that following the assessment with Mr A, she, RN D, and the student nurse stepped out of the room to discuss their assessment. RN F said that she and RN D agreed that Mr A was at a low risk of harming himself. They returned to the assessment room and discussed their clinical judgement with Mr A, who agreed with their assessment and the plan to return home to his family. RN F documented their assessment that Mr A was at low risk of harming himself or other people, and the plan for Mr K to drive Mr A back home and for Mr A to see his GP the following day.

30. RN D told HDC that he discussed the assessment and plan with the on-duty psychiatric registrar, who did not raise any issues in relation to the assessment or plan. The assessment of Mr A's case was also discussed at the ACT multi-disciplinary team (MDT)[5] meeting the following day, in accordance with ACT's standard process. RN F told HDC that those present at the MDT meeting agreed with the assessment and plan.

[5] Present at the MDT meeting were the Mental Health and Addiction Service Medical Lead, as well as a doctor, a Clinical Nurse Specialist, the Clinical Manager, RN D, and RN F.

31. MidCentral DHB told HDC:

> "There were no presenting factors identified at the time of the assessment to indicate that he should be admitted for care in [Hospital 1]. If [Mr A] had declined an admission it was very unlikely compulsory treatment could be legally supported."

32. After these events, MidCentral DHB completed a Triage Review into the assessment of Mr A and the subsequent plan. The Triage Review Report (TRR) noted the following issues:

- There was no record of the discussion of Mr A's case at the MDT meeting.
- No follow-up phone call was made to Mr A to confirm that he had made arrangements to see his GP.
- There was no evidence in the assessment that consideration was given to discussing the risks and safety plan with Mr A's family.
- There was a lack of clarity around why/when ACT asks consumers to make their own GP appointments rather than ACT proactively organising GP appointments for consumers.

Mr A's return home

33. Mr K drove Mr A back home that afternoon. Mrs B told HDC that Mr K rang to let her know that they were on their way.

34. Mrs B then rang DHB2's Mental Health and Addictions Service (MHAS) Crisis Assessment and Treatment Team (CATT) (based in Hospital 3).[6] While there is no record of this telephone call, or of the person to whom Mrs B spoke, DHB2 told HDC that Mrs B rang CATT between 2pm and 4pm that afternoon. DHB2 told HDC that during the telephone call, Mrs B was "reassured that CATT would assess her son upon his arrival [home]".

35. Mrs B told HDC that Mr A arrived home at approximately 7pm that evening. She said that he was dehydrated and she gave him food and water.

36. Mrs B then rang CATT again. This time, she spoke with Community Mental Health Nurse RN E. That evening, RN E was working in CATT alongside RN G and a social worker, Ms J.

37. RN E documented that Mrs B told her that Mr A had returned home early from a work trip owing to his colleagues' concerns about his confused state. RN E also noted that Mrs B was concerned that Mr A was disoriented, was rambling and unable to speak in full sentences, was repeatedly apologising, and could hardly keep his eyes open. RN E told HDC that Mrs B did not mention that Mr A had any form of suicidal ideation. RN E stated: "The nature of the call was totally directed at a medical type issue … There was nothing to indicate to me that there was a mental health issue at play …"

38. RN E advised Mrs B to take Mr A to the Emergency Department (ED), noting: "[Mr A] may be severely dehydrated and confused — if he is medically stable then CATT have agreed to assess." However, RN E told HDC that this note leaves out "an important pre-condition in

[6] At the time of events, CATT was solely based at Hospital 3.

what was expressed, being that this CATT assessment would only be if the ED staff considered that a CATT assessment was warranted".

39. RN G told HDC that no call was made to ED to advise them of Mr A's impending visit.

Assessment in ED

40. Mrs B, Mr A, and Mr A's sister arrived at Hospital 2 ED at 8.20pm. RN H completed a triage assessment of Mr A, noting that his presenting complaint was suicidal ideation. RN H recorded the following examination notes:

> "[Brought in by] Mum & sister [with history] of suicidal ideation over the past few days. Feelings of worthlessness ↑ & afraid of looking at people. Mum concerned re: [patient] safety."

41. RN H told HDC that during the assessment, Mr A was speaking calmly and logically but expressed feelings of worthlessness, a wish to die, and "not wanting to be here". She stated that both Mr A's mother and sister were concerned about Mr A's safety. Mr A kept his eyes closed throughout RN H's assessment.

42. Following completion of the triage assessment, RN H informed ED consultant Dr I of Mr A's arrival and his reason for presentation. Mr A and his family waited in a private room until they were seen by Dr I at approximately 10.10pm.

43. Dr I retrospectively recorded his assessment notes at 2.45am on Day 2. He wrote: "[Mr A] 'thinks it would be better for everyone if he was dead' and he seems resigned to the fact that he is going to die." Dr I further noted that while Mr A had no fixed suicidal plan, he had mentioned methods that were available to him. Dr I assessed Mr A as having a moderate suicide risk, and noted: "[Mrs B] not happy to take him home as feels risk of suicide high."

44. Dr I told HDC that he was unaware of Mr A's presentation to MidCentral DHB that day. He also stated that Mrs B said that CATT were aware of Mr A's presentation, but that ED had not been informed that Mr A was expected to attend.

ED referral to CATT

45. Dr I rang CATT at approximately 10.20pm and spoke with RN E. RN E recorded the following notes about this conversation:

> "[Dr I] advises that [Mr A] has been medically cleared and would like CATT to assess his suicidal risk as is voicing suicidal ideation …"

46. Dr I told HDC that he told RN E that Mr A should be admitted to the Mental Health Unit in Hospital 3 overnight, and have a psychiatric review in the morning. Dr I further stated:

> "I was expecting a CATT review to be performed in [Hospital 2] ED that evening. … I was informed that admission may not be required but that the CATT member would make their own assessment. I was comfortable with this."

47. RN E told HDC that Dr I told her that he wanted CATT to assess Mr A's suicide risk. She said she was told that Mr A wanted to see a doctor and could come to Hospital 3 with family support. RN E stated that she told Dr I: "We had staff working long hours and extra shifts and that I would have to work out how we would respond." She told HDC that she was concerned about staff fatigue, and understood that thunderstorms had been forecast for the Hospital 2 area.

48. RN E also told HDC that following the telephone call with Dr I, she saw a note that the CATT vehicle had been booked in for repairs. She said she then inspected the car and saw that "the front bumper was hanging off, and it looked unsafe to drive". She stated: "I immediately contacted the duty manager to arrange alternative transport." RN E told HDC that a new car became available at approximately 11.30pm.

49. DHB2, however, disputed that the car was not roadworthy. It told HDC that the car had been used to attend the police station earlier that evening, and that the damage was only a superficial scratch to the bumper. DHB2 stated that the CATT car was always available. DHB2 confirmed that RN E reported to the Duty Manager that the car was damaged, but stated that an alternative car was made available immediately. DHB2 further stated: "In essence at no point during that duty did the CATT not have access to a DHB car that they could have utilised."

50. RN G told HDC: "The CATT car was available for use on [Day 1] and I am baffled by [RN E's] request to the duty manager."

51. RN G also told HDC that she was out of the room for five to ten minutes when Dr I spoke to RN E. However, RN G said that she spoke to RN E after the telephone call with Dr I. RN G stated:

> "[RN E] tells me that [Dr I] was panicking and demanding that CATT go down and assess [Mr A]. … [RN E] reported to me that she had told them that we were busy and that we were unable to attend. Her attitude was dismissive and [RN E] was actually joking saying that she had told them we were busy and that we had no vehicle. [RN E] continues and reports that [Dr I] had told her that the mother [Mrs B] was scared to take [Mr A] home as she had never seen him like this."

52. RN E, however, stated that she was not told that Mrs B was not happy to take Mr A home because Mrs B felt that his risk of suicide was high. Dr I cannot recall whether he told RN E this.

RN E's call with Mrs B

53. After obtaining Mrs B's telephone number via RN H, RN E rang Mrs B. RN E said that Mr A and his sister were in the background listening to the conversation, and she could hear them providing input to Mrs B. RN E stated:

> "In light of my understanding that [Hospital 2] ED was busy, and also our own difficulties in getting to [his town], I canvassed with [Mr A's] mother the possibility of her looking after [Mr A] if he was discharged from [Hospital 2] ED."

54. RN E said that Mrs B was comfortable to do this with the support of her daughter. RN E said that she also relayed this plan to the social worker, Ms J, who agreed with it.

Safety plan relayed to ED

55. RN E then rang the ED to speak to Dr I, but he was unavailable, so instead she spoke with RN H. RN E advised RN H that the plan was for Mr A to go home with his family, where he was to take a sleeping pill that Dr I was to prescribe. RN H said that she was advised that the CATT team would arrange for Mr A to see a psychiatrist the following morning, and that CATT could complete a home visit if the family had any concerns overnight.

56. RN E stated:

> "It was ultimately not my decision to rely on this safety plan. That decision was made by the staff who did have the face to face interaction with [Mr A] and his family. If there was any concern on their part, they could have contacted the CATT service again. Indeed, I had anticipated that I would receive a call to discuss whether the safety plan that I had constructed with the family was safe to be implemented. That call never occurred …"

CATT discussion about safety plan

57. RN E recalled that RN G was not present when she spoke to Mrs B. RN E stated that RN G came back into the room later and told RN E that she thought that Mr A was suicidal, and offered to drive there to assess him. RN E said she explained that the safety plan in place had been agreed to by ED staff and Mrs B. RN E further stated that "it was clear [RN G] was unhappy with my decision".

58. However, RN G told HDC that she heard RN E speaking with Mrs B. RN G said that she did not hear RN E ask to speak to Mr A at any time, and that "the other option given to [Mrs B] was that she could bring him to [Hospital 3] for assessment". RN G stated that given that there was clearly some heightened anxiety from ED staff about Mr A's safety, she offered twice to drive to Mr A's home town. She said that RN E declined both times.

Mr A discharged

59. Dr I told HDC that RN H advised that Mr A was to be discharged home with the close supervision of his family, and that he would have face-to-face mental health review in Hospital 3. Dr I said that he was asked to prescribe a single zopiclone for Mr A, which he did.

60. DHB2 told HDC that when Dr I was advised of CATT's plan for Mr A:

> "[Dr I] believed that was reasonable and he was under the impression that the CATT team had based their clinical judgment to discharge on an appropriate assessment. … ED clinicians will consider the safety plans made by other clinical teams prior to discharge from the ED. However, it is uncommon to make an in depth assessment of the other specialist team assessment because there is some reliance on the specialist

team to make an appropriate clinical assessment and formulate an appropriate and safe management plan."

61. Mr A was discharged on Day 1 at approximately 11.20pm. An ED nurse wrote in the clinical notes that Mr A had been given a zopiclone, and that his family was happy to take him home. However, Mrs B told HDC:

> "We were not happy to take [Mr A] home at any stage of that horrible night, we were only offered bad options and although I kept saying that [Mr A] was not safe I was ignored.
>
> …
>
> All we needed was to be given time to access psychiatric care. For us to have taken him home with a single sleeping pill (which has a five hour life) was a totally inadequate response."

Subsequent events

62. Tragically, Mr A died of suspected suicide on Day 2.

Further information

CATT staffing and support

63. RN E told HDC that she had been asked to work two extra shifts (on Day 1 and Day 2), after having already worked her usual four shifts on the previous five days. She stated that, ordinarily, Ms J would take the lead CATT role given that she was considerably more senior than RN E. However, Ms J came in late that evening. In response to the provisional opinion, DHB2 told HDC that it does not support RN E's statement that Ms J was more senior than her. DHB2 said that Ms J had worked in CATT longer than RN E, but Ms J's mental health experience was considerably less than that of RN E.

64. RN E acknowledged that she had the material interactions relating to Mr A, but said that she was not leading the CATT team that evening. RN E stated that at the time, she understood that RN G was a first-year postgraduate nurse and not a Duly Authorised Officer, and was therefore considered "supernumerary"[7] and "had a limited clinical role". RN E commented: "I found this unhelpful and unsafe given [Ms J] was not there to support the shift initially." In response to the provisional opinion, DHB2 told HDC that it does not accept RN E's statement implying that RN G was not there to support RN E. DHB2 stated: "All staff that evening were expected to engage in clinical work."

65. DHB2 told HDC that RN G was not supernumerary, and "was a fully operating Registered Nurse". DHB2 stated that RN E led all the clinical decisions around the care of Mr A from a mental health perspective. It also stated that CATT was supported by an on-call registrar and consultant psychiatrists, an on-call service manager, and an on-site duty manager. DHB2 stated: "None of which were called by [RN E] to support her decision to discharge [Mr A]."

[7] In excess of, or in addition to, regular staff.

Mrs B

66. Mrs B told HDC:

> "Hindsight in a situation like this is a terrible thing. But I believe that if they had treated him in [Hospital 1] or taken him by ambulance to [Hospital 3] and had admitted him to the mental health ward, he would still be alive. We were never offered either of these options. I believe that for mental health conditions, the [Hospital 2] and [Hospital 3] systems are flawed. If [Mr A] had presented with a broken arm or leg, he would have got assistance."

67. Mrs B also told HDC that the receptionist and nurse they saw at Hospital 2 ED were very caring and professional.

MidCentral DHB

68. MidCentral DHB told HDC that it has made the following changes as a result of these events:

- ACT has strengthened its planning processes with consumers by introducing a Crisis Resolution Plan, which is created and discussed with the consumer and signed by the consumer and any attending support person.
- It implemented an "Out of Area Protocol: Assertive Follow up of Clients Post Assessment". Where ACT sees a consumer whose normal place of residence is outside the MidCentral DHB area, this protocol requires clinicians to make telephone contact with future mental health providers, the consumer's GP, and the consumer's self-identified support people to provide relevant clinical information.[8]
- It has amended its Crisis Assessment Form to include prompts to ensure that key points related to mental status examination are attended to, that a crisis resolution plan is completed, and that discussions with the consumer's family are described. RN D was directly involved in the review of the Form.

69. MidCentral DHB further stated that it will review both its documentation and the training and development needs of the clinicians who work with the ACT, with an emphasis on mental health assessment and formulation of treatment plans.

RN D

70. RN D told HDC:

> "[I] acknowledge the loss of [Mr A] to his family, especially his mother. As a parent myself, I can understand the extreme anguish and sorrow that would come with the loss of a much loved son as [Mr A] was to his family. I can also understand the need for family to understand why this happened, as I have also asked myself the same question."

[8] Timeframes for making contact with these parties vary depending on ACT's assessment of the consumer's level of risk. The higher the level of risk, the more quickly the information will need to be provided.

RN F

71. RN F told HDC that since these events she has completed further study with a focus on quality improvement in mental health settings, among other topics. She further stated:

> "I also acknowledge the need for the family to understand why this happened, as I have also thought on this for some time; and wish to express my sincere condolences to [the family], and [the wider community and Mr A's employer]."

DHB2

Root Cause Analysis

72. DHB2 provided HDC with a copy of its Root Cause Analysis (RCA) into the events. The RCA stated:

> "… [T]he RCA team would have expected the team to travel to [Hospital 2] and carry out the assessment as requested by the ED doctor. To date no valid reason has been provided to account for this non-attendance."

73. The RCA noted that the events took place three weeks before changes to the structure of CATT (which had been planned prior to these events). As a result of these changes, a CATT team member is now situated in Hospital 2 ED during the evening unless they have been called out to the community. The RCA also noted that, at the time, video conference equipment was set up at Hospital 2 ED but was not able to be used after hours. However, DHB2 has changed this so that CATT can now assess patients in ED remotely if required.

74. The RCA also commented on the possibility of implementing a screening tool to support ED staff in their decision-making. The RCA notes that when applied retrospectively, the SAD PERSONS assessment tool[9] would have rated Mr A's risk as low.

Position description

75. DHB2's position description for Mental Health Registered Professional (which includes registered nurses, social workers, and occupational therapists) includes the expectation that staff practise "[s]afe quality assessment, care and treatment planning including the use of acute alternative facilities or home based treatment options".

RN E

76. RN E told HDC:

> "I have reflected a lot over this incident and obviously sincerely regret not assessing [Mr A] that night. Had I had any impression that the risk of him committing suicide was not being adequately managed, I certainly would have assessed him. However, I weighed the risks as best I could at the time weighing all of the relevant risks including risks to myself. I would continue to do that."

[9] The SAD PERSONS acronym highlights risk factors for suicide and self-harm.

77. She also stated:

> "[I]t was common for patients to be held in the emergency department in Hospital 2 until a mental health assessment could occur, and that [Hospital 2] ED staff had not previously expressed an issue with having patients stay when necessary. … At all times until the assessment occurs, the decision as to whether the patient left or not remained that of the ED staff."

RN G

78. RN G told HDC:

> "I knew not seeing [Mr A] was the wrong thing to do, and even riskier that we had no previous history. I suppose when you have two senior clinicians who have no value for your voice as a junior nurse can lead to decisions being made for you. I think of how I could have done something better, or even differently that may have eventuated in keeping [Mr A] safe. This loss will impact forever on the decisions I make in my future practice."

79. RN G also told HDC that she spoke with her mentor, Mr L, after the shift ended, at approximately 12.30am on Day 2. DHB2 provided HDC with notes from an interview with Mr L by the Clinical Nurse Director of DHB2's Mental Health and Addiction Services, Mr M. Mr M's notes record that Mr L told him:

> "[RN G's] main concerns when she spoke to me were the lack of response from our CATT team, the active delaying of work appeared to be avoidance. Finally — it was about the idea of them being too busy to complete the assessment but that they were not busy at all — that upset [RN G]."

Ms J

80. Ms J told HDC:

> "The resourcing of the CATT team inevitably [led] to unsafe working hours for staff and the regular travel required to undertake crisis assessments in the [Hospital 3 area], which included driving. This has, at times, included the inability of [DHB2] after hours Duty Managers to find alternative staff e.g. hospital attendants, healthcare assistants or other, who can drive fatigued staff who have identified that it is unsafe for them to do so, particularly when travel is required."

Reponses to provisional opinion

81. Mr B and Ms C, MidCentral DHB, DHB2, RN D, RN F, and RN E were all given the opportunity to comment on the relevant sections of my provisional opinion. Where relevant, their comments have been incorporated into this report.

82. Mr B and Ms C told HDC that they both felt that the "Information gathered" section was a very accurate account of what they know happened that day.

83. MidCentral DHB told HDC that it accepted the proposed recommendations and course of action as set out in the provisional opinion.

84. RN D and RN F both acknowledged the grief experienced by the family and that, in hindsight, they could have done things better. RN D and RN F also submitted that all crisis assessments are a snapshot in time and, in the 14 hours that followed their assessment, Mr A was seen face to face by a consultant doctor and a registered nurse, and in that time Mr A stated that he had active suicidal ideations. RN D and RN F note that this is in contrast to Mr A's denial of any active suicidal ideas at least three times during their assessment with him.

85. RN E told HDC that she has reflected considerably on the events and has taken on board the advice from HDC's expert advisor. She said that she is content to accept the recommendations and is willing to engage with the Nursing Council over any enquiry they want to make around her competence.

86. DHB2 acknowledged the hurt and distress to the family as a result of the failings of DHB2, and the significant impact this event has had. It stated that it has endeavoured to work transparently and directly with the family since the incident.

87. DHB2 also stated that it does not support the practice of waiting for consumers to be cleared medically, and considers that once a consumer is deemed capable of being engaged for mental health assessment, then that assessment can take place concurrently.

88. DHB2 also noted that Hospital 2 is a small community hospital based an hour away from the main centre. It said that Hospital 2 ED is equipped to accommodate mental health assessments but is ill-equipped to harbour consumers with significant mental health issues overnight. DHB2 strongly supports that the safe and preferable action is for consumers to be transferred to Hospital 3 for overnight stay.

89. DHB2 acknowledged the failures identified in this report, and told HDC that it has been addressing, and continues to address, identified shortcomings from its RCA. In addition, DHB2 said that it has just finished a culture update programme — Promoting Professional Accountability — which supports everyone in the organisation to "Speak Up for Patient Safety". DHB2 also told HDC that it has engaged an external provider to triage all CATT enquiries, with contemporaneous record-keeping and risk assessment.

Relevant standards

90. The Nursing Council of New Zealand (NCNZ) Code of Conduct (the NCNZ Code) outlines the following standards expected of registered nurses:

> "1.3 Listen to health consumers, ask for and respect their views about their health, and respond to their concerns and preferences where practicable.

…

3.2 Respect health consumers' rights to participate in decisions about their care and involve them and their families/whānau where appropriate in planning care. The concerns, priorities and needs of the health consumer and family/whānau must be elicited and respected in care planning.

…

4.1 Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.

…

6.1 Treat colleagues with respect, working with them in a professional, collaborative and co-operative manner. Recognise that others have a right to hold different opinions.

6.2 Acknowledge the experience and expertise of colleagues, and respect the contribution of all practitioners involved in the care of health consumers.

…

6.6 Work with your colleagues and your employer to monitor the quality of your work and maintain the safety of those in your care."

Opinion: Introductory comments

91. This report considers the care provided to Mr A by a number of clinicians across two DHBs. First, I would like to acknowledge the loss for Mr A's family. It is tragic that the people who cared about Mr A attempted multiple times to obtain help for him shortly before his death. As noted by my expert advisor, Registered Nurse Dr Anthony O'Brien: "A notable feature of this case is that over three presentations to health services [Mr A] did not receive a comprehensive mental health assessment."

92. Mr A should have received a comprehensive mental health assessment. A number of deficiencies in the care provided to Mr A meant that he did not receive this assessment. These deficiencies are discussed in detail below. However, it is also important to acknowledge that the tragic outcome may not have been averted even if Mr A's healthcare providers had done more.

Opinion: MidCentral District Health Board — breach

Introduction

93. District health boards are responsible for the operation of the clinical services they provide. They have a responsibility for the actions of their staff, and an organisational duty to ensure that the appropriate standard of care is provided, which includes ensuring that adequate assessments are carried out, and facilitating continuity of care. It also includes having the appropriate policies in place. As noted by my expert advisor, Dr O'Brien: "There are elements of system failure in this case, in that the appropriate systems and policies that could ensure information is readily available were not in place."

94. As set out below, I consider that there were inadequacies in the care provided to Mr A when he presented to MidCentral DHB's ACT. In my view, MidCentral DHB bears overall responsibility for these failures.

Mental health assessment

95. On Day 1, Mr A was seen at MidCentral DHB's acute mental health service. Mr A completed a self-assessment form, in which he reported having suicidal ideation among other things. He was then assessed by RN F and RN D. Mr A reported feeling stressed, having intrusive thoughts that he was looking at women in an objectifying manner, and fleeting thoughts of suicide. He also reported that he had considered various means of suicide but denied suicidal intent at least twice when asked. Mr A identified that home with his family was where he felt safest, and expressed a wish to return there. RN D and RN F assessed Mr A as having a low risk of self-harm. The safety plan they agreed with Mr A was for Mr K to drive him home and for him to see his GP the following day.

96. Dr O'Brien advised:

> "There is no reason in a 'walk-in' assessment not to review core features of depression, especially in someone with a history of recent onset of suicidal thoughts who has said that he has had thoughts that life is not worthwhile and has thought of means of suicide. ... I accept as [RN F] points out, that some core features of depression were reviewed, including mood, affect, and suicidal thoughts.
>
> … It is evident that some questions were explored in the assessment and contributed to the decision making, but were not well documented in the written assessment. In particular there was some discussion about the discrepancies between [Mr A's] self-report of suicidal thoughts of 10 days duration, and his statements in the assessment that he was not currently suicidal. In addition, [Mr A's] unusual ideas were explored to some extent. … However I do believe the assessment to have been less than adequate, for what I would regard as an urgent assessment with significant questions of risk."

97. Dr O'Brien also noted that the assessment did not include a review of features of anxiety or panic, and did not record Mr A's subjective experience of his mood or Mr K's collateral

history. Dr O'Brien considered that the inadequate assessment amounted to a moderate departure from accepted standards.

98. I also note that Dr O'Brien considers that MidCentral DHB's policies around mental health assessments were adequate. He stated:

> "In particular, the MidCentral DHB Initial assessment Mental Health and Addiction Service (document MDHB 7187) is very comprehensive. I can imagine that in a crisis service it could be difficult to allocate sufficient time to complete all fields of this assessment form. However the form does give a good indication of the areas of assessment that needed to be undertaken."

99. I agree with Dr O'Brien that the mental health assessment of Mr A was insufficient, notwithstanding the adequacy of MidCentral DHB's policies, and did not appropriately explore all the relevant features of depression, anxiety, or panic, and was lacking detail about Mr A's subjective experience and Mr K's collateral history. I note that two experienced mental health nurses were involved in Mr A's assessment, and, in addition, the assessment was discussed with the psychiatric registrar that day and the following day at the MDT meeting, and these inadequacies were not identified at any stage. MidCentral DHB had an organisational responsibility to ensure that consumers presenting to ACT for acute mental health care were assessed adequately. I am critical that this did not happen in this case.

Management plan and coordination of care

100. Following RN D and RN F's assessment of Mr A, RN F documented that Mr A was at low risk of harming himself or others, and the plan for Mr K to drive Mr A back home and for Mr A to see his GP the following day.

101. Mr A's family was not contacted by ACT staff to discuss the management plan made. There was also no attempt by ACT staff to contact DHB2 or Mr A's GP to notify them that Mr A had presented with mental health concerns and was returning home, where he would seek further treatment from his GP. At the time, MidCentral DHB did not have a dedicated policy or procedure to provide guidance for staff on mental health presentations for people not normally residing in the MidCentral DHB area.

102. Dr O'Brien considered that more could have been done to strengthen the management plan. He advised:

> "The standard care regarding transfer of care across service boundaries (whether within or across DHBs) is to ensure that clinical information follows the patient, and that the receiving services are well informed. This includes informing the client's GP. Where family are to be involved in a safety plan, the accepted standard of care is that they are actively involved in developing the safety plan.
>
> … In my opinion [Mr A] met the threshold for specialist mental health service assessment, so the plan could have been strengthened by direct referral to [DHB2]

> mental health services, rather [than] an agreement for [Mr A] to see his GP. At the very least it would have been helpful for [DHB2] to have had access to the assessment information collected by MidCentral Health."

103. Dr O'Brien considered that the inadequacies in the management plan represented a moderate departure from accepted standards. I agree with Dr O'Brien that the management plan for Mr A should have involved input from his family (with his consent) and a direct referral to mental health services in his home town. I also agree with Dr O'Brien that transfer of care requires that clinical information be sent to providers who are to be involved in a consumer's care subsequently. This is essential in ensuring that the consumer receives continuity of services. I note that the need to coordinate care effectively includes not just when a consumer's care is being transferred from one DHB to another, but also when a consumer's care is transferred to other providers (for example, to a consumer's primary care physician). The fundamentals of coordination of care remain the same in these circumstances.

104. The information collected by ACT therefore also should have been transferred directly to Mr A's GP. The presence of suicidal ideation was a key feature of Mr A's presentation to ACT, even if RN D and RN F's assessment concluded that the risk of suicide was low. This was important information about a significant risk to Mr A's well-being that needed to be disseminated, as appropriate, to those who would provide ongoing care to Mr A.

105. I therefore accept Dr O'Brien's advice and I am critical that the management plan for Mr A was inadequate. In my view, MidCentral DHB had a responsibility to ensure that information collected by ACT was passed on appropriately to other health professionals who would be providing ongoing care to the consumer in the consumer's home area, so as to facilitate continuity of care. I am critical that MidCentral DHB did not ensure that this happened, resulting in inadequate coordination of care for Mr A.

106. However, MidCentral DHB is to be commended for implementing an "Out of Area Protocol" following these events. I note Dr O'Brien's comments that this protocol, alongside MidCentral DHB's amended Crisis Assessment Form and newly developed Crisis Resolution Plan, will support ACT clinicians in their work.

Conclusion

107. MidCentral DHB had overall responsibility for the services that were provided to Mr A when he presented to ACT for acute mental health care. In my view, there were several failures by MidCentral DHB staff in providing care to Mr A. Specifically, the ACT clinicians did not ensure that he received an adequate mental health assessment, and the subsequent management plan that was developed was inadequate. As a result of these failures, an opportunity was lost to identify the extent of Mr A's illness and access appropriate treatment, and Mr A did not receive continuity of services.

108. While individual staff members hold some degree of responsibility for their failings, cumulatively, I consider that the deficiencies outlined above indicate a pattern of poor care. In my view, these omissions amount to a failure to provide services to Mr A with

reasonable care and skill and, accordingly, I find that MidCentral DHB breached Right 4(1) of the Code.

Opinion: RN D — adverse comment

109. Mr A presented to MidCentral DHB's ACT with his supervisor, Mr K, on Day 1, after his mental health had deteriorated while away on a trip for work. Mr A completed a self-assessment form, in which he reported having suicidal ideation among other things. Mr A was then assessed by RN F and RN D. Mr A reported feeling stressed, having intrusive thoughts that he was looking at women in an objectifying manner, and fleeting thoughts of suicide. He also reported that he had considered various means of suicide but denied suicidal intent at least twice when asked. Mr A identified that home with his family was where he felt safest, and expressed a wish to return there. RN D and RN F assessed Mr A as having a low risk of self-harm. The safety plan they agreed with Mr A was for Mr K to drive him home and for Mr A to see his GP the following day.

110. My expert advisor, Dr O'Brien, noted that this was Mr A's first presentation to adult mental health services and, as such, there was no clinical history against which to compare Mr A's current presentation. Dr O'Brien advised: "Lack of any previous assessment creates a stronger need for a more comprehensive assessment on a first presentation."

111. Dr O'Brien also commented that even though Mr A's attendance was a "walk-in", all the core features of depression should have been explored. Dr O'Brien noted that the assessment did not include a review of features of anxiety or panic, and did not record Mr A's subjective experience of his mood or Mr K's collateral history. As Dr O'Brien noted: "Collateral history is especially important when individuals newly present for mental health care as [Mr A] did."

112. Dr O'Brien accepted that Mr A was returning from a high-risk situation to a low-risk situation, but noted: "[H]aving left that situation Mr K considered Mr A's mental state to be sufficiently concerning to seek urgent assessment."

113. Dr O'Brien also commented that the documented assessment did not include an enquiry as to whether Mr A was hearing voices, or had any more general unusual or paranoid ideas. Dr O'Brien added:

> "An assessment should conclude with a formulation, impression, diagnosis, or some other statement of how the clinician interprets the available information. However there is no such conclusion in [RN F's] assessment note."

114. Dr O'Brien further advised:

> "It is evident that some questions were explored in the assessment and contributed to the decision making, but were not well documented in the written assessment. In

> particular there was some discussion about the discrepancies between [Mr A's] self-report of suicidal thoughts of 10 days duration, and his statements in the assessment that he was not currently suicidal. In addition, [Mr A's] unusual ideas were explored to some extent. There was also some documentation of core features of depression. However I do believe the assessment to have been less than adequate, for what I would regard as an urgent assessment with significant questions of risk."

115. In Dr O'Brien's view, Mr A's suicide risk should have been assessed as at least moderate, rather than low. He considered that "the documented assessment was not sufficient to reach the conclusion that he was at low risk".

116. In mitigation, I note that RN D and RN F's assessment of low risk is supported by the comment in DHB2's RCA that the SAD PERSONS assessment tool, applied retrospectively, rates Mr A's risk of self-harm as low. However, I also acknowledge the limitations of the SAD PERSONS tool as highlighted by Dr O'Brien: "[I]t is a mnemonic, or memory prompt. It can be useful for clinicians, but only in guiding an assessment, not in providing objective validity."

117. I acknowledge that Mr A was eager to return to his supportive family and the safety of his home, that Mr A reported having strong protective factors, and that Mr K was able to provide Mr A with a safe means to get home directly. I also acknowledge that RN D was unaware that Mr A's work trip had to be cancelled early due to concerns that he was unwell, and that Mr A had previously been diagnosed with Asperger syndrome and had taken antidepressants in the past. I note that Mr A was assessed by two experienced mental health nurses, which Dr O'Brien advises is a safer process than that of having one nurse working alone. In addition, RN D and RN F confirmed with Mr A at least twice that he was not currently thinking of suicide, and a nationwide search did not reveal any previous contact by Mr A with mental health services in New Zealand. I also note RN D's comments about how busy and in demand the service was that day.

118. These factors may have caused RN D to truncate the assessment to support Mr A to return home that afternoon. The assessment and plan were also discussed with the on-duty psychiatric registrar that day, and at the MDT meeting the following day, and no issues were raised. I also note Dr O'Brien's impression that RN D was professionally committed and concerned to provide good care to consumers, and that the MDT endorsed the assessment and plan.

119. I nonetheless agree with Dr O'Brien that the assessment was inadequate, and I am critical that RN D did not ensure that Mr A received a comprehensive assessment of his mental health. There was a risk of significant harm to Mr A in the form of suicide, even though RN D and RN F assessed that the risk of self-harm was low. Mr K, who knew Mr A personally, had been sufficiently concerned about his mental health to seek an urgent clinical assessment before Mr A returned home. Taking this into account, RN D should have recognised the need for a thorough mental health assessment that included an in-depth exploration of all the core features of depression and Mr A's intrusive thoughts, and the need for a robust overall formulation or impression. As a consequence of this omission, an

opportunity was lost to identify the extent of Mr A's illness and to access appropriate treatment.

Opinion: RN F — adverse comment

120. Mr A presented to MidCentral DHB's ACT with his supervisor, Mr K, on Day 1, after his mental health had deteriorated while away on a trip for work. Mr A completed a self-assessment form, in which he reported having suicidal ideation among other things. Mr A was then assessed by RN F and RN D. Mr A reported feeling stressed, having intrusive thoughts that he was looking at women in an objectifying manner, and fleeting thoughts of suicide. He also reported that he had considered various means of suicide but denied suicidal intent at least twice when asked. Mr A identified that home with his family was where he felt safest, and expressed a wish to return there. RN D and RN F assessed Mr A as having a low risk of self-harm. The safety plan they agreed with Mr A was for Mr K to drive him home and for him to see his GP the following day.

121. Dr O'Brien noted that this was Mr A's first presentation to adult mental health services and, as such, there was no clinical history against which to compare Mr A's current presentation. Dr O'Brien advised: "Lack of any previous assessment creates a stronger need for a more comprehensive assessment on a first presentation." He also noted that even though Mr A's attendance was a "walk-in", all the core features of depression should have been explored. Dr O'Brien commented:

> "I think it is significant that [Mr K] considered it urgent enough to attend to [Mr A's] mental health issues before returning home, rather than waiting until he was back [home]."

122. Dr O'Brien also noted that the assessment did not include a review of features of anxiety or panic, and did not record Mr A's subjective experience of his mood or Mr K's collateral history. As Dr O'Brien noted: "Collateral history is especially important when individuals newly present for mental health care as [Mr A] did." Dr O'Brien also commented that the documented assessment did not include an enquiry as to whether Mr A was hearing voices, or had any more general unusual or paranoid ideas. Dr O'Brien added:

> "An assessment should conclude with a formulation, impression, diagnosis, or some other statement of how the clinician interprets the available information. However there is no such conclusion in [RN F's] assessment note."

123. Dr O'Brien further advised:

> "There is no reason in a 'walk-in' assessment not to review core features of depression, especially in someone with a history of recent onset of suicidal thoughts who has said that he has had thoughts that life is not worthwhile and has thought of

> means of suicide. ... I accept as [RN F] points out, that some core features of depression were reviewed, including mood, affect, and suicidal thoughts.
>
> … It is evident that some questions were explored in the assessment and contributed to the decision making, but were not well documented in the written assessment. In particular there was some discussion about the discrepancies between [Mr A's] self-report of suicidal thoughts of 10 days duration, and his statements in the assessment that he was not currently suicidal. In addition, [Mr A's] unusual ideas were explored to some extent. … However I do believe the assessment to have been less than adequate, for what I would regard as an urgent assessment with significant questions of risk."

124. In Dr O'Brien's view, Mr A's suicide risk should have been assessed as at least moderate, rather than low. He considered that "the documented assessment was not sufficient to reach the conclusion that he was at low risk".

125. In mitigation, I note that RN D and RN F's assessment of low risk is supported by the comment in DHB2's RCA that the SAD PERSONS assessment tool, applied retrospectively, rates Mr A's risk of self-harm as low. However, I also acknowledge the limitations of the SAD PERSONS tool as highlighted by Dr O'Brien: "[I]t is a mnemonic, or memory prompt. It can be useful for clinicians, but only in guiding an assessment, not in providing objective validity."

126. I acknowledge that Mr A was eager to return to his supportive family and the safety of his home, that Mr A reported having strong protective factors, and that Mr K was able to provide Mr A with a safe means to get home directly. I also acknowledge that RN F was unaware that Mr A's work trip had to be cancelled early due to concerns that he was unwell, and that Mr A had previously been diagnosed with Asperger syndrome and had taken antidepressants in the past. I note that Mr A was assessed by two experienced mental health nurses, which Dr O'Brien advises is a safer process than that of having one nurse working alone. In addition, RN D and RN F confirmed with Mr A at least twice that he was not currently thinking of suicide, and a nationwide search did not reveal any previous contact by Mr A with mental health services in New Zealand. I also note RN F's comments about how busy and in demand the service was that day.

127. These factors may have caused RN F to truncate the assessment to support Mr A to return home that afternoon. The assessment and plan were also discussed with the on-duty psychiatric registrar that day, and at the MDT meeting the following day, and no issues were raised. I also note Dr O'Brien's impression that RN F was professionally committed and concerned to provide good care to consumers, and that the MDT endorsed the assessment and plan.

128. I nonetheless agree with Dr O'Brien that the assessment was inadequate, and I am critical that RN F did not ensure that Mr A received a comprehensive assessment of his mental health. There was a risk of significant harm to Mr A in the form of suicide, even though RN F and RN D assessed that the risk of self-harm was low. Mr K, who knew Mr A personally, had been sufficiently concerned about his mental health to seek an urgent clinical

assessment before Mr A returned home. Taking this into account, RN F should have recognised the need for a thorough mental health assessment that included an in-depth exploration of the core features of depression and Mr A's intrusive thoughts, and the need for a robust overall formulation or impression. As a consequence of this omission, an opportunity was lost to identify the extent of Mr A's illness and to access appropriate treatment.

Opinion: RN E — breach

Mrs B's telephone call at 7pm

129. RN E first spoke to Mrs B when Mrs B rang CATT at 7pm on Day 1. RN E documented that Mrs B's concerns about Mr A included that he was confused, disoriented, and unable to speak in full sentences, and largely was keeping his eyes closed. RN E advised Mrs B to take Mr A to ED for medical assessment on the basis that he might have been dehydrated.

130. RN E told HDC that the nature of the call was directed at medical concerns. She stated: "There was nothing to indicate to me that there was a mental health issue at play." While I accept that Mrs B may not have mentioned concerns about Mr A's suicidality in this call, or his earlier assessment by MidCentral DHB's mental health services, I disagree that there was nothing to indicate that there was a mental health issue at play. Mrs B had telephoned CATT — DHB2's acute mental health response team. This alone indicated that Mrs B had some degree of concern about her son's mental health. Further exploration of Mrs B's reasons for calling, including enquiring about Mr A's risk of self-harm or suicide, may have revealed to RN E that Mr A had been seen by another mental health service earlier in the day. It is disappointing that this did not happen.

131. Dr O'Brien advised:

> "The Ministry of Health guidance[10] states that it is not necessary for medical clearance to have been given before mental health assessment takes place. … Waiting for 'medical clearance' resulted in a three hour delay in the CATT team deciding whether or not to attend, by which time it was too late to make the journey of just over one hour to [Hospital 2]."

132. I agree with Dr O'Brien that it was unnecessary for Mr A to be cleared medically before CATT assessed his mental health status, and that this caused unnecessary delay in CATT's decision about whether to assess Mr A in person.

Lack of assessment and development of safety plan

133. Mr A presented to Hospital 2 ED on Day 1 with his mother and sister. He was first seen by RN H and subsequently by Dr I at 10.10pm. Dr I then rang CATT to request an assessment

[10] Ministry of Health. 2016. *Preventing suicide: Guidance for emergency departments.* Wellington: Ministry of Health.

of Mr A's suicide risk. Dr I retrospectively documented (approximately five hours later) that Mr A was at moderate risk of suicide and that Mrs B was not happy to take Mr A home as she felt that his risk of suicide was high.

134. RN E stated that after Dr I rang to ask CATT to assess Mr A's suicide risk, she checked the CATT vehicle and found that the front bumper was hanging off. She then rang her Duty Manager, who made available an alternative vehicle at approximately 11.30pm. However, DHB2 and RN G disputed RN E's account, both saying that the CATT car was available for use that evening. DHB2 advised that the car had been used earlier in the evening. I also note that RN G was prepared to drive to Hospital 2 that night, and evidently was not concerned about the safety of the vehicle at the time.

135. I acknowledge that there are differing accounts as to whether a CATT vehicle was available to RN E at the time of Dr I's call. I note Dr O'Brien's opinion: "As far as I can tell availability of a vehicle does not seem to have been an issue." In light of both DHB2 and RN G stating that the CATT vehicle was available for use, and that RN G was prepared to drive to assess Mr A, I consider it more likely than not that the CATT vehicle was reasonably available that night. In doing so, I also note Dr O'Brien's comment that if RN E felt that it was unsafe to drive, then she should have explored the option of having Mr A stay overnight in Hospital 2 ED.

136. RN E then rang Mrs B. RN E said she could hear that Mr A and his sister were listening to the conversation and providing input in the background. RN E said that she discussed with Mrs B the possibility of her looking after Mr A if he was discharged from ED. RN E stated that she understood that Mrs B was comfortable to do so, with the support of Mr A's sister, and that if ED had any concerns about discharging Mr A, then a further call would be made to CATT. RN E said that she then discussed the plan with Ms J, who agreed with the plan. Mr A was then discharged home from ED after being given a zopiclone tablet.

137. Dr O'Brien advised:

> "The need for a face to face assessment was clear. It was communicated by ED senior medical officer [Dr I]. In addition, [RN G], advocated for the CATT team to attend and assess, but [RN E] resisted this advice. It is my opinion that the main clinical accountability for the CATT team decision making on the evening of [Day 1] rests with [RN E]."

138. In Dr O'Brien's view, the standard of care provided by RN E to Mr A on the evening of Day 1 represented a serious departure from the accepted standards.

139. It is striking that RN E did not speak to Mr A, and apparently made no attempt to do so, when she rang Mrs B. In the context of a consumer with known suicidal ideation, with family who were sufficiently concerned to bring him to ED, speaking directly to the consumer in question is the bare minimum I would expect a mental health nurse to do. As Dr O'Brien noted: "The three way conversation referred to by [RN E] is not likely to provide sufficient opportunity or privacy for [Mr A] to freely express himself." I also note the

conclusion of DHB2's RCA team that it would have expected CATT to travel and assess Mr A as requested by Dr I.

140. I therefore accept Dr O'Brien's advice, and I am highly critical that RN E failed to assess Mr A adequately, and did not even speak to Mr A. In the presence of a risk of significant harm to Mr A in the form of suicide, this demonstrates very poor judgement. Further, without a face-to-face assessment, RN E would not have been able to know whether her plan for Mr A was safe. Mr A was also not known to CATT, which made it more difficult to develop a safe and effective plan. I am very concerned that RN E appeared not to recognise this.

141. I also note that by not speaking to Mr A and not discussing the safety plan with him directly, RN E's actions were inconsistent with standards 1.3, 3.2, and 4.1 of the NCNZ Code. These standards require nurses to elicit and listen to consumers' concerns and health needs, to involve consumers as much as possible in planning care, and to use appropriate care and skill when assessing the health needs of consumers.

Responsibility for safety plan

142. RN E told HDC that ED staff made the decision to rely on the safety plan she developed, and that she expected ED to contact her if they had any concerns. I also note DHB2's comments that Dr I understood that CATT had based their clinical judgement to discharge on an appropriate assessment. DHB2 also stated that typically ED clinicians would rely on specialist teams to make appropriate clinical assessments and formulate appropriate and safe management plans.

143. RN E was the senior nurse on duty at CATT that evening. In my view, it was reasonable for Dr I to rely on RN E to complete an appropriate clinical assessment of Mr A after he referred Mr A to CATT for an assessment of his suicide risk.

144. I note Dr O'Brien's comment:

> "[RN E] states that ultimately it was not her decision to rely on the safety plan for [Mrs B] to take [Mr A] home. In my opinion this statement shows a fundamental misunderstanding of [RN E's] clinical responsibility. It was she, and not the ED staff, who developed the plan after speaking with [Mrs B]. It is not reasonable to hold ED staff responsible for this plan."

145. I agree, and I am very concerned that RN E did not consider herself clinically responsible for Mr A's discharge, which was based on the safety plan she developed for him.

Dismissing RN G's concerns

146. RN E and RN G differ in their recollections of whether RN G heard the conversation between RN E and Mrs B. RN E said that RN G was not in the room during this conversation, whereas RN G said that she did hear RN E speaking with Mrs B. However, they agree that RN G did question RN E's plan, and that RN G offered to drive because she thought that Mr A was suicidal and should be assessed. RN E said that she told RN G that

there was a safety plan in place, which Hospital 2 ED staff and Mrs B had agreed to. RN G said that twice she offered to drive, and RN E declined both times.

147. I note Dr O'Brien's comment:

> "A very unfortunate aspect of this case is that [RN G] does appear to have advocated for [Mr A] to be assessed by CATT on the evening of [Day 1], but her views were dismissed by [RN E]."

148. I am concerned that RN E failed to take into account the concerns raised by RN G. In my view, when RN G questioned RN E's plan, this should have prompted RN E to reconsider her assessment and plan for Mr A in co-operation with RN G. Instead, RN E dismissed RN G's concerns. Standards 6.1, 6.2, and 6.4 of the NCNZ Code require nurses to work with their colleagues in a professional, collaborative, and co-operative manner, and use collegial co-operation to monitor the quality of their work and maintain the safety of consumers. I am critical that RN E failed to comply with these standards.

Conclusion

149. RN E could not have predicted the tragic outcome for Mr A. However, I have serious concerns about her clinical decision-making. Specifically:

- She did not seek to assess Mr A's mental health status when she first spoke to Mrs B, but instead recommended medical clearance at ED.
- She did not assess or speak with Mr A at any stage.
- Her safety plan was developed in the absence of an adequate assessment of Mr A's mental health, in the context of a known suicide risk.
- She did not consider herself responsible for the safety plan she developed.
- She dismissed RN G's concerns.

150. As a consequence of these omissions, the opportunity was lost to identify the extent of Mr A's illness and access timely, appropriate treatment. I note RN E's comments that she felt the pressure of extra responsibility because her senior colleague, Ms J, had started later than anticipated, and because of working with RN G, who RN E considered had a "limited clinical role". In addition, RN E had been asked to work two extra shifts, and was on the second of these on the evening of Day 1. I accept that RN E felt under pressure that evening owing to working extra shifts, and that limited CATT staff were available until Ms J came in later in the shift. However, as outlined above, I do not consider that this materially affected RN E's ability to speak to Mr A and to assess him and plan his care adequately. I also note DHB2's comments that RN G was a fully operating registered nurse, and that there were other clinicians supporting CATT that evening.

151. For the above reasons, RN E failed to provide services to Mr A with reasonable care and skill and, accordingly, I find that she breached Right 4(1) of the Code. In my view, her failures also represent a failure to meet the professional standards set for her by the

Nursing Council (as outlined above). I therefore find that RN E also breached Right 4(2) of the Code.

Opinion: DHB2 — adverse comment

Introduction

152. An employing authority such as DHB2 may be directly liable for a breach of the Code. It may also be vicariously liable for the acts or omissions of an employee under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act). However, a defence to vicarious liability is available to the employing authority under section 72(5) if it can prove that it took such steps as were reasonably practicable to prevent the act or omission by its employee.

153. In my view, there were individual failures in the care provided to Mr A. I also note that DHB2 had a number of on-call and on-site clinical staff members available to support CATT on the evening of Day 1. Therefore, I consider that DHB2 did not breach the Code directly or vicariously.

154. However, I consider that there were several issues with the system in which RN E was operating at the time, for which DHB2 is responsible. These issues are discussed below.

Lack of record of Mrs B's initial call to CATT

155. DHB2 was first contacted about Mr A when Mrs B rang CATT between 2pm and 4pm on Day 1. The call was not documented, and it is not known who spoke with Mrs B. However, DHB2 told HDC that during this call, Mrs B was reassured that CATT would assess Mr A.

156. That this telephone call was not recorded in DHB2's clinical records is disappointing. I expect community mental health providers, and particularly those providing care in the acute/crisis setting, to document all contact with consumers carefully. If this call had been documented, RN E may have had more information to further inform her clinical decision-making and advice to Mrs B in the second telephone call. I note with approval that DHB2 has since engaged an external provider to triage all CATT enquiries, including record-keeping and risk assessments.

Capacity for acute mental health presentations to Hospital 2 ED

157. At the time of events, CATT was based at Hospital 3. According to DHB2's RCA, at the time of events no CATT staff were located in Hospital 2 ED during the evening. The RCA also noted that, at the time, video conference equipment was set up at Hospital 2 ED but was not able to be used after hours. As a result, in order for CATT to undertake a face-to-face assessment for consumers presenting at Hospital 2 ED with mental health concerns, CATT staff had to travel for approximately one hour.

158. RN E told HDC that her clinical decision-making in this case was influenced by balancing staff fatigue and the journey time late at night against the need to assess Mr A. I also note Ms J's comments about fatigued CATT staff having to drive distances to undertake assessments in the DHB2 area.

159. As Dr O'Brien commented, having a crisis team in Hospital 2 would have been helpful in this case. Dr O'Brien also noted that there does not appear to have been any exploration of the option of Mr A staying overnight in Hospital 2 ED as an alternative. Dr O'Brien further commented that there were indications of systemic issues in this case, and suggested that DHB2 review its "response to consumers with suicidality in the emergency department, especially where significant risk factors are present and the consumer is unknown".

160. While I have concerns about individual decision-making in this case, in my view, the ability for CATT staff to assess consumers presenting to Hospital 2 ED with an acute mental health crisis should not have been affected negatively by the facilities and systems in place. I am critical that in not having video-conferencing facilities available in Hospital 2 ED overnight, CATT staff had to drive from Hospital 3 to undertake assessments. In my view, at the time of these events, DHB2 was insufficiently equipped to respond appropriately to acute mental health presentations to Hospital 2 ED overnight. I note DHB2's submission that Hospital 2 ED is equipped to accommodate mental health assessments but is ill-equipped to harbour consumers with significant mental health issues overnight. I remain critical that the lack of video-conferencing facilities available in Hospital 2 ED overnight negatively impacted the ability for CATT staff to assess consumers presenting to Hospital 2 ED.

161. I note that pre-planned structural changes to place CATT staff in Hospital 2 ED during the evening were put in place soon after these events. Had these changes been in place at the time, Mr A may well have received the face-to-face mental health assessment he needed; however, as Dr O'Brien notes, at times a crisis team is likely to have simultaneous demands, and so may not always be able to attend the ED promptly.

RN G's concerns dismissed — other comment

162. After RN E spoke with Mrs B and formulated a plan for Mr A's care, RN G questioned RN E's plan. RN G also offered to drive there because she thought that Mr A was suicidal and should be assessed. RN E said that she told RN G that there was a safety plan in place, which Hospital 2 ED staff and Mrs B had agreed to. RN G said that twice she offered to drive there, and RN E declined both times.

163. I have discussed RN E's actions in further detail above. In addition, I also note that I would be concerned if there was a culture at DHB2 of staff dismissing concerns from their colleagues, including concerns from less experienced or junior colleagues. It is important for DHBs to encourage a workplace culture where it is commonplace for questions to be asked and concerns taken seriously, to and from any point in the hierarchy, at any time. I note that DHB2 has recently completed a culture update programme, which supports its staff to "Speak Up for Patient Safety". I commend DHB2 for taking this step to encourage and support a safe culture.

Recommendations

164. I recommend that MidCentral DHB:

a) Provide a written apology to Mr A's family for the failings identified in this report. The apology is to incorporate apologies from RN D and RN F, and is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

b) Provide HDC with an update on the results of its review of both its documentation (including its Crisis Assessment Form) and the training and development needs of the clinicians who work with the ACT (referred to in paragraph 69 of this report), including any further training it has provided to staff or identified as necessary as a result of this review. This update is to be provided to HDC within three months of the date of this report.

c) Present training to ACT staff on mental health assessments of out-of-area consumers who are unknown to the service, using an anonymised version of this report as a case study. Evidence of the training is to be provided to HDC within six months of the date of this report.

165. I recommend that RN E:

a) Provide a written apology to Mr A's family for the failures identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

b) Provide HDC with a reflective statement on the changes she has made to her practice as a result of these events, including how she seeks advice from colleagues and incorporates this advice into her clinical decision-making. This statement is to be sent to HDC within one month of the date of this report.

c) Provide HDC with evidence that she has attended, or will attend, training on the assessment, management, and care of a consumer who presents with suicidal ideation. This evidence is to be provided to HDC within six months of the date of this report.

166. I recommend that the Nursing Council of New Zealand consider whether a review of RN E's competency, fitness to practise and/or conduct is warranted based on the information in this report.

167. I recommend that DHB2:

a) Provide a written apology to Mr A's family for the issues identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

b) Undertake a review of the effectiveness of the structural changes to CATT (referred to in paragraph 73 of this report) and, in particular, on the clinical capacity of CATT staff working in Hospital 2 ED overnight to respond appropriately to acute mental health presentations to ED and include consumer and family representatives in that review. DHB2 is to provide HDC with the results of this review, including any further necessary changes that are identified as part of the review, within six months of the date of this report.

c) Organise for a review of its policy on suicidal presentations to ED against the Ministry of Health's guidance document "Preventing suicide: Guidance for emergency departments".[11] This review is to be undertaken jointly by ED and CATT staff and include consumer and family representatives in the review. DHB2 is to report back to HDC on the outcome of the review, and evidence of any associated policy changes, within six months of the date of this report.

d) Use this report as a basis for training and reflection for CATT staff, including on the importance of junior staff being able to voice concerns about patient safety and of senior staff taking such concerns seriously. Evidence of that training is to be provided to HDC within six months of the date of this report.

Follow-up actions

168. A copy of this report with details identifying the parties removed, except MidCentral DHB and the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of the names of RN E, RN D, and RN F.

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

170. A copy of this report with details identifying the parties removed, except MidCentral DHB and the expert who advised on this case, will be sent to the Director of Mental Health, the Health Quality & Safety Commission, and Te Ao Māramatanga — New Zealand College of Mental Health Nurses, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[11] Ministry of Health. 2016. *Preventing suicide: Guidance for emergency departments.* Wellington: Ministry of Health.

Appendix A: Independent advice to the Commissioner

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

"Preamble

I have been asked by the Commissioner to provide expert advice on case number C18HDC00301. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications

I began my training as a nurse in 1974. I qualified as a registered male nurse in 1977 (later changed to registered general nurse) and as a registered psychiatric nurse in 1982. I hold a Bachelor of Arts (Education) (Massey, 1996), a Master of Philosophy (Nursing) (Massey, 2003) and a Doctor of Philosophy in Psychiatry (Auckland, 2014). I am a past President and current Fellow and board member of Te Ao Māramatanga, the New Zealand College of Mental Health Nurses. I am currently employed as Nurse Specialist (Liaison Psychiatry) with the Auckland District Health Board and a Senior Lecturer in Mental Health Nursing with the University of Auckland. My current clinical role involves assessment and care of people in acute mental health crisis, including suicidality, and advising on care of people with mental health or behavioural issues in the general hospital. My academic role involves teaching postgraduate mental health nurses, supervision of research projects, and research into mental health issues. In the course of my career as a mental health nurse I have been closely involved with professional development issues, including development of the College of Mental Health Nurses *Standards of Practice*. I have previously acted as an external advisor to mental health services following critical incidents and as advisor to the Health and Disability Commissioner.

The purpose of this report is to provide independent expert advice about matters related to the care provided to [Mr A] by MidCentral DHB and [DHB2].

I do not have any personal or professional conflict of interest in this case.

Instructions from the Commissioner are:

Please review the enclosed documentation and advise whether you consider the care provided to [Mr A] by MidCentral DHB and [DHB2] was reasonable in the circumstances, and why.

In particular please comment on:

MidCentral DHB

The adequacy of [Mr A's] assessment.

The appropriateness of the recommended management plan

Any other matters that you consider amount to a departure from expected standards of care.

[DHB2]

The adequacy of [Mr A's] assessment.

The appropriateness of the recommended management plan.

Coordination of care with the Crisis Team, and the adequacy of the Crisis team's actions.

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

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

What the standard of care/accepted practice is;

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

How the care provided would be viewed by your peers?

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

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

Letter of complaint from [Mrs B], dated […].

A second, undated letter from [Mrs B], raising further concerns (I understand that this letter was received on [date].

Response from MidCentral Health dated [date], with supporting clinical documents for [date].

Further response from MidCentral DHB dated [date].

Clinical records from [DHB2] for [2018], and copies of their relevant policies.

I understand that [DHB2] is in the process of preparing a root cause analysis report which is likely to be available by early June.

Background

[Mr A] was [in his forties]. [He] lived with his parents and sister. […] [His current] work assignment had been in progress for ten days and involved living away from home. On [Day 1] after being seen by the MidCentral Health mental health service [Mr A] was driven [home] by his [manager, Mr K]. From home he was taken by his family to [Hospital 2] Emergency Department. There he was referred to [DHB2] mental health service CATT team on whose advice he was taken home by his family, with an arrangement to be assessed the following day at [Hospital 3] by the CATT team. [Mr A] committed suicide […] later that evening.

Contact with health services

On [Day 1] at 1330 hrs [Mr A] was taken to [Hospital 1] by [his manager], [Mr K]. At [Hospital 1] [Mr A] was assessed by registered nurses [RN F] and [RN D]. The assessment documentation was completed by [RN F]. [Mr A] also completed a self-assessment and a MHAS risk assessment review was completed using a standard MidCentral Health form. On the basis of that assessment [Mr A] was discharged into the care of his friend [Mr K], with an arrangement that [Mr K] would drive [Mr A] to [his home], and [Mr A] would visit his general practitioner the next day. On the drive from [Hospital 1] to [Mr A's] home] [Mr K] phoned [Mrs B] to advise that he was driving [Mr A] home.

That evening ([Day 1]) [Mrs B] phoned the [Hospital 3] CATT team, concerned about her son's mental state. Clinical notes from [DHB2's] mental health and addiction service (CATT team) record a telephone conversation at 1900 hrs in which [Mrs B] reported that her son had returned home from his work assignment in a confused state, was disoriented and unable to speak in a full sentence. [Mr A] seemed very tired and was repeating sentences, rambling to himself. [Mrs B] was advised to take [Mr A] to the emergency department as, according to the CATT team notes, he 'may be severely dehydrated'. The CATT team's plan was to await further contact (presumably from the [Hospital 2] Emergency Department).

[Mr A] was taken by his mother and sister to [Hospital 2] where he was seen in the emergency department. He was seen initially by a nurse, then by an emergency department consultant. Following liaison with the [DHB2] mental health service, [Mr A] was discharged home with his mother.

At the [Hospital 2] emergency department [Mr A's] presenting complaint is recorded in an initial nursing [assessment] written by registered nurse [RN H] as 'suicidal ideation'. The assessment further notes that [Mr A] had recently been feeling worthless, was afraid of looking at people and that his mother was concerned for his safety. The note also recorded that [Mr A] had reported an upset stomach and diarrhoea. The time of this note is not recorded. A second clinical note, this one by [Dr I], records that all the way [home] [Mr A] had been talking about suicide; he said everyone would be better if he was dead, and he seemed resigned to the fact that he was going to die. Due to his concerns that he might offend people, he had been keeping his eyes closed. He had texted his sister to apologise for his behaviour, and had communicated suicidal intent. [Dr I's] mental state assessment notes that he had means of suicide available but had 'no fixed suicidal plan'. The note further records that [Mr A's] mother was not happy to take him home as she felt his risk of suicide was high. However the note goes on to record that in discussion with the CATT team [Dr I] was informed that [Mr A] and his mother were comfortable with a plan for mental health review at 10am the following day, and was given zopiclone for sleep. Two clinical notes by registered nurses record a telephone conversation with ([RN E], community mental health nurse) from the [Hospital 3] CATT team. [RN H] reported that [Mr A's] mother was 'happy to manage

[Mr A] at home' with 7.5mg of the sleeping medication zopiclone with an appointment for 11am the following day.

The second note from the [Hospital 3] CATT team records a telephone conversation with [Dr I]. This note was recorded at 2220 hrs. [Mr A] had been medically cleared and [Dr I] was requesting mental health assessment. The note also records that [Mr A] had specific means of suicide available […], but had no intent to use them. He was requesting to be seen by a doctor the next day in [Hospital 3]. A second phone discussion with [Mrs B] is also recorded in this note. The note states that following discussion with [Mrs B] she had agreed to manage [Mr A's] safety at home and bring him to see the CATT team at 1100 the following day. [Mrs B] and her daughter would stay with [Mr A], and [Dr I] would provide sleeping medication. There was a plan for CATT support overnight if required.

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

MidCentral DHB

1. The adequacy of [Mr A's] assessment.

[Mr A's] assessment at MidCentral Health consists of a note by [RN F], a self-assessment completed by [Mr A], and a MHAS risk assessment review completed on a standard MidCentral Health form. [RN F's] assessment note contains most of the assessment information gained by MidCentral Health. There is a statement of the presenting problem, a history of the presenting problem, a risk assessment, a mental state assessment and a plan of care. The risk assessment identifies protective factors. While these elements are part of a standard psychiatric assessment, there are some aspects of the assessment that could have been developed further.

There is no assessment of core features of depression, such as change in appetite, weight, energy, concentration, sleep or satisfaction with usual activities. There was no review of features of anxiety or panic, which [Mr A] had identified in his self-assessment. The mental state assessment does not record [Mr A's] subjective experience of his mood. Screening for depression was important in [Mr A's] case, as his self-assessment indicated suicidality. [Mr K] was clearly a significant informant in this case, as he had been with [Mr A] over the previous 10 days. However there is no record of [Mr K's] collateral history in [RN F's] assessment note. Collateral history is especially important when individuals newly present for mental health care as [Mr A] did.

The unusual nature of [Mr A's] change in behaviour are not explored. His expression that his eyes were chest level is very unusual, as his apparently groundless belief that women believed he was doing wrong. There is no record of an inquiry as to whether [Mr A] was hearing voices, or had any more general unusual ideas such as whether he believed he was subject to any conspiracy or other untoward intent from others. An assessment should conclude with a formulation, impression, diagnosis, or some other statement of how the clinician interprets the available information. However there is no such conclusion in [RN F's] assessment note.

There is a discrepancy between what is recorded in [RN F's] assessment note which states [Mr A] 'adamantly denies an[y] [suicidal] intent' and [Mr A's] self-assessment, on the MidCentral Health self-assessment form, in which he ticked two boxes saying he had thought of harming himself, had suicidal thoughts, and thought life was not worth living. [Mr A] indicated that he had felt suicidal for 10 days. The box recording *present* (my emphasis) suicidal thought was left blank. [RN F's] note also mentions two specific means of suicide that [Mr A] had considered, […]. The MHAS risk assessment review also mentions the use of […]. Identifying specific means, especially means that are readily available, is something that indicates higher risk. Given his employment […] the mention of […] should have been explored, as he may have had access to […]. The thoughts of suicide are described as 'fleeting' and 'previously' in [RN F's] assessment and as 'in the past' in the MHAS risk assessment review. Given that [Mr A] reported no psychiatric history, and that the information available was that his presenting problems were of 10 days duration, the immediacy of his suicidal thinking seems to have been minimised. Suicidal thinking can fluctuate. Given that [Mr A], in his self-assessment, had stated that he had felt suicidal for 10 days, in my view he should have been assessed as being at least moderate risk of suicide, despite his denial of this. In my view the documented assessment was not sufficient to reach the conclusion that he was at low risk.

Overall, it is my opinion that [Mr A's] assessment was less than adequate given the recent development of suicidality, the unexplained nature of his unusual and intrusive thoughts, his own identification that he had been suicidal for 10 days, and evidence that he had considered lethal means of suicide to which he had access.

The standard of care/accepted practice

The accepted standard of practice is that on initial presentation a triage (brief assessment of urgency) is undertaken to determine the need for more comprehensive assessment and the timing of that assessment. A brief, focussed assessment might be appropriate if there are no immediate safety issues and a robust follow up plan is in place. In either case the most pertinent presenting issues need to be explored. For [Mr A] these were his current suicidal thoughts, the possibility of depression, and his unusual ideas. In my opinion a comprehensive assessment was indicated for [Mr A] on his presentation to MidCentral Health.

Departure from the standard of care or accepted practice, and how significant a departure it is.

In my opinion there was a moderate to severe departure from the accepted standard of care.

How the care provided would be viewed by your peers?

I believe that my peers would regard this as a moderate to severe departure from the accepted standard of care.

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

Use of a standard assessment template might help to prevent a similar occurrence in future, although standard templates are not a substitute for sound judgement. I recommend that the relevant MidCentral Health mental health staff are provided with the opportunity, in a supportive environment, to review this report and consider making changes to existing practice when clients with no previous mental health history present acutely.

2. The appropriateness of the recommended management plan

A management plan is based on a clinical assessment and I have already noted that in my opinion [Mr A's] assessment was less than adequate. In principle the plan for [Mr A] to travel home with [Mr K] is unproblematic. [Mr K] appears to be a responsible and reliable person who had already taken steps to have [Mr A] assessed. He appeared to be trusted by [Mr A] who he had known for several years. There is a good rationale for providing treatment close to home, especially where supportive family are available as they were in this case. I do think there is more that could have been done to strengthen the management plan. In my opinion [Mr A] met the threshold for specialist mental health service assessment, so the plan could have been strengthened by direct referral to [DHB2] mental health services, rather [than] an agreement for [Mr A] to see his GP. At the very least it would have been helpful for [DHB2] to have had access to the assessment information collected by MidCentral Health. Another way in which the plan could have been strengthened is for MidCentral Health to have communicated directly with [Mr A's] mother rather than communicating through [Mr K].

The standard of care/accepted practice

The standard care regarding transfer of care across service boundaries (whether within or across DHBs) is to ensure that clinical information follows the patient, and that the receiving services are well informed. This includes informing the client's GP. Where family are to be involved in a safety plan, the accepted standard of care is that they are actively involved in developing the safety plan.

Departure from the standard of care or accepted practice, and how significant a departure it is.

In my opinion there was a moderate departure from the accepted standard of care.

How the care provided would be viewed by your peers?

I believe that my peers would regard this as a moderate departure from the accepted standard of care.

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

I note from [MidCentral DHB's] letter of 23 March that MidCentral Health is to develop a protocol for out of area presentations, including sending general and risk assessment documentation to the local mental health service and GP. This is a positive development and in my opinion would help to prevent a similar occurrence in future. Any such protocol should include some means of confirming that any documentation sent has been received. I also recommend that: 1) family are actively involved in developing the safety plan, rather than just informed of it, and 2) that consumers and family representatives are involved in developing the out of area protocol.

3. Any other matters that you consider amount to a departure from expected standards of care.

None.

[DHB2]

1. The adequacy of [Mr A's] assessment.

At [Hospital 2], [Mr A] was assessed by an emergency department consultant, [Dr I]. There was no mental health service assessment. [Mr A's] presentation was defined from the outset as a mental health presentation, with the presenting complaint recorded by [RN H] as 'suicidal ideation'. This is consistent with [Mrs B's] letter of complaint which focusses on [Mr A's] mental state, and with the [Hospital 3] CATT note from 1900 which records suicidal ideation. [Dr I's] assessment records suicidal ideation, with mention of […]. It also states that [Mr A] had texted his sister to say that he would be killing himself soon. [Dr I] further records that, initially, [Mrs B] was not happy to take [Mr A] home due to her perception of the suicide risk. Finally the note records that [Mrs B], after discussion with the [Hospital 3] CATT team, was 'comfortable' with the plan to take [Mr A] home with some sleeping medication to be prescribed. In my opinion the assessment by [Dr I] is clinically sound. It outlines the presenting issues, and risk issues. The note does not state, but the Mental Health and Addiction Service note confirms, that [Dr I] requested CATT assessment.

The standard of care/accepted practice

In my opinion the standard of care provided by the [Hospital 2] Emergency Department was good. There was a clear assessment focussed on [Mr A's] presentation, and appropriate action was taken in requesting an assessment by the mental health service.

Departure from the standard of care or accepted practice, and how significant a departure it is.

In my opinion there was no departure from the accepted standard of care in the response of the [Hospital 2] Emergency Department.

How the care provided would be viewed by your peers?

I believe that my peers would regard the care provided by the [Hospital 2] Emergency Department as meeting the accepted standard of care.

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

I have no recommendations to make in this area.

2. The appropriateness of the recommended management plan.

My focus in this section is the management plan developed by [DHB2] mental health services. The management plan for [Mr A] involved his mother taking him home where [Mrs B] and her daughter would care for him overnight. In principle there is no reason why this would not be a safe and effective plan, and it is consistent with current practice in terms of involving family in care, and providing care close to home. However any plan needs to be based on a sound assessment, and [Mr A] did not have a face to face assessment by the mental health service. The assessment by [Dr I] raised significant safety concerns and triggered his request for a mental health review. The Mental Health and Addiction Service note records that [Mr A] had suicidal ideation, including the means […] at home). The note further records that [Mr A] was asking to be seen the next day and that his family would arrange that. This plan appears to have been discussed with [Mrs B] who is recorded as agreeing to the plan, which included [Mrs B] and her daughter staying with [Mr A] who would have sleeping medication prescribed by [Dr I]. There was no face to face assessment by the mental health service; their decision making was based on telephone discussions with [Dr I] and with [Mrs B].

[Mr A] was unknown to the mental health service, making it more difficult to develop a safe and effective plan without a face to face assessment. I do not believe [Mr A's] clinical presentation and risk were adequately evaluated before his discharge. I believe there was sufficient information available for [DHB2] mental health service to recommend, if they were not able to attend, that [Mr A] wait overnight at the [Hospital 2] emergency department for comprehensive assessment in the morning, either at [Hospital 2] Emergency Department or at the [DHB2] mental health service in [Hospital 3].

The standard of care/accepted practice

In my opinion the care provided by the [DHB2] mental health service was not at the accepted standard. New Zealand guidance for responding to suicidal patients in emergency departments state that for patients with more than low risk, mental health assessment should be considered before discharge. [Dr I's] assessment documented significant risk issues, and these were not addressed before [Mr A's] discharge. I do not believe a telephone discussion with [Mrs B] can be regarded as adequate under the circumstances. [Mrs B] was concerned enough to contact the mental health service, although the plan conveyed to her from MidCentral Health (through [Mr K]) was for a GP visit the following day. [Mrs B] was sufficiently concerned about her son's

suicide risk to abandon MidCentral's plan and seek more urgent mental health care. That action, together with [Dr I's] assessment, should have been sufficient for the mental health service to ensure that a face to face assessment was provided before discharge (unless discharge was directly to the mental health service for that assessment).

Departure from the standard of care or accepted practice, and how significant a departure it is.

In my opinion there was a serious departure from the accepted standard of care.

How the care provided would be viewed by your peers?

I believe that care provided by the [DHB2] mental health service would be regarded as not being of the accepted standard, and as a serious departure from the accepted standard.

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

I understand from [Mrs B's] letter that [DHB2] has since decided to establish a crisis team in [the district]. That is obviously something that would have been helpful in [Mr A's] case. However a crisis team is likely to have simultaneous demands for service and may not always be able to attend the emergency department promptly. Decisions will still need to be made about whether patients should wait for mental health service assessment or be discharged home with follow up later.

My recommendation is that [DHB2] review their policy on response to suicidal patients in emergency departments against the 2016 Ministry of Health guidance document. This review should be conducted jointly by the Emergency Department and the mental health service, not by either service alone. Family and consumer advocates should be involved in the review. In particular, the review should consider what actions should be taken when a person who is not known to the mental health service presents in suicidal crisis, including the possibility of providing overnight care until the mental health team can attend. In addition, I recommend that the relevant [DHB2] mental health staff are provided with the opportunity, in a supportive environment, to review this report and consider making changes to existing practice when asked to respond to suicidal clients in the emergency department.

Coordination of care with the Crisis Team, and the adequacy of the Crisis team's actions. These issues are dealt with in the preceding discussion.

3. Any other matters that you consider amount to a departure from accepted standards of care.

There are no other matters that amount to a departure from accepted standards of practice.

General comment

This is a case in which three health services were involved in clinical decision making. [Mr A] had one brief assessment at MidCentral Health, then needed a comprehensive face to face mental health assessment. A notable feature of this case is that over three presentations to health services [Mr A] did not receive a comprehensive mental health assessment. Staff at both MidCentral and [DHB2] appear to have minimised evident risk issues, in the case of [DHB2], without a face to face assessment. It is notable that the [Hospital 3] CATT appear to have formed the view that [Mr A] 'may be severely dehydrated' but without any real indication of that. [Mr A's] presentation at [Hospital 2] emergency department was treated as a mental health presentation from the start. However there appears to have been a view from [Hospital 3] CATT that 'medical clearance' was required before they could respond. The Ministry of Health guidance states that it is not necessary for medical clearance to have been given before mental health assessment takes place. While it would be reasonable, if [Mr A] *was* confused due to dehydration, to delay assessment until he was hydrated. In this case there is no suggestion from the emergency department consultant that [Mr A] was dehydrated. Waiting for 'medical clearance' resulted in a three hour delay in the CATT team deciding whether or not to attend, by which time it was too late to make the journey of just over one hour to [Mr A's home].

There are elements of system failure in this case, in that the appropriate systems and policies that could ensure information is readily available were not in place. It is encouraging to see that MidCentral Health plan to address the systems issue by developing a protocol covering out of area presentations. It is my view that [DHB2] should consider reviewing their policy on response to consumers with suicidality in the emergency department, especially where significant risk factors are present and the consumer is unknown. [Mrs B's] letter expresses the hope that lessons can be learned from the tragic loss of her son, and in that regard strategies to improve communication across service boundaries are a positive development.

Documents consulted

Mental Health Commission. (2012). *Blueprint II: How things need to be.* Wellington: Mental Health Commission.

Ministry of Health (2016). *Preventing suicide: Guidance for emergency departments*. Wellington: Ministry of Health.

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

The following further advice was obtained from Dr O'Brien:

"The [DHB2] Root Cause Analysis reaches identical conclusions to my own report in terms of the standard of care provided by the [DHB2] CATT service. For that reason I have nothing further to add to my own report.

There were some issues that I noticed on reading the Root Cause Analysis report, and I've outlined them below.

Page 4 of the report states that [DHB2] CMHT were not aware of [Mr A's] previous assessment by MidCentral. However the letter [from MidCentral DHB] ([date], p. 3) states that 'the plan included assurance that [Mr A] with [Mr K's] support would make his parents aware that he needed follow up by his GP as soon as possible'. Although the first reported note from [DHB2] CATT does not state that they were told of the previous assessment at MidCentral, it seems odd that this information would not have been passed on by [Mr K], who would have explained the reasons for returning [Mr A] early from his work assignment.

Page 5 of the report talks of the possibility of implementing a screening tool to support ED staff in their decision making. The report notes that the SAD PERSONS tool would have rated [Mr A's] risk as low. My clinical experience and review of literature on use of scales such as SAD PERSONS suggests that such scales have limited utility. On the basis of the history available I would have rated [Mr A] as medium rather than high risk, highlighting that inter-rater reliability is limited with scales such as SAD PERSONS. SAD PERSONS is not a standardised scale, it is a mnemonic, or memory prompt. It can be useful for clinicians, but only in guiding an assessment, not in providing objective validity. The literature on rating instruments, whether standardised or not, is consistent in concluding that rating instruments are not a substitute for sound clinical assessment. A large case linkage study of over 5000 ED presenters found poor predictive validity for the SAD PERSONS scale, and for a modified version of the same scale (Katz et al., 2017). Two other studies reached similar conclusions (Bolton et al., 2012; Warden et al., 2014). In my report I commented that [DHB2] should review their policy on response to suicidal patients in emergency departments against the 2016 Ministry of Health guidance document. I also noted that any such review should be jointly conducted by ED and mental health staff. If any decision aid were to be introduced for ED staff, it would be important that there was agreement on what response from CATT would result if the decision aid indicated a need for face to face assessment before discharge.

References

Bolton, J. M., Spiwak, R., & Sareen, J. (2012). Predicting suicide attempts with the SAD PERSONS scale: A longitudinal analysis. *The Journal of Clinical Psychiatry, 73*(6), e735–e741.

Warden, S., Spiwak, R., Sareen, J., & Bolton, J. M. (2014). The SAD PERSONS scale for suicide risk assessment: a systematic review. *Archives of suicide research*, *18*(4), 313–326.

Katz, C., Randall, J. R., Sareen, J., Chateau, D., Walld, R., Leslie, W. D., ... & Bolton, J. M. (2017). Predicting suicide with the SAD PERSONS scale. *Depression and anxiety*, *34*(9), 809–816."

The following further advice was obtained from Dr O'Brien:

"**Preamble**

I have been asked by the Commissioner to provide further expert advice on case number C18HDC00301. I have previously provided two reports on this case, [dates]. The current request follows receipt by the Commissioner of further information from MidCentral and [DHB2], in particular, responses from clinicians involved in this case and from DHB managers. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications

I began my training as a nurse in 1974. I qualified as a registered male nurse in 1977 (later changed to registered general nurse) and as a registered psychiatric nurse in 1982. I hold a Bachelor of Arts (Education) (Massey, 1996), a Master of Philosophy (Nursing) (Massey, 2003) and a Doctor of Philosophy in Psychiatry (Auckland, 2014). I am a past President and current Fellow and board member of Te Ao Māramatanga, the New Zealand College of Mental Health Nurses. I am currently employed as Nurse Specialist (Liaison Psychiatry) with the Auckland District Health Board and a Senior Lecturer in Mental Health Nursing with the University of Auckland. My current clinical role involves assessment and care of people in acute mental health crisis, including suicidality, and advising on care of people with mental health or behavioural issues in the general hospital. My academic role involves teaching postgraduate mental health nurses, supervision of research projects, and research into mental health issues. In the course of my career as a mental health nurse I have been closely involved with professional development issues, including development of the College of Mental Health Nurses *Standards of Practice*. I have previously acted as an external advisor to mental health services following critical incidents and as advisor to the Health and Disability Commissioner.

The purpose of this report is to provide independent expert advice about matters related to the care provided to [Mr A] by MidCentral DHB and [DHB2].

I do not have any personal or professional conflict of interest in this case.

Instructions from the Commissioner are:

Please review the enclosed documentation and advise on the following:

1. Whether it causes you to amend the conclusions drawn in your initial advice (dated [dates]), or provide additional comments.
2. The standard of care provided by MidCentral DHB, including:
3. The standard of care provided by [RN F]
4. The standard of care provided by [RN D]
5. The adequacy of policies and procedures in place at MidCentral DHB at the time of these events

6. The appropriateness of changes implemented by MidCentral DHB following this incident.
7. The standard of care provided by [DHB2], including:
8. The standard of care provided by [RN E]
9. The adequacy of policies and procedures in place at [DHB2] at the time of these events.
10. The appropriateness of changes implemented by [DHB2] following this incident.
11. Any further recommendations for improvement.

For each question I have been asked to advise on

a) What is the standard of care/expected practice.

b) If there has been a departure from the standard of care or expected practice, how significant a departure do you consider this to be.

c) How would it be viewed by your peers.

d) I have been asked to provide advice in the alternative if there are different versions of events, i.e. based on scenario (a) and scenario (b).

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

- The documents listed in my report of [date]
- The [DHB2] Root Cause Analysis Report subject of my report on [date].
- The following additional documents:
- Letter to HDC Senior Investigator, from [the] Mental Health and Addictions Service, dated [date]
- Response of [RN D] to the Mental Health Commissioner (undated)
- Response of [RN F] to the Mental Health Commissioner, dated [date].
- Letter of offer of appointment and acceptance for [RN D] [date].
- Letter of offer of appointment and acceptance for [RN F] [date].
- MidCentral DHB Risk Assessment Documentation policy (document MDHB-255).
- MidCentral DHB MHAS Entry Criteria policy MidCentral (document MDHB-7435).
- MidCentral DHB Service user and family/whānau participation policy (document MDHB 6853).
- MidCentral DHB Initial Assessment Mental Health and Addiction Service (document MDHB 7187).
- MidCentral DHB Triage policy (document MDHB DHB-675).

- MidCentral DHB MHAS Risk Assessment Review (document MDHB 7173) (replaces form used on [Day 1], see (r) below.
- MidCentral DHB Admission to [mental health services acute inpatient unit] (document MDHB 1513).
- MidCentral DHB Triage Review Report for [Mr A].
- An Action Plan outlining actions following MidCentral DHB's review of [Mr A's] care.
- MidCentral DHB Draft Out of Area Protocol for assertive follow up of client's post assessment.
- Minutes of MidCentral DHB Mental Health Executive Leadership Group, dated [date].
- MidCentral DHB Crisis Resolution Plan template.
- MidCentral DHB MHAS Risk Assessment Review (completed [Day 1]).
- MidCentral DHB Mental Health Service Consumer/Tangata Whaiora administration form (completed [Day 1]).
- MidCentral DHB General adult mental health service self-assessment (completed [Day 1]).
- MidCentral DHB clinical notes completed [Day 1] and [Day 4].
- Letter to Mental Health Commissioner, from [the] Chief Executive [DHB2], dated [date].
- Letter to Mental Health Commissioner, from [Mr M,] Clinical Nurse Director/Professional Advisor for Mental Health & Addiction/Associate DAMHS, [DHB2].
- Statement of [RN H], [Hospital 2] Emergency Department, dated [date].
- Statement of [Dr I], Senior Medical Officer [Hospital 2] Emergency Department, dated [date].
- Statement of [RN G], [DHB2] Mental Health Service, dated [date]
- Statement of [RN G], [DHB2] Mental Health Service, dated [date]
- A statement of additional notes by [RN E] [DHB2] Mental Health Service, (undated).
- Root Cause Analysis report prepared by [DHB2] (undated).
- Details of internal performance management process conducted by [DHB2] in relation to [RN E], dated [date].
- Information on the employment relationship of [DHB2] staff members involved in care of [Mr A].
- [DHB2] performance management and disciplinary policy (includes Code of Conduct and employee Expectations) (document [number]).

- [DHB2] Mental Health & Addictions Service of [Day 1]. Enhanced Engagement and Observation Procedure (document [number]).
- [DHB2] Observation Adult Protocol (includes Confusion Assessment Method form and Daily Watch Information (document [number]).
- [DHB2] Mental Health & Addictions Services Referral Management form (document [number])
- [DHB2] Crisis respite criteria and guidelines (document [number])
- [DHB2] Mental health services admission to acute inpatient guideline (document [number])
- [DHB2] Mental health serious or sentinel event review procedure (document [number])
- [DHB2] Transfer of client into police custody (document [number])
- [DHB2] Mental Health Services Consent to Treatment form (document [number])
- [DHB2] statement around changes to service provision within Crisis Assessment and Treatment Team dated [date].
- [DHB2] Crisis Assessment and Treatment Team running sheets for [Day 1] and [Day2].
- Notes from phone call to [Mr K], [Mr A's] boss and friend, dated [date] (not attributed).
- A printout of records of accessing [DHB2's] electronic client records throughout the evening of [Day 1]. The records are for staff members [RN E], [RN G], [Ms J].
- Minutes of a meeting of [DHB2] staff with [Mr A's] family, dated [date].
- Statement of [RN E], [DHB2] Mental Health Service, dated [date]
- Statement of [RN G], [DHB2] Mental Health Service, dated [date]
- Statement of [Ms J], social worker, [DHB2] Mental Health Service, dated [date]
- Notes from a telephone interview with [Mr L] ([RN G's] clinical mentor) by [Mr M], Clinical Nurse Director/Professional Advisor for Mental Health & Addiction/[DHB2], dated [date].

Background

In preparing this report I have reviewed my previous reports and the documents that informed those reports. I was particularly concerned, in light of statements from the clinicians involved, to consider whether my original conclusions should be amended.

I have read and carefully considered the additional information provided, especially the statements made by clinical staff after reading my report. I have also paid particular attention to the report of [Mr M], [DHB2] and [Mr M's] comments on the practice of [RN E]. In my initial report I was asked to advise on the functioning of the

CATT team rather than of individuals. With the additional information now provided it is possible to comment further.

In all cases there is no change to the expected standard of care, or to how any departure from the expected standard would be viewed by my peers.

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

The standard of care provided by MidCentral DHB

MidCentral DHB have provided significant further information related to this case, including statements from [RN F] and [RN D], an action plan following an internal review of the case, and a draft out of area protocol. I have carefully considered these documents in reviewing my previous advice.

The standard of care provided by [RN F]

I have read [RN F's] statement carefully. The statement contains some new assessment information, such as:

- [Mr A] being asked to comment on the discrepancy between his self-assessment where he recorded having had suicidal thoughts for 10 days, and statements made in [RN F's] clinical assessment, when he denied current suicidality
- [Mr A] was unable to identify any event that contributed to his current presentation.
- [Mr A] denied any intent to act on suicidal thoughts due to how that would affect his family
- [Mr A] identified returning [home] to his family to be most helpful.
- [Mr A] was given an 0800 number to contact if there were changes to his safety or presentation.

I note that the plan was discussed at the multidisciplinary team meeting the following day and there was agreement by the team to the assessment and management plan.

In her comments on the adequacy of [Mr A's] assessment, [RN F] states that [Mr A's] suicidal thoughts had not been continuous over the past 10 days. I accept this comment, however I do think it is significant that these thoughts had been occurring for 10 days, and were troubling enough for [Mr A] to seek mental health care.

I accept that [Mrs B's] letter of complaint provided new information about [Mr A's] mental health history, and this was not known to [RN F] and therefore could not be considered in her assessment.

My opinion remains that [Mr A's] assessment at MidCentral DHB was not adequate given the information available. The assessment is very brief, considering that [Mr A's] friend and manager ([Mr K]) had thought it necessary to seek an urgent mental health assessment. [RN F's] response focusses on suicidal thoughts but does not address [Mr

A's] unusual perceptions and behaviour in the period leading up to this assessment. There is also no review core symptoms of depression, and very little collateral information gained from [Mr K]. I do not wish to amend the conclusions drawn in my initial advice.

The standard of care provided by [RN D]

I have read [RN D's] statement carefully. The statement contains some new assessment information, such as:

> [Mr A] had not had suicidal thoughts 'for a while'.
>
> [Mr A] would not commit suicide because of what it would do to his family and friends.
>
> [Mr A] and his manager were asked if anything had happened at work and both said no.

I accept that [Mr A] was asked if he had current suicidal thoughts, and that he denied this. I note that [Mr A's] assessment and presentation were reviewed by the multidisciplinary team.

[RN D] comments that [Mr A's] suicidal thoughts were not new to him and 'portrayed a chronicity'. That does not seem consistent with his acute presentation, and in any case previous suicidal thoughts, prior to the past ten days, were not explored in his assessment. There is also nothing in [Mr A's] assessment that suggests suicidal thinking prior to the past two weeks. In his self-assessment [Mr A] stated he had no prior history of mental illness. [RN D] comments that there was no indication of any psychotic process. However his unusual ideas of his eyes being at chest level and his belief that he was 'objectifying' women and women's reactions to him indicating he was doing wrong were not explored. While I am not suggesting that these ideas were psychotic in nature that is something that needed to be explored in an assessment. [RN D] notes that [Mr A] could have presented to [other] DHB mental health services if he had been concerned. That is a reasonable point, although it remains that [Mr A] did choose to present to MidCentral DHB rather than return directly to [his home].

I accept [RN D's] comment that history of risk behaviour is the best predictor of future risk behaviour, and [Mr A] denied previous suicidal behaviour. However history of risk behaviour is only one factor in risk assessment. The comments about recent suicidal thoughts being passive rather than active when compared to past suicidal thoughts is new information, not recorded in [Mr A's] assessment. I accept that [Mr A] did not meet criteria for use of the Mental Health Act, based on the information available in the documented assessment.

My opinion remains that [Mr A's] assessment at MidCentral DHB was not adequate given the information available. I do not wish to amend the conclusions drawn in my initial advice.

Comment

[Mr A] was assessed by two experienced mental health nurses, a practice noted by [RN D] to be a safer process than that of having one nurse working alone. I agree with this comment. Both [RN D] and [RN F] commented that the service was busy on the day of [Mr A's] presentation and that his presentation was unexpected. This may have impacted on the response he received. I accept that both [RN F] and [RN D] may have been under some time pressure due to workload, and that [Mr A] agreed to their proposed management plan. [Mr A] was presenting to adult mental health services for the first time, so he was not well known and there was no previous clinical record against which to compare his current presentation. Lack of any previous assessment creates a stronger need for a more comprehensive assessment on a first presentation. The assessment was very brief, and in my opinion should have explored [Mr A's] unusual beliefs.

The adequacy of policies and procedures in place at MidCentral DHB at the time of these events

In most areas the policies and procedures in place were adequate. In particular, the MidCentral DHB Initial assessment Mental Health and Addiction Service (document MDHB 7187) is very comprehensive. I can imagine that in a crisis service it could be difficult to allocate sufficient time to complete all fields of this assessment form. However the form does give a good indication of the areas of assessment that needed to be undertaken.

At the time of [Mr A's] presentation there was no policy or procedure in place around follow up for out of area patients.

In my opinion the procedure of reviewing assessments in the next MDT meeting is an adequate one.

The appropriateness of changes implemented by MidCentral DHB following this incident.

The DHB has developed a draft protocol for follow up care of patients presenting out of area, such as [Mr A]. This is a positive development which will help ensure patients receive timely follow up, and that assessment information is available to future service providers. It does need to be noted however, that the follow up protocol will only be as effective as the assessment that informs it. The protocol would be strengthened by telephone follow up to future service providers and to families or support people. If a GP is to provide follow up the protocol should provide that information is provided to the GP. The Crisis Resolution Plan strengthens the future management of clients assessed by the Acute Care Team. I also note in [the Mental Health and Addictions Service] letter to the Commissioner that the DHB intends to review documentation and training development needs of clinicians who work on the Acute Care team, with emphasis on mental health assessment and formulation of treatment plans. These initiatives should assist in strengthening clinical assessment and decision making processes.

The standard of care provided by [DHB2]

[DHB2] have provided significant further information related to this case, including results of a Root Cause Analysis, statements from staff, details of the DHB's performance management process in relation to [RN E], and other documents. In particular, [DHB2] have provided a letter from [Mr M], Clinical Nurse Director and Professional Advisor which draws on interviews with staff not available to me on my initial inquiry. [Mr M] also draws attention to the individual accountabilities of CATT team members, specifically the senior RN on duty ([RN E]), and practices which in [Mr M's] view breaches the Code of Conduct for nurses. I have carefully considered all the documents provided in reviewing my previous advice.

The standard of care provided by [RN E]

The further information provided raises serious questions about the practice of [RN E]. In my report of 30 May I expressed the opinion that the care provided by [DHB2] CATT service was not adequate, and was a serious departure from the expected standard of care. I continue to hold that opinion. However it now seems that on the evening in question the [DHB2] service was led by [RN E], and in some significant respects her practice was not at the standard required of a registered nurse. The need for a face to face assessment was clear. It was communicated by ED senior medical officer [Dr I]. In addition, [RN G], advocated for the CATT team to attend and assess, but [RN E] resisted this advice. It is my opinion that the main clinical accountability for the CATT team decision making on the evening of [Day 1] rests with [RN E].

The statements provided by [RN E] provide no new information that explains the decision not to attend [Hospital 2] ED and to discharge [Mr A] without face to face assessment. Some of [RN E's] statements are not supported by the clinical notes or other records, for example the comment that [Dr I] ([Hospital 2] ED) suggested [Mr A's] presentation was due to 'Asperger type personality'.

It is my opinion that the standard of care provided by [RN E] was below the standard expected of a registered nurse, and represents a serious departure from the expected standard of care.

Comment

Some of the matters raised in the statement of May 29 by [RN G] go beyond the question of the standard of care provided by [DHB2] and by [RN E]. In particular there is the suggestion that [RN E] sought to dismiss concerns voiced by [RN G] and to minimise [RN G's] knowledge of the case. There is even a suggestion, in [RN G's] statement of 29 May that [RN E] sought to minimise any involvement [RN G] might have in a subsequent investigation. In two instances it appears that statements made by [RN E] were misleading, the first to [Dr I], saying that the CATT team was too busy to attend, and the second to the Duty Manager saying that there was no car available. These statements are questioned by [RN G]. There are also discrepancies in the timeline of events provided by [RN E]. These are serious matters of professional practice.

A very unfortunate aspect of this case is that [RN G] does appear to have advocated for [Mr A] to be assessed by CATT on the evening of [Day 1], but her views were dismissed by [RN E]. It is apparent that [RN G] feels considerable responsibility for the outcome in this case, despite having her views discounted by [RN E]. [RN G] is to be commended for promptly expressing her concerns to her clinical mentor [Mr L], and for her thoughtful reflections on her role in this case.

The appropriateness of changes implemented by [DHB2] following this incident.

The employment of a CATT team member sited at [Hospital 2] ED, planned prior to this incident, will obviously directly address the capacity of the CATT team to respond to mental health presentations at [Hospital 2] ED. However as I stated in my report of 19 June, there will be times when this team member cannot attend immediately, and decisions will need to be made about the safety of patients in [Hospital 2] ED.

I support the recommendation in the Root Cause Analysis report for a nationally streamlined system of inter-DHB alerts for patients travelling across DHB boundaries. I hope this recommendation will be advanced beyond the DHBs involved in this case, to the appropriate national agency.

The recommendations of the Root Cause Analysis report are all appropriate and will address issues raised in that report.

The planned vital signs audit will address the lack of physical observations made on [Mr A's] presentation to [Hospital 2] ED.

Advice in the alternative

There is only one version [of] events in this case."

The following further advice was obtained from Dr O'Brien:

"This letter responds to further statements by [RN D] [date] and [RN F] [date] in relation to Case 18HDC00301 ([Mr A]) and the response of MidCentral DHB on [date]. I have provided initial advice on this case ([date]) and further advice ([dates]).

I have reviewed the previous documentation, especially the assessment reports written on [Day 1], and the previous responses of [RN F] and [RN D].

The case involves [Mr A] who died [by suspected suicide].

There are some general points that need to be made as background to my response to the specific points raised by [RN D] and [RN F]. My opinion about the assessment provided to [Mr A], and the adequacy of the management plan is not based on later events outside MidCentral DHB. It is based solely on what information was available to me about the assessment provided on [Day 1]. The question of hindsight bias has been raised and while I acknowledge that such biases are always possible, I have been very careful to comment only on what the accepted standard of practice is. I also

accept that having [Mr A] drive home with his friend [Mr K] was a reasonable decision, for reasons given in my original advice on [date]. I accept that [Mr A] had, when asked, stated that he had no current plan to act on the suicidal ideas he had had for the past 10 days. As I also noted in my advice on [date] suicidal thinking can fluctuate in relation to numerous factors. I don't think the plan to [go home] was unsafe. However I do remain of the view that the assessment provided was less than adequate in the circumstances, and that the management plan should have included onward referral to a specialist mental health service, rather than leaving [Mr A] or his family to contact their GP. (I acknowledge that [Mr K] was advised to recommend this to the family.)

The remainder of this report responds to specific points raised by [RN D and RN F].

[RN D]

Care of [Mr A] was not viewed as a separate event (from care provided by [DHB2] subsequently). As noted above, I have looked at the assessment information provided on its own terms, not in terms of the later events.

The assessment was a brief assessment supporting ([Mr A]) to return home. It was not intended to be a full assessment. I accept that some aspects of a comprehensive assessment were not possible in the circumstances (such as accessing previous mental health history that [Mr A] did not disclose, but which became known later). However even in accepting this, the assessment provided was less than adequate and did not address some important aspects of [Mr A's] presentation.

[Mr A's] suicide risk was considered low because of the identified protective factors, and going [home] would strengthen these protective factors. I've responded to the issue of the plan to return home above (which I think was in principle a safe plan). On the issue of low risk, I accept that [Mr A] denied current suicidal thoughts, but on his self assessment he noted these had been present for 10 days and were sufficiently concerning for him to seek mental health care. Because of the fluctuating nature of suicidal thoughts this risk could be expected to increase in the future, which was one of the main reasons for concluding that [Mr A] should be referred to a mental health service for further assessment and support.

[Mr A] denied suicidal thoughts at interview, did not disclose a mental health history and identified returning home as a safe option. These points are addressed above.

The unusual nature of [Mr A's] thoughts about women. I accept that there was nothing in the recorded assessment to suggest these thoughts were due to psychosis. However [Mr A] seemed unusually concerned about these thoughts. I thought they merited further exploration.

My statement that [Mr A] chose MidCentral mental health services is misleading, and [Mr A] (or [Mr K] on [Mr A's] behalf) could have chosen to present at [another DHB's] mental health services as his employment was in that area. I don't see the relevance of this comment.

[Mr A] had been safe for two weeks in a high risk situation. I accept this, however having left that situation [Mr K] considered [Mr A's] mental state to be sufficiently concerning to seek urgent assessment.

[RN F]

My review of previous reports involved a prejudiced opinion. As noted above I have reviewed the assessment provided and the management plan independently of the later events.

Despite significant clarification of ([Mr A's]) presentation I have made little acknowledgement of that. I have made various acknowledgments of points raised by both nurses, noting that some information, such as clarifying [Mr A's] denial of current suicidal thoughts against his self-reports having such thoughts, was not included in the documented assessment. I accept that this may have been a somewhat unusual presentation in that [Mr A] had a plan to travel [home] and a safe means of doing so. This is given considerable emphasis in both [RN F's] and [RN D's] latest responses. I can only re-state that I accept that going [home] was a good option in principle, but it did need to be backed up by direct referral to his home mental health team.

My opinion of the expected standard of care was prejudiced by viewing [RN F's] involvement alongside that of multiple other clinicians at a later point. I have addressed this point in my comments above. My focus was on the assessment and management plan in isolation from later events.

There was no information available on [Mr A's] previous mental health or personal history. I accept this point and note that [RN F] made efforts to locate any available history. [Mr A] was also questioned on this but did not disclose any history of mental health issues or of complaints of sexual harassment.

The question of current suicidal thoughts was clarified a number of times with [Mr A]. I accept that this occurred in the interview, and contributed to the decision to support [Mr A] in his decision to travel [home].

There was no communication from [Mr K] to suggest the plan to travel [home] was unsafe, or that [Mr K] had concerns about it. I accept that [Mr K] was in support of the plan. I couldn't see any suggestion in my previous reports that I thought otherwise.

[Mr A's] presentation was a 'walk-in' (and therefore not urgent). Perhaps it is a matter of definition as to what constitutes an 'urgent' assessment. I think it is significant that [Mr K] considered it urgent enough to attend to [Mr A's] mental health issues before returning home, rather than waiting until he was back [home]. By that definition the assessment was urgent.

[Mr A's] unusual behaviour in closing his eyes and his belief that he was objectifying women. My comments on this were not about [Mr A's] presentation in the interview, but about the history that this had been a concern for him over the past two weeks. In

the assessment interview there is no exploration of [Mr A's] unusual behaviour, which was a concern he expressed on presentation. [RN F] states that '[Mr A] was unable to identify any previous incidents or concerns that may have led to this belief' (that he was objectifying women). However the record of the assessment interview does not refer to any explanation sought from [Mr A], or offered by him.

A full review of core symptoms of depression was not undertaken as the assessment was in the context of a 'walk in' (presentation) en route to [Mr A's home]. There is no reason in a 'walk-in' assessment not to review core features of depression, especially in someone with a history of recent onset of suicidal thoughts who has said that he has had thoughts that life is not worthwhile and has thought of means of suicide. Review of core features of depression could be done in five minutes once an interview was in progress. I accept as [RN F] points out, that some core features of depression were reviewed, including mood, affect, and suicidal thoughts.

In relation to collateral information, the plan was discussed with [Mr K] who was not aware of any previous mental health history and had no concerns. I accept that [Mr K] could not be expected to know [Mr A's] mental health history. But he did know [Mr A] well and could have given an opinion about how significant the changes in his presentation were. [Mr K] was concerned enough to bring [Mr A] in for assessment and it would be helpful from a clinical perspective to explore his reasoning for this.

Based on these latest responses from [RN D] and [RN F] it is evident that some questions were explored in the assessment and contributed to the decision making, but were not well documented in the written assessment. In particular there was some discussion about the discrepancies between [Mr A's] self-report of suicidal thoughts of 10 days duration, and his statements in the assessment that he was not currently suicidal. In addition, [Mr A's] unusual ideas were explored to some extent. There was also some documentation of core features of depression. On that basis I can revise my opinion of a moderate to severe breach in standards in relation to the assessment to say this was a moderate breach. However I do believe the assessment to have been less than adequate, for what I would regard as an urgent assessment with significant questions of risk. On the question of the management plan not including referral to the mental health service or direct contact with a family member at [home], my opinion remains that this was a moderate breach of standards. This is not about the plan to drive home with [Mr K], which seems reasonable. I agree that there were no grounds to use the Mental Health Act. Admission to an out of area hospital would also seem a disproportionate and unnecessary response given that [Mr A] had support available at home and a safe way of getting there. But in the circumstances, where [Mr A] had expressed recent suicidal thoughts and consideration of means, where someone who knew him well was sufficiently concerned to request an unscheduled assessment, and where he had not been a particularly forthcoming interviewee, I believe he should have been directly referred to his home DHB for follow up.

I have reviewed the MidCentral DHB's newly developed Out of Area Protocol, Crisis Assessment Form and Risk Assessment Review form, and I believe these documents will support clinicians in their work.

I note the comments by [RN D] and [RN F] about their membership of professional nursing organisations, continued professional development, and contribution to the revised protocols mentioned above. These comments, along with explanations given in relation to this case, show both nurses to be professionally committed and concerned to provide good care to consumers. I acknowledge that it is not an easy process to have one's professional practice closely scrutinised, especially if there are concerns about attribution of blame for adverse outcomes. It is not my role or intention to attribute blame and I acknowledge that there are many contributing factors to adverse outcomes that are outside the influence of clinicians.

I conclude by re-stating that I have not formed the views above on the basis of the later events that occurred once [Mr A] arrived home. My views are solely influenced by what I believe to be the appropriate standard of care provided at the time of [Mr A's] assessment at MidCentral DHB. I hope this and my other reports will help improve our understanding of care processes, and will be of value to clinicians engaged in the complex and challenging work of acute assessment and decision making.

Anthony O'Brien RN, PhD, FNZCMHN"

The following further advice was obtained from Dr O'Brien:

"Case number C18HDC00301 ([Mr A]). Additional report prepared by Anthony O'Brien, RN, PhD, FNZCMHN.

I have had the opportunity to review the statement provided to HDC by [RN E] in [date]. This statement was not available to me when I provided my additional report in [date]. I have been asked to advise whether the information contained in [RN E's] statement changes the opinion provided in my report of [date]. I have reviewed my original reports and some of the original source documents provided by the Commissioner.

In the statement provided [RN E] provides some context to her response to [Mr A], including staffing and service management, some additional detail about events on the night, and some comments on my earlier ([date]) report.

[RN E] comments on the management of the CATT service, including changes in management, long hours of work, and her level of seniority on the night of [Day 1]. She was also working overtime, having completed four regular rostered days immediately prior to [Day 1]. There is a suggestion that [RN E] felt under some pressure to agree to work on the night in question. [RN E's] senior colleague on the night, social worker [Ms J] started late (1800hrs rather than 1500 hours) and for [RN E] this created a sense of carrying additional responsibility. The other nurse on duty [RN

G] was a junior nurse in her first year of clinical practice. [Ms J] said she was 'knackered' (tired) on arriving at work at 1800hrs. [RN E] reports that she was appointed [a year prior to these events] (however she had [several] years of clinical experience by [the time of these events]). For [RN E] there were some issues of work hours, fatigue from working long hours and a sense of carrying much of the clinical responsibility. These issues can certainly impact on performance and decision making.

Another concern raised by [RN E] is that in her opinion the allocated car was not safe to drive owing to having a damaged bumper. [RN E] says 'the front bumper was hanging off' and the car was due to be taken in for repairs. [RN E] arranged for an alternative car to be available. It is not unreasonable for a staff member to refuse to drive an unsafe vehicle. There is no information available to me on whether others had noticed the vehicle was unsafe. In her statement of [date] [RN G] stated that a car was available, and that she ([RN G]) was baffled by [RN E's] request to the duty manager for a car. In any case, a vehicle was available at 2330 hours, although I note that this would have been after the scheduled end of [RN E's] shift.

[RN E] states that suicidal ideation was not mentioned by [Mrs B] in her phone call at 1900hrs on [Day 1]. This does not seem plausible, and in any case likely reflects an inadequate response to [Mrs B's] call. [RN E's] statement made on [date] says [Mrs B] was concerned her son was depressed. Such a concern immediately raises the risk of self-harm or suicide, so [RN E] should have inquired about that. On reviewing the records from the [Hospital 2] emergency department it is very clear that suicidality was seen as the presenting issue there, so it seems unlikely that [Mrs B] would not have mentioned that in her initial call to [RN E]. As I noted above, a call of this nature would be expected to include a triage for suicidality given that [Mr A] was known by [RN E] to be depressed.

[RN E] gives an estimated timeline for [the journey] to assess [Mr A], and return to [Hospital 3]. This would see her completing her shift as late as 0700hrs on [Day 2], having worked through the night. The timeline makes a few assumptions, such as the necessity to use the Mental Health Act, which is not known as [Mr A] was not assessed. [Mr A] voluntarily attended the [Hospital 2] emergency department so there was no known question about [Mr A] refusing care, but it is reasonable for [RN E] to factor this possibility into her decision making as consumers' presentation can change. Assessment and transport to hospital can take a long time, and it is reasonable for [RN E] to anticipate spending several hours on this after leaving [Hospital 3]. However this reasoning about time is based on a starting time of 2330, whereas the first call from [Mrs B] came at 1900.

[RN E] says she canvassed with [Mrs B] the possibility of her looking after [Mr A] if he was discharged from [Hospital 2] emergency department, and she ([RN E]) understood [Mrs B] was comfortable with that. This statement contradicts the statement by [RN G] on [date] that [Mrs B] had told the clinical team (presumably at [Hospital 2] ED) that she was 'scared' to take [Mr A] home. There is a sense in [RN E's] statement that she was relying on ED consultant [Dr I] and [RN H] to endorse her plan for [Mr A] to go

home, and to advise her if he thought it was unsafe. However this was [RN E's] plan and [Dr I] had already expressed concern about [Mr A's] safety. The issue with this aspect of [Mr A's] care is that despite concerns about suicidality he was not given a face to face assessment by the mental health service. It seems that all the discussion was with [Mrs B]. The three way conversation referred to by [RN E] is not likely to provide sufficient opportunity or privacy for [Mr A] to freely express himself.

In relation to comments about workload and staffing there do appear to be some issues of a service with capacity issues resulting in staff working when ideally they would be having time off. However even considering this I don't think these issues were of such severity that a better assessment of [Mr A] wasn't possible. As far as I can tell availability of a vehicle does not seem to have been an issue.

In my opinion of [date] I noted that an option that could have been explored was that [Mr A] stay in [Hospital 2] ED overnight and be seen in the morning. That possibility doesn't seem to have been explored.

In her comments on my [date] report [RN E] to which I respond below:

Information that [Mrs B's] mother was not happy to take [Mr A] home as she felt his risk of suicide was high was not conveyed to [RN E]. I have made some comments on this issue above. My impression from [RN G's] statement of [date] is that this information was conveyed to [RN E]. [RN E] states that ultimately it was not her decision to rely on the safety plan for [Mrs B] to take [Mr A] home. In my opinion this statement shows a fundamental misunderstanding of [RN E's] clinical responsibility. It was she, and not the ED staff, who developed the plan after speaking with [Mrs B]. It is not reasonable to hold ED staff responsible for this plan. [RN E] states that she did not speak to [Mr K]. I did not intend to imply that [RN E] spoke to [Mr K].

Having carefully read [RN E's] statement and the relevant documents my opinion of [date] is unchanged, and is that the standard of care provided by [RN E] represents a serious departure from the expected standard."

The following further advice was obtained from Dr O'Brien:

"Case number C18HDC00301 ([Mr A]). Additional report prepared by Anthony O'Brien, RN, PhD, FNZCMHN.

I have reviewed the following additional documents related to this case:

Letter from [the] barrister, acting for [RN E], dated [date].

Letter to the Commissioner from [RN E], dated [date].

Notes from a phone conversation between [Dr I] ([Hospital 2] Emergency Department) and [Mr M], [DHB2], dated [date].

I have been asked to advise whether the information contained in the above documents changes the advice I have previously given to the Commissioner. In

addition to the above documents I have reviewed the advice previously provided on [four occasions], and the relevant documents provided by the Commissioner earlier.

After reading all the additional documents, my earlier reports, and the relevant sections of documents provided earlier my opinion remains that the adequacy of care provided by [DHB2] was a serious departure from the accepted standard. Below I have given reasons for holding this opinion.

It is clear that [RN E] was the clinician leading the decision making in relation to [Mr A's] presentation on [Day 1].

The first call from [Mrs B] ([Mr A's] mother) to [DHB2] mental health services (CATT) was received at 1900 hours, by [RN E]. (An earlier call appears not to have been documented.) [Mrs B] was advised by [RN E] to take [Mr A] to [Hospital 2] ED for medical review, with CATT to review if he was medically stable. [RN E's] note of [Day 1] states 'if he is medically stable CATT have agreed to assess'. In her letter of [date] [RN E] states that the nature of this call was 'totally directed at a medical type issue' ([Mr A's] confusion and possible dehydration) and not at suicidality. In my report of [date] I have stated it is not plausible that suicidality was not mentioned in that call and I remain of that view. I refer to [RN E's] statement on [date] that [Mrs B] was concerned that her son was depressed. As I noted on [date], such a concern immediately raises the issue of self harm or suicide.

When [Mr A] first presented to [Hospital 2] ED his presenting complaint was recorded by [Dr I] and [RN H] as 'suicidality'. This is consistent with what else is known about [Mr A] on that day, including his presentation to MidCentral DHB with suicidal ideas. I appreciate that [RN E] was not aware that [Mr A] had presented to MidCentral. However this information was easily available via [Mrs B]. The fact that [Mrs B] gave suicidality as the reason for bringing [Mr A] to ED, notwithstanding [RN E's] suggestion of dehydration, tells me that this was always a mental health issue in [Mrs B's] mind. It is clear that [RN E] was aware that [Mr A's] presentation involved a mental health issue, as she agreed (in her phone call with [Mrs B]) to assess [Mr A].

[Mr A] was discharged from [Hospital 2] ED without a face to face assessment by the CATT service. No-one from the mental health service spoke directly to [Mr A]. There is no record of any direct questioning of [Mr A]. He was not given the opportunity to talk to [RN E] alone. This occurred in the context of a mental health crisis, and with an individual who was not known to the service. [RN E] was aware, from her phone call with [Dr I] at 2220 hours, that [Mr A] had expressed suicidal ideas and had thought about specific means.

The plan that [Mrs B] and her daughter would provide overnight care for her son was also made without a face to face assessment of [Mr A], despite it being known that he had expressed suicidal ideas and had contemplated specific means. Without a face to face assessment it is not possible to know if this plan was safe. It is not adequate to rely on a statement made to the ED doctor or nurse that [Mr A] had no plan to act on

his suicidal thoughts. The responsibility for this plan belongs with the mental health service, not with the Emergency Department.

I acknowledge that [RN E] had concerns about the safety of the CATT vehicle, and about the time involved in travelling to [Mr A's home town]. I also note that these concerns were not shared by [RN E's] colleague [RN G] who has stated that she was prepared to drive to [Mr A's home town]. My opinion is that there was enough information available to know that [Mr A] should not leave the hospital without a face to face assessment. [Dr I] had assessed [Mr A], identified his suicidality, and requested an assessment. In my opinion that assessment should have been provided before [Mr A] was discharged. If [RN E] felt it was unsafe to drive [there] the option of an overnight stay in [Hospital 2] ED should have been used.

Having carefully read [RN E's] statement and the relevant documents my opinion of [date] is unchanged, and is that the standard of care provided by [RN E] represents a serious departure from the expected standard."