Canterbury District Health Board

A Report by the

Mental Health Commissioner

(Case 15HDC01202)

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Executive summary

1. Ms A was admitted to the Emergency Department (ED) at Canterbury District Health Board (CDHB) following an episode of self harm. She was noted to have a background of anxiety and depression and daily alcohol use, and it was documented that she had suicidal intent. Ms A was referred to the Psychiatric Emergency Service (PES).

2. The following morning, Ms A was reviewed by a mental health nurse. The documented plan was for Ms A to be discharged and attend a PES risk review the next day.

3. On Day 3, following initial presentation, Ms A was involved in an accident while intoxicated. She was picked up from the Police station by her father, and taken to her PES appointment. Ms A was assessed by a PES case manager (another mental health nurse), and agreed to attend an Alcoholics Anonymous meeting that evening, be referred to the Alcohol and Other Drug Coordination Service (AOD),[1] and attend a review with a PES consultant psychiatrist and the case manager the following day.

4. On Day 4, Ms A attended the review with the psychiatrist. It was documented that Ms A's mood disorder (depressive episode) could not be seen as primary while she was using alcohol in large amounts, and that her risk of suicide was currently low but that this could change depending on her level of intoxication. Ms A was given information about rehabilitation programmes and agreed to attend two Alcoholics Anonymous meetings over the weekend, and was given a prescription to continue using an antidepressant.

5. Ms A's case manager verbally consulted with a clinical nurse specialist at the Community Alcohol and Drug Service (CADS)[2] and requested a referral to the service regarding Ms A's alcohol use. The clinical nurse specialist understood that PES would be continuing to work with Ms A with regard to her mental health issues.

6. Ms A's PES case manager and the CADS clinical nurse specialist noted that they attempted to contact Ms A several times, and left messages requesting return contact. On Day 10, the case manager contacted Ms A's father to advise that Ms A would be discharged from mental health services owing to non-contact with PES and CADS. Ms A was discharged from PES that day.

7. Ms A then contacted the CADS clinical nurse specialist, and a CADS initial telephone screening was undertaken on Day 11. The telephone screening focused on Ms A's motivation to engage in treatment pathways, and the clinical nurse specialist advised that he would arrange an appointment with the outpatient AOD service. Self-harm risks were not discussed during the screening.

8. The CADS clinical nurse specialist referred Ms A to AOD during an allocation meeting, and accordingly the PES referral to CADS was withdrawn. It was agreed that Ms A would be contacted by AOD regarding an appointment. CDHB advised that the intention was for the AOD service to organise an assessment for Ms A in a few weeks' time.

[1] This service provides rehabilitation and support to people with alcohol and drug addictions.
[2] A service responsible for providing comprehensive alcohol and drug assessment, treatment planning, and advice on referral for Specialist Mental Health Services.

9. Ms A had no further contact with CDHB services. She was found unresponsive on Day 26 and died that day.

10. CDHB undertook a Serious Incident Review and found that clinical documentation did not evidence assessment of Ms A's mood and suicidality, that CADS assessment did not occur despite the criteria for assessment being met, and that there were communication issues with Ms A's family.

Findings

11. The Mental Health Commissioner commented that CDHB staff were primarily focused on addressing Ms A's alcohol addiction issues, but that the same level of attention was not being given to her mental health issues or to integrated, ongoing risk assessment. He considered that CDHB staff separated Ms A's mental health and addiction issues from one another and, as a result, Ms A did not receive a coordinated and appropriate standard of care for her mental health issues, and the transfer of her support to alcohol and drug services in the community was insufficient for a consumer dealing with both mental health and alcohol addiction disorders.

12. The Mental Health Commissioner found that the referral of Ms A to AOD and her discharge from PES resulted in no one retaining clinical responsibility for her mental health issues, when either PES or CADS should have done so. Overall, he found that there was a lack of critical thinking in relation to the co-existing disorders, resulting in inadequate coordination of care by CDHB. As CDHB did not ensure co-operation between providers to ensure quality and continuity of services to Ms A, it was found that CDHB breached Right 4(5) of the Code of Health and Disability Services Consumers' Rights.[3]

Recommendations

13. In light of the issues identified in this report, the recommendations made in the CDHB Serious Incident Review, and the expert advisors' comments, the Mental Health Commissioner recommended that CDHB review and update its Service Provision Framework to ensure that it explicitly clarifies and documents the transfer processes between services; the CADS criteria for acceptance; and the CADS telephone screening process. The Mental Health Commissioner requested evidence of changes made as a result of this review, and details of any other improvements to the interaction between Crisis Resolution (formerly PES), CADS, and AOD services.

14. The Mental Health Commissioner also recommended that CDHB provide an apology to Ms A's family for the breach of the Code identified in this report.

[3] Right 4(5) of the Code states that every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Complaint and investigation

15. The Health and Disability Commissioner received a complaint from Mr and Mrs B about the services provided by Canterbury District Health Board to Ms A. The following issue was identified for investigation:

- *Whether Canterbury District Health Board provided Ms A with an appropriate standard of care between Day 1 and Day 26.*

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

17. The parties directly involved in the investigation were:

Mr B	Complainant, father
Mrs B	Complainant
Canterbury District Health Board	District Health Board

18. Information was reviewed from:

Dr C	Consultant psychiatrist
RN D	Registered nurse
RN E	Clinical nurse specialist, registered nurse
RN F	Case manager, registered nurse

19. Independent expert advice was obtained from a consultant psychiatrist, Dr Jeremy McMinn (**Appendix A**), and a registered nurse, Dr Anthony O'Brien (**Appendix B**).

Information gathered during investigation

Background

20. At the time of events, Ms A was in her thirties. Ms A's father, Mr B, told HDC that previously Ms A had been living overseas, and while there had been "not doing very well". He described her as "having panic attacks" and "on medication that did not seem to be helping". Later Ms A moved to back to NZ, which is where the events described took place, and began studying.

Day 1

21. Mr B told HDC that on Day 1 Ms A was "very stressed" because of work that was due. Mr B stated:

> "[Later that day] she arrived home late in the afternoon behaving very strangely. More than drunk — spaced out, talking gibberish. She took herself to bed.
>
> …

> [Mrs B] woke me to tell me that she was taking [Ms A] to [the Emergency Department at CDHB] as she had [harmed herself]."

Admission to ED and referral to Psychiatric Emergency Service

22. At 10.15pm on Day 1, Ms A was admitted to the Emergency Department (ED). Her blood alcohol levels were taken and recorded as 54mmol/L.[4]

23. The ED Medical Assessment Record includes the following comments:

> "Suicidal intent. Sounds impulsive tonight, on background of anxiety and depression. Daily alcohol use. Usually seen in community for anxiety/depression."

24. A plan was documented as follows:

> "If remains stable … can be transferred to [the Emergency Observation Unit] pending [Psychiatric Emergency Service (PES)] review."

25. Ms A was referred to PES.

26. Initially Ms A was seen by a social worker, who documented the following in the Psychiatric Emergency Service Referral Screening Document:

> "[Ms A] presented as distressed and tearful and has stated that she still wanted to die, to not be a part of this world. She has thought about suicide for a long time but has tried to stay alive for the sake of the people around her …"

Psychiatric assessment by RN D

27. At approximately 5am on Day 2, Ms A was reviewed by Registered Nurse (RN) RN D. RN D told HDC: "As is my usual practice, I spent five to ten minutes, before meeting with Ms A, checking computer records for any previous mental health history and reading the ED notes relating to Ms A."

28. RN D assessed Ms A and documented:

> "She is not known to [Mental Health Services (MHS)] however has seen [a consultant psychiatrist] privately on one occasion. He recently changed her medication from Effexor[5] to Escitalopram[6] … Mood depressed between 2001 and 2004, recently feels more anxious than depressed. Sleeping for long periods, up to twelve hours nightly. Eating erratically. Concentration and motivation have been very poor over the last two weeks. Little enjoyment."

29. Under the heading "Anxiety Symptoms", RN D recorded the following:

> "Almost constant anxiety — shaking, stomach discomfort. [Symptoms] of social phobia. No [Obsessive Compulsive Disorder]. No panic."

[4] Almost five times the legal driving limit for alcohol consumption.
[5] A prescription medication for depression, anxiety, and panic disorders in adults.
[6] Used to treat depression, panic disorders, anxiety, and obsessive compulsive disorder.

30. Under the heading "Past Psychiatric History", RN D recorded:

> "[Consultant psychiatrist] privately. Tried Gestalt therapy,[7] not helpful. Was on Effexor 150 mg for three years."

31. Under the heading "Summary", RN D recorded:

> "[Woman in her thirties] is assessed post an impulsive [episode of self harm] … in response to increasing anxiety and stress. She is not known to MHS however has seen [a consultant psychiatrist] privately for a medication review. There have been some recent functional changes and a significant increase in her [alcohol] use. She describes having chronic suicidal thoughts but no current intent."

32. Under the heading "Risk Assessment", RN D recorded the following: "Low to moderate to self. Low to others."

33. Under the heading "Diagnosis/Impression", RN D recorded the following: "[Major Depressive Episode]. Overdose."

34. As above, RN D documented: "[Ms A] describes having chronic suicidal thoughts but no current intent." RN D recorded that Ms A's risk was "low to moderate to self." RN D told HDC that she did not document any suicidal intent as "[Ms A] was unsure of her intent at the time of the [self harm]".

35. Ms A signed a "Contacts and Disclosure Treatment Plan" that allowed full disclosure to Mrs B. RN D stated:

> "In relation to the disclosure form, [Ms A] asked for [Mrs B's] details to be included, which I did. [Ms A] then signed the document with me as her witness."

36. RN D documented that Ms A was to go home with Mrs B with a plan to attend a PES risk review at 3pm the next day (Day 3). RN D noted that Ms A declined the offer of a referral to the Alcohol and Other Drug Coordination Service (AOD), and that Ms A would require a case manager if PES follow-up was to continue.

37. RN D completed a Suicide Risk Information Form on Day 2. This included the following information:

1. Static — historical events and enduring factors: "[Day 2] [Self harm.] Chronic suicidal thoughts but has never acted on them, usually family are a protective factor. [Self harm] was impulsive and under the influence of [alcohol]. Did not leave a suicide note. … Denies any ongoing intent to harm self."
2. Dynamic Internal: "Low mood. Anxiety. [Alcohol] abuse/[depression]."
3. Dynamic situational: "Course very stressful, financial problems. Isolated from friends."

[7] Gestalt therapy is a client-centred approach to psychotherapy that helps clients to focus on the present and understand what is happening in the current moment, rather than what they may perceive to be happening based on past experience.

4. At-risk scenarios: "Risk will increase if under the influence of [alcohol] and in response to conflict and stress."

5. Guidance for future risk management: "Home with [Mrs B]. Sleep today. No [alcohol]. PES risk review [Day 3], PES as required."

38. RN D told HDC:

> "I made this decision [to discharge] based on assessing [Ms A's] current risk, her desire to return home to sleep and [Mrs B] agreeing to her going home. There was also going to be a follow-up appointment the next day, which [Ms A] had agreed to attend.
>
> …
>
> It is also likely that I explained what to do if there were symptoms of acute alcohol withdrawal and I would have discussed with [Mrs B] the removal or securing of medication supplies at her home, as is my usual practice."

39. RN D said that she also provided documentation that included the 24/7 contact number for PES.

40. Mrs B advised HDC that she was not consulted during the risk assessment/management process, and that no one suggested that Ms A should not manage her own medication. Mrs B stated that she told staff on her own initiative that she would take care of it.

Day 3

41. Mr B told HDC that at approximately 1.30pm on Day 3 he received a telephone call from the Police informing him that Ms A had had an accident and that she had been drinking. Mr B went to the Police station and collected Ms A and took her to her appointment at the public hospital.

Telephone conversation between Mrs B and RN F

42. At approximately 2pm, Mrs B telephoned RN F[8] to inform her that Ms A might be late for her appointment at 3pm as she had been involved in an accident. Mr and Mrs B told HDC:

> "[Mrs B] expressed her concerns about [Ms A] saying that she was highly at risk of suicide. [Ms A] had told [Mrs B] she was sorry her suicide attempt had failed and [Mrs B] passed that information on."

43. …

44. Following Mrs B's telephone call, RN F documented:

> "Phone call received from [Mrs B] who advised that [Ms A] lives with them; that she thinks now is the time for her to be admitted to [Mental Health and Addiction Services]. That [Ms A] was now with her father at police having been stopped by police this [morning] and at police station giving blood alcohol sample."

[8] RN F was Ms A's case manager with PES.

45. RN F told HDC that her progress note for this telephone call is incomplete because part-way through her documentation Mr B and Ms A arrived for Ms A's appointment.

Appointment with RN F

46. RN F told HDC:

> "As is my usual practice, I explained the confidential nature of this service and asked [Ms A] whether she wanted her father to accompany her or whether she wanted to be seen alone and that if so I assured [Mr B] that I would be available to him after this interview."

47. RN F stated that Ms A opted to be seen alone. RN F assessed Ms A and documented in a progress note that Ms A had been in an accident, had no memory of it, and had superficial injuries. RN F recorded:

> "[Ms A] remained intoxicated and tearful … After considerable time in discussing the recent events it appears that the [self harm] was impulsive on background of returning to [New Zealand] to further study; missing supports from [overseas] and with long standing chronic passive suicidal ideation [harmed herself]."

48. Under the heading "Risk", RN F documented:

> "Initially presenting with stated intent to return home and drink. [Ms A] has agreed to a trial of [alcohol] recovery with them to clearly identify what issues are paramount for her and may or may not be ameliorated.
>
> RISK to self LOW when sober.
>
> RISK to self MOD[erate] when intoxicated.
>
> RISK to others LOW.
>
> Longer term prognosis poor if alcohol dependence continues."

49. Under the heading "Plan", RN F documented:

> "[Ms A] has agreed to attend [Alcoholics Anonymous] twelve step meeting this evening at [7pm] and to ask for a phone number of a woman there … To attend [Psychiatric Emergency Services] for [review] with [Dr C] (and myself as [case manager]) with a view to a supported home detox. [Ms A] has agreed to a referral to [Alcohol and Other Drug Coordination Service]. (same sent)."

50. In relation to Ms A's self harm, RN F told HDC:

> "[Ms A] talked of her now compounded shame and embarrassment, and on direct questioning explained that the experience had been awful and was not something she would do again and that she had already caused her family enough distress. That suicide was not an option."

51. RN F stated:

> "I then asked about her study, and acknowledged her recent struggles to meet course needs and strongly encouraged [Ms A] to consider a break from this, as now she was in a good place to address her alcohol issue. … [Ms A] appeared to be invested in this and agreed to accept a referral to CADS [Community Alcohol and Drug Services]."

52. In relation to Ms A's alcohol usage, RN F told HDC:

> "We discussed the role of alcohol in impulsivity and thus the increased risk to self, that diagnosing and treating underlying mental health issues was problematic whilst alcohol continued to mask mental health symptoms, and that therefore treating underlying issues was also considered problematic. I advocated a course of Alcohol [and] Drug treatment."

53. RN F stated that she and Ms A discussed her safety and completed a crisis plan, albeit "to the extent that [Ms A] was prepared to contribute to this process". RN F told HDC that initially "[Ms A] declined to provide a copy for her father and declined to give him any disclosure. She was advised that this could be revisited." RN F stated: "After initially declining, with my encouragement [Ms A] eventually agreed to my inviting her father into the room."

54. RN F told HDC that Mr B was then invited into the room, and that she "explained the risk review to [Ms A's] father and discussed [their] conclusion to him by way of offering an assurance of [Ms A's] stated intent of NOT being currently suicidal". RN F stated that she invited Mr B to ask any questions, and provided an explanation of the PES approach of encouraging "those with mental health issues to encourage a recovery approach from alcohol and/or other drugs, with then having the ability to diagnose and treat".

55. RN F documented in the Initial Treatment/Crisis Plan under the "Follow up arrangements" heading: "[Alcoholics Anonymous] meeting today — (daily preferably). 3pm [review] [Consultant Psychiatrist] [Dr C]. [Day 4]."

56. Under the "Other instructions including keeping safe" heading, RN F documented: "PES 24/7 0800. Brief [case management] — [RN F] (RN)." The document indicates that a copy was offered to Ms A, but not to the "family/whānau/carer". The document is signed by Ms A. Ms A and RN F also signed an Initial Treatment Information Form.

57. Mr B told HDC:

> "When I took [Ms A] to her first appointment at PES on [Day 3] the case manager talked to me about the disease of alcoholism. She said that [Ms A] needed to attend Alcoholics Anonymous and she should apply for admission to [a residential service].[9] The case manager told me that [Mrs B] and I needed to look after ourselves and gave me pamphlets for support groups in [the region] for the families of alcoholics. If the

[9] This is a service that provides a safe environment where people with alcohol and other drug dependence can withdraw from substances. There are beds for women and men over the age of 17 years who meet certain criteria.

> case manager had concerns about [Ms A's] anxiety and panic attacks she did not raise them with me at any time."

58. That evening, Ms A attended an Alcoholics Anonymous meeting.

Day 4 — follow-up appointment with RN F and Dr C

59. On Day 4, Ms A presented to Consultant Psychiatrist Dr C and RN F. Dr C wrote to Ms A's general practitioner and recorded:

> "Diagnosis: 1. Alcohol Abuse and Dependence. 2. Depressive episode … [Ms A] now admits to drinking 2–3 bottles of wine daily for an extended period of time (years). She experiences withdrawal symptoms very quickly if not drinking in the form of sweating, vomiting and anxiety. She drinks to the point of blackout at times and has most of the other symptoms of alcohol dependence. … She has started attending [Alcoholics Anonymous] meetings and is currently contemplating which rehabilitation pathway she will take. We have discussed with her home detox through [a support organisation] or going to [another support organisation] for an inpatient detox and rehabilitation with a full support program. She wishes to have some more time to consider her options before making a final decision as she worries about how this will interfere with her course. … While [Ms A] is contemplative, which is encouraging, she has a long way to go to fully committing to treatment. … We will support her over the weekend and assist her to engage with a treatment program of her choice. I believe the mood disorder currently cannot be seen as primary until she is not using the amount of alcohol she currently does. She intends continuing with the citalopram in the meantime and acknowledges that she has not been truthful with other health professionals about the amount she is drinking. Suicide risk currently is low but as expected, this can change depending on her level of intoxication."

60. Under the "Plan" heading, it is documented that Ms A was given information about rehabilitation programmes, and that she would attend two Alcoholics Anonymous meetings over the weekend and be contacted again by RN F on Sunday for support. Dr C also wrote a prescription for citalopram.

61. The "Clinical Risk Assessment and Management" policy in place at the time of events stated:

> "Risk should be formulated in terms of seriousness and in the context in which it is most likely to occur. This will include the nature and magnitude of the potential harm, the imminence and the frequency of it, as well as circumstances that may increase the risk and the availability of the means and opportunity to carry out the harm."

62. Dr C told HDC:

> "When assessing risk and implementing a management plan, I had to assess [Ms A's] risk until her next contact. This was to be on [Day 6] by [RN F] following my consultation with her."

63. Dr C stated that at this appointment, Ms A told her that she had significantly reduced her alcohol intake.

64. Dr C also told HDC:

> "With regard to the underlying possible psychiatric illness, I did not dismiss this, but remain of the opinion that it was not possible to adequately treat [Ms A's] underlying psychiatric conditions while she was consuming alcohol in large amounts."

65. Dr C wrote to Ms A's GP and stated:

> "[Ms A] has been given information about [rehabilitation programmes], she will attend two [Alcoholics Anonymous] meetings over the weekend and be contacted by her case manager, [RN F] again on Sunday [Day 6] for support."

Referral to Community Alcohol and Drug Services

66. CADS is an outpatient service responsible for providing comprehensive alcohol and drug assessment, treatment planning, and advice on referral for Specialist Mental Health Services [SMHS].

67. The Alcohol and Other Drugs Coordination Service is a lower specification service that provides rehabilitation and support to people with alcohol and drug addictions.

68. Clinical Nurse Specialist (CNS) RN E told HDC that he first became aware of Ms A when RN F visited his office on Day 7 and provided him with Ms A's "clinical SAP (CDHB patient information system) note of her contact". RN E said that "from memory this was the Progress Notes dated [Day 3]", and that RN F requested that this be a referral to CADS about Ms A's alcohol use.

69. Dr C told HDC:

> "Transfers to other parts of the service were generally done by way of a written referral but it had become practice to consult and discuss referrals from PES to CADS verbally as they were literally in the office next door …"

70. RN E told HDC:

> "[RN F and I] had a verbal discussion which addressed that [Ms A] had been reluctant to engage in [Alcohol and Other Drugs] treatment and that there had been some difficulty consistently making contact with her. It was my understanding that PES remained involved in her care and would be taking the lead in respect of managing her mental health issues."

71. RN E stated: "[The] clinical documentation (the Progress Note dated [Day 3]) was processed with our secretary staff [and] a referral was opened for the CADS team on [Day 8]." RN E told HDC:

> "It is my recollection that PES remained working with [Ms A] at this stage regarding her other mental health issues and the purpose of the referral was to offer an AOD

> pathway. The referral was therefore discussed in terms of her AOD treatment only. It was highlighted to seek more information about [Ms A's] motivation to seek AOD treatment and a possible match for AOD allocation for alcohol treatment was to be explored based on the referral information from PES."

72. On Day 7, a CADS triage occurred with five CADS staff present. This is documented on the CADS Referral Screening Document as the CADS triage, with the following outcome recorded: "[S]creen for motivation and possible AOD central." The referral screening document also states: "[R]eferral withdrawn … presented to AOD central and case allocated to [outpatient AOD services] … for 1:1 AOD work."

73. On Day 8, RN E documented: "Call placed to cell and landline seeking contact with [Ms A] for a phone screen. Message left."

74. On Day 10, RN E documented: "Email PES case manager re attempted phone screen by nil reply from [Ms A] to date." RN E told HDC that RN F emailed him advising that she had spoken to Ms A's father and informed him of the CADS processes and told him that his daughter would be discharged from PES if there was no further contact, and also that CADS might adopt a similar stance if there was no contact. RN E said that he acknowledged the email.

RN F contact and PES discharge

75. On Day 6, RN F documented that she telephoned Ms A on her landline and also on her mobile number. RN F documented: "No response from landline. [Mobile] phoned with no response; [message] left asking for return contact."

76. RN F told HDC that on Day 6 she made "several attempts on both landline and mobile phones to contact [Ms A] and left messages requesting return contact". These attempts are recorded in Ms A's clinical notes.

77. RN F also told HDC that on Day 10:

> "Further attempts were made to contact [Ms A] and a message left requesting return contact via the 0800 number. I then went onto four night shifts. A point to note is that during this time I made numerous attempts to contact [Ms A] by her mobile phone. Messages were not left as I had previously left them asking for return contact to no effect. Contact from our service comes up on receiving mobile as 'unknown'. While these were not recorded, subsequent to this event I now routinely record the number of attempts made to contact, at the end of a shift and before closing the progress note for the day."

78. On Day 10, RN F documented that she telephoned Mr B and advised him:

> "I shall be discharging [Ms A] due to non engagement. It appears she received phone contact from CADS and again has not returned their contact.
>
> …

> I have advised [Mr B] of the processes around being accepted for treatment and that if [Ms A] does not make contact with either myself (PES) or CADS then she will be discharged from [Mental Health Services]. [Mr B] is worried with regard to this his concern being around the charges she is facing in court and that non-engagement in formal recovery programme may not bode well for her with this court appearance."

79. RN F told HDC that she informed Mr B that the decision to discharge Ms A from the service was discussed "with [the multidisciplinary team] (in which she was discussed on a daily basis whilst under the care of PES) and [Dr C]".

80. RN F documented: "PLAN; further attempt to contact and then for [discharge]." There are no notes detailing further attempts by [RN F] to contact [Ms A], no documentation of the discharge or multidisciplinary team meeting, and no PES progress notes after the Day 10 telephone note.

81. Mr B described to HDC his telephone conversation with RN F:

> "I got a call from the case manager saying [Ms A] had not replied to messages left on her cell phone and if [Ms A] did not reply that day she would be cut from the programme."

82. Mr B told HDC that Ms A said that she had not received any of the messages and immediately made contact.

CADS telephone screening and engagement

83. Ms A engaged with the service again by contacting the CADS team and speaking to RN E. RN E documented that Ms A had telephoned in response to the telephone screen request. RN E recorded:

> "[Ms A] sounded uncomfortable with the phone conversation stating she was in a public place and on a pre paid phone and that it may cut out seeking to end the conversation. She reported drinking a bottle of wine up to [three] times a week and stressed as with [studies] currently as not seeking to stop currently."

84. RN E documented that it was apparent that Ms A was not comfortable having a telephone screening at that time, and they negotiated to undertake it at 2pm the following day.

85. On Day 11, RN E telephoned Ms A on her mobile phone and documented:

> "[Ms A] noted drinking [one] bottle of wine daily since the [accident] on [Day 2]. Was drinking [two to three] bottles of wine daily prior to [accident] for a few years … [Ms A] would like to explore a [residential] detox and was open to 1:1 with [the outpatient AOD service]. She is currently focused upon [studies] and keen [to] see the term out in [a month's time] but able to attend for an assessment preferably on [Wednesday morning] in a few weeks time.
>
> …

> At times [Ms A] seeking to stop drinking but some reluctance and concern about when and the need for support for this to occur and to fit in with her [studies]. [Ms A] agreeable to present to [AOD] for allocation.
>
> Still under PES but about to close case. Risks are linked to drinking.
>
> Plan
>
> AOD presentation for [outpatient] screening appointment time.
>
> To text [Ms A] with an assessment date."

86. RN E told HDC:

> "I undertook an AOD phone screen focusing on her motivation to engage in possible treatment pathways, her current alcohol and drug use, past use and contact with treatment and what goals she had in relation to her AOD treatment. I also explained the role of [residential] detox and counselling with [the outpatient AOD service]. As part of this pathway the client is informed that their referral will be closed with CADS when accepted by another AOD service. … I informed [Ms A] that I would present her case to AOD for an appointment for treatment with [outpatient] AOD services and that I would text her the details. It was agreed with [Ms A] during that last phone call that I could text her information about the referral to [outpatient AOD services] after the meeting. This was the last time I spoke with [Ms A]."

87. RN E said that on Day 11 he emailed RN F confirming that a telephone screen had been completed and that Ms A would be linked with outpatient services for alcohol treatment. RN F replied with confirmation on the same day.

88. RN E told HDC:

> "I acknowledge that this phone call did not include a discussion about self harm risks. The purpose of this phone call was a triage/screen and at this time I still understood PES remained involved, although were moving to discharge. I accept that self harm risks should have been explored."

89. RN E told HDC that on Day 15:

> "I presented to the 10am Alcohol and Drug Central allocation meeting (CAM) at the … site. It was agreed to offer [Ms A] an appointment with [a nurse] from the [outpatient] AOD team for 1:1 AOD counselling with possible discussion of detox needs with [the residential service] at a later date due to her request to have contact in two weeks' time on a Wednesday post exams. I would have noted the involvement of PES in light of her suicide attempt, their move to discharge and the assessment of the risk as being low to moderate but linked to drinking. … I passed copies of the paperwork of the CADS and PES referral information (most likely including a face and contact details sheet, the Progress Note of [Day 3], the letter of [Dr C] of [Day 4], and the CADS referral log) to [the nurse] at that meeting. It was agreed that [the nurse] from [the outpatient] AOD team would contact [Ms A] about a face to face appointment. I came back from the

> meeting and it was my recollection that I sent a text to [Ms A's] cell [phone] confirming the plan that a referral was accepted for alcohol treatment with [the nurse] from [the outpatient AOD service] and his contact details.
>
> …
>
> I withdrew the referral on [Day 15] on the computer referral log which was our process. I would have checked the computer and was aware that PES had closed their case. I understood that PES would not have closed the case without further discussion if the risks of self harm still required active management in short term. … CADS often take referrals where there are mental health concerns that are managed by PES for short periods of time after the referral to CADS to assist transition (I previously referred to this as 'holding on the books'). The CADS triage role at this time was to explore a treatment pathway for [Ms A's] AOD needs and set that in motion."

90. On Day 15, RN E wrote to RN F and stated:

> "Thank you for your referral dated [Day 8]. Our service has received the referral however the referral was withdrawn. Presented to AOD central and case allocated to [outpatient] AOD services for [registered nurse] to be allocated with his team for 1:1 AOD work. Please contact our service if you wish to discuss this decision further."

91. RN E told HDC:

> "In practice the policy for CADS acceptance of case management (as opposed to allocation to a community based resource) is when there are separate moderate to severe mental health concerns that require active management by a specialist team alongside the AOD treatment. In practice the presence of a recent suicide attempt, although a factor, would not necessarily in itself indicate that CADS would manage the treatment. I don't recall it being highlighted at the time of the referral that [Ms A] had previously been under the care of a private psychiatrist. Usually when it is identified that there are separate mental health issues that require specialist treatment, then this is referred to in the handover. [Ms A's] mental health concerns had been diagnosed as 'depressive episode' and in practice this would not usually require CADS case management. CADS also hold a separate role of triaging referrals and identifying appropriate AOD pathways. In this case the issues highlighted were around motivation to engage and the types of treatment that may encourage engagement. The decision that [Ms A's] treatment would be managed in the AOD sector was made by the CADS team at the meeting on [Day 7]. That decision was also agreed to by the AOD … allocation meeting on [Day 15]."

92. There is no record of any further interactions between Ms A and any clinicians at CDHB following this entry. CDHB told HDC that the intention was for the service to organise an assessment for Ms A in a few weeks' time when she had less study.

93. The following week, Mr B found Ms A had passed away.

Policies in place at the time of events

94. The Community Alcohol and Drug Service (Service Provision Framework (CADS-SPF) outlines the circumstances in which a consumer will be offered a comprehensive assessment by the Service. The CADS-SPF stated:

> "Consumers will be offered a comprehensive assessment by the Service if:
>
> 1. The consumer is aged 18 years of age or over; and
>
> 2. The consumer has a confirmed or suspected presenting problem of severe alcohol and/or other drug dependence; and
>
> 3. The consumer has a confirmed or suspected mental illness (which can be compounded by a personality disorder) of a moderate to severe nature which requires specialist assessment; and
>
> 4. The consumer has active dysfunction as a result of mental illness involving:
>
>   Significant threat to safety or wellbeing of self or others
>
>   Or
>
>   Intensive involvement with psychiatric services e.g. is under the Mental Health act and/or admitted more than briefly to mental health inpatient care
>
>   Or
>
>   Impaired ability to function effectively in the community and problems with
>
>   - Independent living and domestic skills
>   - Employment and recreation
>   - Relationships and interpersonal skills
>   - Personal care …"

95. Under "Consumers will be accepted into active treatment by the service" the CADS-SPF stated:

> "1. They have been assessed by CADS …
>
> 2. Have confirmed or probably alcohol/drug dependence or abuse
>
> 3. The consumer is willing to participate in treatment according to their individual treatment plan."

96. Under "Consumers will be accepted for joint management with another Mental Health Service if" the CADS-SPF stated:

"1. They have been assessed by CADS …

2. Have confirmed or probable alcohol/drug dependence or abuse, complicated by another psychiatric disorder.

3. The consumer is willing to participate in treatment according to their individual treatment plan."

97. The CADS-SPF set out the way in which CADS interfaced with other parts of the Specialist Mental Health Service. The PES Interface with CADS (PES referring to CADS) section outlines the following processes:

— The consumer is assessed at PES;

— The consumer is referred to CADS;

— If the referral does not meet the acceptance criteria for assessment, advise PES of non-acceptance, by standard letter including reasons for non compliance — "Refer on".

98. Under the heading "Clinical Responsibility" the interface states:

"[C]ontinue to maintain contact with consumer until their care is transferred to another service. Clinical responsibility is transferred to CADS on presentation at MDT and acceptance of treatment plan."

99. The Psychiatric Emergency Service (Service Provision Framework) outlines the process upon receipt of referral, and includes the following steps:

— Triage and arrange appointment

— Initial assessment

— Appointment arranged

— Interview preparation

— Consumer/caregiver interview (two kinds: "Comprehensive assessment" and "Brief assessment")

— If the consumer meets the assessment criteria, consider whether the consumer needs to be seen by a registrar or consultant psychiatrist (if "Yes", organise an interview)

— Feedback to consumer/caregivers

— Complete documentation

— Medical/multidisciplinary team review of assessment

— Treatment process

— Discharge/Transfer

"If unable to locate consumer — discuss with MDT … and determine appropriate action."

100. Under "Discharge/Transfer Criteria", the Service Provision Framework states:

> "Consumers will be discharged/Transferred from Psychiatric Emergency Service when:
>
> 1. The consumer's ongoing needs are manageable in a primary health care setting; or
> 2. The consumer has been referred to, and accepted by, another Mental Health Service and psychiatric responsibility has been transferred; or
> 3. The consumer withdraws from treatment; or
> 4. The consumer is unlikely to benefit from further psychiatric treatment; or
> 5. The consumer fails to attend after 2 documented attempts to contact."

101. The PES-SPF set out the way in which PES interfaced with other parts of the Specialist Mental Health Service. The "PES Interface with SMHS" section outlines the following processes:

> "Referral
>
> If the referral does not meet the criteria for assessment, then advise PES of non-acceptance by Healthlinks freetext letter, including reasons for non-acceptance."

102. Under the heading "Clinical responsibility", it states: "For CADS — maintain CR [clinical responsibility] until Assessment." Other processes include: Assessment; Informing GP; Discharge, including discharge checklist.

103. Under "Individual Treatment Guidelines", it states:

> "Discharge is planned and documented according to the Psychiatric Emergency Service Protocol."

Serious Incident Review

104. CDHB carried out a Serious Incident Review (SIR). CDHB noted:

> "Core (suicide) risk information throughout PES contact was minimal. It was initially completed post [self harm] and the core documents were not updated after this. It did not provide a formulation or management guidance with regard to [Ms A's] suicidal thinking, review of her antidepressant medication change, and the management of stress and anxiety resulting in use of alcohol."

105. The SIR identified the following:

- Clinical documentation did not evidence assessment of mood and suicidality.
- CADS criteria for assessment includes alcohol and a suspected mental disorder. The assessment did not occur.
- The risk management plan was focused on level of intake of alcohol to assess risk.

- There were communication issues arising from family involvement between family and clinicians, and a lack of documentation in the clinical record around family contact.

106. In regard to communication issues, CDHB stated:

> "It is our standard practice to encourage patients to include as many of their family and friends as they wish to be added to their disclosure list. While [Ms A] only asked for [Mrs B] to be on her disclosure list this should not have prevented us from listening to the concerns raised by her father."

107. The SIR noted:

> "CADS staff were informed that alcohol was the primary issue and that [Ms A's] low mood stemmed from her drinking. The CADS clinician understood that the risk to self was low and there were no significant mental health issues. The referral was a clinical note, and a discussion occurred between the PES and the CADS clinician.
>
> …
>
> The referral from PES strongly confirms alcohol as the main issue and [Ms A's] mood being negatively impacted by drinking.
>
> …
>
> The CADS staff member was not handed over information about [Ms A's] mood, but was aware that she had [harmed herself]. Had the referral to CADS and the CADS telephone screen been more comprehensive, it may have been appropriate for [Ms A] to go on CADS caseload in view of her coexisting problems."

108. During the SIR, CDHB "planned to undertake training in coexisting disorders that will include the development of safety plans with family involvement".

Changes made

109. CDHB told HDC:

> "There have been significant service delivery improvements made since. Crisis Resolution is a new Specialist Mental Health Service combining the resources of the former Psychiatric Emergency Services and Community Intensive Care teams. The Crisis Resolution service is a function of the community mental health teams. It provides the necessary care, treatment and support in the community, preferably in the home, to deal with emergency presentations."

110. As a result of the SIR, CDHB used the subsequent report as a learning tool for staff, with a focus on managing and treating consumers with coexisting disorders and identifying communication issues to staff. In addition, AOD and community services at CDHB developed "collaborative processes for those who present with alcohol dependence and suicidality". CDHB also identified that the Service Provision Frameworks needed to be updated to "clarify and document" the transfer processes between services, the CADS criteria for acceptance, and the CADS telephone screening process.

Responses to provisional opinion

111. Mr and Mrs B were given an opportunity to comment on the "information gathered" section of the provisional report. Where appropriate, some of their comments have been incorporated above. Mr and Mrs B stated that their experience was that of being excluded by CDHB from its process, and from any attempts by them to help to create safety and wellness for Ms A. They also noted that a prescription for ongoing medication was made without consulting them.

112. CDHB advised that it accepted the provisional opinion and recommendations.

Opinion: Introduction

113. This case highlights the importance of an integrated system of health care for consumers with co-existing mental health and addiction disorders. Expert advice relating to the systems at CDHB's Psychiatric Emergency Service and its Community Alcohol and Drugs Services was obtained from a consultant psychiatrist, Dr Jeremy McMinn. Expert advice in relation to the individual nursing care was obtained from a registered nurse, Dr Anthony O'Brien.

Opinion: Canterbury District Health Board — breach

114. District health boards are responsible for the operation of the clinical services they provide, and are responsible for service failures. They have a responsibility for the actions of their staff, and an organisational duty to facilitate continuity of care. This includes ensuring that appropriate policies are in place, that all staff work together and communicate effectively, and that all staff comply with the DHB's policies and procedures.

PES risk assessments

Day 4

115. On Day 4, Dr C reviewed Ms A and confirmed alcohol dependence as her primary diagnosis. He documented: "Suicide risk is currently low, but as expected, this can change depending on her level of intoxication."

116. Dr McMinn advised:

> "Given recent presentations of recurrent very intoxicated presentations, and her ambivalence about alcohol treatment, it is arguable whether this risk statement was a misleading understatement — essentially intoxication in the near future was surely more likely than not, therefore the risk was more likely not to be low."

117. Dr McMinn further advised:

> "The tendency to consider her risk from a baseline of not drinking is questionable. Being dependent on alcohol meant that she was very unlikely to cease drinking. So, counterfactually, it would have been more realistic to expect she would continue to drink heavily until she had made substantial progress through alcohol treatment. Therefore, at the stage she was being seen … her risk should have been assessed to reflect the likelihood of ongoing heavy drinking … her risk of harm overall was not low, even if the immediate risk of suicide in the context of her appointments was felt to be low."

118. I accept Dr McMinn's advice and am concerned that PES based the risk assessment for Ms A as being relative to her being sober. I note that Dr McMinn also advised that, in his view:

> "[Ms A] should not have been seen as Low Risk for harm overall — and the overall approach taken to her management should have reflected this. Instead there was a separating out of risks of suicide and risks of heavy drinking, as if the two had no bearing on each other.
>
> This failure to integrate an assessment of risk appears to have meant that when PES pulled out from [Ms A's] care, there was no commensurate step-up by CADS to approach her risk to take account of the absence of non-alcohol mental disorder management."

119. I also note Dr C's statement:

> "With regard to the underlying possible psychiatric illness, I did not dismiss this, but remain of the opinion that it was not possible to adequately treat [Ms A's] underlying psychiatric conditions while she was consuming alcohol in large amounts."

120. Unfortunately, it was the low risk assessment that was then conveyed to the CADS team, and that low risk assessment may have contributed to PES's decision to discharge Ms A from its oversight when contact became difficult.

121. I am highly concerned at the communication failure around the level of risk.

Clinical responsibility

122. PES referred Ms A to CADS solely for the management of her addiction issues, without retaining any clinical responsibility for her mental health. I hold the opinion that PES should have evaluated Ms A's level of risk adequately, and either retained a level of clinical responsibility for her mental health issues, or referred her to CADS for assessment on account of both her mental health and addiction issues.

123. RN E told HDC that he first became aware of Ms A when RN F visited his office and provided him with the progress note dated Day 3. Dr C told HDC:

> "Transfers to other parts of the service were generally done by way of a written referral but it had become practice to consult and discuss referrals from PES to CADS verbally as they were literally in the office next door …"

124. RN E told HDC that on Day 7 he attended a meeting of five CADS staff, where the referral was discussed. RN E stated:

> "It is my recollection that PES remained working with [Ms A] at this stage regarding her other mental health issues and the purpose of the referral was to offer an AOD pathway. The referral was therefore discussed in terms of her AOD treatment only. It was highlighted to seek more information about [Ms A's] motivation to seek AOD treatment and a possible match for AOD allocation for alcohol treatment was to be explored based on the referral information from PES."

125. The CDHB SIR noted:

> "CADS staff were informed that alcohol was the primary issue and that her low mood stemmed from her drinking. The CADS clinician understood that the risk to self was low and there were no significant mental health issues. The referral was a clinical note, and a discussion occurred between the PES and the CADS clinician."

126. CDHB's SIR also acknowledged: "The referral from PES strongly confirms alcohol as the main issue and [Ms A's] mood being negatively impacted by drinking."

127. The SIR findings included:

> "The CADS staff member was not handed over information about [Ms A's] mood, but was aware that she had [harmed herself]. Had the referral to CADS and the CADS telephone screen been more comprehensive, it may have been appropriate for [Ms A] to go on CADS caseload in view of her coexisting problems."

128. I am thoughtful of RN E's statement that he still believed that PES was involved in the monitoring of Ms A's mental health issues, and that CADS was solely responsible for locating an appropriate alcohol rehabilitation programme for her. I also note that there is no evidence that RN E's telephone screening of Ms A was intended to be an assessment for the purposes of the CADS-SPF to determine admission.

129. In this instance, PES provided a corridor handover, and it is clear that RN E left the handover believing that PES was still involved in establishing any remaining risks regarding Ms A's mental health, and that PES had given CADS the sole task of locating a suitable alcohol rehabilitation programme for Ms A. As noted above, this information is reflected in the findings of CDHB's SIR.

130. Dr O'Brien advised:

> "Given [Ms A's] very recent suicidality it is my opinion that there should have been a plan in place to manage any re-emergence of this problem. This could have involved Psychiatric Emergency Service's continued case management of [Ms A] until an initial face to face CADS assessment, or an active plan on the part of CADs in relation to this. Either way, one service needed to clearly hold this responsibility and it is not clear that either service did clearly hold this responsibility."

131. It is also apparent that the PES policy in place at the time of events outlined that PES retained a level of clinical responsibility until Ms A had been assessed by CADS. Dr McMinn advised:

> "The PES-SPF PES/SMHS OP Interface is also supplied. It is questionable whether this was followed correctly. This policy indicates PES should have maintained Clinical Responsibility until the CADS completed their assessment. I do not accept that the CADS had completed its assessment, the telephone screening being inadequate for this purpose in [Ms A's] case."

132. I agree with my two experts that one service needed to take responsibility for coordinating Ms A's care, and I am very critical that neither service took that responsibility.

133. I further note that the clinical decision-making in CADS stemmed from the information provided to it about Ms A's reported "low risk of harm", and in the absence of her full mental health history being provided. As noted above, it also stemmed from the referral from PES being focused on Ms A's addiction issues. However, I also note Dr McMinn's advice that the CADS criteria for admission would have been met by Ms A. Specifically, Dr McMinn advised:

> "It was not appropriate for CADS to refer [Ms A] elsewhere, primarily because she met the criteria for CADS in having suspected Alcohol Dependence of sufficient severity, and suspected other mental illness sufficient to include mood or anxiety difficulties and put her at risk of attempting suicide … The decision to refer elsewhere meant that care of a level realistic to [Ms A's] needs was delayed. This was a moderate departure from standard of care, being a direct failure to offer the care CADS was charged to provide."

134. RN F advised RN E that PES was moving to discharge Ms A on Day 10. While I accept that there was no indication given by PES to CADS that CADS was to assess Ms A, I am disappointed that no one in CADS thought critically about Ms A's situation. In particular, I note that CADS had received the progress note from RN F that reported a "moderate risk to self when intoxicated", and Ms A's admission to RN E that she was drinking one bottle of wine daily. I am disappointed that no one in CADS thought critically about the extent of Ms A's drinking and the moderate nature of her risk when intoxicated, and that no one sought further information and discussion with PES about whether Ms A should be assessed by CADS.

Conclusion

135. It is clear that CDHB staff were primarily focused on addressing Ms A's alcohol addiction issues, but that the same level of attention was not being given to her mental health issues or to integrated, ongoing risk assessment. It is my opinion that CDHB staff separated Ms A's mental health and addiction issues from one another and, as a result, Ms A did not receive a coordinated and appropriate standard of care for her mental health issues. The transfer of Ms A's support to alcohol and drug services in the community was insufficient for a consumer dealing with both mental health and alcohol addiction disorders.

136. I note Dr McMinn's advice: "While many of the individual steps reflect a mild or moderate level of departure from the expected standard, the combination of failings led to an overall more serious departure from the standard of care."

137. I share Dr McMinn's view that the effect of the departures was that Ms A did not receive appropriate treatment, and she was lost from the care environment that she required at the time.

138. In conclusion, I am of the view that the referral of Ms A to AOD and her discharge from PES resulted in no one retaining clinical responsibility for her mental health issues, when either PES or CADS should have done so. Overall, I find that there was a lack of critical thinking in relation to the co-existing disorders, resulting in inadequate coordination of care by CDHB. Accordingly, I find that CDHB did not ensure co-operation between providers to ensure quality and continuity of services to Ms A and, accordingly, that CDHB breached Right 4(5) of the Code.

Family engagement — other comment

139. I note that on one occasion Ms A requested that she be seen without her father, Mr B. On that day, Ms A was significantly intoxicated and upset following an accident. Dr McMinn advised:

> "[Ms A] had the potential benefit of family desirous of being closely involved. It was not evident how much the PES (and the CADS) reviewed her initial position of excluding them, despite her reliance on their ongoing practical support of her needs.
>
> Her initial exclusion of her family's involvement means that there was no departure from the standard of care for family involvement, but care could have been significantly enhanced had she been able to change her position."

140. While I accept that Ms A wanted to be seen alone by Dr C for her appointment, I am thoughtful of the fact that there is no evidence or clinical record outlining the support Ms A's family was offering to her, or that the value of that support was emphasised to Ms A by clinicians at CDHB at a later stage. I encourage CDHB and the clinicians involved in Ms A's care to reflect on this.

Recommendations

141. I recommend that CDHB provide an apology to the family of Ms A for its breach of the Code. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding to the family.

142. In light of the issues I have identified in this report, the recommendations made in the CDHB SIR, and my experts' comments, I recommend that CDHB review and update the Service Provision Framework to ensure that it explicitly clarifies and documents:

i. the transfer processes between services,
ii. the CADS criteria for acceptance, and

iii. the CADS telephone screening process.

Evidence of any changes made as a result of this review should be provided to HDC, along with details of any further improvements to the interaction between the Crisis Resolution, CADS, and AOD services, within three months of the date of this report.

Follow-up actions

143. A copy of this report with details identifying the parties removed, except Canterbury District Health Board and the experts who advised on this case, will be sent to the Director of Mental Health, the Mental Health Foundation of New Zealand, the Coroner, the Royal Australian and New Zealand College of Psychiatrists, and the New Zealand College of Mental Health Nurses, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from consultant psychiatrist Dr Jeremy McMinn:

"23rd February 2018

Complaint: Mental Health Services at Canterbury District Health Board/Ms A (dec)

Your ref: C15HDC01202

Thank you for requesting expert advice on behalf of the Commissioner on the care provided to [Ms A] by Mental Health Services at Canterbury District Health Board (CDHB) between [Day 1–26].

I was originally provided with a letter of instruction, dated 8th March 2016, with the following enclosures:

1. A copy of a letter of complaint from [Mr and Mrs B], dated …;
2. A copy of a coronial file of [Ms A], including [the Coroner's] findings, dated 18th May 2015;
3. Response and clinical notes from CDHB, including results of Serious Incident Review, DHB reference [number];
4. Final Decision Paper: Alcohol and Other Drugs Service Structure Outpatient Services, dated 30th April 2015

The letter of instruction outlines a brief background to [Ms A's] difficulties from [Day 1] until her death on [Day 26].

The original request sought my opinion on 6 listed issues, with subsections in some issues, resulting in 13 different parts. These are reiterated in this report in bold italics as headings for each section for ease of reference.

You subsequently requested some expansion of the detail of the report, specifically in clarifying the level of any departure from an accepted standard of care.

In May and August 2017, you requested further clarification, specifically whether there were any departures from an expected standard of care in relation to the care provided by [Dr C].

The expansion and clarification were appended in my original responses. However, in view of your further requests for advice, I have incorporated these and further revisions into the body of the report for ease of reading. In addition, I have revised the wording of some parts where it seemed my original comments might be unclear.

You have provided further documents. These are:-

1. Policies in place at CDHB at the time of events, namely the Service Provision Frameworks for the Psychiatric Emergency Service and for the Community Alcohol & Drug Service;
2. A current CDHB family and whānau policy;
3. CDHB position descriptions of a Clinical Nurse Specialist (2015) and of a registered Nurse (2016);
4. CDHB's response to the HDC, dated 8th December 2017;
5. Additional clinical records from CDHB;
6. Statements from [RN D], [Dr C], [RN E], and [RN F]

You have requested my opinion on 4 further points. These are each addressed in this report in bold italics as headings for each section for ease of reference, as per original opinion request.

Comments on the adequacy of the triage and assessment processes by the Mental Health Liaison Team (MHLT), the Psychiatric Emergency Service (PES), and the Community Alcohol and Drugs Service (CADS), including the adequacy of the clinical documentation

Contact on [Day 2] by [RN D]

The clinical file indicates MHL/PES registered nurse [RN D] saw [Ms A] at 5am on [Day 1] following the her presentation to the Emergency Department (ED). [Ms A] had [harmed herself] and consumed alcohol to the extent her blood levels were more than 3 times the legal limit to drive.

The complainants, [Mr and Mrs B] have estimated [RN D's] assessment lasted less than 15 minutes only. [RN D] notes in her statement that her assessment took approximately 40 minutes. No time duration is recorded in the clinical file to clarify this discrepancy.

No reference is made to her current state of sobriety despite her excessive blood alcohol levels on presentation. There is no renewed blood or breath testing to identify her remaining degree of intoxication.

Despite concerns about her alcohol use, and details in the presentation that relate to an Alcohol Use Disorder, [RN D] did not draw these together towards suggesting an alcohol-related provisional diagnosis. There were details strongly indicative of Alcohol Dependence — increased use; high tolerance; withdrawal shaking; adverse feedback from family about her drinking; persistent drinking in the face of other priorities; the sense that she was minimising her alcohol use (borne out by her blood alcohol level on presentation).

In her statement, [RN D] describes her consideration of the possibility of Alcohol Dependence. However, she did not document this as [Ms A] did not identity her alcohol as problematic. I see little wisdom in this — in other conditions, this would not be a common approach *(e.g.* someone who was psychotic but identifying mood issues only would nonetheless be noted to be psychotic also) — and the family emphasised the alcohol as a problem also.

The Serious Incident Review (SIR) indicates the 'legacy archive appears not to have been accessed' — *i.e.* no attempt was made to confirm whether she had contact with services before. [RN D] states she spent 5–10 minutes checking the computer records for previous mental health history. I am unable to account for what appear to be opposite findings.

[RN D] did not attempt to contact her private psychiatrist or GP because of the early hour — this is understandable. I accept [RN D's] position that it might be common practice to hand over some of this responsibility to the Multi-Disciplinary Team (MDT). She also confirmed that GP would receive a letter of her assessment.

There is no record of discussion of the case with a psychiatrist or psychiatric registrar on call. Thresholds for involving on call medical staff vary across the country: electing not to so on this occasion in these circumstances (family carers involved, impending follow up, *etc.)* falls within the standard of care.

There was no record in the record of the advice given to [Ms A's] family about immediate safety plans. [RN D] has noted it is her usual practice to give such advice. I remain uncertain what advice was given about acute alcohol withdrawal, especially given the questions about the identification of an Alcohol Use Disorder in the assessment. As it later turned out, [Ms A] resumed heavy drinking within the next 24 hours.

…

I see [RN D's] role as providing an initial screening and limited input assessment. An early review (the next day) by PES and the provision of PES details were useful aspects that could be expected to compensate for the shortfalls noted.

I am not able to account for the discrepancies noted above: whether background information was adequately sought; and the duration of the assessment.

Contact on [Day 3] by PES

[Mrs B] forewarned [RN F] by telephone that the family thought [Ms A] should be admitted. In her statement, [RN F] describes this call lasting from shortly after handover (?1400hrs) until just before the 1500 appointment with [Ms A]. [Ms A] and then her father were seen from 1500hrs to around 1700hrs.

[RN F's] statement describes … limited agreement on behalf of the patient for carer involvement.

When [RN F] met [Ms A] she was intoxicated, had [had an accident] and had limited memory through alcohol 'blackout' of the day's earlier events.

Essentially this was an attempted assessment with some limited treatment in someone who was intoxicated. In such a situation, information gathering, mental state assessment, and detailed treatment planning should be circumspect. The close involvement of any available support people becomes paramount, given the likelihood

they will be left to take the lead in looking after the patient safely until she is next assessed.

[RN F's] statement indicates this situation was severely hampered in addition by [Ms A's] refusal in the heated session to allow adequate information sharing with her father.

[RN F] noted that a risk review was undertaken, and she was subsequently assessed as low suicide risk. Given the circumstances, a more sophisticated review of risk was indicated. In the past 48 hours, [Ms A] had been involved in 2 very serious incidents. Recurrent heavy consumption of alcohol was evident: given the circumstances already, this should have been an evident major concern of ongoing note. The … limited allowed carer involvement meant that [Ms A's] position was potentially isolated from the safeguards family often provide in unwell community patients.

Given the above, I consider that [RN F] should have seen [Ms A's] case as moderate to high risk of serious harm. A review the next day by a psychiatrist and to consider detoxification and ongoing alcohol rehabilitation was essential.

Contact on [Day 4] by PES

[Dr C] assessed [Ms A] and confirmed Alcohol Dependence as the primary diagnosis. There were conflicting accounts given about her consumption of alcohol before the appointment (with an admission by [Ms A] that she had been untruthful previously about her consumption).

[Dr C] noted her to be *'shaky and emotionally labile … alert and reactive'*. She did not record her opinion whether [Ms A] was hung over, intoxicated, in acute alcohol withdrawal, or suffering the tertiary complications of her years of excessive consumption. Any of these conditions was likely, and might have immediate ramifications on how to proceed.

There was no breath alcohol taken, an easy intervention that should be reasonably available in a PES, in my opinion, but commonly is not.

There was no physical examination, or arrangement for examination, or deskside checking to assess for the complications of alcohol dependence or other conditions. [Dr C] stated that it was her expectation that [Ms A's] physical state of health would have been properly examined in the ED and by her GP — I accept this expectation as the usual practice in the area. However, having turned the focus to an Alcohol Use Disorder, [Dr C] could have enhanced the quality of her assessment by undertaking an alcohol/addiction-focussed physical re-examination. Outside of an Addiction Service, the fact that she did not do so would not be a departure from the standard of care.

[Dr C] has confirmed that she discussed the risks from sudden alcohol cessation, and that [Ms A] appeared to heed these risks.

[Ms A] was not prescribed thiamine, preventative treatment for the potentially fatal Wernicke's Encephalopathy or irreversible Korsakov's Dementia. [Dr C] described that since she was expecting [Ms A] to be taken into alcohol treatment within the coming

week(s), thiamine was not prescribed immediately. In similar circumstances, I would recommend the thiamine is started immediately to take any opportunity to easily prevent serious and permanent disability that might have an imminent onset. However, again, outside of an Addiction Service, and in the expectation of fuller treatment to come, the fact that [Dr C] did not do so would not be a departure from the standard of care.

Mr B was not invited into this assessment, despite being present outside of the room. [Dr C] noted she did not wish to override [Ms A's] previous wish to limit her father's input. In the circumstances of [Ms A] having close and reliant contact with her family, … it may have been useful for [Dr C] to re-examine this family exclusion with [Ms A], or at least confirm the limits around some reasonable family engagement.

I agree with [Dr C's] statement: *'The mood disorder currently cannot be seen as primary until she is not drinking.'*

She prioritised [Ms A] to be directed towards alcohol treatment, and this was sensible. In the light of no current suicidal intent, [Dr C] considered [Ms A] to be low risk. For the reasons outlined in paragraphs 18, 19, 36, & 39, I consider this to be too limited an assessment of overall risk.

…

Contact with CADS

The referral to CADS was received on [Day 7]. Attempts to make contact by CADS to [Ms A] went unanswered on [Day 8] & [Day 10], on top of the unsuccessful attempt by [RN F] to make contact on [Day 6]. Contact was achieved on [Days 10–11] for 'phone screening', which gave conflicting information about amounts consumed and treatment intentions.

Liaison with family in this process was limited to seeking out [Ms A's] contact details.

Initial intentions were to involve the [outpatient] alcohol counselling and consider [a] social detoxification. It is not easy to understand from the documentation of a telephone assessment why such a limited response was planned.

This level of intended redirection into a service with lower specification reflected an underestimation of need in 2 ways — in a failure to address the co-existence of alcohol and suicidality; and in a failure to consider how severe an Alcohol Use Disorder she had.

There was a failure to adequately plan the management of a patient presenting with likely Co-Existing Problems (CEP) of Alcohol Dependence and other Mental Disorder, as yet poorly quantified.

CADS Clinical Nurse Specialist [RN E's] statement indicates a sense of relying on the PES to carry the non-alcohol mental disorder aspects of [Ms A's] case, rather than there being an integration of treatment for her co-existing problems.

As noted above, [Ms A] should not have been seen as Low Risk for harm overall — and the overall approach taken to her management should have reflected this. Instead there was a separating out of risks of suicide and risks of heavy drinking, as if the two had no bearing on each other.

This failure to integrate an assessment of risk appears to have meant that when PES pulled out from [Ms A's] care, there was no commensurate step-up by CADS to approach her risk to take account of the absence of non-alcohol mental disorder management.

In retrospect, [RN E] states that as PES were moving to discharge, the 'self harm risks should have been explored'. This emphasises that telephone triage was an unsuitable tool to use in this case. It also emphasises the poor results from running services that aim to keep addiction and non-addiction mental health treatment in different service silos without adequate integration. This is an issue covered at length in the Ministry of Health's 2010 Te Ariari o to Oranga — The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems.

In addition to not incorporating an adequate understanding of the interplay of risk factors, CADS appears to have concluded that [Ms A's] alcohol use disorder was sufficiently mild to aim for only a social detoxification response. On the contrary, [Ms A's] record of service contact to date should have raised many red flags that she was drinking large amounts; had been doing so for years; was going to find it difficult to sustain commitment to treatment; was facing multiple difficulties arising from her drinking; and had various psychiatric risks.

Electing to leave further input for this for a 'few week(s)' until the end of term, when she had yet to be seen in any session entirely sober, appears naïve in the circumstances.

It should have been clear from [Dr C's] assessment that specialist intervention, including prescribing medications specifically for Alcohol Dependence would be indicated. An immediate pick up for face-to-face sessions with staff able to provide some degree of combined Motivational Interviewing and Mental State monitoring was also outstanding.

Comments on the Adequacy of the Triage and Assessment Processes of PES and CADS taken as a Whole

Each part of [Ms A's] transition through PES and CADS had limitations, ultimately resulting in her not receiving effective treatment. These processes departed from the national standard of care.

The failure to assimilate each part of her contacts with CDHB into an effective care response is a moderate to severe departure from the standard. The impression given is that her care would reflect a level of practice that might commonly fail for patients with similar difficulties.

This moderate to severe departure from the standard of care for [Ms A], in the context of a system that might commonly fail for similar patients, would be viewed by peers

with consternation. [Mr and Mrs B's] wish to see changes in the manner of care provided to [Ms A] should be welcomed as an opportunity to make fundamental changes to the structure and quality of services.

The poor integration of services compounded the failure to assimilate the overall level of risk with which she presented. In this light, [Dr C's] statement that 'In Canterbury we work in a very integrated way' is belied by [Ms A's] case, and by the impression given of how the service she received was described.

Comments on whether it was appropriate for CADS to refer [Ms A] to the Alcohol and Other Drug (AOD) Central Coordination Service

As noted above (paragraphs 30–41), it is not clear why [Ms A] was to be passed on to services with a lower level of 'specification'. This view is strongly echoed in the SIR (Pages 9 & 10 of 11).

[Ms A] was not completely accurate in her details about her alcohol use; she was inconstant in responding to telephone messages or texts, and she was ambivalent about how to proceed with treatment. This put her in the company of at least a substantial minority of people with Alcohol Dependence, especially if severe. These qualities cannot be a defence of the departure from the standard of care she received.

It was not appropriate for CADS to refer [Ms A] elsewhere, primarily because she met the criteria for CADS in having suspected Alcohol Dependence of sufficient severity, and suspected other mental illness sufficient to include mood or anxiety difficulties and put her at risk of attempting suicide.

The decision to refer elsewhere meant that care of a level realistic to [Ms A's] needs was delayed. This was a moderate departure from the standard of care, being a direct failure to offer the care CADS was charged to provide. Only the fact that arrangements were made for [Ms A] to be offered at least some care means that this was not a severe departure from the expected standard of care.

Comments on the adequacy of the mental health care planning

There was a gradual transition towards a better understanding of [Ms A's] difficulties, indicating that the consolidation of each step achieved something of an iterative progression. This meant that Alcohol Dependence became more evident, although did not mean that this was well treated.

The identification of Alcohol Dependence coincided with a reducing focus on suicide risks or care of any underlying condition obscured by the Alcohol Dependence. Over the subsequent week, the focus on her risk overall, and the planning concerning non-alcohol related mental health difficulties appeared to diminish entirely.

This represents a departure from the standard of care expected in cases of Co-Existing Problems (CEP). There would be an expectation that her care would be orientated towards a CEP perspective to take account of both the alcohol and non-alcohol parts to [Ms A's] presentation. The nature of this departure from the standard of care was

moderate in its own right, but ultimately contributed to the severe departure from the standard of care that led to [Ms A] not receiving adequate care overall.

[Ms A] had the potential benefit of family desirous of being closely involved. It was not evident how much the PES (and the CADS) reviewed her initial position of excluding them, despite her reliance on their ongoing practical support of her needs.

Her initial exclusion of her family's involvement means that there was no departure from the standard of care for family involvement, but care could have been significantly enhanced had she been able to change her position.

Comments on the adequacy of the handover between PES and CADS

The file documentation provided does not record the quality of handover between the PES and the CADS. The SIR suggests handover was enhanced by corridor conversation — this can be an efficient means of handover. [RN E] stated that the handover included comprehensive verbal and document exchange, and gives the impression it must have included details about the [self harm and the accident].

The adequacy of handover between PES and CADS appears to have been adequate overall. It seems more likely that factors other than the handover led to inadequate integration of service appropriate to [Ms A's] level of need.

Comments on the adequacy of the overall risk assessment and risk management in [Ms A's] care

As noted in paragraph 18, 19, 36 and 39, a more sophisticated review of risk was indicated than was undertaken. In the past 48 hours, [Ms A] had been involved in 2 very serious incidents. Recurrent heavy consumption of alcohol was evident: given the circumstances already, this should have been a major ongoing concern. The ... limited allowed carer involvement meant that [Ms A's] positon was potentially isolated from the safeguards family often provide in unwell community patients.

The tendency to consider her risk from a baseline of not drinking is questionable. Being dependent on alcohol meant that she was very unlikely to cease drinking. So, counterfactually, it would have been more realistic to expect she would continue to drink heavily until she had made substantial progress through alcohol treatment. Therefore, at the stage she was being seen by the PES and CADS, her risk should have been assessed to reflect the likelihood of ongoing heavy drinking.

Her risk of harm overall was not low, even if the immediate risk of suicide in the context of her appointments was felt to be low.

The risk assessment was poor: the risk management was poor as a result. What to do in the immediate term in the face of changing levels of risk was not described, outside of the broad thrust of undertaking treatment over the longer term.

Comments on the adequacy of the initial risk management plan following [Ms A's] presentation to ED on [Day 1]

The initial risk management plan was inadequate. This was mainly because of the failure to perceive the sustained extent alcohol was playing in [Ms A's] difficulties, and thereby not take account of this in the risk assessment.

There was no renewed blood or breath testing to identify her remaining degree of intoxication. There was no direct liaison with the GP [with regard to her method of self harm].

Comments on the appropriateness of the interventions to address her alcohol and drug problems

There was no renewed blood or breath testing to identify her degree of intoxication at reviews outside of her acute ED presentation and the police breath alcohol before her review on [Day 3].

There was no physical examination, or arrangement for examination, or deskside checking to assess for the complications of Alcohol Dependence or other conditions. With hindsight, it seems likely that [Ms A] would have been increasingly debilitated by years of excessive alcohol consumption, leaving her vulnerable to death from … that might otherwise have been survivable in someone less debilitated. Had she been subjected to more searching physical examination, this might have been foreseen.

There was no more detailed clarification of [Ms A's] ambivalence about committing to treatment — leaving this for a 'few week(s)' until the end of term, when she had not yet been seen in any session entirely sober, was inadequate.

[Ms A] was not prescribed thiamine, a mandatory medication for someone now recognised to have 'years' of excessive alcohol use, to reduce the likelihood of the potentially fatal Wernicke's Encephalopathy or irreversible Korsakov's Dementia.

Initial CADS intentions were to involve the [outpatient] alcohol counselling and consider a [residential] social detoxification. It is not easy to understand why such a limited response was planned. It should have been clear from [Dr C's] assessment that specialist intervention, including prescribing medications specifically relevant to Alcohol Dependence and mood monitoring would be required. An immediate pick up for face-to-face sessions with staff able to provide some degree of combined Motivational Interviewing and Mental State monitoring was also outstanding. Consideration of Naltrexone prescribing was relevant, even in someone incompletely committed to abstinence, but this did not happen.

Comments on the adequacy of managing her alcohol and drug detoxification/ withdrawals

Medical management of alcohol or drug detoxification is frequently offered prematurely to people who are not sufficiently committed to abstinence thereafter. This commitment will usually need to be reflected in good engagement in treatment, specifically around relapse prevention.

In [Ms A's] case, it was understandable and appropriate that the CADS, [Dr C] and [RN F] did not immediately arrange for a medically supervised detoxification. Without adequate preparation, this intervention is itself potentially dangerous.

For the weekend of [Day 5–6], [Dr C's] advice to [Ms A] to reduce, but not cease her alcohol consumption was realistic in the circumstances.

The CADS' intention to engage [Ms A] in 1-to-1 work on her alcohol use was a sensible part of her preparation for a future detoxification. However, the CADS was planning that this should be undertaken outside of their auspices with the risk of delay, loss of continuity of care (both of which happened), and at a lower level of specialisation, inappropriate to [Ms A's] needs. As emphasised above, this was a mistake and, as noted in paragraph 52, this was a moderate departure from the standard of care.

Comments on whether enough attention was given to address her mental health

In isolation, I agree with [Dr C's] statement: *'The mood disorder currently cannot be seen as primary until she is not drinking.'*

[Mr and Mrs B] were concerned that the services did not take into account [Ms A's] difficulties with mood and anxiety. However the clinical record illustrates long-standing, excessive alcohol use that would obscure any underlying other diagnosis. Furthermore, the use of alcohol to such a degree would by itself generate mood and anxiety symptoms — the treatment of choice for these symptoms would be to tackle the alcohol disorder primarily. It is not clear to what degree this was explained to the family.

There was limited record of the risk of renewed suicidal actions or her safe containment. It was accepted that she was not now suicidal in the review appointments, but the security of this seemed based on relying on her not to become intoxicated again.

…

Other than to note the provision of an antidepressant, and its change by a private psychiatrist, there was limited attention paid to her self-critical/worthless depressed mood. To be fair to the PES and CADS, it may have been impossible to quantify her state of mind outside of the effects of alcohol. The pattern of her use suggests that she would have always been on a trajectory to intoxication, hangover, or withdrawal.

Admission to a psychiatric ward could have been considered. However, given that the alcohol use appeared to be the more primary condition, it was reasonable to look for her to be assertively followed up by the CADS, albeit with the expectation that attention was paid by at least one organisation to the ongoing non-alcohol mental health issues.

Ongoing follow up by staff able to focus on both the mental health and alcohol-related mental health aspects of her presentation was necessary. Initially, this was planned for, with the joint involvement of both the PES and CADS. However, the PES decided to

discharge her and the mental health aspects of the supervision were not adequately taken up by the CADS.

[RN F] was discussing her discharge with [RN E] on [Day 10], *i.e.* only 8 days after her initial presentation of [self harm], and a week after [the accident]. In my opinion, this was precipitous given the extent of overall risk in [Ms A's] case. While it may be the working practice of a PES to move patients through as quickly as this, there were lots of red flags highlighting a need to ensure continuity of care that covered the components of both mental health and addiction care.

The poor level of contact achieved with her; the exclusion of family; the coexisting problems; the risks to self and others by [self harm and the accident] were all factors that justified a more cautious, planned process of discharge. In the light of this, even though the CADS was remiss in its approach to offering [Ms A] care at the right level, the PES also was remiss in foreshortening their input.

The foreshortened PES input may have felt justified by the appraisal of [Ms A's] difficulties as Low Risk. As noted above, this was not a realistic quantification of the interrelated aspects of her risk of harm. By extension, justifying an early discharge without confirmation of adequacy of follow up was wrong.

Taken as a whole, there were inadequate overall risk assessment and management; management of her alcohol and drug conditions, and attention paid to her mental health issues. While many of the individual steps reflect a mild or moderate level of departure from the expected standard, the combination of failings led to an overall more serious departure from the care of care. This departure was such that she seems to have received no actual treatment of great effect, and ultimately that she was lost from the care environments that might have been instrumental in avoiding her premature death. In this light, the overall departure from the standard of care was severe.

In May 2017, clarification was sought on whether there were any departures from an expected standard of care in relation to the care provided by [Dr C]

In considering whether there were departures from an expected standard of care in relation to the care provided by [Dr C], this falls into 2 areas. How was the care she provided directly in the meeting of [Day 4]; and did she have a wider responsibility over and above the meeting of [Day 4].

During the meeting of [Day 4], it was helpful that [Dr C] consolidated the focus on Alcohol Dependence. Progress would be challenging without alcohol management. There was the intention to assist her towards addiction treatment.

It was disappointing that a prescription of thiamine (and multivitamins) was not provided immediately, even though she was unsure about further addiction treatment. Thiamine is a simple vitamin treatment that finds favour even with patients not prepared to commit to wider treatment, and has an important role in preventing a type of dementia in heavy drinkers. [Dr C] described that since she was expecting [Ms A] to be taken into alcohol treatment within the coming week(s), thiamine was not prescribed immediately. In similar circumstances, I would recommend the thiamine is started

immediately for reasons based around taking any opportunity to easily prevent serious and permanent disability that might have an imminent onset. However, again, outside of an Addiction Service, and in the expectation of fuller treatment to come, the fact that [Dr C] did not do so would not be a departure from the standard of care.

There was no breath alcohol taken, an easy intervention that could be reasonably expected in a PES. Breath alcohol monitors are cheap and should be easily available in emergency settings. However, I note this is commonly not the case nationally at this time, reflecting a standard of healthcare that could easily be enhanced with sufficient willingness.

There was no physical examination, or arrangement for examination, or deskside checking to assess for the complications of alcohol dependence or other addictions. [Dr C] stated that it was her expectation that [Ms A's] physical state of health would have been properly examined in the ED and by her GP — I accept this expectation as the usual practice in the area. However, having turned the focus to an Alcohol Use Disorder, [Dr C] could have enhanced the quality of her assessment by undertaking an alcohol/addiction-focussed physical re-examination. Outside of an Addiction Service, the fact that she did not do so would not be a departure from the standard of care.

…

With the clearer identification of Alcohol Dependence as a leading problem, assessment of her ongoing risk of suicide became equivocal. [Dr C] noted:

> *'Suicide risk currently is low … but … depending on … intoxication'*

Given recent presentations of recurrent very intoxicated presentations, and her ambivalence about alcohol treatment, it is arguable whether this risk statement was a misleading understatement — essentially intoxication in the near future was surely more likely than not, therefore the risk was more likely not to be low.

Overall, for the care provided directly by [Dr C], there appears to have been departure in a framing of the risk in a way that did not reflect the likely future. In the context of other parts of the assessment that were otherwise appropriately focussed on Alcohol Dependence and steering an ambivalent [Ms A] towards treatment, this departure from the standard of care was low, given that follow up was imminent. I suspect peer psychiatrists would see the [Day 4] consultation as a below average point of care, but headed on the correct trajectory. Had other parts of [Ms A's] care functioned well, this shortfall in [Dr C's] care might have been nullified.

Moving on from the direct care provided by [Dr C], there is the question whether she had a wider responsibility for care. …

The standard of communication between the Specialist Mental Health Services at CDHB and [Ms A's] family. In particular, do you consider that there was suitable involvement of [Ms A's] family in discussions about her treatment? Please note that [Mr and Mrs B] dispute the veracity of claims made by the clinicians that they were actively involved in interviews with [Ms A]

The discrepancy between [Mr and Mrs B's] sense of how much they were involved compared to that suggested by [RN F] is noted, but cannot be clarified further in this report.

The complainants, [Mr and Mrs B] have estimated [RN D's] assessment lasted less than 15 minutes only. [RN D] notes in her statement that her assessment took approximately 40 minutes, although this was not recorded contemporaneously. I am not able to account for the discrepancies between accounts of the duration of the assessment.

In her statement, [RN F] provided more detail about the content of [the session with Ms A's father], and the relatively long duration commensurate with working through strained relationships. Her statement explains some of the issues I had earlier concerns with *i.e.* whether the AA advice was inadequate and why the effects of intergenerational alcohol abuse were focussed on.

I can understand that [Mr B] would feel that he was excluded from his daughter's care — because it seems he was excluded at her wishes, which [RN F] would have been duty-bound to respect. It would have been useful for this decision to exclude key supports to have been explicitly re-addressed, as the aftermath of the car crash settled. The family and whānau involvement policy indicates [Mr B] should have been made '*aware of the level of disclosure the consumer has allowed'*.

There was no significant liaison with family in the CADS screening process, such as it was.

There was no record of communication with [Ms A's] mother before [Ms A's] death.

As far as I can tell from the information available, the communication with [Ms A's] family reflects a mild departure from the expected standard of care. There was some communication, and there had been an explicit refusal from [Ms A] to involve her father on a day of a fraught appointment. However, given the family's role in supplying many of [Ms A's] needs, and the substantial benefit their involvement could have provided, more attempts should have been made to help [Ms A] accept her family's involvement.

The Commissioner may wish to consider how to account for the discrepancies between the family's perceptions of how they were treated and how the staff perceived they involved the family. It may be that the Commissioner identifies the departure from the standard of care to be more serious in the light of the family's comments (listed below: The family found staff 'lacking in warmth', 'disingenuous'; 'duplicitous', 'lacking in empathy'; 'indifferent'; 'aggressive and threatening'; 'condescending and dismissive'. [Mr B] was left believing the services held no hope for his daughter).

Comments on the adequacy of the CDHB SIR report, including whether you consider the recommendations made in this report to be appropriate

The SIR used the widely accepted London Protocol and was conducted by a realistically composed team of a Psychiatrist, Nurse Consultant and Family Advisor.

Selected staff and family were interviewed, in a manner likely to further inform the Review, above a more discrete Clinical Records-only review.

The interview of CADS staff was limited to a Clinical Nurse Specialist. Given the subsequent issues raised in the Review about the inadequacy of the CADS response (and my own concerns about risk assessment and CEP practice), it seems to me that the Alcohol and Drugs Service Clinical Director and/or Team Leader should have been included in the Review.

The Review identified a number of care delivery problems that align with the shortcomings in this report also. In my view, the consistency between the Review finding and this report is high.

The reviewers may have been employees of CDHB or have relationships with the DHB. The review would have been more credible had the reviewers been selected externally. This is particularly the case where there may be issues arising from an insular service culture.

Where the Review and my findings differ is mainly in the area of the assessment and management of the risks running through the PES and CADS arising in a case with co-existing problems. The assessment and management of Co-Existing Disorders, Co-Existing Problems (CEP) or Dual Diagnosis have been areas of psychiatric care repeatedly highlighted by the Ministry of Health over the past decade and more.

The recommendations of the SIR were appropriate but in my view too lightly outlined and insufficient to foster confidence that cases similar to [Ms A's] would not readily recur.

Essentially the recommendations are of a CEP learning tool, including a vignette; and slightly better collaboration strategies between CADS and ACS. The responsibility for the CEP and communication was the responsibility of 'CoP', and all of these recommendations were to be completed within 3 months.

Lots of opportunities for CEP learning already existed nationally and presumably locally, yet CEP-capable practice did not seem to have been achieved. The SIR did not identify how the new learning tool would achieve significantly more progress, and how this progress could be confirmed.

Similarly, how staff would become more effective in their communication by the creation of a single training vignette was not detailed.

The clarification of the transfer processes and CADS criteria within the Service Provision Framework (SPF) seems worthy, but how this would mean staff actually correctly follow the processes and criteria, that were presumably already largely in place, was not mentioned.

The CADS telephone screen process was mentioned in the recommendations, but not with any direction. My impression is that this is an embedded form of local practice that is unsafe, especially for more unwell clients: I do not understand why this practice

was not subject to more doubtful scrutiny. Overconfidence bias seems likely (the belief that because we do it, it is right).

The SIR did not address the shortfalls likely after a client has channelled through the CADS. This was perhaps beyond the SIR remit: [Ms A] should have stayed with CADS, as per the service specifications.

There was very little in the SIR findings, and nothing in the recommendations, that addresses the more complex attitudinal issues that may have played underpinning roles in [Ms A's] case. The family found staff 'lacking in warmth', 'disingenuous'; 'duplicitous', 'lacking in empathy'; 'indifferent'; 'aggressive and threatening'; 'condescending and dismissive'. [Mr B] was left believing the services held no hope for his daughter.

Other attitudes that may have been present include finding reasons not to directly assist a client, but instead see other services as more applicable. This repeated pushing on to the next service silo can be particularly undermining of hope and expectations of recovery.

Problematic staff attitudes can be difficult to identify and address. Given that the other concerns raised by [Mr and Mrs B] seem to reflect notable shortfalls in services, it seems to me they deserve to understand how CDHB intends to also demonstrate how its clinicians maintain their empathy.

Any other comments you may wish to make regarding the services provided to [Ms A]

Involvement of Medical Specialists

There was parsimonious involvement of medical specialists (psychiatrists). One session with [Dr C] took place only. There were no other appointments, reviews, discussions, oversight or supervision. There was no recorded involvement of any specialist oversight (psychiatrist or addiction specialist) of what appears to have been definitely flawed CADS' processes. I could find no record of an MDT that included a psychiatrist.

In my view, the limited involvement of medical specialists may be an important reason why overall quality of care was so low for [Ms A].

Alcohol Breathalysing

It is easy to breathalyse and gain an immediate, accurate result to aid examination substantially. Breathalysers are a cheap piece of machinery, easily used without training. It is not clear to me why they are not routine equipment for emergency psychiatric teams or CADS units. CDHB is in the majority in not investing in this area however.

Comments on the Final Decision Paper of the Alcohol and Other Drugs Service Structure

You have included the Final Decision Paper of the Alcohol and Other Drugs Service Structure — Outpatient Services, dated 30th April 2015. This document has primarily

arisen from the 2013 External Review of the [region's] Methadone Programme, undertaken in response to a number of external complaints. This External Review appears to have coincided with the SMHS Alcohol and Drug Service re-development of models of care and completed changes in the Adult Community Service (ACS). The detail pertaining to the AOD and ACS is minimal in the Final Decision Paper provided — the paper is mainly occupied with the relationships between the [region's] Opioid Substitution Service ([ORS]) and CADS. However the Response/Changes implemented for the CADS Team Structure on page 12 & Consumer Roles within AOD on page 14 read well and are relevant to some of the details in [Ms A's] case.

It may be useful for the Commissioner to be aware that the impression of the National Association of Opioid Treatment Providers (NAOTP) is that the changes in [ORS] have been substantial and positive in response to the 2013 External Review. In particular, the Association understands that client journeys into and through Opioid Treatment have been more fluid and supported. It is reasonable to hope this is also the case for CADS clients and clients shared between CADS and ACS.

Comments on the adequacy of the policies in place at CDHB at the time of the events

[The Customer Services Coordinator] provided the PES Service Provision Framework ED/MHLT Interface. This policy appears to have been followed by [RN D].

The PES-SPF PES/SMHS OP Interface is also supplied. It is questionable whether this was followed correctly. This policy indicates PES should have maintained Clinical Responsibility until the CADS completed their assessment. I do not accept that the CADS had completed its assessment, the telephone screening being inadequate for this purpose in [Ms A's] case.

The PES-SPF PES/SMHS OP Interface goes on with *Does the consumer still require assessment from SMHS/OPHS PSE OP unit?* [Ms A] best fitted into the *If unable to locate consumer — discuss with MDT … and determine appropriate action.* I do not have a record of an MDT discussion concerning discharge — I would expect [Dr C] or another doctor to have a role in this discussion, as befits an MDT. An MDT discussion can be an important safeguard against premature discharge. This policy suggests CDHB should be able to confirm to the Commissioner that this MDT took place, at the appropriate juncture, and who was present.

The CADS-SPF components reviewed include Acceptance Criteria; Intake Process, PES Interface and general comments.

The Acceptance criteria were met by [Ms A], in particular given that she was over 18; had a suspected severe alcohol problem; had a suspected mental illness of a moderate to severe nature; and had active dysfunction as a result of mental illness involving significant threat to her safety and could be reasonably expected to have impairments in relationships, independent living and employment (study).

Despite this, she was not accepted into the CADS treatment, an error also found by the SIR.

The Intake Process is difficult to follow to someone unfamiliar with local acronyms and services, but seems to indicate that [Ms A] should have been assessed face-to-face within 4 weeks. She was not, and there was not the intention to do so, but instead refer her on to an NGO of lower specification. My impression includes concern that undue reliance was placed on a phone contact process that can easily fail to identity more serious cases.

In the CADS-SPF PES Interface, [Ms A] should have been found to meet the criteria for assessment. This should have meant the referral was accepted, and the clinical responsibility reviewed by an MDT. The MDT 'must contain a Consultant Psychiatrist/Clinical Head'. This policy suggests CDHB should be able to confirm to the Commissioner that this MDT took place, at the appropriate juncture, and who was present, and how the risks [Ms A] presented with would be managed.

In general comments, the CADS-SPF is difficult to follow to someone unfamiliar with local acronyms and services, and seems to have multiple sidesteps designed to categorise patients differently, towards different responses. This seems to present a risk that pathways will be followed incorrectly, or that even correct pathways lead to different approaches for essentially the same patient needs. I cannot see how this framework easily lends itself to support a client journey through a complex system.

The Family and whānau involvement in the consumer's treatment policy is provided. This document reflects a common standard. Of note, the policy states *'staff will ensure the consumer has the opportunity to review their family's involvement regularly'; 'that family can meet separately with staff and give information regardless of the level of disclosure';* and *'that support for the family should be provided throughout the treatment process ... in terms of ... reducing particular stresses for that family, building capacity and resilience within the family, dealing with relapse,' etc.*

There was no documentation, or mention in the staff statements of the regular review by the consumer of family involvement.

The feedback from [Mr and Mrs B] brings into question whether the directives were met that *'family can meet separately with staff and give information regardless of the level of disclosure'* and that *'support for the family should be provided throughout the treatment process ... in terms of ... reducing particular stresses for that family, building capacity and resilience within the family, dealing with relapse, etc'.*

For the management of co-existing conditions, [the Customer Services Coordinator] refers the Commission to the CADS-SPF. The only use of the word 'Co-existing' I could find in the SPF was in the final section's mention of CEP (Co-existing Problems) needs being the level of competency expected at an Advanced Specialist Level. This section appears to be an addendum that does not altogether sit within the SPF as a whole.

This at least indicates that [RN E] and the psychiatrist involved in CADS should have CEP skills. [RN E] is correct to identity that he should have explored [Ms A's] self harm risks.

It also again leads me to question why the Alcohol and Drugs Service Clinical Director and/or Team Leader were not included in the Serious Incident Review (paragraph 95).

In my experience the minimal use of the word Co-existing is out of step with most documents concerning mental health and AoD services, and out of step with the Ministry of Health's 2010 *Te Ariari o te Oranga — The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems.*

I was not able to find *any* mention of Co-existing (or CEP) in the psychiatric arm of the SPF, the PES-SPF.

These SPFs refer to each other and make some note of the presence of mental illness in addiction, and addiction in mental illness. However, the overall impression is of approaches based around fitting patients into silos of either one condition or the other. The lack of significant mention of CEP is indicative of this.

This silo approach to CEP was a fundamental issue in the shortfalls in [Ms A's] care. The Ministry of Health published *Te Ariari o te Oranga — The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems* in 2010 highlighting this area of concern. [Ms A's] progress through services was in 2014.

The 2012 Clinical Risk Assessment and Management policy is provided. This policy covers a number of areas that may have been missed with [Ms A]. '*Identification of scenarios that are likely to result in significant risk*' would have readily highlighted her moderate to severe risk when returning to the expected excessive alcohol consumption. '*Interventions to address situational factors contributing risk (… social stressors including relationships, … access to alcohol*' were dealt with in only limited degree, except through the longer view of seeking alcohol treatment. '*Who is responsible for various parts of the [risk] plan*' was not carried through into the CADS involvement. The '*dynamic nature of risk*' was not reflected in the risk management plan.

The Clinical Risk assessment and Management document did not entirely clearly emphasise the nature of static risk — eg historical suicidal acts may increase risk outside of a more dynamic or contextual context. This is perhaps better put in the 2016 Structured Risk Framework and the appended Long Term risk factors for suicide.

My overall comments then are twofold. The policies in place at the time had inherent limitations concerning the management of someone presenting with the overlapping challenges in [Ms A's] case. But also, there were numbers of ways these policies may not have been followed, that could have directly contributed to [Ms A] not receiving appropriate care.

Comments on the adequacy of the policies and initiatives currently in place at CDHB
The documents supplied are the Consultation Document of the Review of Alcohol and Drug Service Structure Outpatient Services October 2014; some print-outs relating to the Canterbury Suicide Prevention Initiative (CaSPI); a Structured Risk Framework; some notes titled Long Term Risk factors for suicide; and a collection of memoranda

relating to the Crisis Resolution service including a Mental Health Telephone Triage Scale and a CADS/AoD clinical pathway for adults admitted to an inpatient unit.

It is not possible to comment on the overall adequacy of the policies currently in place with this collection of possibly incomplete information provided.

The collection of the 2012 Clinical Risk Assessment and Management, if still used; the 2016 Structured Risk Framework; the 2016 Long Term Risk Factors for suicide; the reference to the Ministry of Health 2016 Preventing suicide: Guidance for emergency departments; the Risk Documentation: Using Core Information; and the 2015 Mental health Triage Scale (of risk) are all useful documents or references pertaining to risk management. However, this represents something of a jumble of partially overlapping documents rather than a more useful coherent policy.

With what is provided, it is not possible to comment directly on the success or otherwise of this initiative. However, some relevant points can be made.

Firstly, the intention of the initiative speaks directly to many of the concerns in [Ms A's] care. The initiative aims align so closely with her case that it could either have been generated as a fulsome response to her case; or, more darkly, it reflects the repeated findings of similar cases emphasising the need for change. In either case, the initiative is to be applauded.

Secondly, the review of the Alcohol and Drug Service structure was proposed to align with the review of the [region's] Methadone Programme (CMP). As noted in paragraphs 112–114, the impression has been that the revision of the CMP to the [region's] Opioid Recovery Service ([ORS]) has progressed well. A presentation by [ORS] of the early effects of the revision to the National Association of Opioid Treatment Providers in 2017 was received positively.

It is reasonable then to be optimistic concerning the review of AoD services. [The manager] in particular is well thought of in the field, and has had senior involvement with both the AoD review consultation in 2014 and the [ORS] revision.

The CaSPI includes positive information about a Wellness-based approach with emphasis on responses to self harm and suicidality. These are both encouraging. It is not clear from the information provided how and how well these are incorporated into current services.

The memoranda relating to the Crisis resolution services adds little to my understanding of the evolution of services. The CADS/AoD pathway for inpatients looks sensible, but its relevance is limited.

Does the response from [Dr C] change my previous advice in any way?

The revision of parts of this report reflects changes to my advice in the light of [Dr C's] statement. In particular, her statement helped me to understand better, with some reassurance, the aspects covered in paragraphs 20 to 29.

However, I have also noted a lack of effective integration of services, and whether this was recognised as an issue (paragraphs 42–45); concerns about the adequacy of overall risk assessment and management (paragraphs 57–60 & 79–81); and the processes of foreshortened PES discharge that I would consider it was [Dr C's] or some other lead clinician's role to oversee.

Overall, [Dr C's] response helped me understand some of the thinking during her consultation with [Ms A]. Although not clear on what leadership role she played during the severe departure from the standard of care for [Ms A], I am more reassured by the CDHB intention to substantially revise the AoD Service Structure and achieve better integration with Adult Community Services. Her response does not alter my conclusions in paragraph 81 about there being a severe departure from the standard of care; or my concerns about the family's perceptions about how they were treated (paragraphs 93 & 100).

Does the response from CDHB change my previous advice in any way
[The Customer Services Coordinator] suggested my advice has been provided through an addiction specialist lens. I do not concede that my perspective is limited to this. I work in a forensic setting currently, which includes managing acutely unwell adult psychiatric patients. I am on the on-call emergency roster for general psychiatry, and so regularly see patients in emergency settings. In 2015 & 2016 I also worked primarily in general adult community settings.

Where I have adopted a particular addiction perspective, this is noted in the text, and generally to the effect that I would not expect a level of addiction practice outside of explicit addiction areas.

The response from CDHB has altered my advice in ways that are reflected in this revised report. Overall, the key aspects have been to consolidate my concerns that risk assessment and management were performed inexpertly, and the CEP context was not adequately addressed.

The result of this is nonetheless that CDHB's response does not alter my conclusions that there was a severe departure from the standard of care, or my concerns about the family perceptions of how they were treated.

I hope this report is of assistance. Please do not hesitate to contact me to address further or unclear issues.

Yours sincerely

Dr Jeremy McMinn MBBS FRANZCP FAChAM MAoME
Consultant Psychiatrist Addiction Specialist

Assessor's Qualifications

Dr Jeremy McMinn is a registered medical practitioner of the New Zealand and United Kingdom Medical Councils; a Fellow of the Australian and New Zealand College of Psychiatrists; a Fellow of the Australasian Chapter of Addiction Medicine (a Chapter of

the Royal Australasian College of Physicians); and a Member of the Academy of Medical Educators.

He is employed as a Consultant Psychiatrist by Capital & Coast DHB Regional Forensic Services. He has been accepted on the Advanced Training in Forensic Psychiatry programme. He worked for over 15 years as a Consultant Psychiatrist or Addiction Specialist for Capital & Coast DHB. He is a RANZCP registrar educational supervisor and was a Clinical Senior Lecturer in Alcohol & Drug Disorders for the University of Otago (in Wellington). He is a Substance Addiction (Compulsory Assessment and Treatment) Act 2017 designated Authorised Specialist.

From 2014, he has worked in addiction, general adult, adolescent, forensic, emergency psychiatry settings. He provides independent medical assessments for the medical, nursing, dental, midwifery, and pharmacy councils, Health and Disability Commissioner, District Health Boards and legal profession within his specialist areas of general adult psychiatry and addiction through McMinn and Quiller Limited. He has appeared for both the prosecution and the defence.

He is the Medical Advisor to the Veterinary Council of New Zealand. He sits on the PHARMAC Mental Health Subcommittee and the Royal College of Physicians Policy & Advocacy Committee. He is a member of the Australian and New Zealand Association of Psychiatry, Psychology and the Law. Until recently, he was a member of the Australasian Professional Society on Alcohol and other Drugs; Co-Chair of the National Association of Opioid Treatment Providers (NZ); and NZ branch Chair of the Australasian Chapter of Addiction Medicine."

Further expert advice obtained:

"***Should CADS have assessed [Ms A] (in the light of the CADS SPF criteria)***

The CADS SPF states that consumers will be offered a comprehensive assessment if the consumer:

1. Is aged 18 years or over — [Ms A] was;
2. Has a … suspected presenting problem of severe alcohol … dependence — She did, or if this was not suspected, there were fundamental shortfalls in the threshold for this suspicion;
3. Has a suspected mental illness of a moderate to severe nature requiring specialist assessment — the original suicide attempt was significant and required specialist input to delineate the mood and AoD elements, so this criterion should have been accepted, at least from a perspective of screening for likely clients;
4. Has active dysfunction … involving significant threat to safety … or impaired ability to function effectively with independent living …, [and/or] employment — these were all issues for [Ms A];
5. Is within 6 months of prison release — this was not relevant;
6. Has opioid dependence — this was not relevant;

7. Has a written referral from a CDHB specialist mental health service — she did (assuming the Psychiatric Emergency Service would fall into this definition, or if it did not, then this criterion is unconscionably exclusive);
8. Is an NZ resident living in the CDHB area — she was.

In short, CADS should have assessed [Ms A] in light of the CADS SPF criteria. If there is some question of this, it is difficult to understand who would have been assessed by this service.

Should CADS have accepted [Ms A] into CADS treatment (in light of the CADS SPF criteria)

The CADS SPF states that a consumer will be accepted into treatment if the consumer:

1. Has been assessed by CADS — as noted above she should have been;
2. Has confirmed or probable alcohol … dependence — there seems little doubt this was the case;
3. Is willing to participate in treatment — this was not adequately tested: I have previously commented on the unsuitability of the telephone triage process as a means of determining readiness for engagement.

In my view, [Ms A] should have been accepted with alacrity into treatment. This view is echoed in the findings of the CDHB SIR.

…

Yours sincerely

Dr Jeremy McMinn MBBS FRANZCP FAChAM MAoME
Consultant Psychiatrist Addiction Specialist"

Appendix B: Independent advice to the Commissioner

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

"17 January 2017

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

Preamble

I have been asked by the Commissioner to provide expert advice on case number 15HDC01202. 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 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 Maramatanga, the New Zealand College of Mental Health Nurses. I am currently employed as Nurse Specialist (Liaison Psychiatry) with the Auckland District Health Board and a Senior Lecturer in Mental Health Nursing with the University of Auckland. My current clinical role involves assessment and care of people in acute mental health crisis, including suicidality, and advising on care of people with mental health or behavioural issues in the general hospital. 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 [Ms A] by nursing staff at Canterbury DHB.

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

Instructions of the Commissioner are:

Please provide comment on:

1. The reasonableness of the care provided by [RN D]; in particular, the adequacy of the [Day 2] assessment and the appropriateness of the decision to send [Ms A] home.
2. The reasonableness of the care provided by [RN F]; in particular:
    a. The adequacy of the [Day 3] assessment, including the appropriateness of the referral to AOD

   b. The appropriateness of the plan on [Day 10] to discharge [Ms A] from MHS if [RN F] did not receive a response from her.
3. The adequacy of the telephone interview on [Day 11] performed by [RN E], including the appropriateness of the plan to close [Ms A's] case under PES and for [Ms A] to present to AOD.
4. The adequacy of the level of communication between nursing staff and [Mrs B], who [Ms A] had authorised Canterbury DHB staff to disclose information to.
5. The adequacy of the level of communication between nursing staff and [Ms A's] father, [Mr B].
6. The adequacy of the triage and assessment performed by nursing staff at Canterbury DHB.

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

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

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

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

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

1. The complaint and background and timeline from [Mr and Mrs B] dated …
2. Copy of the coronial file of [Ms A], including [the Coroner's] findings; and
3. Witness statement from [Police]
4. Police statements from:
   a. [Mr B] [Day 26]
   b. [Mrs B] [Day 26]
   c. [Police] [Day 26]
   d. [Police] [Day 26]
5. New Zealand Police job sheet [Day 26]
6. Cell phone download synopsis ([Ms A]) [to Day 26].
7. Response and clinical notes from CDHB, including results of Serious Incident Review.
8. HDC's guideline for independent assessors.

Background

[Ms A] was a [woman in her thirties], under the care of the Canterbury District Health Board (CDHB) mental health and alcohol and drug services when she died as a result of suicide on [Day 26]. [Ms A] had a substantial history of dependent drinking with significant mental health and social consequences. She was first seen by CDHB mental health services on [Day 1] following [an incident of self harm]. This was followed by a series of further assessments and telephone contacts until [Day 11] when she was screened by Community and Alcohol Drug Services. Following some further stressful events … [Ms A] died by suicide on [Day 26].

[Ms A's] history of mental health issues dates from at least …, at which time she was living [overseas]. At that time, or early [the following year], she contacted her father, [Mr B], to say that she was a 'functioning alcoholic'. By the end of that year [Ms A] was continuing to drink very heavily. She was also taking antidepressant medication. Her personal and social functioning was considerably adversely affected to the point where [Mr and Mrs B] supported her ([Ms A's]) idea to return to [NZ to study] where she stayed with [them]. She began studying …, something she is reported to have found stressful … She worked part time …

A number of significant events impacted [Ms A's] life. A brief relationship ended … She was struggling academically, had failed assignments, and had accidentally wiped an assignment, for which she had to seek an extension and would suffer an academic penalty. Due to intoxication, [Ms A] was unable to meet a commitment [on Day 2]. She was faced with two counts of driving under the influence, one from [Day 3] (see below) and another from earlier in the year. She was also facing significant financial pressures and had some conflict in relationship to her employment.

On [Day 1] at 2215hrs [Ms A] was admitted to [the] Emergency Department [after an episode of self harm]. Her alcohol level was 54mmo1/L, representing a considerable degree of intoxication. In Emergency Department, in addition to her medical treatment for [self harm], [Ms A] was initially seen by [a social worker]. She was seen by [RN D] at 0500hrs (Day 2). The timing of [the social worker's] note is not given, but must have been between admission at 2215 [Day 1] and midnight that day, as it is dated [Day 1]. When seen by [RN D], [Ms A's] risk of harm to self was assessed as low to moderate. A plan was made for a return to Emergency Department for further assessment on [Day 3].

Before attending this appointment [Ms A] was involved in [an accident] and was facing police charges. At 1702hrs [Ms A] attended her assessment with [RN F], supported by her father who attended the last 10 minutes of the assessment. [Ms A] was noted to be intoxicated and had no memory of [the accident] earlier in the day. [Ms A's] risk to self was assessed as low, with the qualification that it would increase to moderate with use of alcohol. At this assessment [RN F] spoke to [Ms A's] father about alcoholism. She was told of a family history of alcoholism and recommended contact with Families Trust for support in understanding interpersonal boundaries when an alcoholic lives in the family home. The outcome of the assessment was a referral to Alcohol and Other Drug (AOD) Services, and an appointment for further review by consultant psychiatrist [Dr C] and [RN F] on [Day 4].

At the review on [Day 4] [Ms A] acknowledged that in the past she had not been truthful about the extent of her drinking. She was reported as being contemplative about dealing with her alcoholism, which means she was at an early stage of committing to alcohol treatment. Her father was [disturbed] about her drinking, but supportive. [Ms A's] risk of suicide was assessed as low, again with the qualification that this could change depending on her level of intoxication. There was a plan for support over the weekend, including contact from [RN F] on Sunday. There was no response from [Ms A] to a landline call from [RN F] on [Day 6]. At 1438 [RN F] also left a cellphone message.

The [Day 4] review was the last time [Ms A] was seen face to face. Further contacts over the following week by mental health services and Community Alcohol and Drug Services were all by telephone. These included voicemail messages and voice conversations. Over the week until [Day 11] there were several telephone conversations and voice messages left, including communication between [Ms A's] father and [RN F]. [Mr B] phoned [RN F] about [Day 7] to express concerns about [Ms A]. There is no record of this contact in the file provided. On [Day 8] and [Day 10] Clinical Nurse Specialist [RN E] from Community Alcohol and Drug Services left voicemail messages, and emailed the Psychiatric Emergency Service to say he had not had a response. [RN F] also attempted telephone contact on [Day 10]. When she was unsuccessful she phoned [Ms A's] father to say [Ms A] would be discharged from the mental health service due to non-engagement. On the same day, [Mr B] phoned [Ms A] to discuss the voicemails she had not responded to. In response, [Ms A] phoned [RN E], but was unable to complete the planned screen over the phone as she was in a public place. That screen was competed by phone the following day, and as a result [Ms A] was referred to the AOD Central Coordination Service to set up appointments. Following this screen there was no contact between either the mental health service or CADS and [Ms A] for a period of two weeks. On [Day 26] [Ms A] committed suicide.

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

1. The reasonableness of the care provided by [RN D]; in particular, the adequacy of the [Day 2] assessment and the appropriateness of the decision to send [Ms A] home.

[RN D's] assessment is fairly brief, but covers all expected areas of psychiatric assessment. I note that the assessment records that [Ms A] was accompanied by [Mrs B] but it does not say whether [Mrs B] was included in any part of the interview, or involved in any subsequent discussion. The assessment record does indicate that some collateral information was provided by [Mrs B] who expressed concern about [Ms A's] drinking and course related stress. It establishes [Ms A's] history of mood difficulties and alcohol use, the latter including increased tolerance and withdrawal symptoms. The assessment records [Ms A's] treatment by her psychiatrist, and the recent change in medication. I would have expected to see a note of her intent at the time of her [self harm], i.e. did she intend to die, and if so, how did she now feel about that. Establishing intent is important in fully assessing someone with self-harm. There is no comment in the assessment or discharge plan about how Mrs B or any other family member would be involved in maintaining [Ms A's] safety on discharge. In particular, there is no mention providing contact numbers for psychiatric services available 24 hours. This may have been an oversight in the documentation, but it is an important aspect of acute assessment of people presenting with self-harm. The discharge plan includes a follow up appointment for the following day. This is sound clinical practice in terms of containing risk of further self-harm. Both the future focus of the appointment and the opportunity for further review are therapeutic factors involved in making follow up appointments. I consider that the decision to send [Ms A] home was an appropriate one, given that further care was planned and [Ms A] had agreed to that. Psychiatric hospital admission is not standard practice for people presenting with alcohol related self-harm

and is unlikely to have offered any benefits. [Ms A] declined [RN D's] offer of AOD referral.

It is my opinion that the lack of documentation of suicide intent, and non-involvement of Mrs B in a safety plan would be regarded by my peers as a mild departure from expected standards.

2. The reasonableness of the care provided by [RN F]; in particular:

a. The adequacy of the [Day 3] assessment, including the appropriateness of the referral to AOD

[RN F] was [Ms A's] allocated case manager. She made a follow up assessment of [Ms A] the day after her initial assessment and attended the interview with [Dr C] on [Day 4]. [RN F] also recorded a number of telephone contacts with [Ms A] over the week following this interview. In addition, [RN F] phoned [Ms A's] father to advise that [Ms A] had either not taken or not returned calls from [RN F] or from CADS.

At the time of [RN F's] assessment of [Ms A] on [Day 3] [Ms A] was intoxicated, having a few hours previously been charged with driving while intoxicated. The value of mental state and symptom assessments and case formulation with intoxicated individuals is limited due to impaired judgment and subsequent poor recall of issues discussed.

In my opinion it was appropriate to refer to AOD services at this point, in view of [Ms A's] escalating drinking and the escalating adverse consequences as noted by [RN F]. I also note that [RN F] included [Ms A's] father in this [and] some discussion around alcohol treatment. This is good practice in enlisting the family's support and engagement in this aspect of care.

[RN F's] assessment does not include a risk formulation or safety plan. In view of [Ms A's] very recent [self harm] and the compounding effect of a second drink driving charge I believe it would be important to review safety at this time, and to include the family in a safety plan. Most especially, this should include steps to be taken in any further crisis in which [Ms A] might consider suicide. I do note that [RN F's] assessment concludes with a plan for further review with psychiatrist [Dr C] and this does give an opportunity for further consideration of safety issues. In my opinion it would have been helpful at this stage to develop a safety plan involving the 24 hour contact number and providing this to both [Ms A] and her father. This intervention reinforces concern for safety, includes the family in the safety plan, and provides an option for the consumer if they become acutely suicidal.

It is my opinion that the non-involvement of [Mr B] in a safety plan would be regarded by my peers as a mild departure from expected standards.

b. The appropriateness of the plan on [Day 10] to discharge [Ms A] from MHS if [RN F] did not receive a response from her.

The appropriateness of this decision rests on whether there is an appropriate handover of care to CADS. Failure to respond to phone calls or other communications is commonly used as an indicator of service engagement, so in itself this is not

problematic. However whether this indicator should have been used on this occasion depends on whether the recently identified risk of further self-harm was being managed.

[Ms A's] presentations show a degree of volatility, no doubt influenced by her alcohol consumption, but also by the anxiety and mood issues noted in the clinical assessments of [Day 2] ([RN D]) and [Day 4] ([Dr C]). Although I agree with [Dr C] that the mood disorder could not at that stage be seen as primary, it is still an important aspect of [Ms A's] overall care.

There is no clear written process of handover of care in the clinical notes provided to me. My initial reading of the CADS screening was that CADS had accepted the referral and were actively managing [Ms A's] care. However on reading the CDHB Serious Incident Review it appears that this was not the case, and the telephone screen was only aimed at identifying the appropriate service for [Ms A]. I have commented further on this in Question 3 below. Given [Ms A's] very recent suicidality it is my opinion that there should have been a plan in place to manage any re-emergence of this problem. This could have involved Psychiatric Emergency Service's continued case management of [Ms A] until an initial face to face CADS assessment, or an active plan on the part of CADs in relation to this. Either way, one service needed to clearly hold this responsibility and it is not clear that either service did clearly hold that responsibility.

It is my opinion that the lack of a plan of care provided to CADS by the Psychiatric Emergency Service and the lack of development of such a plan by CADS would be regarded by my peers as a mild departure from expected standards.

3. The adequacy of the telephone interview on [Day 11] performed by CNS criteria, including the appropriateness of the plan to close [Ms A's] case under PES and for [Ms A] to present to AOD.

My response to this question draws on my response to the previous question. The decision to discharge a patient with significant ongoing risk issues, such as [Ms A], cannot be made in isolation from the decision of another service to accept responsibility for her care. Further to that, the adequacy of the telephone interview depends on its purpose. If it is merely to determine what service a consumer needs, that is quite different to the interview as a clinical assessment. Generally, screening is not regarded as a full assessment. The telephone interview of [Day 11] established no new information about [Ms A], other than her willingness to consider [admission for alcohol detoxification] and willingness to engage in one to one therapy with the [outpatient AOD service]. The interview focussed solely on alcohol issues and makes no reference to [Ms A's] recent suicidality or current mental state. Of concern, the interview record states that [Ms A's] case with the Psychiatric Emergency Service was about to be closed, but there is no comment on whether her suicide risk was now contained, or what the current strategy for managing that risk was. In my opinion this interview should have addressed risk issues in some way, and should have included some plan for a more formal handover of care from the Psychiatric Emergency Service.

I note a comment in the Serious Incident Review report to the effect that the CADS clinician understood that the 'risk to self was low and there were no significant mental health issues'. This is hard to understand in light of the Psychiatric Emergency Service notes documenting a recent suicide attempt and ongoing elevated risk in the context of drinking, and that continued drinking was the reason for the referral. There is no documentation in [RN E's] note of [Day 11] relating to mental health issues or risk.

A follow up comment ([Day 15]) notes that [Ms A's] case was presented at a care coordination meeting and that she was allocated to [the outpatient AOD service] for one to one intervention. There is no record of whether or not this decision was communicated to [Ms A].

It is my opinion that the lack of documentation of risk and mental health issues in the CADS screen would be regarded by my peers as a moderate departure from expected standards.

4. The adequacy of the level of communication between nursing staff and [Mrs B] who [Ms A] had authorised Canterbury DHB staff to disclose information to.

An authorisation to disclose information to a family member, while not giving staff *carte blanche* to pass on all clinical details represents a consumer's preference that important information is passed on. This would include at a minimum information about safety and about the next stage of care.

I find it difficult to assess the adequacy of communication between nursing staff and [Mrs B] as there is little reference to it in the clinical notes. I have noted above (Question 1) that [Mrs B] is recorded by [RN D] as providing collateral information, specifically concern about [Ms A's] drinking and course related stress. [RN F's] note of [Day 3] does not include reference to [Mrs B], but that is understandable as [RN F] communicated with [Ms A's] father on that occasion. I also note that [RN F] made telephone contact with [Mr B] to advise that [Ms A] had not been in contact with Psychiatric emergency Services or CADS and that this resulted in [Ms A] phoning CADS to engage in telephone screening. One area of information that could have been shared with [Mrs B] is the current safety plan, in particular the availability of the 24 hour telephone emergency services. As [Ms A] had authorised information to be disclosed to [Mrs B] this could have included discussion about the use of emergency contact numbers, future appointments and plans for future care.

I note reference in the complaint to [Mrs B] taking responsibility for ensuring that there was no further medication available to [Ms A] following her discharge from hospital on [Day 2]. It is common and accepted practice for clinicians, on assessing individuals presenting with self-harm, to enquire about the safety of the home environment pending discharge home. This generally includes availability of medications or other potential means of further self-harm. This review can present an opportunity for family involvement while also promoting safety on discharge.

It is my opinion that the relatively low level of documented involvement of [Mrs B] in [Ms A's] care, especially in relation to the safety plan, would be regarded by my peers as a mild departure from expected standards.

5. The adequacy of the level of communication between nursing staff and [Mr B].

My comments in Question 4 above are also relevant here. As the case manager, [RN F] would have been the nurse who communicated with [Mr B]. There were several occasions when [Mr B] is specifically noted to have been involved in communication with [RN F]. The first is [RN F's] ten minute discussion with [Mr B] following her hour long assessment of [Ms A]. [RN F] also phoned [Mr B] to note [Ms A] had not responded to calls and was to be discharged from the Psychiatric Emergency Service. While it is always difficult to determine what is the appropriate level of family involvement for an adult with capacity (such as [Ms A]) it seems that, as with [Mrs B], this should have included involvement in the safety plan, discussion about the use of emergency contact numbers, and the plan of the next stage of care.

It is my opinion that the relatively low level of involvement of [Mr B] in [Ms A's] safety plan would be regarded by my peers as a mild departure from expected standards.

6. The adequacy of the triage and assessment performed by nursing staff at Canterbury DHB.

[The social worker's] triage on [Day 1], at the point of [Ms A's] initial presentation to Emergency Department is adequate in flagging that [Ms A] was expressing suicidal intent, and should not be allowed to leave the hospital. The timing of this triage is not recorded but must have been between 2215 and midnight to have taken place on [Day 1].

My comments above cover all the assessments provided by CDHB nursing staff. Comments regarding the expected standard of care also apply here.

General comment

This case has elements of one in which, on retrospective analysis, some service gaps can be identified. Most notably, there is a two week gap in between [RN E's] record of [Day 11] and [Ms A's] eventual suicide on [Day 26]. It was clear on [Day 11] that [Ms A's] case with Psychiatric Emergency Service was about to be closed. At the point of her death there was no appointment noted for a further face to face assessment. Two weeks is a significant gap for someone who has recently attempted suicide.

I note in [Mr and Mrs B's] complaint the many comments that relate to the style of communication Mr B experienced, especially that [RN F] 'lacked empathy' and that [Mr and Mrs B] found [RN F's] attitude at different times 'condescending and dismissive, and aggressive and threatening.' These are very significant complaints which if true would reflect poorly on [RN F] and CDHB. I don't feel able to comment on the truth of these statements. Clinical notes typically don't capture the style of communication between clinicians, consumers and families. I can only say that [RN

F's] written communications are objective and professional and not suggestive of the complaints noted above. I note that CDHB has made a response to the Commissioner to comments such as those above in particular about the different perceptions of [Mr and Mrs B] on the one hand, and clinical staff on the other.

In their complaint, [Mr and Mrs B] also refer to what they see as 'inaccurate' and 'disingenuous' reporting by clinicians in the CDHB Serious Incident Review. As with the comments noted in the paragraph above these are significant complaints. Some of the points referred to may be due to use of language, for example I note that [RN D's] note of [Day 2] states that [Ms A] was accompanied by [Mrs B], but does not say she was present at the interview. The brief summary in the Serious Incident Review suggests Mrs B was present at the interview. As I have noted in Question 1 above, [RN D's] clinical note refers to collateral information provided by [Mrs B], which does suggest Mrs B was spoken to in the course of the assessment or perhaps immediately before or after. In regard to the complaint that [Mrs B] did not witness [Ms A] signing a release document, there is a document in the file ('Contacts and disclosure transfer form') which has been signed by both [Ms A] and [RN D] on [Day 2]. The document does not record the name of any witness. [Mr B] has responded to the Serious Incident Review report by saying that he was not present at the psychiatrist interview on [Day 4], contrary to the report saying clinical notes record him as present for that interview. In [Dr C's] report of that meeting I can see no reference to [Mr B] being present although I note that he took [Ms A] to the interview. … There are clearly differences of perceptions on many of the issues outlined in this paragraph, but I can see no evidence of any deliberate mis-statement on the part of CDHB staff.

In regard to [Mr and Mrs B's] concern about the focus on alcohol abuse, it is my view that management of [Ms A's] escalating alcohol use was clearly a major priority based on [Ms A's] clinical history. It is unlikely that she would get optimum benefit from her antidepressant treatment while she continued to drink the amount she was. Having said this, anxiety is a significant mental health issue and is associated with suicidality and so did need to be addressed in [Ms A's] care. However it is my opinion that the emphasis on alcohol use was not excessive. [RN F's] intervention in advocating for [Ms A] to become involved in alcohol treatment seems to have been effective in that she did subsequently engage to some extent, as noted in [RN E's] telephone screen of [Day 11], which noted that [Ms A] had attended two AA (Alcoholics Anonymous) meetings in the past week.

The actual point of discharge, or process of discharge is not clear in the clinical notes; nor is it evident what formulation of risk was handed over to CADS beyond that included in the clinical assessments of [Day 2] ([RN D]) and [Day 4] ([Dr C]). Handover or transfer of care from one service to another requires a clear statement of the consumer's full range of health issues, not just those of most immediate concern to the specialist service.

The notes show considerable use of telephone messages to communicate important aspects of care. It is my experience that this is common and accepted practice in crisis mental health services. However telephone is not a substitute for face to face contact, especially if no-one from the service has met the consumer. In this case [Ms A's] care

was handed over to the Alcohol and Other Drug service, but after two weeks she had not seen a clinician face to face. This is a very long gap for someone who has made a recent suicide attempt and does not reflect guidelines for management of care following a suicide attempt.

I note from the telephone records that [Ms A] had frequent messages from her telephone service provider asking her to listen to telephone messages or to add credit to her plan. [Ms A] was a student who was also noted to have some financial difficulties. Under such circumstances reliance on telephone messages may lead to gaps in communication.

I note that CDHB now has a new Crisis Resolution service to deal with emergency presentations such as that of [Ms A]. The Alcohol and Drug Service has also undergone significant redevelopment outlined in the Final Decision Paper of 30 April 2015. One of the issues in [Ms A's] case was the handover of responsibility from the Psychiatric Emergency Service to the Alcohol and Other Drug Service (in this case, CADS). There appears to have been a two week gap in which no clinical service was engaged with [Ms A], a woman who had [harmed herself] and expressed further suicidal intent. Redevelopment of each individual service will only address problems of gaps between services if there are clear protocols about who holds clinical responsibility while further intervention is planned. CADs had made a referral to the AOD Central Coordination Service to set up appointments, but this does not address her needs in the interim. It was clear that the Psychiatric Emergency Service had discharged [Ms A]. In that case, my view is that CADS was [Ms A's] nominated service provider and had a responsibility to respond to her full range of needs, including any ongoing suicidality.

While some of the comments above reflect on the practice of individual clinicians, those clinicians work within a service framework that needs to require and support sound clinical decision making. It is not clear that the process of referring consumers for the Psychiatric Emergency Service to CADS is sufficiently robust. Corridor conversations as a means of communicating core clinical information are dangerously unsafe and need to be replaced with formal documentation. I note that CADS staff reported to the Serious Incident Review that it is not uncommon for the Psychiatric Emergency Service to 'hold people on their books' until the alcohol and drug treatment provider took over their clinical care. It is difficult to know what 'holding people on their books' means, but it does not suggest that any service is clinically engaged. In the case of consumers with recent suicidality 'holding on books' does not seem to be an adequate clinical response.

In recent years Ministry of Health initiatives have signalled the need for mental health and alcohol and other drug services to be better integrated. This is a response to a tendency for either service to work in isolation and to offer either only a mental health service or only an alcohol or other drug service. The term 'coexisting problems' is currently used to signal that it is common for consumers to have both mental health and alcohol and other drug problems. Recent policy and health strategy has emphasised the need for clinicians in all services to respond to consumers' full range of needs rather than only those that are the core business of the service. In my opinion [Ms A] clearly had a primary alcohol use disorder and so was appropriately referred to the AOD service. However she also had significant issues with mood and anxiety, to the point

where she had made a suicide attempt, something that is not uncommon for people with primary alcohol or other drug problems. These issues should have been part and parcel of her referral to the AOD service and of that service's response.

I note that CDHB plans further training in coexisting disorders and development of safety plans involving family. This will be a positive development and will reinforce the need for specialist clinicians to also be aware of and respond to consumers' full mental health and addiction needs.

Documents consulted

Carter, G, Page, A, Large, M, Hetrick, S, Milner, A J, Bendit, N, & Burns, J (2016). Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm. *Australian & New Zealand Journal of Psychiatry*, 50(10), 939–1000.

Hawton K, Bergen H, Casey D, et al. (2007) Self-harm in England: A tale of three cities. *Social Psychiatry and Psychiatric Epidemiology* 42:513–521.

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

Te Ao Maramatanga. *Standards of practice for mental health nursing in Aotearoa New Zealand* (3rd Edition) Auckland, Te Ao Maramatanga.

Te Pou. *Te whare o tiki. Coexisting problems knowledge and skills framework.* Te Pou, Auckland."

The following further expert advice was obtained:

"The answer to the question of whether it was appropriate for PES to discharge [Ms A] depends on two factors:

1. Whether it is consistent with PES policy, and

2. Whether, if needed, care had been appropriately transferred to another service.

Table 1a of the PES service provision framework is clear that the service is a short term one, which provides emergency intervention before transferring care to another appropriate service.

In my experience, this role of short term emergency care is consistent with emergency mental health service models nationally.

Table 1c states that the PES provides a service where the principle (sic) disorder is not alcohol or drug related. [Ms A] clearly met criteria for entry to the PES initially ([Day 1]), but as the crisis resolved, her alcohol addiction became the primary problem, meaning she no longer met PES service criteria. There is no 'bright line' at which this point occurs, however the referral to CADS was made on [Day 8], and the PES case was about to be closed on [Day 11]. Her case was referred by CADS to an AOD service for 1:1 therapy on [Day 8], which indicates to me that CADS had assumed responsibility for [Ms A's] care. However a subsequent note ([Day 10]) from [RN F] at

PES indicates that the PES remained involved, and was waiting for [Ms A] to return contact to CADS before finally discharging her. The wording of the note suggests that discharge from the mental health service also meant discharge from CADS. This is despite CADS having referred [Ms A] for 1:1 therapy. I think the process of transfer of care could have been clearer, especially the point at which CADS became the team with clinical responsibility. A referral does not constitute a transfer of care, but allocation of a client for therapy does indicate that the referral was accepted. It would have been clearer for PES to close the case on [Day 8], or at least to clarify what continuing role they had. Conversely, it would have been clearer for CADS to have clarified whether or not they had accepted the referral.

In summary, in light of the Psychiatric Emergency Service Framework in place at the time, and on the basis of the information/risk assessments/diagnosis they had at the time it was appropriate to make the decision to discharge [Ms A] from PES. By [Day 8], although she was clearly continuing to struggle with multiple issues, alcohol addiction was clearly the main driver of her problems and it was therefore appropriate, and consistent with PES policy, to discharge [Ms A] to an alcohol treatment service. Having said that, the process of transfer of care between PES and CADS does not seem to be clear.

I hope the above is helpful and I'm happy to clarify any issues.

nga mihi

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