Bay of Plenty District Health Board

A Report by the
Mental Health Commissioner

(Case 18HDC00288)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a young man by Bay of Plenty District Health Board's (BOPDHB's) mental health services. The man was admitted to the Mental Health Ward for two nights, with suicidal ideation. After he was discharged, he was seen regularly by a BOPDHB psychologist, and his care was discussed at multidisciplinary team meetings; however, he was not seen by a BOPDHB psychiatrist. Tragically, he died the following year.

2. The Mental Health Commissioner considered that there was a striking lack of psychiatrist input into the man's care, and that the processes of discharging and transferring the man from the various parts of BOPDHB's Mental Health Service was extremely poor.

Findings

3. The Mental Health Commissioner was critical that the man was not seen by a consultant psychiatrist during his hospital admission, and not given the opportunity to meet with a psychiatrist when he continued to be unwell; in addition, the multidisciplinary team did not play an effective role in optimising the man's care, and the man did not have a case manager separate from his BOPDHB psychologist. The Mental Health Commissioner found that BOPDHB failed to provide services to the man with reasonable care and skill, and breached Right 4(1) of the Code.

4. The Mental Health Commissioner also found BOPDHB in breach of Right 4(5) of the Code, and criticised BOPDHB's failure to formulate and communicate a written plan with the man for his discharge from the community mental health service (CMHS), and to communicate this to his family, his GP, and his private psychologist. This was particularly important because at the time of the transition of care, the man was at risk and vulnerable, and required ongoing support.

5. The Mental Health Commissioner was also concerned that the consultant psychiatrist did not see the man during his admission, and that the consultant psychiatrist transferred the man to the care of the CMHS psychologist after the man had missed only one appointment. The Mental Health Commissioner acknowledged the mitigating circumstances outlined by the consultant psychiatrist.

Recommendations

6. The Mental Health Commissioner recommended that BOPDHB and the consultant psychiatrist provide a written apology to the man's family, and that BOPDHB provide feedback on the implementation of the recommendations made in its serious incident review; consider introducing a procedural requirement for CMHS clients to be seen by a psychiatrist every three months; implement a requirement that no staff involved in a client's care are to be part of the serious incident review team; and review its processes for discharging clients from the CMHS to ensure that a clear and comprehensive plan is established.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided to his late son, Mr A, by Bay of Plenty District Health Board's (BOPDHB's) Mental Health Service. The following issue was identified for investigation:

- *Whether Bay of Plenty District Health Board provided Mr A with an appropriate standard of care between Month2[1] and Month9 (inclusive).*

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

9. The parties directly involved in the investigation were:

Mr B	Complainant/consumer's father
BOPDHB	Provider

10. Further information was received from:

Mr C	Clinical psychologist
Dr D	Psychiatric consultant
Dr E	Psychiatric registrar
Ms F	Private clinical psychologist

11. Also mentioned in this report:

Dr G	General practitioner

12. Independent expert advice was obtained from consultant psychiatrist Dr Alma Rae (Appendix A) and clinical psychologist Tina Earl (Appendix B).

Information gathered during investigation

Background

13. Mr A first had contact with Mental Health and Addiction Services (MHAS) in 2014, when he was in his late teens. Mr A became mentally unwell again in Month1 2016 and had a hospital presentation after self-harming. On 21 Month2, Mr A was taken to the Emergency Department (ED) at the public hospital after being found intending to harm himself. He was admitted to the Mental Health Ward owing to his suicidal ideation, and he was discharged on 24 Month2.

[1] Relevant months are referred to as Months 1–9 to protect privacy.

14. After this discharge, Mr A received follow-up care from a BOPDHB clinical psychologist, Mr C. Mr A was also scheduled to see a consultant psychiatrist, Dr D, soon after discharge from hospital, but Dr D transferred Mr A to Mr C's care after Mr A did not attend his follow-up appointment with Dr D. In response to the "information gathered" section of the provisional opinion, Mr A's family stated: "[W]e never received an outpatient appointment when we departed from [the mental health ward]." Tragically, Mr A was found deceased on 31 Month9 by suspected suicide. This report concerns the care Mr A received from BOPDHB's Mental Health and Addiction Services.

Chronology of events

15. On 16 Month2, Mr A was taken to the ED at another district health board (DHB2) after having self-harmed. This was in the context of being mentally unwell following relationship issues.

16. Mr A was already taking fluoxetine (used to treat depression), which had been prescribed to him by a general practitioner (GP). On 18 Month2, Mr A was seen again at DHB2 after self-harming. He was prescribed lorazepam to assist with sleeping and ruminative thinking.

BOPDHB inpatient care

17. Mr A then returned to live with his parents. On 21 Month2, Mr A was taken to the ED after being found intending to harm himself and having suicidal ideation. He was admitted to the mental health ward voluntarily. Psychiatric registrar Dr E assessed Mr A on admission and documented his presenting problems and reasons for admission as anxiety, low mood, self-harm, and suicidal ideation. While on the ward, Mr A's fluoxetine medication was reduced, and quetiapine (an antipsychotic medication that is also used for treatment of anxiety) was commenced. BOPDHB told HDC that consultant psychiatrist Dr D had primary responsibility for the services provided to Mr A while he was an inpatient.

18. BOPDHB's policy and protocol indicates that a psychiatric inpatient should be seen by a senior medical officer (SMO) within 24 hours of admission. BOPDHB told HDC: "It was unusual that this [did] not occur." Dr D told HDC that all patients who are admitted are discussed with him via email or telephone. However, BOPDHB told HDC that on this occasion, Dr D has "consistently maintained that he has no recollection of discussing [Mr A] with [Dr E] and has expressed surprise and regret that this was the case". Dr E told HDC that he does not remember Mr A or his admission. However, Dr E stated: "In line with usual procedures, I expect that I would have discussed my initial assessment and management plan with the responsible SMO that same day."

19. Mr A was not reviewed physically by any senior psychiatrist between 21 and 24 Month2 while he was an inpatient. BOPDHB told HDC that the lack of consultant psychiatrist review of Mr A was not in keeping with its policy and protocol regarding the continuum of patient care.

20. Dr E told HDC that patients admitted to the Mental Health Ward were assigned to one of two SMOs, and during normal working hours inpatient admissions were always discussed with the SMO who would be responsible for the patient's care. Outside of normal working

hours, an on-call SMO would make the decision whether to admit the patient, and the relevant mental health ward SMO would be notified the following morning. He said that typically the SMOs visited the ward daily. He stated: "[I]n my experience it would have been highly unusual for one of them not to do so for a period of three continuous days … and I do not recall this ever happening." Dr E said that through their communication, the SMOs "oversaw and supervised the management plans for our patients".

21. An inpatient multidisciplinary team (MDT) meeting was held on 23 Month2, and Mr A's care was discussed. The plan was for Mr A to stay in hospital for another two days to give his parents respite, and to refer him for counselling, as he would need this "longer term". The notes do not record who was in attendance, although Dr E said:

> "I expect that I was and that I reported on [Mr A's] presentation and progress. Invariably the SMO psychiatrists attended their inpatient MDT meetings (unless they were on leave) and so I would expect that [Mr A's] responsible SMO was in attendance also."

22. Mr A was discharged from hospital on 24 Month2. The discharge summary document is signed by a house officer, but Dr D is listed as Mr A's doctor. Mr A's discharge diagnosis was "anxiety secondary to depressive symptoms", and it was noted that he had no current thoughts of self-harm. The discharge plan included the following:

- Review in outpatient clinic by Dr D on 22 Month3
- Psychiatric nursing follow-up in one week
- Referral to counselling through community mental health team
- Discharge home with parents to care of GP (the discharge summary was sent to Mr A's GP practice).

23. The discharge summary recorded that Mr A's fluoxetine was reduced and replaced with quetiapine.

24. Dr E said that he did not review Mr A on 24 Month2 prior to his discharge from the mental health ward, and as far as he is aware he was not involved in the decision to discharge him from hospital that day, which was a day earlier than had been planned at the MDT. Dr E stated: "[I]t is my expectation that whoever was involved in the decision to discharge [Mr A] that day would have done so in consultation with the responsible SMO."

25. Dr D told HDC that he does not know of any cases where he has not discussed a patient's progress or management plan, and is "perplexed and confused" as to why he was not involved in Mr A's discharge planning, as it was a practice for Dr E to discuss cases with him. Dr D stated: "Assuming I couldn't be found, then there should be another SMO, who is always present if [Dr E] was concerned." BOPDHB told HDC that there is no evidence of Dr E having discussed Mr A's case with an SMO prior to discharge.

26. The clinical notes for 24 Month2 do not show any medical staff involvement that day, and it is unclear who was involved in Mr A's discharge. A nurse recorded: "[Mr A] expressed that he wanted discharge home today. Mother initially reluctant, but having spoken to [Mr A's] father, returned to collect [Mr A] at 12.15."

Care under BOPDHB Community Mental Health Service

27. On 31 Month2, Mr A saw Dr G at his usual GP practice. Dr G wrote in her clinical notes: "I'll write to psychiatrist for guidance about medication." She then made a "semi-urgent" referral to BOPDHB Community Mental Health Service (CMHS) the next day, stating:

> "Apparently counselling or psychology has been arranged for 21 Sept and the community mental health nurse is going to visit this week. I would like a review to give us some guidance around medication and whether we should be trying to initiate something else or what the plan is."

28. There is no evidence that any action was taken by BOPDHB in response to this referral.

29. On 12 Month3, Mr A was assessed by CMHS clinical psychologist Mr C, who noted that Mr A was very depressed but denied suicidal intent. Distraction techniques, relaxation techniques, and harm prevention strategies were noted as having been introduced. Mr C recorded that Mr A's appetite had decreased, and that he was unable to sleep without medication. Mr A was seen again by Mr C on 19 Month3.

<u>Transfer of care from CMHS psychiatrist to CMHS clinical psychologist</u>

30. On 22 Month3, Mr A did not attend the pre-arranged follow-up appointment with Dr D. In response to the information gathered, Mr A's family explained that they did not receive the appointment on discharge from the mental health ward, and that they were told that this was a separate part of the mental health service that could not be arranged by the hospital. Dr D wrote a letter to Mr A that day explaining that he had spoken to Mr C, who was prepared to offer regular counselling to Mr A, and that there was no need for psychiatric input at that stage. Dr D wrote: "I will therefore transfer your care to [Mr C] and we will obviously monitor the situation as it progresses in [our MDT] Meeting." Dr D also wrote to Mr A's GP advising her of this.

31. Dr D stated that the plan was discussed with Mr C one to one, and also discussed at an MDT review. However, there is no evidence of an MDT review having occurred until 3 Month4, after Dr D had transferred Mr A to Mr C's care. Dr D stated that it was his clinical judgement not to reschedule Mr A's appointment and to transfer him to Mr C's care. Dr D said that he knew that Mr C would contact him if he were ever concerned.

32. BOPDHB told HDC that its protocol is to cease attempts at follow-up after a consumer misses two consecutive psychiatrist appointments. At the time Dr D transferred Mr A to Mr C, Mr A had missed only one psychiatrist appointment.

Clinical psychologist care and MDT reviews

33. On 26 Month3, Mr A was assessed by Mr C, who noted: "Mood improved. No self-harm." However, Mr C also noted that Mr A had lost weight, had non-existent libido, and was feeling ugly and worthless. Cognitive restructuring[2] was carried out.

34. BOPDHB told HDC that Mr A's care was discussed at an MDT meeting on 3 Month4. Brief notes from the meeting record: "[R]eviewed in MDT referred depression and self-harm. Working, past [self-harm]. Adjustment issues, CBT ongoing, no self-harm within 4 weeks." Dr D was present at this meeting.

35. On 17 Month4, Mr A and his parents met with Mr C, and Mr A's parents noted their concerns that Mr A was not sleeping well and had very low mood. A change of medication, breathing exercises, and other such techniques were discussed.

36. Mr A did not attend two appointments between 17 Month4 and 8 Month5.[3]

37. On 7 Month5, Mr A's care was discussed at an MDT review. Brief notes from the discussion state that Mr A was "presenting as depressed/obsessional" and "requesting Ψ[4] input". A Medical Officer Special Scale[5] (MOSS) was present at this MDT meeting.

38. On 8 Month5, Mr A was assessed by Mr C and a CMHS crisis worker, Nurse Practitioner (NP) Mr H. Mr A's mother had reported to Mr C that Mr A's mood was very low. A plan was made with Mr A around relaxation and control, and he was encouraged to be more active socially.

39. On 15 Month5, Mr C met with Mr A and noted that his ruminations had decreased and that he had plans to work and then backpack overseas. Self-reward, self-instruction, and goal setting were discussed.

40. Mr A missed his appointments on 21 Month5, 24 Month5, and 19 Month6, owing to his work schedule, so he did not have any appointments during this period.

41. On 13 Month7, Mr C telephoned Mr A's mother, who reported that Mr A had been struggling over the holiday period but was functioning and still working.

42. On 16 Month7, Mr C next met with Mr A, who reported feeling bad physically and crying over the previous two weeks. Mr A's mother told Mr C that her son had harmed himself.

43. On 31 Month7, Mr C talked with Mr A's parents by telephone and discussed how to deal with Mr A's moodiness and self-harm.

[2] Cognitive restructuring is a group of therapeutic techniques that help people to notice and change their negative thinking patterns.

[3] Mr A had obtained employment in a remote location and found attending mental health appointments difficult.

[4] This symbol is shorthand for psychiatry or psychology.

[5] A non-training position for a doctor who has not yet specialised or not yet gained a postgraduate qualification, but is not eligible for a consultant role because they do not meet the requirements for a vocational scope of practice.

44. On 1 Month8, Mr C and a CMHS social worker met with Mr A. Notes record: "[Mr A's] [m]ood appear[s] dysthymic and affect flat … Is future focussed, denies immediate suicidal plans but admits to thinking about self-harm." Various strategies to overcome loneliness were discussed.

45. Mr C told HDC that his plan was to take the case to MDT "to ask [for] psychiatry review for meds".

46. On 8 Month8, Mr A's GP requested crisis assessment because Mr A had expressed suicidal thoughts. Mr A was seen by the CMHS crisis team, and he denied suicidal ideation or intent. Mr A was prescribed venlafaxine (an antidepressant) by his GP, on the advice of the crisis team.

47. On 10 Month8, follow-up by the CMHS crisis team occurred. Mr A reported feeling better after starting venlafaxine. Also on this date, Mr A's parents contacted a private clinical psychologist, Ms F, and asked her to meet with Mr A.

48. Mr A's care was discussed again at an MDT review on 13 Month8, and very brief notes are recorded. Mr C told HDC that at the meeting it was suggested that Mr A's care be transferred to another psychologist or provider. Mr C stated: "To my knowledge, this was discussed with Mr A." A MOSS was present at this MDT meeting.

49. On 17 Month8, Mr C received a letter from Mr A's mother, who reported that Mr A had been looking at suicide websites and had his father's old amitriptyline (an antidepressant) in his bedside drawer. She also reported that Mr A was very depressed. Mr C took Mrs B's letter to a crisis meeting for discussion, but the crisis team "did not think it was severe enough to warrant a call out at [that] moment". Mr C met with Mr A later that day. Mr A denied current suicidal ideation but admitted having looked at suicide websites and on occasion thinking about suicide. Distraction activities were discussed and crisis line and after-hours numbers provided. Mr C contacted Mr A's parents and asked them to monitor their son's medications and to remove the non-prescribed amitriptyline.

50. Mr C next met with Mr A on 20 Month8, and noted: "[M]uch more relaxed and animated … [D]enies on-going active suicidal thoughts and ideation … Mood improved."

Involvement of private clinical psychologist

51. Mr A first met with Ms F on 24 Month8. She said that Mr A presented as an anxious, psychologically fragile young man with low mood, and that he engaged in an open and honest way about his experiences and feelings, including suicidal ideation, low and critical self-perception, and disconnection from others. Ms F noted that Mr A was to see Mr C on the following Monday, and that she had Mr A's permission to speak with Mr C because she was soon to take leave, and Mr C might be able to see him while she was away.

52. Mr A did not attend the scheduled appointment with Mr C on 27 Month8.

53. On 3 Month9, Mr A's mother left a voice message with Mr C saying that Mr A was depressed but still working. Mr C rang back and left a message about an appointment the following week.

54. On 6 Month9, Ms F contacted Mr C and told him that she was also working with Mr A. Mr C documented that he would discuss this with the MDT, as he was "not comfortable with … having [both himself] and [Ms F] as [Mr A's] psychologists". Mr C told HDC that apparently Ms F was able to see Mr A after hours, and was happy to take over Mr A's care. Mr C also told HDC that Ms F had indicated to him that "she had [Mr A's] ongoing care in hand". However, Ms F told HDC that she asked Mr C to "keep an eye on" Mr A while she was away from 10 to 21 Month9, and she documented: "[Mr C] will look after him while I'm away on holiday."

55. Also on this date, Mr A's mother left a message with Mr C saying that Mr A was depressed and requesting an urgent appointment. Mr C rang back and left a message. Mr C told HDC that he had concerns about the ethical issues and, in particular, a conflict of interest. He stated: "To continue working with another clinician's patient, is a breach of ethics." He therefore took the matter to the MDT meeting, where it was agreed that Mr A could be discharged into Ms F's care. A consultant psychiatrist was present at this MDT meeting. The brief notes from the meeting record the team's plan to discharge Mr A to his private psychologist.

Discharge from CMHS

56. On 8 Month9, and in accordance with the decision made by the MDT, Mr C discharged Mr A from CMHS into Ms F's private care.

57. Mr C told HDC: "[Mr A] was not transferred to [Ms F], he and his parents chose to go to her, I was only informed after they had had two sessions already." Mr C stated that if Ms F had not gone on leave almost immediately after taking on Mr A's care, then he and CMHS "may well have [undertaken] a more formal transfer of care". Mr C said that during Ms F's absence, the CMHS crisis team was still available to Mr A. There is no evidence of a discharge plan being made with, or shared with, Mr A, his family, his GP, or Ms F.

Further events

58. Mr A saw Ms F again on 8 Month9, and she recorded that his suicidal ideation had been fleeting that week, but at times had been very intense. She noted: "He's not concerned about it because he 'knows' he's not going to commit suicide." She also recorded: "I gave feedback about my contact with [Mr C] who will be available while I'm away."

59. On 15 Month9, Mr A saw his GP, who noted that Mr A was "no longer suicidal" and was enjoying his work, and that quetiapine was helping his sleep and he was "doing better" on venlafaxine. He was prescribed further quetiapine and venlafaxine.

60. On 27 Month9, Mr A saw his GP again along with his mother. The GP noted that Mr A's mood had slipped again and he had felt suicidal over the weekend. It is recorded that Mr A did not think that an acute crisis team assessment was warranted at that stage, but that he

would contact CMHS to arrange an appointment. The GP increased Mr A's venlafaxine dose and arranged a review in two weeks' time, or sooner if he deteriorated.

61. On 28 Month9, Mr A's mother took her son to CMHS as she was concerned about his suicidality. It was noted that his GP had increased his venlafaxine dose the previous day. Mr A was offered admission to the ward, but he declined. Mr A told the on-call crisis worker that he was no longer suicidal, and it was noted that he appeared to be future focussed.

62. On 30 Month9, CMHS crisis worker Mr H tried to follow up with Mr A but he had changed his cell phone number. Mr H spoke to Mr A's mother, who reported that Mr A was "okay" but talking of suicide, and that it was very distressing for her. Mr H suggested waiting to see whether the increased venlafaxine dose helped. Mr A's mother told Mr H that she would obtain her son's new cell phone number and give it to Mr H.

63. HDC was told that the plan put in place was referral back to CMHS, and in the meantime for crisis workers to provide follow-up until regular case management was in place.

64. At 6pm on 30 Month9, Mr A's mother gave Mr H her son's new phone number. Mr H spoke to Mr A on his landline (as he was getting no response via the cell phone) and noted that he "sounded reasonably cheerful" and that he was "feeling a bit better" and was talking about work the following day. Mr C told HDC that during this discussion, Mr A was offered an admission to the Mental Health Unit, but this was declined.

65. At approximately 1am on 31 Month9, Mr A left home whilst his family was asleep. Mr A's family told HDC that his ex-girlfriend called them to advise that she was very concerned about him. Mr A's mother called Mr A to tell him to come home, or she would call the Police to help search for him.

66. Sadly, at approximately 10am, Mr A was found deceased.

Other information

67. Mr C told HDC that Mr A had cancelled or failed to attend 13 sessions with CMHS, making it "extremely difficult to establish a working therapeutic alliance and to get therapy working optimally". Mr C said that Mr A also under-reported his drug and alcohol intake, and did not disclose the extent of his contact with his ex-girlfriend.

68. BOPDHB completed a Serious Incident Review (SIR) on 19 April 2018. Mr C and Mr H were on the review team. The review noted a number of issues, including:

- Mr A did not see a senior psychiatrist for diagnostic formation despite being an inpatient, and he did not attend the outpatient psychiatrist appointment that was made for him.
- Mr A's case management defaulted to his therapist.
- Mr A appeared to function at a level that was incongruent with the level of his distress, e.g., he was working effectively until the time of his death.

- Mr A had not disclosed to family and clinicians some of his behaviours that would have alerted them to the high risk and degree of unwellness that he was experiencing.

69. The SIR also made a number of recommendations, including that:

- All mental health inpatients have a consultant psychiatrist review within 24 hours of admission.
- Where complex therapy is required, there is a separation of roles between the therapist and case manager.

70. In response to the SIR recommendations, Mr C told HDC that a comprehensive risk assessment was completed by mental health ward staff and was deemed adequate, as it highlighted Mr A's self-harm and suicidal intent. Mr C further said that risk was assessed in every session, which at times led to the involvement of the MDT and crisis workers.

71. BOPDHB's Mental Health and Addiction Service protocol A1.22 Admission to Inpatient Psychiatric Care has since been reviewed, and now states that psychiatric review "will occur within 24 hours of admission and is the responsibility of the client's designated Responsible Clinician/[SMO] and registered nurse".

72. BOPDHB's policy and protocol MHAS A1.31 Discharge 3.4 indicates that psychiatric inpatients who are discharged to community mental health follow-up are to have a clinical review appointment with a psychiatrist. BOPDHB reiterated that "[i]t was unusual that this did not occur". It told HDC that since these events, "[CMHS] has initiated a process to manually identify for each case manager in its 2 geographical sector teams, when their cases had last been reviewed by a Psychiatrist, and when the next appointment is due". In addition, BOPDHB's CMHS has established an automated electronic system to indicate the date of the last SMO review, when the next appointment is due, the date of the last MDT review, and when the next MDT review is due.

73. Mr C told HDC that a psychiatrist was in attendance at each MDT meeting. He said that he requested psychiatric review on each occasion, and that none was provided because "the consensus view of the MDT and of the psychiatrist in attendance at the meetings being that psychiatrist review was not deemed necessary at that time".

74. BOPDHB told HDC that normally community clients are appointed a case manager separate from a psychologist who is providing therapeutic services. However, in Mr A's case, both his case management and therapy were undertaken by Mr C. BOPDHB has since changed its practice to ensure that CMHS clients are allocated a case manager as well as a psychologist if a psychologist is providing therapeutic services.

75. An MDT protocol introduced in 2017 sets out the standards to be met during an MDT meeting, including the specific documentation requirements in relation to each client reviewed. One of the objectives listed in the protocol is to ensure that a three-monthly review of client progress is documented.

76. BOPDHB is part of a Health Quality & Safety Commission project entitled "Connecting Care — Improving Service Transitions". The aim of the project is to increase by 50%, by July 2021, the number of clients who have a transition plan that meets service requirements and supports their recovery.

Responses to provisional opinion

77. Mr A's family, BOPDHB, Dr D, and Mr C were given an opportunity to comment on relevant sections of the provisional opinion. Where appropriate, information has been included in the "information gathered" section above.

78. BOPDHB told HDC that the MHAS leadership team accepts the provisional findings and does not wish to raise any objections or dispute the findings. It stated that it is committed to implementing the recommendations made in the report.

79. Dr D reiterated that he was not advised of or involved in Mr A's care while Mr A was in the inpatient unit. Dr D told HDC that he is confident about this because he strictly followed a very structured process for inpatient management (including, for example, assessing any new patient as soon as possible and attending the ward to discuss progress with the registrar). Dr D stated:

> "I can be confident that the reason I did not see/review [Mr A] during his admission is because he was either not allocated to my caseload or discussed with me during his admission/discharge planning. Either way what happened was exceptionally unusual and was due to a breakdown in the admission process within the unit."

80. Dr D said that he would like to emphasise that had he been informed of Mr A's admission, he would have reviewed him without hesitation. Dr D also noted that his name is not mentioned in the clinical records to show that he was not contactable, which he believes "demonstrates that [he] was not involved in any aspect of [Mr A's] care during the inpatient admission".

81. Regarding the decision to transfer Mr A's care to Mr C, Dr D stated:

> "In [Mr A's] case, psychological intervention was necessary immediately and nothing would be gained by [Mr A] waiting for another rescheduled appointment with me. He would have experienced a lengthy waiting time during which he could have suffered from more emotional dysregulation … [I]f [Mr C] had any concerns about [Mr A], he could discuss these concerns with me immediately — we worked closely together and would regularly discuss patients."

82. Dr D told HDC that he was not aware of the referral from Mr A's GP (requesting medication guidance), and said that there is no question that he would have reviewed Mr A if requested.

83. Dr D retired in Month6. He extended his sincere condolences to Mr A's family for the events that occurred. Dr D stated: "I am also sorry that I was not present at the DHB in

early 2017 to actively intervene, as I would have, when intervention was sought by the psychologist [Mr C]."

84. Mr C confirmed that he had no comment on the provisional opinion.

Opinion: Bay of Plenty District Health Board — breach

Introduction

85. Mr A was an inpatient in the mental health ward for three days from 22 Month2, after which he received clinical psychology services from Mr C through the CMHS. Mr A was discharged from BOPDHB CMHS on 8 Month9. Tragically, Mr A was found deceased on 31 Month9.

86. District health boards are responsible for the operation of the clinical services they provide, and can be held responsible for failures in the provision of those services. In my opinion, there was a striking lack of psychiatrist input into Mr A's care, and the processes of discharging and transferring Mr A from the various parts of BOPDHB's Mental Health Service were extremely poor. I find that overall BOPDHB is responsible for these failings, and ultimately did not provide Mr A with the standard of care he had the right to receive.

87. While I am critical of aspects of the care Mr A received from BOPDHB, it is not my role as Mental Health Commissioner to determine the reasons for Mr A's death. I note the reference by my independent advisor, clinical psychologist Tina Earl, to the Ministry of Health Guidelines: *Preventing suicide: Guidance for emergency departments*. The guidelines state:

> "Predicting and mitigating suicide risk in the short term is very difficult for the clinician given the current evidence base, which indicates that:
>
> - most risk factors are poor predictors of imminent and short-term risk
> - unconscious or implicit attitudes are arguably the most powerful imminent and short-term predictors of suicide, but currently these are difficult to assess in the clinical setting
> - while thought may have gone into a suicide attempt, it is often not a thoughtful act but made in a state of severe emotional distress, where suicide seems the only solution."

Inpatient care

88. While Mr A was an inpatient in the mental health ward, he was seen by registrar Dr E. However, Mr A was never reviewed in person by a consultant psychiatrist. BOPDHB policy and protocol indicates that a psychiatric inpatient should be seen by the SMO within 24 hours of admission. BOPDHB told HDC that "[i]t was unusual that this [did] not occur". BOPDHB stated that Dr D had primary responsibility for the services provided to Mr A

while he was an inpatient. However, there is no evidence that Dr D either saw Mr A in person or discussed Mr A with more junior medical staff. Dr D has "consistently maintained that he has no recollection of discussing [Mr A] with [Dr E]". Dr E noted that it was usual practice to discuss all patients with the SMO, and that an inpatient MDT meeting was held on 23 Month2. The notes do not record who attended the meeting, but Dr E believes that he would have attended and would have discussed Mr A's presentation and progress, and that Mr A's responsible SMO would also have been in attendance.

89. Dr E said that he did not review Mr A on 24 Month2 prior to his discharge, and that as far as he is aware he was not involved in the decision to discharge him that day, which was a day earlier than had been planned at the MDT. Dr D told HDC that he is "perplexed and confused" as to why he was not involved in Mr A's discharge planning. Mr A's discharge from the mental health ward was recorded in the clinical notes by a nurse as being at Mr A's request, and the discharge summary was signed off by a junior doctor. However, it is not clear whether senior medical staff were involved in the discharge.

90. My independent advisor, consultant psychiatrist Dr Alma Rae, noted that the accepted practice when someone is admitted is that a consultant will see the person within 24 hours of admission. She stated: "For a consultant not to have seen a patient who was in hospital for 3 days and then an outpatient for a further 6 months is astonishing."

91. I share Dr Rae's concern that Mr A was not seen by Dr D or another consultant psychiatrist during his admission to the inpatient unit. From the information I have available, I am unable to determine what, if anything, was discussed between Dr D and Dr E about Mr A's presentation and discharge planning. I am concerned that there is no documentation of any such discussions, and that neither Dr D nor Dr E consider that they were involved in the decision to discharge Mr A from the unit on 24 Month2. Given the seriousness of Mr A's presentation, I am very critical at the lack of consultant psychiatrist input during Mr A's admission to the mental health ward, including his discharge, and note that this was in contravention of BOPDHB processes and generally accepted practice.

Outpatient CMHS care

92. After his discharge from the mental health ward, Mr A was seen in the community regularly by Mr C. While BOPDHB told HDC that normally its community clients are appointed a separate case manager, in Mr A's case, both his case management and therapy were undertaken by Mr C.

93. Along with providing therapy sessions, Mr C discussed Mr A at MDT meetings on 3 Month4 and 7 Month5, and 13 Month8 and 6 Month9. Dr D was in attendance on 3 Month4, and other psychiatrists were at the other three meetings. Mr C told HDC that he requested psychiatric review on each occasion, and that none was provided because "the consensus view of the MDT and of the psychiatrist in attendance at the meetings being that psychiatrist review was not deemed necessary at that time". The minutes taken of the MDT meetings are very brief, and do not record detail of the discussions about Mr A's case effectively.

Lack of psychiatrist input

94. Dr Rae was very critical of BOPDHB's decision not to organise a psychiatry review of Mr A between Month3 and Month9. She stated: "[T]he lack of a psychiatry review during this extended period of mental health represents a severe departure from the expected standard of care." She also commented: "Given the lack of progress made by [Mr A] during this period, and the fact that he had NEVER been seen by a Consultant Psychiatrist, I remain adamant that he should have been reviewed during this period" (emphasis in original). Dr Rae noted Mr C's request for psychiatrist input during the MDTs, and commented: "If this was an opportunity missed for psychiatrist input, it is most regrettable."

95. Despite Mr A continuing to be unwell between Month3 and Month9, he was not given any further opportunity to meet with a psychiatrist for input into his care. I accept Dr Rae's advice that this was a severe departure from the expected standard of care.

MDT meetings

96. Dr Rae advised that the MDT did not play an effective role in optimising Mr A's care. She noted that the records do not detail the substance of any discussions about Mr A, so she cannot tell what information Mr C conveyed to the MDT, nor what the team may have offered. BOPDHB accepts that the documentation of the MDT discussions was not consistent with its standards. Dr Rae advised:

> "MDTs at that time represented a departure from expected standards in that they were poorly recorded and that [Mr A] was not discussed from 7 [Month5] until [13] [Month8], which exceeds … the three months observed in other DHBs for many years."

97. Dr Rae was also concerned at the lack of continuity of the consultant psychiatrist who was in attendance at the MDT meetings. Further, she noted that there is no record of the MDT considering the use of an antidepressant medication for Mr A, and stated that this was an "accessible, inexpensive and indeed appropriate treatment" that should have been considered ahead of options such as a referral to another facility.

98. I agree with Dr Rae's assessment that the MDT did not play an effective role in optimising Mr A's care. I am concerned at the lack of documentation of the discussions around Mr A's management, and that there was a gap in discussion of his case from 7 Month5 until 13 Month8. Overall, I am not satisfied that the MDT meetings were conducted or recorded in such a way as to provide an acceptable standard of care to Mr A.

Case management

99. Ms Earl advised that had Mr C not been both Mr A's treating therapist and his case manager, "there may have been further input and oversight by other clinicians therefore ensuring stronger processes". Similarly, Dr Rae advised:

> "Had [Mr A] had a separate case manager he would have had someone else to discuss things with and may have been better engaged with the service as a whole. In all the services I have worked in (7 different DHBs) CMHS patients have a case manager and a

> psychiatrist and if a clinical psychologist is also involved that makes three clinicians in all."

100. BOPDHB has acknowledged that normally community clients are appointed a case manager separate from a psychologist who is providing therapeutic services. In my opinion, the failure to adhere to this normal process in Mr A's case was a shortfall in BOPDHB's management, and it meant that Mr A's engagement with CMHS may have been compromised.

Discharge from CMHS to private clinical psychologist

101. Mr A first met with Ms F on 24 Month8. She contacted Mr C on 6 Month9, and told him that she was also working with Mr A. Ms F told HDC that she asked Mr C to "keep an eye on" Mr A while she was away from 10 to 21 Month9, and recorded in her notes: "[Mr C] will look after him while I'm away." However, Mr C discussed this with the MDT because he was not comfortable having both himself and Ms F as Mr A's psychologists. At the MDT meeting, it was agreed that Mr A could be discharged into Ms F's care, and the discharge occurred on 8 Month9. There is no evidence of a discharge plan being made with Mr A or shared with Mr A, his family, his GP, or Ms F. BOPDHB accepts that the discharge process to Ms F was not consistent with its own standards.

102. Ms Earl identified a moderate departure from acceptable standards in respect of the transfer of care from Mr C to Ms F. Ms Earl advised:

> "There was not a well explicated process. The need for a robust handover is due to [Mr A's] high acuity with severe depression and high risk of suicide … [T]here was no discharge/transfer of plan on file, and there was no contact with or by CMHAS services documented for the period 8 to 21 [Month9]. … [T]here are systemic issues present with the CMHAS regarding the unclear discharge/transfer of care process of the client, and the subsequent ongoing care plan."

103. Ms Earl commented: "[Mr A] was high risk and was also vulnerable due to the process of transition of care, so the need for continuity of care, risk management, follow up and support was high." She advised that regardless of whether Ms F was taking leave or not, there remained a need to provide a written plan. Ms Earl stated:

> "Transfer of care at a CMH[S] usually requires a discharge/transfer of care process which would involve contact and discussion with the client and family themselves; discussion and decision with MDT; a plan (including medication review, outcomes and recommendations for treatment, updated risk management plan); and contact with relevant providers such as GP, new practitioner/care provider, and agencies involved in the care of the client. Given any complicating issues such as a practitioner going on leave, then ongoing active involvement by a service is appropriate and some form of shared care may be necessary to mitigate risk."

104. Dr Rae was similarly critical of the process of discharging Mr A into Ms F's care, and stated: "There does not appear to have been any discharge planning, collaboration or coordination prior to his abrupt ejection from the service on 8 [Month9]."

105. I accept the advice of Ms Earl and Dr Rae on this point. I am concerned at the lack of planning that went into discharging Mr A from CMHS into Ms F's care, and that despite Ms F's request for assistance over the period she was to be on leave, the decision was made by the MDT to discharge Mr A from the service. I am critical that there was a failure to plan Mr A's discharge from the CMHS with him. There was also a failure to make a written plan about the discharge and communicate this to Mr A, his family, his GP, and Ms F. This was particularly important because at the time of the transition of care, Mr A was at risk and vulnerable, and required ongoing support.

106. I note and accept the advice of Ms Earl that the other aspects of care provided by Mr C to Mr A were consistent with recommended guidelines and within accepted practice.

Conclusion

107. In my opinion there were multiple areas in which BOPDHB failed to provide services of an appropriate standard to Mr A. I note Dr Rae's general comment:

> "In the conduct of this case by the BOPDHB's mental health service there were significant departures from what I and my peers would regard as acceptable practice."

108. I find that BOPDHB failed to provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) for the following reasons:

a) Mr A was not seen by a consultant psychiatrist during his admission to the mental health ward.

b) Mr A was not given any further opportunity to meet with a psychiatrist for input into his care while he continued to be unwell between Month3 and Month9, despite a number of requests to the MDT by the treating psychologist and a request by Mr A's GP for psychiatrist input.

c) The MDT did not play an effective role in optimising Mr A's care, its discussions were poorly documented, and there was a gap in discussion of Mr A's case from 7 Month5 until 13 Month8.

d) Mr A did not have a case manager separate from Mr C.

109. Right 4(5) of the Code states that every consumer has the right to cooperation among providers to ensure quality and continuity of services. I also find that BOPDHB breached Right 4(5) of the Code because there was a failure to plan Mr A's discharge from the CMHS with him. There was also a failure to make a written plan about the discharge and communicate this to Mr A, his family, his GP, and Ms F. This was particularly important because at the time of the transition of care, Mr A was at risk and vulnerable, and required ongoing support.

Opinion: Dr D — adverse comment

Inpatient care

110. While Mr A was an inpatient in the mental health ward, he was seen by registrar Dr E. However, Mr A was never reviewed in person by a consultant psychiatrist. BOPDHB policy and protocol indicates that a psychiatric inpatient should be seen by the SMO within 24 hours of admission. BOPDHB told HDC: "It was unusual that this [did] not occur."

111. BOPDHB stated that Dr D had primary responsibility for the services provided to Mr A while he was an inpatient. However, there is no evidence that Dr D saw Mr A in person, discussed Mr A with more junior medical staff, or was even aware of Mr A's admission. Dr D has "consistently maintained that he has no recollection of discussing [Mr A] with [Dr E]". Dr E noted that it was usual practice to discuss all patients with the SMO, and that an inpatient MDT meeting was held on 23 Month2. Dr E expects that he would have discussed Mr A's presentation at this meeting, and that Mr A's responsible SMO would have been in attendance. In response to the provisional opinion, Dr D reiterated that he was not advised of or involved in Mr A's care while he was in the inpatient unit. Dr D stated:

> "I can be confident that the reason I did not see/review [Mr A] during his admission is because he was either not allocated to my caseload or discussed with me during his admission/discharge planning. Either way what happened was exceptionally unusual and was due to a breakdown in the admission process within the unit."

112. My independent advisor, consultant psychiatrist Dr Alma Rae, noted that the accepted practice when someone is admitted is that a consultant will see the person within 24 hours of admission. I am concerned that as the person with primary responsibility for Mr A's care, Dr D did not see Mr A during his admission. I note that this was in contravention of BOPDHB processes and generally accepted practice. However, I accept that Dr D was not aware of Mr A's admission to the mental health ward, and consider this to be a systemic problem, which I have discussed in my opinion about BOPDHB.

Transfer from CMHS psychiatrist to clinical psychologist

113. Following his admission to the mental health ward, Mr A was scheduled to attend a follow-up appointment with Dr D on 22 Month3, but did not attend. Subsequently, Dr D wrote to Mr A explaining that he had spoken to Mr C, who was prepared to offer regular counselling to Mr A, and that there was no need for psychiatric input at that stage. Dr D wrote: "I will therefore transfer your care to [Mr C] and we will obviously monitor the situation as it progresses in [our MDT] Meeting." Dr D also wrote to Mr A's GP advising of the plan. Mr A never saw Dr D. Dr D explained to HDC that it was his clinical judgement not to reschedule Mr A's appointment, and to transfer him to Mr C's care. In response to the provisional opinion, Dr D stated:

> "In [Mr A's] case, psychological intervention was necessary immediately and nothing would be gained by [Mr A] waiting for another rescheduled appointment with me. He would have experienced a lengthy waiting time during which he could have suffered from more emotional dysregulation … [I]f [Mr C] had any concerns about [Mr A], he

could discuss these concerns with me immediately — we worked closely together and would regularly discuss patients."

114. BOPDHB's policy MHAS A1.31 Discharge 3.4 indicates that psychiatric inpatients who are discharged to community mental health follow-up are to receive a clinical review appointment with a psychiatrist. BOPDHB noted that "[i]t was unusual that this did not occur" in Mr A's case. BOPDHB told HDC that its protocol is to cease attempts at follow-up only after a consumer misses two consecutive psychiatrist appointments.

115. Dr Rae advised that Dr D's decision to discharge Mr A from his case load after Mr A did not attend the appointment on 22 Month3 was a serious departure from acceptable standards. She noted that in her experience, usual practice is to discharge after three missed appointments, and stated: "Given that so far [Dr D] [had] not seen the patient at all, I find this decision incomprehensible." Dr Rae also raised concern that Mr A was not followed up by a consultant or registrar to assess possible side effects, because his antidepressant had been withdrawn during his admission to the mental health ward.

116. I accept Dr Rae's advice, and I am particularly concerned that Mr A was transferred from Dr D's care despite having missed only one appointment, in contravention of BOPDHB policy and usual practice as described by Dr Rae. Dr D had never seen or spoken to Mr A, and steps should have been taken to offer Mr A a further appointment with either Dr D or another psychiatrist. It remains my opinion that this was an important opportunity that was missed for Mr A to have consultant psychiatrist input into his care. This was especially important because psychiatrist input did not occur during Mr A's admission to the mental health ward, and recent changes had been made to his antidepressant regimen. In making this criticism, I acknowledge the safety-netting that Dr D had put in place by transferring Mr A's care to another CMHS team member (Mr C), agreeing to review Mr A's case in MDT meetings, and informing Mr A's GP of the arrangement.

Recommendations

117. I recommend that BOPDHB:

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

b) Provide feedback to HDC on the implementation of the recommendations arising from the SIR. This should include comment on, and analysis of, the effectiveness of the changes made.

c) Consider introducing a procedural requirement for every CMHS client to be seen by a psychiatrist at least three monthly.

d) Implement a requirement that no staff involved in a client's care are to be part of the SIR team (other than for the purpose of explaining their involvement in the client's care).

e) Review its processes for discharging clients from CMHS to ensure that a clear and comprehensive plan is established, taking account of the following points recommended by Ms Earl:

   i. The plan is communicated to, and agreed with, the client and (where appropriate) the family.
   ii. Clear and detailed documentation is held on file.
   iii. The discharge process itself involves checking that this has occurred.
   iv. Requests for cover of care are documented clearly, with a plan agreed to by the client and family, by all services, and communicated to all concerned.

118. Feedback on the implementation of recommendations b) to e) should be provided to HDC within three months of the date of this opinion.

119. I recommend that Dr D provide a written apology to Mr A's family for the issue identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

Follow-up actions

120. Bay of Plenty District Health Board will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

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

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

Addendum

123. The Director of Proceedings filed proceedings by consent against BOPDHB in the Human Rights Review Tribunal. The Tribunal issued a declaration that BOPDHB breached Right 4(1) of the Code by failing to provide services to Mr A with with reasonable care and skill, and Right 4(5) of the Code by failing to ensure that there was effective collaboration among providers to ensure quality and continuity of services.

Appendix A: Independent advice to the Mental Health Commissioner

The following expert advice was obtained from psychiatrist Dr Alma Rae:

"Thank you for referring this case to me for expert advice. In preparing this advice I have received and read:

- Letter of Complaint dated 10 February 2018.
- Response from Bay of Plenty DHB dated 23 April 2018.
- Clinical Records from Bay of Plenty DHB covering the period 21 [Month2] to 31 [Month9].
- Clinical Records from [the] Medical Centre covering the period 18 [Month2] to 31 [Month9].
- Serious Incident Review dated 19 April 2018.
- Clinical Psychologist [Ms F's letter] dated 26 September 2018, including her attached clinical records.
- A copy of [Mr A's mother's]) note to Clinical Psychologist Mr C received by him on 17 [Month8].

I have also read and agree to follow the Guidelines for Independent Advisors. My qualifications are listed in the attached CV.

I have been asked to comment on:

1. The level of involvement by a consultant psychiatrist in [Mr A's] care, including:
   a. His assessment by a psychiatric registrar during his admission to the mental health unit at the public hospital;
   b. [Dr D's] decision to discharge [Mr A] from his case load following cancellation of the appointment in [Month3]; and
   c. CMHS decision not to organise psychiatry review between [Month3] and [Month9].
2. The coordination of care:
   a. Between CMHS and [Mr A's] GP; and
   b. Between CMHS and private psychologist [Ms F] after they became aware of her involvement.
3. The attempts made by CMHS to engage [Mr A].
4. The process followed by the Bay of Plenty DHB in their Serious Incident Review and the recommendation made as a result.
5. Any other matters warranting comment.

OPINION

1. The level of involvement by a consultant psychiatrist in [Mr A's] care.

There was no involvement of a consultant psychiatrist in [Mr A's] care. At no time was there a meeting of [Dr D] and [Mr A], either during or after the inpatient admission from 22–24 [Month3]. There is no documentation of any consultant involvement other than MDT discussions promised by [Dr D] in his letters of 22 and 23 [Month3].

There is no record of any MDT meetings except one held while [Mr A] was an inpatient. Neither is there any mention of the Registrar discussing the case with a consultant.

The accepted practice when someone is admitted is that a consultant will see that person within 24 hours of admission. For a consultant not to have seen a patient who was in hospital for 3 days and then an outpatient for a further 6 months is astonishing. The accepted practice in the outpatient setting is for the patient to be seen at least once every 3 months unless they are extremely stable, AND under a mental health team only because either they are under an Indefinite Compulsory Treatment Order (s29 of the MHA), or taking the drug Clozapine.

Therefore, I consider this to be a severe and unacceptable departure from accepted practice, and I have no doubt my peers would agree. [Dr D] should familiarise himself with accepted practice in NZ and abide by its standards. The BoPDHB should adjust its policies to reflect accepted practice.

a. His ([Mr A's]) assessment by a psychiatric registrar during his admission to the mental health unit at the public hospital;

This assessment was reasonably thorough and even easily legible, thus enhancing patient care. I take issue with use of the term 'reported attempt' referring to [Mr A] being found …, and wonder if that led to or indicates an underestimation of the risk, exacerbated by referral to 'maladaptive support seeking' and his aim to discharge 'today or tomorrow'. Also, there is no functional enquiry recorded, which is an essential aspect of diagnosing the presence of a depressive disorder that requires anti-depressant treatment. However, the registrar has considered most relevant factors and made a good plan for the first 24 hours of admission, including a plan to meet with [Mr A's] parents, which meeting occurred on 23 [Month2] and was well documented by the registrar. By that time the consultant should have seen [Mr A] and rectified any deficits in his registrar's assessment.

I do not find that in all the circumstances this assessment departed from accepted practice or from a reasonable standard of care.

b. [Dr D's] decision to discharge [Mr A] from his case load following cancellation of the appointment in [Month3];

The usual practice is to discharge after 3 missed appointments IF there is no good reason for their being missed. Given that so far [Dr D] had not seen the patient at all, I find this decision incomprehensible, and in my opinion a serious and significant departure from the standard of care expected. I am sure my peers would agree. [Dr D] should familiarise himself with accepted practice in NZ and abide by its standards. The BoPDHB should adjust its policies to reflect accepted practice.

c. CMHS decision not to organise psychiatry review between [Month3] and [Month9].

… In [Mr C's] notes (which are barely legible) (26 [Month3]) we see that [Mr A] is tired, losing weight, has no libido and feels angry, ugly and worthless. On 17 [Month4] 'low mood, not sleeping, anxious, parents concerned'. On 16 [Month7] [Mr A] reported feeling lower for the previous 2 weeks, crying and feeling 'shit'. One would expect a clinical psychologist in a CMHT to recognise these symptoms of depression and arrange an early appointment with a psychiatrist.

On 1 [Month8] significant initial insomnia, anhedonia, decreased appetite, feeling tense and anxious, crying and suicidal thinking, isolating and psychomotor agitation are all recorded. In this note [Mr C] records his intention to discuss with MDT and to discuss medication with psychiatrist. There is no evidence that these things occurred, not least because it is not the practice of this team to record their MDT meetings. However, neither is there a note by [Mr C] to the effect that such discussions occurred at all.

On 8 [Month8] [Mr C] presents [Mr A] with Kleinian psychoanalytic concepts, as if a depressed … NZ male is going to find that useful. On 17 [Month8] it is clear from [Mr C's] note that [Mr A] has still made no progress. On 20 [Month8] he seems brighter but by then he has an undisclosed appointment with an independent clinical psychologist and that may well be the reason. He did not attend any further appointments with [Mr C], who discharged him on 8 [Month9], without [Mr A] ever being seen by a consultant psychiatrist.

In my opinion, the lack of a psychiatry review during this extended period of mental ill health represents a severe departure from the expected standard of care …

The BoPDHB needs to address its policy in this area (see my recommendations below).

2. The coordination of care:

a. Between CMHS and [Mr A's] GP

When [Mr A] consulted his GP on 31 [Month2] she had not received the discharge summary from his brief stay on the ward. She wrote to CMH asking for advice re medication and for a review so that she could participate in their plan. There is no evidence of a response. The usual allowance for discharge letters to be dispatched is 2 weeks. The GP had received the Emergency Department note, however, while the handwritten Mental Health Discharge Information form dated 24 [Month2] could presumably have been faxed or scanned to the practice, it appears to have gone only internally i.e. within the DHB.

On the other hand, on 8 [Month8] [Mr A's] [usual GP] phoned CMHS for an urgent review, which was done in a timely fashion at the GP office by two members of the team. [The GP] then started [Mr A] on an appropriate antidepressant on the advice of the CMHS.

Apart from the above there seems to have been no direct contact between the GP and CMHS, but that is not surprising given that there were no doctors involved in [Mr A's] care.

Thus although communication with the GP after [Mr A's] admission was slow, I do not think that represents a significant departure from usual standards, while the CMHS response on 8 [Month8] was excellent.

Despite the post-discharge communication falling within the limits of widely accepted practice, some units throughout NZ fax or email initial discharge summaries (or similar) on the day of discharge and follow up with a more detailed letter. I would recommend that this practice be followed in all areas as it is much safer for all.

b. Coordination between CMHS and private psychologist [Ms F] after they became aware of her involvement.

There was no coordination. [Ms F] rang and spoke with [Mr C] specifically to ask him to 'keep an eye on' [Mr A] during her planned vacation. She gave him the dates. [Mr C's] note of 6 [Month9] states that he discussed this at the MDT and they 'agreed that I can discharge him to [Ms F's] care'. [Mr C] subsequently discharged [Mr A] two days before her vacation was due to begin, in direct contradiction of her perfectly reasonable and humane request.

3. The attempts made by CMHS to engage [Mr A].

By and large these were diligent and not always reciprocated. However, [Dr D's] decision to discharge [Mr A] from his clinic after one no-show was highly unusual, and its ill effects compounded by the fact that, after that, only one person was responsible for his care and, reading between the lines, I suspect that [Mr C] and [Mr A] were not well-suited. This is not rare but had [Mr A] had a separate case manager he would have had someone else to discuss things with and may have been better engaged with the service as a whole. In all the services I have worked in (7 different DHBs) CMHS patients have a case manager and a psychiatrist and if a clinical psychologist is also involved that makes three clinicians in all.

Therefore, the attempts made to engage [Mr A] were quite reasonable, but it is not good practice to have only one clinician involved in a patient's care. I have commented above on [Dr D's] decision; apart from that there was not, in my opinion, a significant departure from accepted standards as regards attempts made to engage [Mr A]. However, had more than one clinician been involved, that could only have enhanced those attempts.

4. The process followed by the Bay of Plenty DHB in their Serious Incident Review and the recommendation made as a result.

Process

I am amazed to see that the two health professionals most involved in [Mr A's] clinical care constituted half the review team. This represents a serious conflict of interest.

They should have been witnesses of fact only. Their presence on the review team must unavoidably render the whole exercise incapable of the necessary objectivity.

I would certainly regard this as a serious departure from accepted practice. I have no doubt that my peers would agree.

Recommendations of the Serious Incident Review

These are mostly reasonable, albeit they reveal that some practices prior to the review were sadly lacking in rigour.

However, there are four more recommendations I would have liked to see:

- That every CMHT patient should be seen by a psychiatrist at least every 3 months.
- That no CMHT patient should have only one person involved in their care.
- That every CMHT patient should have a quarterly MDT review.
- That every MDT meeting should be minuted.

All these practices are standard in most places, and should be standard everywhere.

The result of that last failure is that there is no documentary evidence that any MDT meetings occurred at all, let alone who was there, what was discussed, and what decisions were taken. Frankly, that is appalling. And I might add that the standard of care received by [Mr A] reflects the distinct possibility that his case was discussed only once, just prior to his ill-advised discharge.

…

I extend my heartfelt sympathy to [the family].

Dr Alma Rae FRANZCP MBHL
Consultant Psychiatrist"

The following further advice was received from Dr Rae:

"**Response to BOPDHB's letter of 9 April 2019 regarding my Opinion.**

Accepted

I am pleased that the main points I made in my Opinion have been accepted. However there are inconsistencies in what the BOPDHB says they have accepted, and what they say they have not accepted. I have outlined these below.

Requires Further Consideration

In my experience the only patients seen less that 3 monthly by a psychiatrist are those who are stable and only in a mental health service because they are on Clozapine or under an Indefinite Compulsory Community Treatment Order (s29 of the Mental Health Act 1992). As long as they remain stable, these two categories of patients are seen six monthly. Everyone else is seen at least three monthly. I appreciate that there

is no nationally applicable policy regarding this, but it is not clear to me why it would be harder in a small place than a large one. The notion seemingly implied here, that general adult psychiatrists in large cities are not as busy, is erroneous.

Not Accepted

I disagree that 'there is use of emotive language, rather than factual reporting and objective opinion'. In fact all three of these are present, the emotive language proceeding from the litany of clearly delineated omissions by the BOPDHB in the care of [Mr A].

1. The level of involvement by a consultant psychiatrist in [Mr A's] care:

I did not claim that discharging a patient after three missed appointments is a 'national standard' and did not quote any 'national guideline'. I merely stated that it is 'usual practice'. My opinion to that effect is based on my experience in seven different DHB's over the last five years, and I have not come across any service where that is not the practice. In this particular case, no attempt was made by the psychiatrist to see [Mr A] after he had missed only one appointment, which was not only 'unusual' but extraordinary (indeed, incomprehensible) given that no psychiatrist had seen him while an inpatient either.

Quibbling about whether two or three missed appointments are necessary before discharge is irrelevant in this case because there was only one appointment given, while the BOPDHB itself accepts in **Accepted (b)** that 'the lack of a consultant psychiatrist review of [Mr A] was not in keeping with BOPDHB Policy and protocols regarding the continuum of patient care'.

b. [Dr D's] decision to discharge [Mr A] from his case load following cancellation of the appointment in [Month3];

'[Dr D] communicated [Mr A's] ongoing care arrangements to his GP and to [Mr C]. The communication was clear that [Mr A's] follow-up care was with [Mr C], Clinical Psychologist and a treatment plan agreed with [Mr A].'

I fail to see how communicating with [Mr A's] GP in any way mitigates [Dr D's] failure to see [Mr A] at any time.

'[Dr D] was also clear in his letter that he would be a member of the MDT who was continuing to provide treatment to [Mr A].'

Unfortunately there is no record of any of these meetings.

c. CMHS decision not to organise psychiatry review between [Month3] and [Month9].

Given the lack of progress made by [Mr A] during this period, and the fact that he had NEVER been seen by a Consultant Psychiatrist, I remain adamant that he should have been reviewed during this period. Appointments with other members of the team are

important but do not obviate the need for input from a psychiatrist. Had he at any point been seen by a psychiatrist, my opinion here might differ, but no such meeting occurred at any stage, a fact which the BOPDHB accepts in (b) and states that 'the lack of a consultant psychiatrist review of [Mr A] was not in keeping with BOPDHB Policy and protocols regarding the continuum of patient care'. Therefore I am bemused as to why the DHB says it does not accept this part of my opinion.

… Again, other members of the team are important and certainly many suicides occur as noted above but the comment 'frequent consultant psychiatrist reviews mitigate against legal challenges' is offensive. This is a young man's life we are talking about. I have not suggested 'frequent' reviews. This young man had NONE. That is not a legal problem so much as a dereliction of the BOPDHB's duty of care.

5. Process followed … In their Serious Incident Review and the Recommendations made as a result.

I accept that there were two members of the SIR team who were independent and that currently there is variability and not much guidance on how these reviews are conducted. I am happy to withdraw my opinion on this aspect of the case. Nevertheless, there are DHBs where no person involved in the actual care of a patient would be part of the review committee. They would be interviewed by a member of the committee but not part of the deliberations, for the very good reason that their objectivity would be compromised by the obvious conflict of interest. I would recommend that the BOPDHB give this serious consideration.

5. Any other matters warranting comment

I accept that the BOPDHB may well have appropriate policy and procedure documents in place, and apologise for my assumption that they did not. That assumption was based on the haphazard conduct of [Mr A's] management. However, I do maintain my view that, given the number of regrettable features of this case, a thorough review is needed and attention paid to how staff do or do not carry out the requirements that do exist. …

In summary

My opinion is not based on 'National Guidelines' and I have not read the BOPDHB documents on policies and procedures. The HDC requests that I comment on specific questions with regard to 'the standard of care/accepted practice' and how my peers would view the matters in question. My opinion as to the accepted standard of care and practice is based on 30 years' experience in NZ psychiatry, for the last 15 of which I have been a Consultant Psychiatrist, and on my wide experience of the current NZ scene having in the last five years worked in a total of seven different DHBs.

I am happy to change parts of my opinion as noted above.

In the conduct of this case by the BOPDHB's mental health service there were significant departures from what I and my peers would regard as acceptable practice. In my opinion, these added up to [Mr A] not receiving adequate care …

Dr Alma Rae
BSc MBChB FRANZCP MBHL
Consultant Psychiatrist"

The following further advice was received from Dr Rae:

"Thank you for referring this case to me for further advice. In preparing this advice I have received and read:

1. Response from the BoPDHB 27 August 2019
   a) Health record
   b) Statement from [Dr D]
   c) Policies and Protocols
      i. Ceasing attempts to follow up psychiatric patients
      ii. Discharge and transfer of patients
      iii. Follow-up of non-attendance
      iv. External transfer and discharge
      v. Handover between clinical staff
      vi. Multi-Disciplinary Team Meetings
      vii. Supervision and oversight of junior doctors providing care to MH and AS patients
2. Response from BoPDHB 24 March 2020
3. Statement from [Dr E] 2 June 2020

I have also where useful re-read previous documents provided previously, and listed in my previous advice.

The HDC has asked me to:

1. Please review the enclosed responses and policies and advise whether they change your previous advice in any way, or raise any new issues.
2. For the areas where you identified a level of departure in your previous advice, please refer to any policies, general standards or national standards, and identify whether any have not been followed.
3. In your previous advice, you were critical of the lack of MDT meeting minutes and the coordination between BoP CMHS and [Ms F].
4. Please comment on the level of departure, if any, regarding these issues.
5. Please comment on the adequacy of the policies (particularly regarding Discharge and Transfer of Care) that were in place at the BoPDHB at the time.

Please review the enclosed responses and policies and advise whether they change your previous advice in any way, or raise any new issues.

1. **Letter from BoP DHB of 27 August 2019** Administration records made available regarding MDT reviews of [Mr A] indicate that his case was raised 4 times in approximately 6 months. [Dr D] in his letter recalls one MDT at which he discussed the case with [Mr C]. This seems from the records to have occurred either on 3 or 10 [Month4]. [Dr D] is not recorded as having attended any of the other three meetings where [Mr A] was discussed. There is no record available regarding the substance of any discussions about [Mr A] and so I cannot tell in any detail what information [Mr C] conveyed to the MDT, nor what the team may have offered. It is apparent only that despite no improvement in [Mr A's] mental condition over several months, no referrals to any other members of the team were made and no changes in management occurred. In the note made at the 7 [Month5] meeting it says '— requesting ψ input' but it is not clear whether [Mr C] or [Mr A] was requesting 'psych' input, nor what exactly was meant by that i.e. did it mean psychiatrist input, or just more psychology. If this was an opportunity missed for psychiatrist input, it is most regrettable.

2. In any case, [Mr A] was not mentioned between 7 [Month5] and 13 [Month8] which does not, in my opinion, justify the DHB's statement in their letter of 27 August 2019 that [Mr C] 'sought regular input' from the MDT. Given the lack of progress his patient was making, I find [Mr C's] failure to seek MDT input and ask for a medical review difficult to understand.

3. …

4. There is ample evidence in his health record that [Mr A] was suffering from a significant Major Depression. [Mr C's] Comprehensive Assessment dated 12 [Month3] records '*He is quite depressed … shows signs of sleeplessness (only dealt with by medication) and his appetite has decreased. He shows psychomotor retardation in his movements*.' These are all signs of a significant depressive process and ought to have led to a psychiatrist seeing him promptly with a view to prescribing medication. Further, as noted in my first advice, '*In [Mr C's] notes (26 [Month3]) we see that [Mr A] is tired, losing weight, has no libido and feels angry, ugly and worthless.* On 17 [Month4] *'low mood, not sleeping, anxious, parents concerned'.* On 16 [Month7] *'[Mr A] reported feeling lower for the previous 2 weeks, crying and feeling "shit"*.' Two of these records pre-date the MDT on 7 [Month5] but did not lead to a psychiatrist consult being requested or occurring; then, it was not until 4 weeks after the [Month7] note that a further MDT discussion occurred, again with no change to his management. While the prediction of suicide is notoriously inaccurate, the assessment of suicide risk still has standard applicable factors that are considered, rightly or wrongly, to contribute to the risk. These include untreated depression, ruminations, male sex, impulsivity and previous suicidality. These factors were present and ought to have led to a psychiatrist assessment and an antidepressant in an adequate dose. While [Mr A] was rightly started on an antidepressant by his GP in early [Month8] the dose was low and not increased quickly enough. At this stage [Mr A] had probably

been depressed for two years, a fact quickly recognised in [DHB2] where fluoxetine was started not long before [Mr A] returned [home].

5. I also see in the latest tranche of documents forwarded from the DHB via the HDC that on 1 [Month3] [Dr G] sent a semi-urgent referral to Community Mental Health/… requesting '*a review to give us some guidance around medication and whether we should be trying to initiate something else or what the plan is. We have not received [a] discharge summary*.' I wonder what became of this referral. I wonder whether, when [Dr D] decided on 22 [Month3] that [Mr A] did not need to be seen by a psychiatrist, he had ever seen it.

6. The DHB seeks to inform me of the phenomenon of hindsight bias. I am already aware of hindsight bias. I agree entirely with the paragraph the DHB quotes, and note further that much more recent papers have also drawn attention to the problem (e.g. 'Inconvenient truths in suicide prevention: Why a Restorative Just Culture should be implemented alongside a Zero Suicide Framework' Turner et al, 2020).

7. I reject the suggestion that hindsight coloured my opinion of [Mr A's] treatment or lack thereof. The inadequacies of his management were numerous and egregious. I do take the point that it can never be known for certain whether [Mr A] would have died in another set of circumstances (i.e. had he received adequate and appropriate treatment). However, had [Mr A] lived and my advice sought, I would still be equally critical of the failures of the BoP MH&AS to provide him with appropriate, assertive and joined-up care.

8. **[Dr D's] letter** Essentially, [Dr D] is not able to shed any light on his failure to see [Mr A] during the in-patient admission. He expounds on his usual practices but has no recollection of why or how he came not to see [Mr A] on the ward. Given the time elapsed, this is unsurprising, but it does not mitigate the original failure. The policy 'Discharge from Mental Health and Addiction Services' MHAS.A1.31 issued in Sep 2015 states in 3.1 'Ultimate responsibility for the discharge documentation rests with the responsible SMO who is responsible for the patient's management and includes the monitoring of the discharge process.' But (see my para 10) the patient was in fact discharged a day early from the ward with seemingly no SMO oversight at all.

9. Given that he had not met [Mr A], yet chose not to see him after one missed appointment, [Dr D's] statement that '*In my clinical opinion this was a suitable response*' does not appear to be based on his own clinical evaluation of [Mr A], but on others' views. Those views do not appear to have been well-founded. As I note in para 4 above, [Mr A], according to a number of observations made beginning on 12 [Month3], was clearly suffering a depressive illness. [Dr D] further states in his letter that '*I had feedback that this patient was not a good attender*.' In fact, [Mr A] had by then attended both his scheduled appointments with [Mr C], on 12 [Month3] and 19 [Month3], and so this 'feedback' was without any basis, and in

any case ought not to have been a significant factor in the decision. The policy on 'Active Follow-up of Consumers who do not Attend Pre-arranged Appointments' issued in May 2018 states in 2.4 'minimum course of action requires two (2) appointments offered'. I do not know whether that stipulation was in force in [Month3], but in terms of accepted practice in NZ it really is a bare minimum.

I remain of the view that this was a severe departure from accepted standards.

10. **[Dr E's] letter** Again, [Dr E] cannot shed light on the precise events related to [Mr A] not being seen by a consultant, nor on his not recording any discussion with a consultant about [Mr A], nor on who authorised [Mr A's] discharge a day earlier than planned by the MDT. I accept [Dr E's] suggestion that a consultant was almost certainly at that MDT meeting, in which case that meeting appears from available records to be the only time a consultant was apprised of [Mr A's] precise presentation. I also accept that much time has passed and no-one remembers everything about such fairly routine admissions.

Relevant Policies

11. Medical responsibility for inpatient care

This policy was in force at the time of the admission (Issue date [2016]) but was not followed. Para 1.12 states 'In all cases it is mandatory that the responsible specialist physically review the patient either on the day of, or during the day following, admission.'

As noted above, this did not occur.

12. Policies on: Clinical Communication, Active Follow-up of Consumers who do not Attend Pre-arranged Appointments, Transfers of Care, Mental Health and Addiction Services Admissions to Acute Inpatient Unit, are all dated as having been issued after [Month9]. I have commented on them where they have relevance to the topic.

13. MDT minutes and policy.

    (i) The new policy, MHAS.A1.58 is sound. At time of writing I do not know what preceded it and so cannot judge to what extent the outpatient MDT records in [Mr A's] case notes stray from the standard expected at the time. They do strike me as lacking in detail and not usefully reflecting the contents of actual discussion. I also find fault with the lack of MDT discussions pertaining to [Mr A], and with the fact that despite clear reasons for a psychiatrist referral, none was made. Some of the reasons for this may rest with [Mr C], and with the lack of his having any other clinician routinely involved, such as a separate case manager.

    (ii) Now that I have evidence that there were some MDT discussions of the case, I retract my original opinion that a major departure from accepted standards

occurred. Clinically speaking the meetings did not achieve anything useful for [Mr A], but it is impossible on the basis of the information I have to know exactly why. Nevertheless, I still consider the MDTs at that time represented a departure from expected standards in that they were poorly recorded and that [Mr A] was not discussed from 7 [Month5] until 17 [Month8], which exceeds the three months as required in the new policy, and the three months observed in other DHBs for many years.

(iii) There are two matters that concern me about the MDT: one is that on 17 [Month8] the notes state that they considered referring [Mr A] to [another facility] but had not, apparently, ever thought that an antidepressant could be useful, the latter being a vastly more accessible, inexpensive and indeed appropriate treatment. The other is the ambiguous MDT note made at the 7 [Month5] meeting '— requesting ψ input' that does not make clear whether [Mr C] or [Mr A] was requesting 'psych' input, nor what exactly was meant by that i.e. did it mean psychiatrist input, or just more psychology. If this was an opportunity missed for psychiatrist input, it is most regrettable. It is also poor note-taking.

Given these various deficits, I would rate the departure by the MDT's operations from accepted standards as moderate.

14. Co-ordination between [Ms F] and the BoP CMHS

There was no coordination.

In early [Month9] (the exact date is illegible as it has been stamped over but it seems to have been the day of the MDT meeting on 6 [Month9]) [Mr C] recorded having been contacted by [Ms F]; he writes: '*it transpired that he [Mr A] has been less than honest about things.*' He did *not* record or comment on the reason for [Ms F's] call, which was that she was taking some leave, was concerned about [Mr A] and please would [Mr C] and the CMHT look after him in her absence. As well as this humane and reasonable request of a fellow professional, there had also been a letter from [Mr A's mother] ([Mr C's] note on 17 [Month8] records that he had received a letter, presumably since the previous session on 8 [Month8]) to the effect that she and her husband were '*really stressed*' by their son's continuing depression, perusal of internet suicide sites, [storage of his father's medication] and [continued attempts to contact his ex-girlfriend]. On 20 [Month8] [Mr C] had written '*I explained the necessity for rituals to say goodbye*' but there is no record of such. Despite all this, the discharge occurred abruptly on 8 [Month9], leaving [Mr A] without support.

For a CMHT professional to ignore such a request from [Ms F] is extraordinary. On purely humanitarian grounds the discharge should have been delayed until her return. Even if [Mr C] was not involved, the crisis team could have phoned [Mr A] perhaps twice a week to see how he was. There appears to have been NO coordination instigated by [Mr C] in response to [Ms F], among any of the parties i.e. the consultant, [Mr A], his parents, his GP or the crisis team.

In my opinion this is a most serious departure from accepted standards of care.

15. Discharge and Transfer of Care policy

(i) Protocol MHAS.A1.9

This is dated [month] 2017 and so did not apply at the time of [Mr A's] discharge. The STANDARDS TO BE MET, and the procedures, are laudable and fit for purpose. These standards were completely unmet by [Mr A's] discharge from the BoP CMHT.

(ii) Protocol MHAS.A1.31

This policy is not as clearly written as A1.9 above but does provide much useful guidance on the safe discharge of mental health patients.

It was in force at the time of [Mr A's] discharge and if followed, would have most likely meant that he was not discharged at all (see Standards to be Met, 1. Discharge Criteria, wherein not one of the five criteria is met by this case.) I cannot find any evidence of Discharge Planning having occurred in any formal or documented form, nor of any collaboration with whānau, or communication with non-DHB service providers. In other words the Standards of this 2015 document were not met either.

This discharge represents a severe departure from accepted standards of reasonable care; I believe my peers would agree.

16. SUMMARY

The death of [Mr A] was preceded by a classic line-up of the holes in the cheese, as some have characterised this kind of event.

- He was not seen by a consultant during his inpatient admission, contrary to existing policy.
- He was not discussed with a consultant during his inpatient admission, contrary to existing policy.
- Despite his antidepressant being withdrawn as a result of the admission, for possible side effects, he was not seen by a consultant or registrar to assess the effect of this.
- Instead, after one failure to attend, the consultant, who had never met [Mr A] and furthermore seems to have had incorrect information about him, decided he did not need to be seen.
- The clinical psychologist to whom [Mr A] was directed failed, despite much evidence that [Mr A] was suffering from a persistent and medically treatable depressive illness, to refer him for a consultant opinion.
- The clinical psychologist was the only team member seeing [Mr A].

- The clinical psychologist persisted for six months with ineffective treatment.
- The clinical psychologist took this case to the MDT only four times in six months, the longest gap exceeding three months.
- There was no consultant continuity at those MDT meetings.
- The clinical psychologist ignored a perfectly proper request from [Mr A's] private psychologist for the CMHT to take care of him in her planned absence.
- The MDT, for reasons that are unclear, did not play an effective role in optimising [Mr A's] care.
- There does not appear to have been any discharge planning, collaboration or coordination prior to his abrupt ejection from the service on 8 [Month9].

I remain disturbed by this case and again extend my deepest sympathies to [Mr A's] parents].

However, it is encouraging to see that improvements in practices have occurred, and will continue to occur, as a result of the tragedy.

Dr Alma Rae BSc MBChB FRANZCP MBHL
Consultant Psychiatrist"

The following further advice was received from Dr Rae:

"**ADDENDUM TO MY REPORT**

1. What happened to the incoming GP referral dated 1 [Month3]?

2. What did the cryptic note '— requesting ψ input' in the MDT record of 7 [Month5] actually mean? Did the adjacent observation that he had a full-time job lead the team to assume that he could not attend an appointment with a psychiatrist and so the idea was dropped?

Further comment on the BoPDHB response dated 27/8/2019

3. In para 10, last bullet point, they state that '*[Mr A] had not disclosed some of his behaviours to his family and clinicians that would have alerted them to the high risk and degree of unwellness that he continued to experience.*' I am not aware of the nature of these undisclosed behaviours and wonder what they were. His mother in the note she wrote to [Mr C] [in early 2016] listed [Mr A's behaviours] and that the parents were 'really stressed' and that [Mr A] was 'very depressed'. Were there other behaviours as well? Was this list not sufficient to alert them to the high risk etc?

4. Under 'Scheduling and Booking of Outpatient Reviews' the DHB refers to '*[Mr A] declining to attend the scheduled appointment*'. The word 'declining' suggests a deliberate and wilful decision not to attend the appointment with [Dr D] but in fact there is no information as to why he did not attend and he may just have forgotten. Use of the word 'declining' here risks the appearance of shifting blame to [Mr A].

Also, had there been a case manager, direct contact with [Mr A] would have been made, the non-attendance explained and an opportunity created for [Mr A] to receive another appointment.

…

Dr Alma Rae BSc MBChB FRANZCP MBHL
Consultant Psychiatrist"

Appendix B: Independent advice to the Mental Health Commissioner

The following advice was received from clinical psychologist Tina Earl:

"I have been asked to provide an opinion to the Commissioner of case number C18HDC00288. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications and experience:

MA (Hons) Dip Clin Psych (Otago 1992)

I am a qualified clinical psychologist, with NZ registration. I have practised for twenty six years, with 13 years being employed with District Health Board (Waitematā). My clinical work there has been in adult mental health psychological assessment, diagnosis, and treatment. As psychology leader my work oversaw professional and clinical domains across the DHB services of adult, older people, child and youth, Forensics and Addictions. I have previously had a private practice, and also worked with the family court and ACC undertaking specialist psychologist reports. For the past 7 years I held a senior lecturer position in the Health Psychology clinical training programme at Auckland University. I worked as project lead with Te Pou (National Mental Health and Addictions Research and Development Centre), for the past 5 years. Then as clinical service manager at Procare PHO for the past year and a half. I currently work in private practice.

The writer is requested to offer expert advice regarding:

(From letter dated 16 January 2019, from [HDC].)

Please advise whether you consider the care provided to [Mr A] by [Mr C] was reasonable in the circumstances, and why.

In particular please comment on:

- The ongoing treatment and management of [Mr A's] risk of self-harm.
- The treatment programme undertaken by [Mr C].
- Whether input and review from other healthcare providers was appropriately sought.
- The transfer of care between [Mr C] and [Ms F].
- Any other matters in this case that you consider amount to a departure from acceptable standards.

Sources of information:

- Letter dated 16 January 2019, from [HDC].
- Copy of HDC website complaint submission dated 10/02/2018, 01.45p.m.

- Copy of letter/report dated 23 April 2018, [the] Quality and Patient Safety Manager/Acting General Counsel, Bay of Plenty (BOP) DHB.
- Copy of letter/report dated 17 April, 2018, [Mr C], Clinical Psychologist, [CMHAS].
- Copy of letter/report dated 26 September, 2018, [Ms F], Clinical Psychologist, [address]
- Copy of letter dated 14 February 2019, Bay of Plenty (BOP) DHB.
- Mental health service notes for [Mr A] from: Bay of Plenty DHB; [DHB2]; Student Health and Counseling [tertiary institute].
- Code of Health and Disability Services Consumers' Rights. (Regulation 1996).
- Code of Ethics for Psychologists working in Aotearoa/New Zealand (revised edition 2014).
- Guidelines on Informed Consent, April 2016. New Zealand Psychologists Board.
- 'The assessment and management of people at risk of suicide', NZ MOH (May 2003);
- 'Preventing Suicide. Guide for emergency departments'. NZ MOH (April 2016).
- NICE (UK) guidelines for Depression (2009) and Anxiety (2011);
- Te Pou, 'Talking Therapy. A guide to evidence based talking therapies' (2017, 2009).

Brief summary:

Taken from letter dated 16 January 2019, from [HDC].

'In [2014] [Mr A] was referred to MHAS Bay of Plenty, with a history of mild low mood and anxiety. He was referred to Mental Health and Addictions Services (MHAS) at Bay of Plenty DHB in [2014], and followed up by the Crisis and Consult Liaison Psychiatry after a presentation to the Emergency Department (ED) at [the public hospital] in [2015].

In [2016] [Mr A] left home to study. He began experiencing suicidal ideation and his GP at student health prescribed Fluoxetine 20mg and referred him to a university counsellor. [Mr A] was seen twice by the Crisis Service at [DHB2] in [Month2] for deliberate self harm and on 18 [Month2] he was referred to [the] Community Mental Health Services (CMHS).

On [Month2] [Mr A] was admitted to the mental health unit at [the public hospital] after presenting to ED with suicidal ideation. During his admission [Mr A's] Fluoxetine was reduced with a plan to discontinue and he was started on Quetiapine. [Mr A] was discharged on 24 [Month2] to CMHS with a referral to [Mr C] for cognitive behaviour therapy. Review by consultant [Dr D] was scheduled in [Month3]. [Mr A] later cancelled this appointment and was discharged from [Dr D's] case load on the understanding that he would be followed up by [Mr C].

[Mr A] was seen by [Mr C] until [Month9] when he was discharged from the CMHS after his parents organized for him to see private psychologist [Ms F]. (Note by report writer — from BOP DHB file notes, it is not clear who in the family made the choice to change psychologists?) He presented to CMHS on 28 [Month9] with suicidal ideation and was assessed by crisis worker [Mr H] who offered admission to the Mental Health Unit at the public hospital. [Mr A] declined, stating he was no longer suicidal, and a plan was made for referral to CMHS with follow-up by [Mr H] in the interim. On 31 [Month9] [Mr H] spoke with [Mr A] at 6pm, noting he appeared future focused and reported he was pleased with the recent increase of his Venlafaxine from 75mg to 150mg (started by his GP on 8 [Month8]). However, later that night [Mr A] left his parents' house stating he intended to [kill] himself and sadly was found dead the following morning.

Comments on:

Question 1: The ongoing treatment and management of [Mr A's] risk of self-harm.

[Mr C's] ongoing treatment and management of [Mr A's] risk of self-harm was consistent with recommended guidelines.

[Mr A's] risk to self-harm was long standing with admissions for risk as documented:

2013 — admission to ED Bay of Plenty DHB. Notes that this did not appear to be a deliberate act of self-harm but was a serious ETOH ingestion.

2015 — a second drug ingestion and ED admission where he was referred to [CMH] with a six month history of low mood and anxiety (medication Paroxetine scripted at this time), with some suicidal ideation. This followed a 2014 admission to [CMHS] for dysthymia, mood swings and poor motivation.

[Month2], self-harm reported via [tertiary institute] with …

[Month2], admitted to Mental Health Crisis Service, [DHB2] with suicidal ideation (thoughts of … and [self harm].

22 [Month2], admitted to Mental Health [at the public hospital] with attempted … with the intention of killing himself. (Transfer of care to [a CMHC], following discharge on 24 [Month2].)

12 [Month3] Mental Health assessment by [Mr C], which assessed [Mr A] as having severe depression and suicidal intent.

[Month3]–[Month8] — [Mr A] was seen at [a CMHC], by [Mr C].

8 [Month8] GP request for crisis assessment (completed) as [Mr A] expressing suicidal thoughts.

28 [Month9] Crisis assessment

Over the period above there are also numerous references to risk in the file notes. See appendix 1 of Quality and Patient Safety report 23 April 2018: [nine occasions]

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

Reference is made to: 'The assessment and management of people at risk of suicide', NZ MOH (May 2003); and 'Preventing Suicide. Guide for emergency departments'. NZ MOH (April 2016). Code of Ethics for Psychologists (2012 2.1.1, 2.1.6,); HDC Code of Health and Disability Services Consumers' Rights (1996). There will also be BOP DHB policies and procedures (not sighted by writer) for mental health services for the management of risk.

Accepted practice for management of risk is recommended by MOH (May 2003) and includes:

'Many people with suicidal ideation can be treated successfully as an outpatient. In such circumstances, the following treatment measures should be put into place.

- Increase the frequency of outpatient visits and between visitor telephone contacts.
- Assess the degree of risk at every contact, including evaluation of the need for hospitalisation or respite options in an ongoing way.
- Ensure that the person has access to 24 hour emergency support (give the number for the crisis assessment and treatment team/psychiatric emergency team).
- Review the treatment plan regularly and revise as needed if risk level changes.
- Consult with colleagues or multidisciplinary teams.
- Consult with [whānau]/family/support people where appropriate.'

[Mr C's] treatment and management of [Mr A's] risk of self-harm, occurred at [the public hospital] over the period from [Month2] to [Month8]. This is documented in the report dated 23 April 2018, [the] Bay of Plenty DHB; the report dated 17 April, 2018, from [Mr C], Clinical Psychologist, [CMHAS]; and in clinical mental health record for [Mr A] on file from [the public hospital]. [Mr C's] treatment and management of risk was in accordance with the standard of care and accepted practice.

There were frequent outpatient visits and phone calls as documented in the mental health notes.

The degree of risk was assessed, often jointly with another staff member, and consultation with psychiatrist and MDT (multi disciplinary team) occurred as appropriate.

Crisis and emergency numbers were given to [Mr A], and services responded to contacts.

The treatment plan was revised by [Mr C] as needed in the relevant session with [Mr A], and appropriate actions taken.

Consultation with psychiatrist and MDT (multi disciplinary team) occurred as appropriate.

Consultation with family and whānau occurred on a regular basis initiated by both the clinicians and the family.

However there are factors that cannot be mitigated for by [Mr C]. It is noted that with reference to 'Preventing Suicide. Guide for Emergency departments'. NZ MOH, (April 2016):

'Predicting and mitigating suicide risk in the short term is very difficult for the clinician given the current evidence base, which indicates that:

- most risk factors are poor predictors of imminent and short-term risk
- unconscious or implicit attitudes are arguably the most powerful imminent and short-term predictors of suicide, but currently these are difficult to assess in the clinical setting
- while thought may have gone into a suicide attempt, it is often not a thoughtful act but made in a state of severe emotional distress, where suicide seems the only solution.'

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

There has not been any departure from the standard of care or accepted practice. However there does appear to be a possible area of vulnerability in [Mr A's] care. This refers to the transfer from CMHAS and [Mr C] to the private psychologist [Ms F], and cover for [Mr A's] care while [Ms F] was on leave. Please see my response to question 4 below.

How would it be viewed by your peers?

This would be seen as accepted practice, given that the intervention was documented, and clinical consultation was obtained where appropriate, and relevant interventions taken. [Mr C] also sought professional supervision regarding issues of risk.

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

See response to question 4.

Question 2: The treatment programme undertaken by [Mr C].

The treatment programme as documented by [Mr C] is consistent with accepted practice for the treatment for depression, anxiety and management of risk. Sources such as MOH (NZ 1998, 2007) guidelines, and NICE (UK 2009, 2011) guidelines, recommend that a combination of medication and therapeutic intervention (talking

therapies primarily CBT — cognitive behavior therapy) is recommended practice for moderate to severe depression and anxiety.

[Mr C's] treatment programme focused on CBT and used both cognitive and behavioural interventions to treat depression and anxiety (including social anxiety). This was applied consistently over the treatment period [Month2] to [Month9]. He tailored each session to [Mr A's] needs and his ability to implement the treatment recommendations. [Mr C] referred to a CMHAS psychiatrist for intervention with medications, and included assessment and consultation with crisis clinicians and the MDT where appropriate. He also liaised with [Mr A's] parents about treatment progress.

From the file notes I reviewed it appeared that [Mr A] showed partial constructive response to the interventions. [Mr C] completed a 3 month review on 20 [Month8] with the MDT indicating that obsessive thoughts were a barrier to recovery. As noted in my response to question 1, 'unconscious or implicit attitudes' are a powerful and complex influence on cognition and behavioural outcomes, and can be complex to treat. [Mr A] cancelled appointments due mainly to work commitments, so some continuity of treatment was lost here.

Treatment by [Mr C] ceased on 8 [Month9] when [Mr A] and/or the family made the decision to see a private psychologist. [Mr C] assessed that there would be a conflict of interest if he also continued to see [Mr A], as well as [Ms F] seeing him, and transferred care to [Ms F], after consultation with his service MDT. [Mr A] was in [Ms F's] care from 8 [Month9] to 31 [Month9] during which time she was partly away on leave. Cover was also provided by the adult community mental health service (refer to letter from BOP DHB 14.2.19).

What is the standard of care/accepted practice?

Reference is made to MOH (NZ) guidelines for 'Management for major depressive disorder' (May 2007), and for Anxiety (1998); NICE (UK) guidelines for Depression (2009) and Anxiety (2011); and Te Pou, 'Talking Therapy. A guide to evidence based talking therapies' (2016, 2009). These recommend that a combination of medication and therapeutic intervention (talking therapies) primarily CBT (cognitive behavior therapy) is best practice for moderate to severe depression and anxiety.

Regarding dual relationships, the code of Ethics for Psychologists states: Principle 3.4.1: Psychologists seek to avoid dual relationships where that might present a conflict of interest.

Principle 3.4.2: Where dual relationships are unavoidable, psychologists identify any real or potential conflicts of interest and take all reasonable steps to address the issue in the best interests of the parties.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

There has not been a departure from accepted practice. [Mr C's] treatment was consistent with guidelines.

How would it be viewed by your peers?

This would be seen by my peers as acceptable practice.

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

More detailed documentation in the clinical notes regarding ongoing intervention and progress may better assist with reviews of treatment progress.

Question 3: Whether input and review from other healthcare providers was appropriately sought.

[Mr C] appropriately sought input and review from other healthcare providers. This was in relation to:

The initial assessments (22 [Month2]) involved nursing staff. [Mr C] included a nurse (19 [Month4]; 8 [Month5]), and social worker (1 [Month8]) to attend assessments where risk was indicated. [Mr A] was also seen by the crisis service as noted on 8 [Month8], and in liaison with [Mr C] received follow-up.

MDT reviews occurred regularly, and issues were taken to crisis team meetings (10 [Month4]; 17 [Month8]; 20 [Month8]; 6 [Month9]) for discussion and review.

Medication and reviews for depression, anxiety and sleeping problems were scheduled with the CMHAS psychiatrist, but [Mr A] did not attend the appointment (23 [Month3]; 1 [Month8]). [Mr C] also liaised with [Mr A's] GP over this time.

[Mr C] also took this case for discussion to his clinical supervisor as noted on 17 [Month8].

What is the standard of care/accepted practice?

In a CMHC the clinical psychologist is part of the MDT and may also be the primary care clinician, as was the case with [Mr C]. This role is often done in conjunction with a key worker role usually another health clinician such as a nurse, but this did not appear to be so with [Mr A's] case. The primary care provider would be expected to have routine reviews with the MDT, discussion of any issues of concern, gain input from other clinicians as appropriate (such as psychiatrist or nurse), and liaise with the crisis team to manage risk as appropriate. [Mr C] adhered to this and also liaised with the GP. Where there are broader issues such as family or welfare issues other health care or social welfare agencies may also be involved but this was not the case with [Mr A].

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

There has not been a departure from accepted practice. [Mr C] has been consistent with the role, communication and liaison expected of a primary care clinician in an MDT.

How would it be viewed by your peers?

This would be seen by my peers as acceptable practice.

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

No further recommendations.

Question 4: The transfer of care between [Mr C] and [Ms F].

The process of discharge/transfer of care on 8 [Month9] between CMHAS and [Mr C] to [Ms F], creates an area of vulnerability in [Mr A's] care.

1) The need for a comprehensive discharge/transfer of care plan that was documented on file, implemented, and well managed.

This process would be accepted practice within a CMHAS, and within private practice it is also recommended. With regards to the discharge and transfer of care for [Mr A], a verbal transfer was noted on the CMHAS file, but there was no written detail of what this entailed. [Ms F] also documented the verbal transfer of care in her file (6 [Month8]). She also noted that she had arranged with [Mr C] to 'keep an eye on him' ([Mr A]), while she was away, and that she had informed [Mr A] of this.

My review found that there was not a well explicated process. The need for a robust handover is due to [Mr A's] high acuity with severe depression and high risk of suicide; ongoing previous high level of contact by the CMHAS service; and that [Ms F] was going to be on leave, thereby requiring CMHAS to remain actively involved.

The contacts with CMHAS clinicians for the months of [Month8] and [Month9] show a high level of risk and service intervention.

01 [Month8]	Assessed by crisis team and [Mr C]
08 [Month8]	Seen by [Mr C]
08 [Month8]	Crisis team assessment on request from GP
10 [Month8]	Crisis team follow-up
10 [Month8]	[Ms F] was contacted by [Mr A's] parents for an appointment.
15 [Month8]	Appointment with [Mr C] cancelled by [Mr A]
17 [Month8]	Seen by [Mr C], and discussed with crisis team (not seen). Contact by [Mr A's] mother regarding his depression.
20 [Month8]	Seen by [Mr C]
27 [Month8]	[Mr A] DNA with [Mr C]

21 [Month8]	[Mr A] seen by [Ms F]
03 [Month9]	[Mr A's] parents contacted [Mr C], regarding [Mr A's] depression. [Mr C] left phone message with an appointment for the following week
06 [Month9]	[Mr C] was contacted by [Ms F] informing him that she was now seeing [Mr A]
06 [Month9]	[Mr C] received phone call from [Mr A's] parents requesting an urgent appointment regarding his depression. He phoned back and left message.
08 [Month9]	[Mr A] was discharged from [Mr C's] care
08 [Month9]	[Mr A] seen by [Ms F]
10 [Month9]–21 [Month9]	[Ms F] was on leave and organized with [Mr C] to provide cover for [Mr A] while she was away.
28 [Month9]–31 [Month9]	Crisis team follow-up

Further indicators for the need for comprehensive discharge/transfer of care and active involvement by CMHAS were: [Mr A's] inconsistency of attending treatment appointments; mother's high level of concern for his safety; and the recent discharge from [Mr C's] care.

However there was no discharge/transfer of plan on file, and there was no contact with or by CMHAS services documented for the period 8 to 21 [Month9].

2) The unclear process for the care of [Mr A] while [Ms F] was away on leave.

The verbal request for cover by [Ms F] to [Mr C], may have led to a lack of clarity regarding his care. A care plan, and a process of clear communication was needed as [Mr A] had been discharged from [Mr C's] care and then referred to the crisis team. It may have been difficult for [Mr A] and the family to make contact with CMHAS and [Mr C] having made a choice to change psychologists. There appears to have been no discussion around the motivation for the change of practitioner, nor regarding who had made the choice to change? Discussion around the appropriateness of changing practitioners at this time was also needed given the severity of [Mr A's] presentation. The subsequent reduced contact with CMHAS contributed to poor continuity of care for [Mr A] at this time.

However, there is no clear indication that the above area of vulnerability of care would have had an influence upon the course of [Mr A's] progress. Given also the discussion under question 1, about the difficulty of predicting and mitigating suicide risk.

In summary, most of the practice concerning [Mr A's] care was well managed, but there are systemic issues with the CMHAS discharge and transfer of care process, and ongoing care plan, where it could have been better explicated and managed.

Transfer of care at a CMHC usually requires a discharge/transfer of care process which would involve contact and discussion with the client and family themselves; discussion and decision with MDT; a plan (including medication review, outcomes and recommendations for treatment, updated risk management plan); and contact with relevant providers such as GP, new practitioner/care provider, and agencies involved in the care of the client. Given any complicating issues such as a practitioner going on leave, then ongoing active involvement by a service is appropriate and some form of shared care may be necessary to mitigate risk.

Plans and reports would be documented on CMHAS file, with copies/information going to the client/family, the new care provider, GP and relevant others.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

There appears to have been a moderate departure from the standard of care and accepted practice, in that there are systemic issues present with the CMHAS regarding the unclear discharge/transfer of care process of the client, and the subsequent ongoing care plan.

How would it be viewed by your peers?

This would be seen by my peers as requiring clear discharge/transfer of care processes to be in place, with appropriate documentation, with evidence of a well managed ongoing care plan.

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

With regards to CMHAS, to ensure that:

- a comprehensive process and discharge/transfer of care plan is well articulated and is implemented by both the CMHAS and the clinician.
  - this is communicated to and agreed with by the client and family.
  - clear and detailed documentation is held on file
  - the discharge process itself involves checking that this has occurred.
  - 'requests for cover of care' are clearly documented with a plan agreed to by the client and family, by all services, and communicated to all concerned.

With regards to the private practitioner/receiving clinician to ensure that:

- a transfer of care plan/report is agreed to and received.

- processes are in place to receive the transfer of care, including robust risk management processes.
- clear documentation is held on file.
- 'requests for cover of care' are clearly documented with a plan agreed to by the client and family, by all services, and communicated to all concerned.

5. Any other matters in this case that you consider amount to a departure from acceptable standards.

No other issues."

The following further advice was received from Ms Earl:

"The writer is requested to: offer further advice regarding my Independent Advisors Report of case number C18HDC00288, of 7 March 2019. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

'*Please review the enclosed responses and policies and advise whether they alter your previous advice in any way or raise any new issues.*

In particular, please also comment on the transfer of care from [Mr C] to [Ms F], and whether any general standards/national standards or policies have been breached in relation to this.'

Please refer to the original report of 7 March 2019 for further details. Only relevant parts of this report will be quoted as below.

Question 4: The transfer of care between [Mr C] and [Ms F].

The process of discharge/transfer of care on 8 [Month9] between CMHAS and [Mr C] to [Ms F], creates an area of vulnerability in [Mr A's] care.

1) The need for a comprehensive discharge/transfer of care plan that was documented on file, implemented, and well managed.

This process would be accepted practice within a CMHAS, and within private practice it is also recommended. With regards to the discharge and transfer of care for [Mr A], a verbal transfer was noted on the CMHAS file, but there was no written detail of what this entailed. [Ms F] also documented the verbal transfer of care in her file (6 [Month8]). She also noted that she had arranged with [Mr C] to 'keep an eye on him' ([Mr A]), while she was away, and that she had informed [Mr A] of this.

My review found that there was not a well explicated process. The need for a robust handover is due to [Mr A's] high acuity with severe depression and high risk of suicide; ongoing previous high level of contact by the CMHAS service; and that [Ms F] was going to be on leave, thereby requiring CMHAS to remain actively involved.

The contacts with CMHAS clinicians for the months of [Month8] and [Month9] show a high level of risk and service intervention.

* Note — text in green is added due to further information received in June 2020.

01 [Month8]	Assessed by crisis team and [Mr C]
08 [Month8]	Seen by [Mr C]
08 [Month8]	Crisis team assessment on request from GP
10 [Month8]	Crisis team follow-up
10 [Month8]	[Ms F] was contacted by [Mr A's] parents for an appointment.
13 [Month8]	MDT review
13 [Month8]	Letter to [Mr C] from [Mr A's] mother stating her concern.
15 [Month8]	Appointment with [Mr C] cancelled by [Mr A]
17 [Month8]	Seen by [Mr C], and discussed with crisis team (not seen).
	Contact by [Mr A's] mother regarding his depression.
20 [Month8]	Seen by [Mr C]. Correction — does not appear to have been seen on this date, this was 3 month review with MDT
27 [Month8]	[Mr A] DNA with [Mr C]
21 [Month8]	[Mr A] seen by [Ms F] — documented in her notes as 24.2.20
03 [Month9]	[Mr A's] parents contacted [Mr C], regarding [Mr A's] depression. [Mr C] left phone message with an appointment for the following week.
03 [Month9]	Appt booked for [Mr A] ([Ms F's] notes), not documented if attended?
06 [Month9]	[Mr C] was contacted by [Ms F] informing him that she was now seeing [Mr A]. Given case information verbally by [Mr C]. [Mr C] stating that [Ms F] had received information from [Mr A] on 2 sessions (dates unclear in [Ms F's] notes) and that she accepted the care of [Mr A].
06 [Month9]	[Mr C] received phone call from [Mr A's] parents requesting an urgent appointment regarding his depression. He phoned back and left message.
06 [Month9]	MDT review with psychiatrist present and deemed psychiatric assessment was not required ([Mr C's] notes)
08 [Month9]	[Mr A] was discharged from [Mr C's] care
08 [Month9]	[Mr A] seen by [Ms F]. ?? No record of this in [Ms F's] notes

10 [Month9]–21 [Month9]	[Ms F] was on leave and organized with [Mr C] to provide cover for [Mr A] while she was away. However [Mr C] had discharged [Mr A] from the service on 8 [Month9].
27 [Month9]	[Ms F] received text from [Mr A's] parents requesting appt. but this was deferred until she had seen [Mr A].
28 [Month9]	Phone call by [Mr A's] mother to [Mr C] stating concern and risk. GP requested re-admission to mental health, [Mr C] referred this to crisis team.
28 [Month9]	Crisis assessment ([name]), [Mr A] declined offer of inpatient admission, and was referred back to community mental health service.
28 [Month9]–31 [Month9]	Crisis team follow-up.

Further indicators for the need for comprehensive discharge/transfer of care and active involvement by CMHAS were: [Mr A's] inconsistency of attending treatment appointments; mother's high level of concern for his safety; and the recent discharge from [Mr C's] care. However there was no discharge/transfer of plan on file, and there was no contact with or by CMHAS services documented for the period 8 to 21 [Month9].

2) The unclear process for the care of [Mr A] while [Ms F] was away on leave. The verbal request for cover by [Ms F] to [Mr C], may have led to a lack of clarity regarding his care. A care plan, and a process of clear communication was needed as [Mr A] had been discharged from [Mr C's] care and then referred to the crisis team. It may have been difficult for [Mr A] and the family to make contact with CMHAS and [Mr C] having made a choice to change psychologists. There appears to have been no discussion around the motivation for the change of practitioner, nor regarding who had made the choice to change? Discussion around the appropriateness of changing practitioners at this time was also needed given the severity of [Mr A's] presentation. The subsequent reduced contact with CMHAS contributed to poor continuity of care for [Mr A] at this time.

However, there is no clear indication that the above area of vulnerability of care would have had an influence upon the course of [Mr A's] progress. Given also the discussion under question 1, about the difficulty of predicting and mitigating suicide risk.

In summary, most of the practice concerning [Mr A's] care was well managed, but there are systemic issues with the CMHAS discharge and transfer of care process, and ongoing care plan, where it could have been better explicated and managed.

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

Transfer of care at a CMHC usually requires a discharge/transfer of care process which would involve contact and discussion with the client and family themselves; discussion and decision with MDT; a plan (including medication review, outcomes and recommendations for treatment, updated risk management plan); and contact with relevant providers such as GP, new practitioner/care provider, and agencies involved in the care of the client. Given any complicating issues such as a practitioner going on leave, then ongoing active involvement by a service is appropriate and some form of shared care may be necessary to mitigate risk.

Plans and reports would be documented on CMHAS file, with copies/information going to the client/family, the new care provider, GP and relevant others.

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

There appears to have been a moderate departure from the standard of care and accepted practice, in that there are systemic issues present with the CMHAS regarding the unclear discharge/transfer of care process of the client, and the subsequent ongoing care plan.

c. How would it be viewed by your peers?

This would be seen by my peers as requiring clear discharge/transfer of care processes to be in place, with appropriate documentation, with evidence of a well managed ongoing care plan.

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

With regards to CMHAS, to ensure that:

— a comprehensive process and discharge/transfer of care plan is well articulated and is implemented by both the CMHAS and the clinician.

— this is communicated to and agreed with by the client and family.

— clear and detailed documentation is held on file

— the discharge process itself involves checking that this has occurred.

— 'requests for cover of care' are clearly documented with a plan agreed to by the client and family, by all services, and communicated to all concerned.

With regards to the private practitioner/receiving clinician to ensure that:

— a transfer of care plan/report is agreed to and received.

— processes are in place to receive the transfer of care, including robust risk management processes.

— clear documentation is held on file.

— 'requests for cover of care' are clearly documented with a plan agreed to by the client and family, by all services, and communicated to all concerned.

June 2020 — additional information reviewed.

- Letter from HDC 23/5/20 requesting updated opinion.
- Letter to HDC 16/8/20 from [Ms F], practitioner.
- Letter to HDC 27/8/20 from [BOPDHB] with attached policies and file notes.
- Letter to HDC 27/8/20 from [Mr C], psychologist.

Updated Advice.

'Please review the enclosed responses and policies and advise whether they alter your previous advice in any way or raise any new issues.

In particular, please also comment on the transfer of care from [Mr C] to [Ms F], and whether any general standards/national standards or policies have been breached in relation to this.'

Having reviewed the further information, my opinion has not changed regarding the need for a transfer of care plan or discharge plan from the DHB, and the need for good continuity of care for [Mr A].

The relevant BOP DHB policies and protocols:

- MHAS.A1.9 Transfer of care to other DHB and External Service,
- MHAS.A1.31 Discharge

require detailed and documented plans that are agreed by providers, and consumers, and communicated to all those concerned.

These confirm the requirements for such plans, which did not appear to be completed.

I note that it was not considered a 'transfer of care' by [Mr C] (point 9e in his letter 28/8/20) as the family chose to go to a private practitioner. However there was a duty of care to reliably transfer care between the new provider and the previous provider. Whether it was a transfer of care or a discharge of care from DHB to a new provider, in either case there needed to be a detailed, documented plan. This did not appear to be the case. Similarly, whether [Ms F] was on leave or not, there remains the need to provide a written plan.

MHAS.A1.9 Transfer of care to other DHB and External Service, which also includes continuity of care, consumer participation, co-operation and agreement between services, and that this is documented and communicated to those concerned.

MHAS.A1.31 Discharge, which also includes management of risk; and details of requirements under para 2.4; and the requirement of a relapse prevention plan. Again, that this plan is documented and communicated to those concerned.

Although [Mr A's] parents, and [Ms F] had knowledge of the mental health systems this cannot be assumed, and there did not appear to be any plan in place in the event of [Mr A's] possible relapse. [Mr A's] mother contacted the GP, and [Mr C] on the 28 [Month9] concerned at his health and risk. However at this stage [Mr C] had discharged [Mr A] and was therefore not involved in his care, so contingency plans that were explicit, would have been appropriate given [Ms F's] leave of absence.

Further if [Mr C] had not been both the treating therapist and the case manager there may have been further input and oversight by other clinicians therefore ensuring stronger processes. I note the DHB are addressing this issue and the appropriate separation of roles (ref. DHB letter 27/8/20).

There appears to remain a lack of contact and follow-up over the period 9 [Month9] to 27 [Month9] by either the DHB or [Ms F]. As noted in my previous report (ref. 7/3/19) this client was high risk and was also vulnerable due to the process of transition of care, so the need for continuity of care, risk management, follow-up and support was high. This may have been better addressed if a robust transfer of care/discharge plan was in place, and communicated to all concerned.

Therefore as stated in my previous report (ref. report of 7/3/19) there appears to be a departure from accepted standards of care, and this is confirmed by the apparent absence of the required compliance with the DHB policies and protocols discussed above, by the service and providers.

I note, and support, the BOP DHB project 'Connecting Care — Improving Service Transitions' (ref. Letter 27/8/20), which has the aim of improving the number of clients with a transition plan to be at 90% by February 2020."