# Consultant Psychiatrist, Dr C
# District Health Board

## A Report by the
## Deputy Health and Disability Commissioner

## (Case 19HDC01547)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

## Contents

Executive summary ..... 1
Complaint and investigation ..... 2
Information gathered during investigation ..... 2
Opinion: Dr C — breach ..... 14
Opinion: District health board — adverse comment ..... 19
Changes made ..... 20
Recommendations ..... 21
Follow-up actions ..... 23
Addendum ..... 23
Appendix A: Expert advice to the Commissioner ..... 24
Appendix B: *Good Medical Practice* ..... 46

## Executive summary

1. This report concerns the care provided by a psychiatrist and a district health board (DHB) to a woman in 2018.

2. The woman was referred to Mental Health Services by her GP. She presented with deteriorating mood, marked anxiety, tiredness, and trichotillomania (a hair-pulling disorder). The psychiatrist met with and reviewed the woman frequently over a period of four months.

3. The report highlights the importance of appropriate risk assessment, diagnostic process, and medication prescribing by a clinician, and of keeping adequate clinical documentation to support patient care and safety.

### Findings

4. The Deputy Commissioner found the psychiatrist in breach of Right 4(1) and Right 4(2) of the Code. The Deputy Commissioner was critical that the psychiatrist did not carry out a comprehensive risk assessment, and hence no treatment plan was evident; he continued his strategy for managing her symptoms without reflecting or seeking peer review when this strategy was not achieving any positive outcomes; his pattern of prescribing higher doses of medications and repeatedly changing medications was inadequate (and in particular the prescription for one month's supply of a specific medication (Medication A) was concerning); and his diagnostic process was poorly documented and difficult to elicit.

5. The Deputy Commissioner was critical that the psychiatrist's clinical documentation was inadequate and did not meet the expected standard of keeping clear and accurate patient records.

6. The Deputy Commissioner was concerned about the DHB for gaps in enacting treatment plans; missed telephone calls to the woman; and the psychiatrist not being made aware of the appointment with the woman on one occasion.

### Recommendations

7. The Deputy Commissioner recommended that the psychiatrist undertake further training on keeping clear and accurate patient records, in particular in relation to risk assessment and diagnosis, undertake reflective practice reviews and/or peer reviews to support consideration of alternative plans, and provide a written apology to the woman's family. The Deputy Commissioner recommended that the Medical Council of New Zealand consider whether a competence review of the psychiatrist is necessary.

8. The recommendations proposed for the DHB have all been completed.

## Complaint and investigation

9. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided by Dr C and the district health board to Ms A. The following issues were identified for investigation:

- *Whether the district health board provided Ms A with an appropriate standard of care between Month1[1] and Month4 2018 (inclusive).*
- *Whether Dr C provided Ms A with an appropriate standard of care between Month1 and Month4 2018 (inclusive).*

10. This report is the opinion of Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

11. The parties directly involved in the investigation were:

| | |
|---|---|
| Mrs B | Complainant/consumer's mother |
| Dr C | Consultant psychiatrist/provider |
| DHB | Provider |

12. Further information was received from:

| | |
|---|---|
| Mr D | Consumer's brother |
| Ms E | Occupational therapist/case manager |
| The Coroner | |

13. Independent expert advice was obtained from Dr Lindsay Twiss, a consultant psychiatrist, and is included as Appendix A.

## Information gathered during investigation

### Background

14. Ms A, aged in her twenties, was under the care of the Crisis Resolution Service and the DHB Community Mental Health Team (the community team) from Month1 until her death on 3 Month4. Ms A was under the care of locum consultant psychiatrist Dr C.

### Referral

15. On 19 Month1, Ms A was referred to Mental Health Services by her GP. She presented with deteriorating mood, marked anxiety, and tiredness. She had a past history of sexual abuse and deliberate self-harm. She had current work pressures and was concerned about her ability to cope and return to work. Ms A had started to pull out her hair on her legs with tweezers as a method to relieve stress. She had tried antidepressant medications but had

[1] Relevant months are referred to as Months 1–4 to protect privacy.

experienced side effects, and recently had started on the antidepressant mirtazapine. The GP referral noted that Ms A did not tolerate clonazepam[2] — her anxiety did not go away, and a day later she felt worse with dark thoughts and suicidal ideation, and she stopped taking the medication.

16. On 22 Month1, the Mental Health Contact Centre nurse telephoned Ms A. The MHAIDS[3] Intake form records that Ms A had deteriorating mood, marked anxiety, no interest or motivation, was feeling helpless/hopeless and forgetful, and had broad suicidal ideation. The form notes that she was flatting and had intermittent contact with family, her mother was a source of support, and since starting mirtazapine she had been sleeping up to ten hours but was still feeling tired. The form records a history of deliberate self-harm and notes: "[Ms A] [h]as used THC[4] all her life … Long term use of THC." An appointment was made for Dr C to undertake an assessment of Ms A on 26 Month1.

**First consultation with Dr C**

17. Ms A met Dr C and Registered Nurse (RN) F at the DHB's Crisis Resolution Service on 26 Month1.

*Assessment*

18. The MHAIDS comprehensive assessment recorded Ms A's "Mental Health Notes and GP letter" as other sources of information considered. The record includes that Ms A presented as very depressed and unable to concentrate or think, with marked anxiety and hair pulling,[5] and currently was unable to work. It is noted that at times she felt very good and would work 15 hours a day but would still be unable to sleep. The assessment recorded a history of childhood sexual abuse, and noted that Ms A lived alone[6] but had a boyfriend. The section "Alcohol, other drugs & addictive behaviours" recorded "Nil[7] She is a social drinker". Risks were recorded as: "[S]uicidal ideas but no plans. Suicide remains a risk if her condition is not treated properly." Ms A had "symptoms of depression and anxiety and increasing sense of hopelessness in regard to getting some effective treatment to treat symptoms".

19. The assessment summary stated that Ms A presented with major depression and anxiety, and hair pulling. The predisposing factor of childhood abuse is noted, together with a number of current stressors in her life (including the loss of two close friends, and being bullied and overworked at work). RN F completed the MHAIDS initial assessment documentation.[8]

20. Dr C told HDC that he looked at Ms A's previous records, noting that he did not have access to Ms A's historical GP records, and went through a detailed psychiatric history and mental

[2] Used to treat panic disorder and the movement disorder known as akathisia.
[3] Mental Health, Addictions and Intellectual Disability Service.
[4] THC is the principal psychoactive constituent of cannabis.
[5] The hair-pulling disorder trichotillomania involves recurrent, irresistible urges to pull out body hair.
[6] Ms A did live with flatmates.
[7] Ms A did use cannabis.
[8] The DHB told HDC that risk assessment is documented in the Initial Assessment and Comprehensive Assessment forms.

state examination. He identified suicidal ideation, depression, and loss of loved ones as applying to Ms A, and that she was a social drinker and did not use drugs. He said that Ms A was reluctant to talk about her family, so it was difficult to gather information about her social supports.

21. Dr C told HDC:

> "I did ask [Ms A] about substance abuse, past self-harm and past suicidal attempts and was falsely assured by her. I appreciate my notes should have included these discussions that took place."

22. Dr C said that he was not made aware through his discussions with Ms A that she had made two past attempts at suicide. He did not believe that substance abuse was a significant risk factor as she did not present as being under the influence of drugs, and never indicated that she used cannabis on a daily basis. Dr C told HDC: "If [Ms A] had confirmed she used drugs, I would have recorded this piece of critical information and acted in response to it."

23. Dr C said that the reality of the service at the time was that "we were very time poor". He said that he made best efforts to review as much information as he could before seeing a new patient, but at times there simply was not time to get through all of the referral and intake information before the patient was at the door.

*Treatment and follow-up*

24. When Ms A presented to Dr C she was taking mirtazapine, and Dr C added lamotrigine.[9] He stated that he discussed lamotrigine "in detail" with Ms A, including the most serious side effect.[10] RN F was present at the consultation, but cannot recall any discussion around potential side effects of medication. Dr C told HDC that as Ms A was reluctant to talk about her family, "[they] respected her feelings and the family did not feature in [their] treatment plans".

25. The treatment plan included a follow-up appointment with Dr C on 5 Month2, and "to give daily phone calls through the weekend to check on mood and medication effects". However, telephone calls to Ms A were documented only on 27 and 29 Month1, and on 3 Month2 to confirm the venue for the appointment with Dr C. Ms A was also given the service's 0800 number to make contact if required. On 27 Month1, Ms A reported not sleeping well but feeling good, and looking forward to her partner returning on 28 Month1. On 29 Month1, her partner returned and she did not feel the need to be contacted over the weekend. However, she reported that she had had a bad day on 28 Month1 and that she was "faking it" today. Her suicidal thoughts continued, she was pulling out hairs, and she felt that her medication was not right.

[9] Used to delay or prevent the recurrence of depressive episodes in bipolar disorder.
[10] Stevens-Johnson syndrome — a disorder of the skin and mucous membranes.

**Consultation with Dr C 4 Month2**

26. Dr C reviewed Ms A and noted that her depression was worsening, and recorded: "[Her] depression is suggestive of a bipolar 2 component[11]."

*Assessment*

27. Dr C told HDC that he undertook a comprehensive assessment that clearly showed signs and symptoms[12] of post-traumatic stress disorder (PTSD)[13] and bipolar affective disorder (BPAD), but that unfortunately he did not document the assessment thoroughly. He said that he is confident in his recollection of the risk assessment because he uses a structured approach[14] for all his new patients and asks the same questions,[15] and he has a strong recollection of Ms A's case as he spent time considering her presentation after he learned of her death.

28. Dr C said that he assessed Ms A's risk continuously, and believes he had a good rapport with her and a good understanding of her risk. Dr C told HDC that he assessed for hopelessness continually, and that Ms A's relationship and employment "were not either wholly positive or wholly negative" as risk factors. He said that he was aware that she was experiencing bullying at work but was engaged with her employer in resolving matters. Similarly, while he was aware of difficulties with her long-distance relationship, the commitment was still regarded as a protective factor. Dr C said that he was aware that Ms A had lost two friends to (apparent) suicide, but commented that she was not badly affected by this as she had not had a close or consistent relationship with the friends in the period prior to their deaths.

*Treatment and follow-up*

29. Ms A's mirtazapine dose was increased to 30mg daily, and her lamotrigine to 50mg twice daily. Ms A was still not fit for work,[16] and was to be followed up by the community team. On 5 Month2, arrangements were made to transfer her care to the community team.

30. On 11 Month2, Ms A was contacted by a male[17] nurse (her allocated case manager). She reported poor sleep, and requested a female case manager. Dr C was to continue as her doctor, and her care was transferred to the community team, with an appointment with Dr C arranged for 18 Month2.

31. On 13 Month2, Ms A telephoned the duty worker and reported experiencing effects from the increased dose of lamotrigine. She felt generally worse on lamotrigine, and was feeling "spaced out, wasted and confused, sleep up and down". She requested advice from Dr C, who was at the Crisis Resolution Service. Dr C's view was that the symptoms were unlikely

[11] A disorder associated with episodes of mood swings ranging from depressive lows to manic highs.
[12] In his response to HDC, Dr C listed how Ms A's signs and symptoms fitted the criteria for PTSD and bipolar affective disorder 2.
[13] A disorder characterised by failure to recover after experiencing or witnessing a terrifying event.
[14] Based on structured interviews for the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases diagnoses (ICD).
[15] This included asking about past attempts, family history, suicidal ideation, hopelessness, mental illness, substance abuse and dependence, chronic disease, and personal tragedies.
[16] Dr C provided a medical certificate saying that Ms A was unfit for work from 4 Month2 to 3 Month3.
[17] The DHB commented that the need for a female case manager was not known at the time.

to be caused by lamotrigine,[18] and that mirtazapine and her mood, anxiety, and stress could be factors. He suggested that she continue with the medication and telephone him if required. This was reported back to Ms A by the duty worker.

32. Dr C told HDC that Ms A had a qualified person available 24/7 to assist, and he had provided her with his telephone number and advised that she could call him if she needed anything, at any time. He described this as an "extra layer of protection in a difficult situation".

**Consultation with Dr C 18 Month2**

33. On 18 Month2, Ms A was seen by Dr C at the Crisis Resolution Service. He recorded that she felt spaced out and unable to follow conversations, and that this had occurred when the lamotrigine and mirtazapine doses were increased.

*Treatment and follow-up*

34. Dr C said that because of the risk of side effects, usually he starts lamotrigine at 25mg every second day, but he escalated Ms A's dose sooner, as in his opinion the severity of her clinical condition outweighed the risk.

35. Dr C reduced mirtazapine back to 15mg and started moclobemide[19] 150mg twice daily, as Ms A remained "significantly depressed" and "continue[d] to have suicidal ideas". Ms A also mentioned that she could not tolerate escitalopram[20] and venlafaxine.[21] The plan was for Ms A to be seen once a week with telephone calls every second day. The note ends with: "A follow-up booking needs to be made for next week."

36. There is no record of telephone calls made to Ms A, and no follow-up booking was made. On 24 Month2, Ms A telephoned the Crisis Resolution Service asking if an appointment had been made. The service contacted the community team, who then booked an appointment for 27 Month2 and informed Ms A.

37. Dr C told HDC that the case manager was expected to follow up the booking of appointments and telephone calls to Ms A. As noted above, on 11 Month2 Ms A was allocated a male case manager and requested a female instead. Occupational therapist Ms E was not allocated as Ms A's case manager until 9 Month3.

**Appointment 27 Month2**

38. Ms A attended the appointment with the community team on 27 Month2, but owing to a miscommunication, Dr C was unaware of the appointment and not available. Ms A was seen by the male case manager, who was the duty worker. The DHB told HDC that Dr C did not formally start work with the community team until 14 Month3, and prior to that he worked for the Crisis Resolution Service.

[18] As Ms A had been on lamotrigine since 26 Month1 (and had not vomited then), and was on a relatively low dose.
[19] Used to treat depression and social anxiety.
[20] Used to treat major depressive disorder or generalised anxiety disorder.
[21] Used to treat major depressive disorder, generalised anxiety disorder, panic disorder, and social phobia.

39. Ms A reported feeling worse, being more forgetful, struggling to communicate, and pinching and scratching herself, and her thoughts of suicide had increased in intensity. The duty worker recorded that Ms A "did not believe the medication was helping and was keen to commence talking therapy with a ca[s]e manager as well as starting Dialectical Behaviour Therapy (DBT)". The duty worker discussed grounding techniques and exercises, encouraged her to telephone if she needed support, and rescheduled a meeting with Dr C for 30 Month2 at the Crisis Resolution Service. The duty worker noted that a community team case manager should be allocated as soon as possible.

**Consultation with Dr C 30 Month2**

40. On 30 Month2, Dr C saw Ms A at the Crisis Resolution Service and recorded that her depression had become worse, she had had very little sleep, and she had been vomiting.

*Treatment and follow-up*

41. The plan was to telephone Ms A the next day to see how she had slept and check the level of suicidal ideation, and for Dr C to see her "on Friday".[22] Dr C telephoned Ms A on 1 Month3 and arranged an appointment for 3 Month3.

42. Dr C told HDC that he regarded the combination of moclobemide, lamotrigine, and mirtazapine as the most likely cause of Ms A's vomiting because it started on that combination. He said that he was aware of cannabinoid hyperemesis syndrome[23] but did not consider this as a potential cause for Ms A's vomiting as he was not aware of her consistent cannabis use.

43. Dr C stopped the moclobemide. He told HDC that he started Ms A on "Medication A" 50mg, to be increased to 75mg in a week's time, owing to the urgency in lifting her depression and because antidepressants take two to four weeks to take effect. Dr C said that he considered Ms A's potential vulnerability to side effects and was aware that the side-effect reaction in patients is unpredictable. He stated that he understood the doses he prescribed, although his reasoning was not recorded in his notes.

44. Dr C acknowledged that prescribing a month's supply of Medication A was an oversight. He reflected that this has been a good "wake up call" for him, and he has since been "even more conscious" to consider the dispensing rate.

*Multidisciplinary team (MDT) meetings*

45. Dr C told HDC that all patients were discussed weekly, and at these meetings the entire MDT, including two or three psychiatrists, were present. Dr C said that he explained the rationale for the treatment plan in place for Ms A, including the medication being trialled and the perceived chronic suicidal risk, and that no concerns were raised. Dr C stated: "If there was something significantly wrong with my prescribing it would have been pointed out by my colleagues at those meetings." Dr C also commented:

[22] Which would have been 4 Month3.

[23] A condition that leads to vomiting in daily long-term users of cannabis.

> "No concerns were raised by pharmacists at the time of prescriptions, nor were issues proposed by my colleagues at the [Crisis Resolution Service] and [the] Community Mental Health Services."

46. The DHB told HDC that specific prescribing is not discussed consistently, and "it is not known whether [Dr C's] prescribing with respect to [Ms A] was discussed".

47. The DHB's Crisis Resolution Service told HDC that medical staff discussed the acute case load in the morning meetings, Monday to Friday, but these meetings were not MDT meetings.[24] Formal MDT meetings were arranged for clients with complex or higher needs. The DHB community team stated that the procedure at the time was for new clients to be presented at an MDT meeting within six weeks[25] of treatment commencing with the team.

**Consultation with Dr C 3 Month3**

48. On 3 Month3, Ms A telephoned to reschedule her appointment as she was experiencing dizziness, nausea and vomiting, and was feeling off balance. She thought that this was related to her change from moclobemide to Medication A. An appointment was arranged with Dr C that day, and he noted that Ms A was "depressed but very sensitive to antidepressant medication".

*Treatment and follow-up*

49. Dr C stopped Medication A and replaced it with escitalopram 10mg daily for a week then 20mg daily. Dr C stated that he prescribed escitalopram, despite noting two weeks earlier that Ms A was unable to tolerate it, as he regarded it as the best option for Ms A considering her sensitivity to most antidepressants. He said that there was not a total inability to tolerate escitalopram, more that she had side effects such as nausea, vomiting, and headaches. Dr C stated that these side effects were "common initial and transient side effects of most antidepressants" and usually decrease significantly by the second week and are absent by the third week. He said that the dose of escitalopram can be started at 10 or 20mg, with a balance to be made between the urgency of the situation and tolerance.

50. Dr C said that he asked Ms A which antidepressants caused her the least side effects, and she said the SSRIs.[26] He stated: "This made me feel comfortable about starting [escitalopram] at 10 mgs. I understood the dosing but considered the urgency as being more important." Dr C told HDC that Ms A was sensitive to antidepressant medication and had used a number of medications that had to be stopped because of side effects, including venlafaxine, moclobemide, and Medication A. He commented that when prescribing he took Ms A's previous medication history into account, using information from Ms A and GP records from the MHAIDS intake information.

[24] According to the MHAIDS Client Pathway.
[25] Although Ms A had been seen on 11 Month2, her treatment with the team did not start until 14 Month3.
[26] Selective serotonin reuptake inhibitors class of drugs, including escitalopram.

51. Dr C told HDC that the prescribing for Ms A "was a balancing act between an urgent serious complex mixture of conditions,[27] sensitivity of [Ms A] and the long delay in effective working of antidepressants". He also commented: "Experienced psychiatrists will practi[s]e in different ways, based on the clinical picture they are faced with and their subjective interpretation of the same." Dr C stated that he made a few changes to Ms A's medications when a medication was not tolerated or lacked efficacy.

52. The plan was to review Ms A in a week's time to see how she tolerated the medication.

53. On 8 Month3, Ms A requested support for a work meeting, and this was arranged on 9 Month3 with a referral to an organisation for employment support.[28] Also on 9 Month3, Ms E telephoned Ms A to say that she was her new case manager from the community team. Ms A asked about the waitlist for a DBT skills group as she was keen to start some therapy. Ms E offered her some 1:1 work in the interim, which Ms A accepted.

*Trichotillomania (hair pulling)*

54. Dr C told HDC that escitalopram and mirtazapine were also prescribed to treat the hair-pulling disorder. The DHB told HDC that there was no evidence of a treatment plan for Ms A's trichotillomania. However, Ms A was noted to be in the early stages of engagement, and treatment planning was ongoing. The focus was on the acute phase of her illness, and then the community team's support focused on Ms A's employment.

**Consultation with Dr C 14 Month3**

55. On 14 Month3, Ms A was seen by Dr C and Ms E at the Crisis Resolution Service. Dr C documented that Ms A had improved on the escitalopram 20mg daily, and the vomiting had "settled down", her sleep had improved, and her depression was lifting, but her energy levels were low. Dr C reported that he expected total recovery from major depression.[29]

*Treatment and follow-up*

56. Ms E referred Ms A to the Emotion Regulation Skills Group,[30] which was due to start in four weeks' time. Ms A was motivated to start some 1:1 work, and Ms E undertook emotion regulation skills work with Ms A, which is informed by DBT.

57. The plan was for an appointment with employment support on 16 Month3. However, Ms E said that Ms A cancelled the appointment as she was visiting her mother, Mrs B, and asked for it to be rescheduled. On 22 Month3, Ms E recorded that Ms A had rescheduled the appointment and was "feeling really miserable" and did not want to talk to or see people, and asked to reschedule the appointment again.

[27] Dr C told HDC that he prescribed escitalopram 20mg for depression, PTSD/anxiety, and trichotillomania, mirtazapine 15mg for depression, PTSD/anxiety, lamotrigine 50mg for depression, and diazepam 5mg for PTSD/anxiety.

[28] An organisation that works with people who are facing personal or health challenges, and supports them to return to or stay in employment.

[29] An email to this effect was sent to Ms A to share with her employer.

[30] The Personality Disorder Service Group.

58. On 23 Month3, Ms E attempted to reschedule the appointment, and Ms A texted: "[E]verything is bad at the moment. I haven't had a good day or any energy for a while now." She was encouraged to employ distraction and self-soothing techniques and to attempt small tasks and get some fresh air if possible. The plan was to contact Ms A the next day. However, there is no record of a telephone call on 24 Month3. Ms E told HDC that she believes she attempted to telephone Ms A and that the call went through to voicemail, and she had intended to ring again but either forgot or became caught up with other work.

**Consultation with Dr C 29 Month3**

59. On 29 Month3, Ms A was seen by Dr C and Ms E. Dr C recorded: "[Ms A] believes very strongly that the medication is making her depression worse. She wants to stop all medication and see if things improve." Ms A was taking escitalopram 20mg daily, lamotrigine 50mg twice a day, and mirtazapine 15mg daily. Dr C's view was that the dose of lamotrigine needed to be increased.

*Treatment and follow-up*

60. Dr C told HDC: "[Ms A] had already made up her mind to stop all medication and I had no option than to reluctantly accept this course." It was decided to stop her medication slowly over six weeks, with close follow-up by Ms E. The plan was for Ms A to telephone Ms E daily as she came off the medication, and for Ms E to visit Ms A weekly. Ms A was to see Dr C in two weeks' time, and also start the skills-based component of the DBT.

61. Dr C told HDC:

> "[Ms A's] risk, based on her history of chronic suicidal thoughts but no suicide attempts and her denial of suicide intent or plan at times of her assessments, and in particular her last assessment, together with her improved clinical presentation, my impression was that [Ms A's] short term suicidal risk was low but I was aware that there was a chronic moderate suicidal risk."

62. Dr C prescribed diazepam 5mg daily as required[31] for extreme stress during this period. He told HDC that he cannot recall whether he was aware of Ms A's prior response (dark thoughts) to clonazepam[32] described in the GP referral, but added that he would probably still have prescribed diazepam as it is not contraindicated by dark thoughts.

63. On 30 and 31 Month3, Ms E contacted Ms A and planned a home visit for 1 Month4. Ms A had been sleeping poorly and had had an anxiety attack, and cancelled the visit as she was feeling overwhelmed and exhausted and was having difficulties with her partner. She was encouraged to use the diazepam but said that she would prefer to get through it without medication and to telephone for support if required. Cognitive behavioural therapy (CBT) techniques were discussed, and she discussed her social plans. The plan was for an appointment with Dr C and Ms E on 5 Month4.

[31] PRN (pro re nata).
[32] Clonazepam and diazepam are both benzodiazepines.

64. Sadly, Ms A died by apparent suicide on 3 Month4.

**Further information**

*Mrs B*

65. Mrs B commented that she is very grateful to the occupational therapist, Ms E, who tried to form a meaningful relationship with her daughter.

*Dr C*

66. Dr C conveyed his deepest sympathies to Ms A's family and friends for their tragic loss.

Documentation

67. Dr C told HDC:

> "[I accept that my] note taking could have been more comprehensive in this case. The medical record does not accurately reflect the comprehensive discussions I in fact had with [Ms A] on each occasion I saw her. They do not reflect the comprehensive discussions I had with [Ms E], occupational therapist and [Ms A's] Ca[s]e Manager. The notes do not capture in full my clear rationale for treatment and the management plan I had in place."

68. Dr C stated:

> "This investigation has made exceptionally clear to me the importance of making detailed notes of my impressions and treatment rationale. The extent of my record keeping has let me down, as despite my recall of the consultations with [Ms A], [HDC advisor] Dr Twiss identifies that my clinical justification has not been recorded in enough detail to fully corroborate my recollections."

69. Dr C commented:

> "[My note taking] was not as comprehensive as usual because of time pressures at the time, working in a stretched service and having to shift across two teams. This was an unfortunate reality of the service at the time, and we all did the best we could within time constraints that were beyond our control."

70. In response, the DHB commented that the Crisis Resolution Service was "very busy as usual". The community team had 2.1 FTEs[33] allocated for senior medical officers (SMOs), of which Dr C provided locum cover for 0.4, two permanent SMOs provided 1.3, with 0.4 FTE not covered.

Therapy

71. Dr C told HDC that he did not tell Ms A that he would not start her on therapy until she had started to take the medication prescribed, and did not tell Ms A that she would need to be

[33] Full-time equivalent.

sectioned if she became worse and would potentially be subject to shock therapy. Dr C commented that alternative methods of therapy were considered, but said:

> "[I]t was not in my view appropriate — on view of [Ms A's] presentation — to limit treatment to this alone. [Ms A] required medication as her primary intervention."

72. Dr C stated that he was aware that Ms A wished to receive talk therapy, and commented that he and Ms E provided it through psychoeducation and supportive psychotherapy. He recognised that DBT could provide benefit for Ms A's PTSD, but added that it works best when a person's depression is not too severe. Thus Dr C was treating the depression first, and Ms A was booked in for DBT.[34]

*DHB mental health pharmacist*

73. An opinion on the medication prescribing was obtained by the DHB at the request of Ms A's family. The pharmacist commented that the titration of lamotrigine for Ms A was twice the usual titration rate. A slow titration of lamotrigine can lower or prevent the risk of serious skin/systemic hypersensitivity reactions. The pharmacist commented that sometimes prescribers increase the rate of titration.

74. The escitalopram was started on 10mg daily, to be increased to 20mg daily after a week. The pharmacist commented that Ms A was very anxious, and antidepressants like escitalopram (an SSRI) are started at a low dose to try to avoid the common increase in anxiety/agitation that can be experienced with starting SSRIs. A 5mg starting dose of escitalopram (or even 2.5mg) may have been better than 10mg. A therapeutic dose for one person may be too much (or too little) for another person because of variation in how people handle the metabolism of medicines.

75. The pharmacist commented that she did not think there were any absolute contraindications to the medicines Ms A was prescribed, although probably there could have been more caution with some dosing. In her view, Ms A appeared to be sensitive to medication, which could mean that her body did not metabolise medicines in the same way as other people.

*Serious Adverse Event Review (SAER)*

76. The DHB's Serious Adverse Event Review was an internal review undertaken by an individual senior clinician. The review findings were:

1. There are concerns with some aspects of Dr C's practice.
2. Ready access to a full range of treatment options beyond medication is essential.
3. There is a lack of availability of talking therapies within Adult Community Mental Health teams.
4. There was a failure to listen to the client's voice and no evidence of MDT discussion.

[34] Dr C told HDC that he had meant to say CBT and not DBT, as DBT is for borderline personality disorder and CBT is one of the therapies for PTSD.

77. The SAER recommendations were:

1. The Professional Leader for Psychiatry was to follow up concerns about Dr C's practice.
2. The MHAIDS Risk Workshop was to include information on the importance of clear follow-up plans with clear assignment of responsibility and confirmation that this information has been received. For clients in crisis this should include the time and place of their next appointment, and ideally, the name and role of the clinician they will be meeting.
3. The SAER report was to be brought to the attention of the Talking Therapies Project Group.
4. The client pathway steering group was to develop guidelines for MDT process incorporating the different needs of each sector.

78. In response to the provisional opinion, the DHB stated that Dr C had left the DHB by the time the SAER was completed, so concerns about his practice were not followed up. Regarding point two in the paragraph above, the DHB stated that this information is now woven through the Risk Workshop and forms part of the training, with risk management involving properly connecting with the person and their family, collaboratively planning with them, and communicating the plan clearly.

79. The DHB confirmed that the SAER has been shared with the Talking Therapies Project Group and action taken (see the recommendations section of this report). The DHB also confirmed that draft procedure and guidelines have been developed for the MHAIDS MDT process and, following consultation, should be finalised by December 2021.

80. Dr C commented that the DHB's SAER was "seriously flawed" as the process should involve a meeting of the review team, the clinical team, and family if available. He stated that a proper and fair review cannot occur in the absence of the treating clinical team and risks inaccuracies.

81. The DHB told HDC that SAERs would not usually include interviews of staff or family members. The DHB commented that Dr C was not provided with a copy of the draft report, as he had left employment with the DHB by this time.

**Responses to provisional opinion**

*Mrs B and Mr D*

82. Mrs B and Ms A's brother, Mr D, were given an opportunity to respond to the "information gathered" section of the provisional opinion. Where appropriate, changes have been made to the "information gathered" section in response to their comments.

83. Mr D told HDC:

> "[Ms A] was a kind, light-hearted, artist and one of the most genuine people you will ever meet. Her identity was hers and she was unique in all aspects of her being. She was a loved daughter, sister, aunty, [and] friend."

84. Mr D stated:

> "The system as a whole has let [Ms A] down and that is not something that can ever be corrected but in speaking out, challenging the mental health professionals that are supposed to help some of our most vulnerable people can hopefully help someone else get the help the[y] tru[l]y need and deserve an[d] to hopefully stop another famil[y's] heartache."

*DHB*

85. The DHB was given an opportunity to respond to the provisional opinion, and accepted the proposed recommendations. The DHB stated that although many aspects of the care provided to Ms A were of a high standard, it acknowledged that "there were some areas where communication could be improved".

*Dr C*

86. Dr C was given an opportunity to respond to the relevant sections of the provisional opinion, and he accepted the findings. Dr C told HDC that he was devastated to learn of Ms A's death, and said that it was unexpected, based on his consultations with her.

87. Dr C agreed to comply with the recommendations made in the provisional report.

---

## Opinion: Dr C — breach

88. Ms A was referred to the DHB Mental Health Services by her GP and was under the care of consultant psychiatrist Dr C from Month1 until her death on 3 Month4. My expert advisor, Dr Lindsay Twiss, commended Dr C for the frequency of his reviews, but she has significant concerns about aspects of the care Dr C provided to Ms A, including Dr C's lack of clinical documentation, and his risk assessment, medication prescribing, and diagnostic process.

**Risk assessment and associated documentation**

89. Dr C acknowledged that his note taking could have been more comprehensive, and stated that the medical record does not accurately reflect the comprehensive discussions he had with Ms A and Ms E, and does not capture in full his rationale for treatment and the management plan.

90. The lack of documentation complicates an evaluation of Dr C's risk assessment and diagnostic process. I have had to weigh the statements provided by Dr C, which rely on his recall of events, against the sparse contemporaneous documentation.

91. I agree with Dr Twiss that it is difficult to ascertain whether Dr C's risk assessment was sufficient or whether his documentation of that assessment was very poor. However, Dr Twiss advised that from reading Dr C's statements to HDC:

> "[T]here were significant aspects to [Ms A's] presentation and history that he failed to appreciate, in particular with regard to risk. It appears he underestimated the presence of a number of risk factors, which suggests inadequate assessment (as opposed to '*just*' inadequate documentation)."

92. Dr C described that he went through a detailed psychiatric history and mental state examination, and identified suicidal ideation, depression, and loss of loved ones as applying to Ms A, and that she was a social drinker and did not use drugs. He said that information about social supports was difficult to gather as Ms A was reluctant to talk about her family.

93. Dr Twiss advised that Dr C appears to have "underestimated" the following risk factors for Ms A: no past history of attempts at suicide identified, Ms A's long-term daily use of cannabis, the recent death of two friends, her lack of social support, and the risk with hopelessness. Dr C told HDC:

> "I did ask [Ms A] about substance abuse, past self-harm and past suicidal attempts and was falsely assured by her. I appreciate my notes should have included these discussions that took place."

94. Without adequate documentation it is difficult to know whether Dr C asked about past suicide attempts and whether Ms A's answer reassured him. However, I have also considered the information recorded on the MHAIDS intake form of a history of deliberate self-harm. This was available for Dr C to review, and would have made him aware of previous episodes of risk. Dr C told HDC that he reviewed as much information as he could before seeing Ms A, but added that the reality of the service at the time was that "we were very time poor". I remain critical that Dr C did not assess Ms A's risk adequately, as he failed to identify her past history of attempts at suicide, even though previous episodes of self-harm were recorded on the MHAIDS intake form.

95. Dr C told HDC that in his view, "substance use was not a significant risk factor"; however, he was not aware of Ms A's long-term daily use of cannabis. Again I refer to the MHAIDS intake form, which was available to Dr C, and records that Ms A had "used THC[4] all her life … Long term use of THC". Dr C refers to the cannabis use as "critical information" that he would have "acted in response to". I am critical that Dr C did not identify Ms A's cannabis use as part of his assessment of the information available to him, or during his consultation with Ms A.

96. Dr Twiss advised that Dr C appears not to have considered how the recent death of two of Ms A's friends might increase Ms A's risk of suicide. Dr C told HDC that he was aware of these losses, but said that Ms A had not been badly affected, as she had not had a close or consistent relationship with the friends in the period prior to their deaths. This differs from the assessment form on 26 Month1, which described the loss of two "close friends". There is little documentation to support Dr C's assertion that he took this risk factor into account, and his statement does not appear to match the description in the assessment form. In addition, there are varying descriptions of social support from family and friends. Dr Twiss advised that "[t]hese issues are important in that they describe the context in which a client

lives and speaks to their stressors (likely to increase risk) and their support (likely to reduce risk)". I am critical of Dr C's assessment of this risk factor.

97. Dr C told HDC that Ms A's relationship with her boyfriend and her employment "were not either wholly positive or wholly negative" as risk factors. He said that he was aware that she was experiencing bullying at work but was engaged with her employer in resolving matters. Similarly, while he was aware of difficulties with her long-distance relationship, the commitment was still regarded as a protective factor. Again, there is a lack of documentation that records this assessment.

98. Dr C told HDC that "[a]ll risk factors were discussed within [his] consultations with [Ms A]". He commented that he assessed for hopelessness continually. Dr Twiss's view is that Dr C had "an overly optimistic assessment of the situation" considering that the assessment form on 26 Month1 described low self-esteem and hopelessness, impaired insight and judgement, and that "suicide remains a risk if her condition is not treated properly".

99. Dr Twiss advised that if Dr C did undertake a comprehensive risk assessment utilising a structured approach, as he has told HDC, then he met the accepted standard of care for risk assessment, but his failure to document such an assessment is at least a moderate departure of care. However, if Dr C did not undertake a comprehensive risk assessment, this is a serious departure from the expected standard of care for a psychiatrist.

100. It is clear that Dr C has not met the Medical Council's Good Medical Practice standard on documentation.[35] I am critical of this and consider that Dr C has failed to keep clear and accurate patient records.

101. I note Dr C's comment that his documentation was not as comprehensive as usual because of time pressures. However, taking into account the other information available to Dr C at the time, I am satisfied that on the balance of probabilities, Dr C did not undertake a comprehensive risk assessment. Dr C's risk assessment was inadequate, as discussed above. In addition, clearly his documentation was inadequate. I am therefore critical of the quality of the risk assessment he provided to Ms A, and of the lack of documentation.

**Medication prescribing**

102. Dr C's prescribing for Ms A was characterised by frequent changes and additions to her medication regimen, including higher than usual initial doses. Dr C told HDC that when a medication was not tolerated by Ms A or lacked efficacy, he changed it. He said that in prescribing for Ms A he balanced "an urgent serious complex mixture of conditions", her sensitivity to antidepressant medication, and the long delay in effective working of antidepressants. I note Dr C's comment that "[e]xperienced psychiatrists will practi[s]e in different ways, based on the clinical picture they are faced with and their subjective interpretation of the same".

[35] Refer to Appendix B.

103. Dr Twiss advised:

> "Antidepressant medication typically takes several weeks before the patient experiences benefit. The recurrent changes in medication for [Ms A] repeatedly delayed the time it would take for medication to be effective. More conservative initial prescribing and more consideration as to alternate explanations for her reported adverse effects may have meant she was more able to tolerate and hence more willing to continue with medication, and therefore would sooner have experienced benefit."

104. Both Dr Twiss and the DHB's mental health pharmacist who reviewed the prescribing noted that lamotrigine was prescribed by Dr C at twice the usual titration rate. Dr Twiss also noted that this was a quadrupling of what Dr C describes as his usual practice. Dr C told HDC that owing to the risk of side effects, usually he starts lamotrigine at 25mg every second day, but he escalated Ms A's dose sooner, as in his opinion, the severity of her clinical condition outweighed the risk. Dr C told HDC that he discussed possible side effects with Ms A, but this is not documented, and RN F, who was present at the consultation, cannot recall any discussion around potential side effects.

105. My expert advisor also raised concern about Dr C's prescribing of Medication A as one month's supply to be dispensed at once. Dr Twiss advised:

> "[P]sychiatrists would typically be very cautious about prescribing medication […]; weekly or fortnightly dispensing would have been a safer option."

106. I agree with Dr Twiss and am critical of Dr C's prescription for Medication A. Dr C acknowledged that prescribing one month's supply of Medication A was an oversight, and said that he has since been "even more conscious" to consider the dispensing rate.

107. I note that Dr Twiss is critical of Dr C's decision to commence Ms A on a full dose of escitalopram knowing that she was sensitive to adverse effects. Dr Twiss advised that escitalopram is prescribed in the range of 10–20mg, with a usual starting dose of 5mg, or 2.5mg in people sensitive to the medication. On 3 Month3, Dr C commenced Ms A on escitalopram 10mg daily for a week then increasing to 20mg.

108. On 29 Month3, the decision was made to stop Ms A's medication slowly over a six-week period, in response to her request. More specific instruction about how to do this is not documented. Dr Twiss is concerned about Dr C's prescribing of diazepam for extreme stress, and considers that it may have increased Ms A's thoughts of suicide, as the GP referral noted that Ms A felt worse with dark thoughts after taking another benzodiazepine medication, clonazepam. Dr C cannot recall whether he was aware of Ms A's prior response to clonazepam, but said that he would probably still have prescribed diazepam, as it is not contraindicated by "dark thoughts".

109. Dr C stated that if there had been something significantly wrong with his prescribing, his colleagues would have pointed it out at MDT meetings. However, the DHB told HDC that specific prescribing is not discussed consistently, and "it is not known whether [Dr C's] prescribing with respect to [Ms A] was discussed".

110. Dr Twiss advised:

> "Whilst [Dr C's] individual prescribing decisions may have each only been a mild departure from the accepted standard of care, considered in totality I perceive [Dr C's] prescribing to be a **moderate departure** from the accepted standard of care." (Emphasis in original).

111. I agree with Dr Twiss and am critical of Dr C's pattern of prescribing, in particular his prescription for one month's supply of Medication A.

**Diagnoses**

112. Dr Twiss advised that Dr C failed to reach an expected standard of care in that he did not document his findings from the history or examination of Ms A in support of his diagnoses. She described this as at least a moderate departure from the expected standard of care, especially considering the number of times he met Ms A.

113. Dr Twiss commented that if Dr C elicited the signs and symptoms of PTSD and BPAD, she has no argument with his diagnoses, but his failure to document these findings is a moderate departure from accepted standards. If, however, Dr C did not complete a comprehensive assessment with regard to signs and symptoms of the disorders, this is an additional mild to moderate departure. Based on the evidence available, I am unable to reach a conclusion as to whether Dr C did elicit the signs and symptoms of PTSD and BPAD. I remain highly critical of Dr C's lack of documentation, which makes it difficult to elicit the rationale for his diagnoses.

**Conclusion**

114. Dr C reviewed Ms A frequently during the period of Month1 until her death on 3 Month4. I agree with my clinical advisor, Dr Twiss, that aspects of Dr C's care did not meet acceptable standards of care. In particular, I find:

- Dr C did not carry out a comprehensive risk assessment, hence no treatment plan was evident;
- He continued with his self-described strategy for managing her symptoms, which did not appear to be working, without reflecting or seeking peer review;
- Dr C's medication prescribing was inadequate:
  - particularly in relation to prescribing a month's supply of Medication A to be dispensed at once, and
  - overall, in prescribing higher doses of medications and repeatedly changing medications, when Ms A was known to have negative side effects.
- Dr C's rationale for the diagnoses made is unclear.

115. Accordingly, I find that that Dr C breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) for failing to provide Ms A services with reasonable care and skill.[36]

116. In addition, I am critical of the lack of record-keeping by Dr C and, accordingly, I also find that Dr C breached Right 4(2) of the Code.[37]

## Opinion: District health board — adverse comment

117. My expert advisor, Dr Twiss, has advised that many aspects of the care provided to Ms A were of a high quality, such as prioritising early assessment, regular telephone contact, referral to the Personality Disorder Service and to employment support, and rescheduling of missed appointments. Dr Twiss also commends the frequency of doctor reviews. However, Dr Twiss has identified some gaps in enacting treatment plans, which she says may have contributed to Ms A losing faith in the treatment she was receiving. Dr Twiss described these communication lapses as "not ideal care but not reaching [the] threshold for 'departure of care'". These include:

- Daily telephone calls did not occur regularly after the assessment on 26 Month1, despite this being in the treatment plan.
- Telephone calls every second day were not made after 18 Month2, and Ms A had to telephone the service herself on 24 Month2.
- Dr C was not aware of the appointment with Ms A on 27 Month2 and, as a consequence, was not available to see her.
- Ms E planned to telephone Ms A on 24 Month3 but this was not done, and there was no further contact with Ms A until her appointment on 29 Month3.

118. I agree with Dr Twiss and am critical that there were gaps in communication with Ms A. As outlined above, the DHB carried out a Serious Adverse Event Review of Ms A's care, which identified team factors regarding continuity of care and the MDT process. I note that the frequency of MDT meetings has been reviewed and changes made, in both the Crisis Resolution Service and the community team (see the "Changes made" section of the report below). These changes will also provide further opportunities for clinicians to discuss the management of clients. The DHB has implemented an electronic Internal Transfer of Care procedure to ensure consistency with the transfer from one team to another.

119. Dr Twiss also commented that when Ms A asked to be assigned a female case manager on 11 Month2, this took four weeks to be actioned (Ms E contacted Ms A on 9 Month3). I note that the DHB commented that the need for a female case manager was not known at the

[36] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[37] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

time. Whilst not necessarily a departure of care, Dr Twiss advised that this seems a long wait for reallocation, and ideally Ms A would have been asked prior to the allocation of a case manager whether a male case manager would be acceptable, considering her past history of sexual trauma. I agree with Dr Twiss that this is an area for improvement for the DHB to consider. I note that in the interim Ms A was supported by the community team duty clinician and the Crisis Resolution Service.

120. Overall I am critical of the lapses in communication with Ms A. I believe there were areas for improvement in ensuring that communications occurred in accordance with Ms A's treatment plan, and around asking whether Ms A had a preference for a male or female case manager and ensuring a timely reassignment to a new case manager. I am also concerned about the lack of involvement of family and key staff in the DHB's Serious Adverse Event Review process, and encourage the DHB to consider this in future processes.

121. The DHB has identified a number of improvements around MDT meeting reviews, and has introduced a procedure to support the transfer of clients between teams. I commend these quality improvements.

## Changes made

### Dr C

122. During the course of HDC's investigation, Dr C reflected on the care he provided Ms A and considered what could have been done better. He acknowledged that his documentation had deficiencies. He told HDC:

> "I am very aware of the importance of comprehensive documentation and I understand that I let myself down in this regard in this case. This investigation has been a 'wake up' call to ensure consistent high standards are maintained, irrespective of time pressure or working in a stretched service. I have already applied this to my 5-month locum run that I have just completed … I will continue, in my practice, seeking the advice and views of my colleagues as I believe obtaining broader perspectives is a useful safeguard."

### DHB

123. The DHB has reviewed the frequency of MDT meetings in the community team. Urgent and acute meetings are now provided as required. All people new to the service are discussed and reviewed in the MDT within six weeks of the first face-to-face contact, and this is documented in the electronic notes.[38] After the meeting, the primary clinician updates the person/whānau and the GP about the review outcome, and provides copies of the electronic notes.

124. The DHB's Crisis Resolution Service now has a designated clinician to manage cases on the morning and afternoon shifts. A weekly MDT meeting has been introduced on Tuesday

[38] This includes all MDT attendees, a summary of the clinical outcome, and the updated comprehensive plan.

afternoons to discuss all clients on the case load. All acute work is discussed daily at the handover meetings.

125. The MHAIDS Risk Workshop included the importance of clear follow-up plans, assignment of responsibility, and communication (this included the time and place of next appointments, and the name and role of the clinician the person would be meeting). This was completed in January 2020.

126. The SAER was discussed and disseminated to the Talking Therapy Working Group members. The Talking Therapies Project Group is progressing the training and provision of talking therapies. MHAIDS has already implemented Emotion Regulation Skills training dates in its Learning and Development.

127. The DHB has implemented an electronic Internal Transfer of Care procedure to ensure consistency with the transfer from one team to another within MHAIDS.[39]

## Recommendations

128. I recommend that Dr C provide Ms A's family with a written apology. The apology is to be sent to HDC within three weeks of the date of this report being issued, for forwarding to the family.

129. I recommend that Dr C undertake further training on keeping clear and accurate patient records, in particular in relation to risk assessment, diagnosis, and formulation of a treatment plan, and provide evidence of this to HDC within six months of the date of this report.

130. I also recommend that Dr C undertake reflective practice reviews and/or peer reviews to support consideration of alternative plans, and report back to HDC within six months of the date of this report.

131. I recommend that the Medical Council of New Zealand consider whether a competence review of Dr C is necessary on consideration of the information in this report.

132. In the provisional opinion, I recommended that the DHB:

a) Provide an update to HDC from the Talking Therapies Project Group on the progress of training and provision of talking therapies to ensure that talking therapy is offered and available for people who wish to access this service (where appropriate).

   In response, the DHB stated that the Talking Therapies Project Group is increasing access to talking therapies for people receiving care and treatment from MHAIDS, by implementing training and provision of talking therapies for all clinicians. This includes

[39] MHAIDS Internal Transfer of Care procedure, issued 17 December 2019.

training on Motivational Interviewing, Emotional Regulation, Dialectical Behaviour Therapy, and Cognitive Behaviour Therapy.[40]

The DHB told HDC that clinicians can access the training dates, any waitlist is monitored frequently by the Learning and Development Team, and training is communicated via the MHAIDS Update Newsletter.

b) Provide an update to HDC on how it involves family and key staff in the Serious Adverse Event Review process, and refer to guidance from the Health Quality & Safety Commission's mental health and addiction service quality improvement programme in doing so, and advise HDC of the outcome of its consideration.

In response, the DHB stated that MHAIDS has a number of approaches to the review methodology it uses, which are commissioned by the DHB's Serious Adverse Event Committee using the Health Quality & Safety Commission guidelines. In this case, a casefile review was undertaken, which would not normally involve family or clinicians.

MHAIDS told HDC that it has now implemented a process in which the consumer/family are always asked if they have anything they wish to contribute to the review. If a casefile review has been commissioned and family indicate that they do wish to contribute, staff are then also contacted, and the review is changed from a file review to a review with interviews.

c) Provide an update to HDC on how the DHB is covering the psychiatry senior medical officer FTE requirement in the Crisis Resolution Service and the community team and, if there are any shortfalls, advise how these are being addressed.

In response, the DHB stated that it does everything it can to maintain appropriate staffing levels, but this is not always possible. Where there are resignations, the DHB attempts to recruit into these positions as soon as possible. When there are vacancies, it will access locum cover, although the ideal situation is to have these positions filled with permanent staff.

133. Taking into account the actions taken by the DHB in response to the provisional recommendations, I consider that no further recommendations to the DHB are necessary.

[40] The DHB provided a breakdown of the content of each training course and the time required to complete it, and the number of staff that attended each course in 2020–2021.

## Follow-up actions

134. Dr C 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. In making this referral I have had regard to the multiple departures of care identified, the seriousness of the breach, the particular vulnerabilities of Ms A where the risks should have been known, and the public interest in holding providers to account.

135. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand and the Royal Australian and New Zealand College of Psychiatrists (RANZCP), and they will be advised of Dr C's name in covering correspondence.

136. A copy of this report will be sent to the DHB.

137. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Coroner, the Director-General of Health, the Director of Mental Health, the Mental Health and Wellbeing Commission, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

## Addendum

138. The Director of Proceedings decided not to issue proceedings.

## Appendix A: Expert advice to the Commissioner

The following expert advice was obtained from consultant psychiatrist Dr Lindsay Twiss:

"**Re: HDC Complaint C19HDC01547**

Thank you for the opportunity to provide an opinion to the Commissioner on case C19HDC01547. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I am not aware of any personal or professional conflicts in providing this report. I understand that my role as an expert is to provide this advice to you independently. I will ensure I keep within my area of expertise.

**Qualifications**
With regard to my qualifications and experience, I graduated with a Bachelor of Medicine and Surgery from the University of Auckland in 2000. I began my specialist training in psychiatry in 2001 working in a range of community and inpatient settings in the Auckland region. I achieved Fellowship to the Royal Australian and New Zealand College of Psychiatrists in 2007, having also completed a Certificate of Advanced Training in Adult Psychiatry. Since 2007 I have worked as a consultant psychiatrist in community mental health centers for Waitematā, Auckland and Counties Manukau District Health Boards. For the majority of that time my work has included both acute work (such as that provided by [the DHB's] Crisis Resolution Service (CRS) and ongoing care (such as that provided by [the DHB's] Community Mental Health Team (CMHT)) — noting that [Ms A] accessed care from both teams and [Dr C] worked across both services.

I have since 2015 been a member of the Expert Advisor Panel to the Health and Disability Commissioner, providing expert opinion in situations of complaint to the HDC.

**Expert Advice Requested**
I have been asked to review the documentation provided and advise as to whether I consider the care provided to [Ms A] was reasonable in the circumstances. In particular I have been asked to comment on:

1. The adequacy of the psychiatric care provided to [Ms A] by [the DHB] from 19 [Month1] to 3 [Month4];
2. The adequacy of the assessments undertaken, particularly with regard to [Ms A's] level of risk;
3. The appropriateness of any treatment plans put in place;
4. The appropriateness of the psychiatric care provided to [Ms A] by [Dr C] from 19 [Month1] to 3 [Month4]; including but not limited to the appropriateness of [Dr C's] prescribing;
5. The appropriateness of the care provided to [Ms A] by other relevant individuals at [the DHB] from 19 [Month1] to 3 [Month4];

6. The adequacy of the attached relevant policies and procedures in place at [the DHB] at the time of these events;
7. The adequacy of the changes made at [the DHB] since these events;
8. Any other matters that you consider amount to a departure from accepted standard of care;
9. Whether any departures from accepted standards you have identified represent system failings within [the DHB], or if they can be attributed to individual staff.

**Sources of Information**

1. Letter of Complaint to HDC dated 3 August 2019
2. [The DHB's] response to HDC dated 30 October 2019
3. [Dr C's] response to HDC dated 22 June 2020
4. Clinical records from [the DHB] covering period 19 [Month1] to 3 [Month4]
5. [The DHB's] Serious Adverse Event review
6. Relevant [DHB] policies and procedures
7. Information from the Coroner (though I note this does not include any report of Coronial Findings).

**Background**

[Ms A] was referred to [the DHB's] mental health services by her GP on 19 [Month1] with regard to 'deteriorating moods and marked anxiety'. The GP noted adverse effects with medication and wondered as to the contribution of PTSD.

[Ms A] was under the care of the [DHB] Crisis Resolution Service (CRS) and the … Community Mental Health Team (CMHT) with consultant psychiatrist [Dr C] working across both teams in providing assessment and treatment to [Ms A].

On 03 [Month4] [Ms A] was found deceased, by apparent suicide.

**Opinion**

Having reviewed the information available I have some concerns about the care provided to [Ms A] by [the DHB], in particular I perceive a departure from the standard of care provided by [Dr C].

**1. The adequacy of the psychiatric care provided to [Ms A] by [the DHB] from 19 [Month1] to 3 [Month4]**

Many aspects to the care provided to [Ms A] were of a high quality. For example I note following the referral from her GP, the triage by the Intake clinician prioritised an early assessment by [Dr C], she was frequently reviewed by [Dr C], there was regular phone contact with [Ms A], her preference for a female case manager was accommodated, a referral was made to the … Personality Disorder Service ([PDS]) for skills work (I presume with regard to emotions management), her difficulties in her work were

supported via a referral to employment support, missed appointments were rescheduled, including an urgent doctor review when her physical symptoms were noted to be likely medication related, her preference for medication to be discontinued was respected with a titration downward of medication and some advice about how best to proceed with this.

I do however have significant concerns about aspects to her care, largely this will be captured in answering questions 2 (adequacy of assessments) and 4 (care provided by [Dr C]) below.

I also note that there were gaps in enacting treatment plans. Following [Dr C's] initial assessment on 26 [Month1] there was a plan for daily phone calls (to check on mood and medication effects), this occurred the following day, but not the day after.

On 18 [Month2] [Dr C's] plan included 'phone calls ever[y] 2nd day' (in the context of noting [Ms A] continued to 'have suicidal ideas'). This doesn't appear to have been enacted, with the next contact between mental health services and [Ms A] occurring on 24 [Month2] when [Ms A] herself phoned to clarify her follow up.

On 24 [Month2] [Ms A] was advised by the **CMHT duty clinician of a further appointment with [Dr C] for 27 [Month2], however when she attended on 27 [Month2] [Dr C] was not available to see her** (described in notes as being due to 'miscommunication').

On 23 [Month3], in the context of [Ms A] describing increasing despondency, case manager OT [Ms E] recorded a plan 'will contact Ms A again 24 [Month3]' but there are no notes in the following days to confirm that this did happen.

These gaps in [Ms A's] care were unfortunate. One could speculate that they may have contributed to [Ms A] losing faith in the treatment she was receiving but I'm not convinced they represent a significant departure from accepted practice.

On 11 [Month2] [Ms A] was contacted by [RN H] who had been allocated to be her case manager with the community team. [Ms A] requested a female case manager. Four weeks later on 09 [Month3] [Ms E] phoned [Ms A] to introduce herself as the new case manager. Whilst not necessarily a departure of care this seems a long wait for re-allocation. It is not uncommon for women with a history of sexual trauma to have difficulty in forming trusting relationships with male clinicians, ideally [Ms A] would have been asked about this prior to the allocation of [RN H]. Her care was in the interim supported by the CMHT duty clinician and CRS.

**2. The adequacy of the assessments undertaken, particularly with regard to [Ms A's] level of risk**

There was inadequate assessment, or at least inadequate documentation of assessment of risk for [Ms A]. Without knowing more about the systems and expectations of roles at [the DHB] it is difficult to clarify with whom the responsibility

for this primarily sits. In question four you will read that I am very critical of [Dr C's] lack of risk assessment and the factual errors in his letter to the HDC.

The MHAIDS Intake documentation shows good initial triage assessment and it is noted that [Ms A] was experiencing thoughts of suicide, feeling 'desperate', 'helpless/ hopeless' and that 'life's not worth living'. The triage assessment noted that she had a past history of deliberate self harm, including … and inferred a lack of protective factors.

The MHAIDS Intake Assessment, Comprehensive Assessment and GP correspondence following [Ms A's] initial assessment with [Dr C] on 26 [Month1] were completed by [RN F]. It is beyond my expertise to comment on the documentation provided by a registered nurse but to say it looks adequate. It lacks some of the sophistication I would expect for an initial assessment completed by a consultant psychiatrist. It lacks detail as to any assessment of prior possible manic or hypomanic symptoms or any exploration of trauma sequelae — particularly significant given [Dr C's] later diagnoses of bipolarity and chronic post traumatic stress disorder. This information needs to have been captured. Typically the responsibility for this would sit with the assessing psychiatrist.

[RN F's] documentation following [Ms A's] initial assessment identifies the risk factor of 'hopelessness leading into suicidal thinking'. It doesn't capture other risk factors for suicide such as her prior self harm, her past history of attempts at suicide or the recent suicides within her social circle (instead describes as 'death of 2 close friends').

Many DHBs utilise specific risk assessment forms or have sections within other forms that encourage the documentation of static and dynamic risk factors, ideally ending with a formulation of risks and a plan to moderate this risk. I'm unsure whether [the DHB] utilises such a system of documentation. If they do, it doesn't appear to have been completed for [Ms A]. Good risk assessment doesn't require completing yet more forms, but in their absence this information needs to be captured elsewhere which hasn't occurred for [Ms A].

This lack of documentation with regard to risk is a significant departure from the expected standard of care and would be viewed as such by my peers.

The clinical documentation you have provided me with includes the MHAIDS Comprehensive Plan and the MHAIDS Wellness Plan, both uncompleted. Often such forms are completed by case managers. Such forms typically require a relationship with and good knowledge of a client. [Ms E] had been working with [Ms A] for less than a month at the time of her death, as such I am not critical that these forms were not yet completed.

**3. The appropriateness of any treatment plans put in place**

[Ms A's] treatment plan included frequent doctor review with contact between these appointments by other CRS and CMHT clinicians. She had the contact details for CRS including their 0800 phone number so as to be in contact as needed and later she was encouraged to be in contact with her case manager and/or CMHT if needed. Her

treatment plan included trials of medication to assist in improving her mood and anxiety. There was support provided with regard to her employment situation. I see in her notes clinicians offering a number of psychological interventions also, for example: the CMHT duty clinician [RN H] described teaching grounding techniques to manage acute distress, her allocated case manager [Ms E] offered one on one work (presumably distress tolerance skills) prior to her starting with the [PDS] skills group (again I presume teaching skills to manage distress). Her case manager also provided information about CBT (cognitive behavioural therapy) and the capacity to change behaviour and negative thinking. Self soothing, gentle exercise, social connection and distraction were also encouraged.

This appears to be a very appropriate treatment plan for a woman presenting with depression complicated by complex post traumatic stress disorder (cPTSD) or borderline personality disorder (BPD) or traits. As discussed below, cPTSD or BPD are not stated diagnosis, rather inferred from the treatment plan. Referral to [PDS] makes little sense if [Ms A] didn't have a personality disorder. [Dr C's] report to the HDC references PTSD (not cPTSD), in which case referral for one on one psychology work, comprising for example EMDR (eye movement desensitisation and reprocessing) would have been more appropriate.

Two additional aspects to [Ms A's] care that don't appear to have been attended to (though of course it may have been offered and declined but not documented) are liaison with her family and assessment and/or treatment with regard to her cannabis use.

**4. The appropriateness of the psychiatric care provided to [Ms A] by [Dr C] from 19 [Month1] to 3 [Month4]; including but not limited to the appropriateness of [Dr C's] prescribing**

As discussed below, my concerns with regard to the psychiatric care provided by [Dr C] to [Ms A] fall within the 4 broad categories of documentation, risk assessment, diagnosis and medication treatment.

<u>Documentation</u>

Reviewing [Dr C's] care provided to [Ms A] is complicated by the very limited clinical notes he is has written. You confirmed via email that I have a complete set of clinical documentation of [Ms A's] episode of care with [the DHB]. These notes show [Dr C] to have assessed or reviewed [Ms A] on six occasions. I commend [Dr C] and [the DHB] for the frequency of doctor reviews. But I have significant concerns about the paucity of clinical documentation provided by [Dr C]. From [the DHB's] Serious Adverse Events Review I understand that the MHAIDS Comprehensive Assessment Form was completed by a CRS nurse, not by [Dr C]. Subsequent reviews by [Dr C] have been documented by a brief note only, albeit slightly longer on the final assessment of 29 [Month3]. This makes it difficult to understand his rationale for his diagnoses and subsequent treatment plans. I note that none of his notes include any documentation of a mental state examination and on only two occasions has he recorded any assessment as to her

risk of suicide, on 18 [Month2] and 29 [Month3] he noted the presence of 'suicidal ideas', but with no broader risk formulation.

I think this a mild to moderate departure from the expected standard of care. It might be that peers working in an especially busy crisis or community team were more sympathetic to the time pressures that may have impacted his capacity to complete his clinical notes.

Risk Assessment

It is difficult for me to say whether [Dr C's] risk assessment was insufficient, or that his documentation of it was very poor, ie: he may have undertaken an appropriate risk assessment but then failed to document it. [Dr C's] letter to the Health and Disability Commissioner (HDC) does however suggest there were significant aspects to [Ms A's] presentation and history that he failed to appreciate, in particular with regard to risk.

In discussing 'whether any attempt was made to carry out a full risk assessment of [Ms A] and her suicidal ideation' [Dr C] has written about a number of risk factors for suicide and that they were not relevant to [Ms A]. Unfortunately it appears he underestimated the presence of a number of risk factors, which suggests inadequate assessment (as opposed to '*just*' inadequate documentation).

[Dr C] (in his letter to the HDC) said that [Ms A] had no past history of attempts at suicide. In contrast to this her GP reported to the Coroner a hospital admission in 2010 following [self harm] and in 2013 to the Intensive Care Unit following [self harm], experiencing thoughts of suicide at this time. As [Dr C] himself wrote with regard to suicide, 'the strongest predictor of future behaviour is past behaviour'. It is of course possible that [Dr C] asked [Ms A] about past attempts at suicide and she incorrectly reassured him that this wasn't the case. Without documentation of their discussion this is unknown.

[Dr C's] letter to the HDC said [Ms A] had no family history of suicide and spoke of the significance of this in terms of genetic vulnerability, learned behaviour and grief; again he wrote that this wasn't an issue for [Ms A]. However he failed to note that several friends had died recently, which is a risk factor, particularly given the GP report to the Coroner says the partner of a friend had recently died by suicide. The GP notes also mention suicide of a friend (GP notes [2018]) which may represent a further suicide in [Ms A's] social circle, or may speak of the same person. Additional GP notes ([2017]) note that … gives rise to the possibility another friend was also lost to suicide. These losses likely increased [Ms A's] risk (including via learned behaviour and grief) but appear not to have been considered.

In his letter to HDC [Dr C] wrote about the role of 'hopelessness' in increasing the risk of suicide, again his impression was that this was not an issue for [Ms A]. He described her as future focussed, having started a new relationship and being engaged in processes around her return to work. It seems likely that this was an overly optimistic assessment of the situation. I see in the Comprehensive Assessment form (completed

by CRS nurse following [Ms A's] initial assessment with [Dr C] on 26 [Month1]) that [Ms A] is described as 'having thoughts of hopelessness with situation'. Her mental state examination is recorded as showing 'low self esteem and hopelessness', her insight and judgement both assessed as being 'impaired'. The same form describes that 'suicide remains a risk if her condition is not treated properly' (which it then wasn't, given [Ms A's] intolerance of medication and tendency to disengage when distressed). [RN F's] letter to the GP of the same date described 'increasing sense of hopelessness'.

Notes on 27 [Month2] by [RN H] of CMHT record that 'thoughts of suicide have increased in intensity'. On 23 [Month3] case manager [Ms E] recorded that [Ms A] told her that 'everything is bad at the moment'. At [Ms A's] final review she told [Dr C] that despite having had depression for most of her life she now felt worse than ever (she attributed this to the medication she was on). This doesn't seem a context in which [Dr C] should have felt reassured that [Ms A] was not feeling hopeless.

With regard to the possible protective effect cited by [Dr C] in terms of her relationship, it should be noted that her new partner lived in … (ie: at some significant geographical distance from her) and that prior to her death (clinical notes 01 [Month4]) she disclosed to her case manager [Ms E] that she was 'having some trouble with her partner … which is increasing her feelings of worthlessness and bringing back past negative feelings from relationships'. I see her interactions with her employer [were] more likely a stressor for her than a protective factor.

The other area in which [Dr C] appears to have been factually incorrect in his letter to the HDC with regard to [Ms A] and her risk of suicide is with regard to her substance use. [Dr C] stated that 'substance abuse is both a dynamic and static risk factor. This did not apply to [Ms A]'. In contrast to this, the Intake Form (completed by [DHB] Mental Health services on 22 [Month1] following the referral by her GP prior to her face to face assessment with [Dr C]) noted 'long term use of THC' (cannabis). Her GP's report to the Coroner likewise describes cannabis use, '[Ms A] used daily cannabis to help her mood and wellbeing'.

Because [Dr C] has documented so sparsely it is difficult to know what understanding he had of the social supports around [Ms A]. The review of her clinical notes suggest differing impressions as to her degree of support and the closeness of relationships. In considering her risk of suicide it would have been important to reconcile these divergent impressions. I see variably written in the [DHB] notes, 'no relationship with dad and a poor relationship with mum' versus 'close to mother and siblings' versus 'has contact with her mother and her little brother intermittently'. I see that the family were described as being under stress 'family stress …' and that [Ms A] hadn't wanted to disclose her current distress to her mother as 'she is leaving … this week so … she knows she can't help her'. Likewise [Ms A] is described as both 'she lives alone' and 'she lives in a supportive flat with flatmates'.

I perceive [Dr C's] lack of documented risk assessment and his apparent errors of understanding with regard to [Ms A's] risk factors for suicide as a significant departure

from accepted care, particularly given his role as a crisis doctor. I believe it would be viewed similarly by our peers.

If it was that [Dr C] had indeed asked [Ms A] about issues such as her substance use and prior history of deliberate self harm and attempts at suicide and she had falsely reassured him I would be less critical; I would however still think his documentation inadequate and think it naïve of him to conclude '[Ms A] had not reached a stage of hopelessness'.

Medication Prescribing

[Dr C's] prescribing for [Ms A] was characterised by frequent changes and additions to her medication regime, including at higher than usual initial doses. None of his individual prescribing decisions were highly egregious (with the possible exception of a script for a month's worth of [Medication A]) but in combination have contributed to my sense that his care of [Ms A] was a departure from the accepted standard. As noted previously [Dr C's] lack of clear documentation makes it harder to understand his treatment decisions and the rationale for these.

[Ms A] had commenced mirtazapine (antidepressant) via her GP prior to referral to [the DHB]. The treatment plan following her first consultation with [Dr C] was to increase her mirtazapine and to commence lamotrogine. I have no criticism of his decision to increase the mirtazapine.

Lamotrogine is a mood stabilising medication with efficacy in bipolar but not unipolar depression. It is also utilised off-licence for affective instability such as that experienced as a symptom of Borderline Personality Disorder. In [Dr C's] later clinical notes he describes that her 'depression is suggestive of a bipolar 2 component' (though as discussed below he doesn't expand on how he has reached this impression). As such, the use of lamotrogine may be have been indicated for [Ms A].

[Dr C] titrated [Ms A's] prescription of lamotrogine at twice the recommended rate. Lamotrogine is associated with adverse drug reaction rashes, these are typically mild and self limiting but there is the risk of the potentially life threatening Stevens-Johnson Syndrome (a rare but serious disorder of the skin and mucous membranes). Because of the risk of Stevens-Johnson Syndrome, there are specific guidelines (for example, in New Zealand the Medsafe prescribing information) about initiating Lamotrogine so as to minimise this risk. In the appendix to [the DHB] response to the HDC, [the DHB's] clinical pharmacist likewise noted [Dr C] initiated lamotrogine at twice the usual titration rate. There may have been clinical indications to do so, for example [Dr C] may have felt the risk the depression posed to [Ms A] outweighed the increased risk of Stevens-Johnson Syndrome, however he hasn't provided this as a rationale for doing so or any indication that he discussed this increased risk with [Ms A].

Moclobemide (another antidepressant) was later added but shortly after discontinued as [Ms A] reported vomiting. There is no discussion in the notes about possible considerations as to other reasons she was vomiting. Nausea and/or vomiting are

possible with starting moclobemide but as [the DHB] pharmacist has noted the lamotrogine may have been a more likely explanation. Equally I wonder if her anxiety or her daily cannabis use might have been to blame. Her GP notes list her medical history as including 'irritable bowel syndrome — stress related nausea and vomiting'.

[Ms A] was then prescribed [Medication A], starting at 50mg with a plan to increase to 75mg after a week. This was then stopped less than a week later as Ms A was again reporting vomiting. Nausea and vomiting are recognised as possible adverse drug reactions to [Medication A], but as with the moclobemide I wonder if there were other more likely explanations for her vomiting (particularly given she was already reporting vomiting prior to starting [Medication A]). The recommended starting dose for [Medication A] is 25mg at night, rather than the 50mg [Dr C] started Ms A on. As with the lamotrogine, he may have felt there was an urgency in her treatment, but given he had clearly established she perceived herself to be very vulnerable to medication adverse effects, a slow titration was indicated.

I also have concern about [Dr C's] prescription of [Medication A] in that his script allowed for a whole month of medication to be dispensed at once. […] psychiatrists would typically be very cautious about prescribing medication …; weekly or fortnightly dispensing would have been a safer option.

[Medication A] was then changed to escitalopram (a more modern antidepressant of the selective serotonin reuptake inhibitor (SSRI) family of drugs) starting at 10mg, increasing to 20mg after a week.

I am also critical of [Dr C's] decision to commence escitalopram at 10mg. In his brief clinical note of 03 [Month3] (the day he prescribed the escitalopram) [Dr C] wrote '[Ms A] is depressed but very sensitive to antidepressant medication'. Previously (18 [Month2]) he had noted that [Ms A] 'said that she could not tolerate escitalopram and venlafaxine'. I am not critical of a retrial of the escitalopram, but am critical that knowing she was sensitive to adverse effects that he started her at a full dose. Reading [Dr C's] letter to the HDC I suspect he has misunderstood the dosing of escitalopram. In paragraph 25 he has written that 'escitalopram can be started at 20mg or 10mg'. As described above escitalopram is a selective serotonin reuptake inhibitor (SSRI), it is in a family of medications that includes other SSRIs such as citalopram, fluoxetine and paroxetine. Escitalopram however has twice the potency of citalopram, fluoxetine and paroxetine, such that whilst citalopram has a dose range of 20–40mg, with a usual starting dose of 10mg, escitalopram is prescribed with a dose range of 10–20mg and has a usual starting dose of 5mg, or as [the DHB] pharmacist has already suggested, in particularly sensitive people, a starting dose of 2.5mg. Starting at a low dose further delays the time to effective treatment but typically makes difficult to tolerate medication significantly more tolerable.

Antidepressant medication typically takes several weeks before the patient experiences benefit. The recurrent changes in medication for [Ms A] repeatedly delayed the time it would take for medication to be effective. More conservative initial prescribing and

more consideration as to alternate explanations for her reported adverse effects may have meant she was more able to tolerate and hence more willing to continue with medication, and therefore would sooner have experienced benefit.

When [Ms A] met with [Dr C] for the final time on 29 [Month3] she informed him of her intention to discontinue medication. Appropriately [Dr C] advised that if she were to do this she should withdraw her medication slowly but unfortunately he hasn't provided more specific instruction about how to do this; or maybe he did verbally but has failed to document it.

At his final review [Dr C] also provided [Ms A] with a script for diazepam, to be used if needed for 'extreme stress'. Diazepam is a benzodiazepine. Benzodiazepines are short acting medication with a role in reducing anxiety and distress and assisting with sleep. They tend to be useful as a short term intervention but risk tolerance and dependence in the longer term. Typically the short term occasional use of a benzodiazepine for high distress is an intervention my peers and I would endorse, however my concern about the prescription of diazepam for [Ms A] is that for her it may have increased her thoughts of suicide. I say this because the GP referral sent to [the DHB] describes that following prior use of clonazepam (clonazepam being another benzodiazepine) [Ms A] reported 'day after felt worse with dark thoughts, suicidal ideation'. It seems likely that [Dr C] had not read this referral (given the Comprehensive Assessment documentation and GP letter say that she self referred rather than that she was referred by her GP).

Whilst [Dr C's] individual prescribing decisions may have each only been a mild departure from the accepted standard of care, considered in totality I perceive [Dr C's] prescribing to be a moderate departure from the accepted standard of care. I believe it would be viewed similarly critically by our peers.

<u>Diagnosis</u>

[Dr C] has failed to reach an expected standard of care in that he has not documented his findings from the history or examination of [Ms A] in support of his diagnoses. It is difficult to extrapolate from this whether he did or did not undertake the necessary assessment (he may have undertaken the assessment but then not documented his findings).

The impression documented by the CRS nurse following [Dr C's] initial assessment is of 'Major Depression and Anxiety'. Following his review on 04 [Month2] [Dr C] writes 'her depression is suggestive of a bipolar 2 component'. Following his final review on 29 [Month3] [Dr C] wrote 'her depression has a bipolar component but she also has PTSD from all the sexual abuse that she has experienced'.

There is sufficient symptomatology described in the Comprehensive Assessment and GP letter following [Dr C's] initial assessment on 26 [Month1] (as completed by CRS RN) to support the diagnosis of a Major Depressive Episode.

There is however insufficient history or examination detail provided in any assessment to justify a diagnosis of a Bipolar Affective Disorder (BPAD) — this is not to say that [Ms A] could not have had this diagnosis, rather that given the lack of documentation, I am unsure as to its validity. The only comment I can find in support of this diagnosis is in the Comprehensive Assessment it is written that [Ms A] has 'experienced times when she has felt very good and would work 15 hours straight and still be unable to sleep'. This might indicate periods of pathological mood elevation but equally might reflect a young person working in [a creative] industry. Further exploration and documentation is needed to clarify her symptoms. Also, given [Dr C] has recommended DBT (Dialectical Behavioural Therapy) which is a treatment for Borderline Personality Disorder (BPD), which typically presents with affective instability (ie: rapidly changing mood states) assessment was indicated to clarify whether any mood variability was better understood within a diagnosis of BPD rather than BPAD.

PTSD (Post Traumatic Stress Disorder) arises from past trauma and is characterised by persistent re-experiencing of the trauma (intrusive memories, flashbacks, nightmares etc), avoidance of reminders of the trauma, changes to cognition and mood and alterations to arousal (irritability or aggression, hypervigilance, poor sleep, heightened startle etc). Clearly [Ms A] has a significant past history of trauma … I also see in her GP notes she was previously in an abusive romantic relationship. However, as with the diagnosis of Bipolarity, [Dr C] has failed to document the presence or absence of symptoms to clarify this diagnosis. This is particularly relevant given the initial GP referral requests diagnostic clarification with regard to 'if PTSD part of her current situation' (sic).

[Dr C] recommended that [Ms A] engage in DBT (Dialectical Behavioural Therapy) for her PTSD via the [PDS]. This is in the absence of him having made a diagnosis of a personality disorder. DBT is not typically a recommended treatment for PTSD.

I wonder therefore if [Dr C's] diagnosis would more appropriately have been complex PTSD — though really this is speculative, trying to make sense of the treatment plan in the absence of sufficient assessment documentation with regard to history and examination.

Complex PTSD (cPTSD) is a relatively recent concept, it is recognised as a disorder within the ICD-11 classification system but not the DSM. cPTSD has significant overlap with the DSM diagnosis of Borderline Personality Disorder in both etiology and presentation. BPD and cPTSD can co-occur. Anecdotally I am aware of some clinicians who see cPTSD as a 'rebranding' of BPD given historically BPD has been a diagnosis of some stigma. PTSD is generally related to a single traumatic experience (for example, car crash, earthquake, sexual assault) whilst cPTSD follows prolonged trauma (such as childhood abuse or neglect, ongoing intimate partner violence, prolonged war trauma). cPTSD is more likely to result in emotional dysregulation, negative sense of self and difficulties in relationships. cPTSD might therefore encompass [Ms A's] difficulties. Given its overlap with Borderline Personality Disorder this might then explain the referral to the Personality Disorder Service, but this is increasingly speculative on my part.

I perceive [Dr C's] lack of diagnostic clarification to be an at least moderate departure from the expected standard of care, particularly given that he met with [Ms A] not only for an initial assessment, but then saw her on five further occasions. I expect it would be viewed similarly by my peers. If it were that [Dr C] undertook a comprehensive assessment that clearly elucidated symptoms that fitted the diagnostic criteria for BPAD and PTSD but then didn't document his findings, I would reduce this to being a mild departure.

**5. The appropriateness of the care provided to [Ms A] by other relevant individuals at [the DHB] from 19 [Month1] to 3 [Month4]**

The HDC Guidelines for Independent Advisors remind advisors that they should give advice only on matters within their area of expertise. As such it is largely beyond my scope to discuss the care provided by crisis nurses and CMHT case managers. Reviewing the clinical notes provided I have no specific concerns about the care provided by any individual, though as described in question one, there were occasional gaps in enacting the treatment plan (for example, in terms of follow up phone calls as planned).

**6. The adequacy of the attached relevant policies and procedures in place at [the DHB] at the time of these events**

I am mindful of both not overstepping my areas of expertise, and of the expectation on the hours spent preparing this report, as such my review of the various policies you sent me has been cursory. I have no specific concerns about inadequacy in these policies.

**7. The adequacy of the changes made at [the DHB] since these events**

Given my greatest concern is with regard to the care provided to [Ms A] by [Dr C] and I understand he is no longer employed by [the DHB] this is a significant change and likely is of itself adequate.

I see from [the DHB's] letter to you of 30/10/19 that [the DHB] [has] increased the frequency of their multidisciplinary meetings within the CMHT which may be relevant here. Also of significance, there is now a designated clinician on the Crisis Resolution Service tasked with case management, hopefully this would prevent issues with missed phone calls and doctor reviews that were offered to the client but not booked with the psychiatrist.

**8. Any other matters that you consider amount to a departure from accepted standard of care**

There are no other matters that I consider a departure from accepted standard of care.

**9. Whether any departures from accepted standards you have identified represent system failings with [the DHB], or if they can be attributed to individual staff**

Without knowing more about the systems in place at [the DHB] it is difficult to know if gaps in [Ms A's] care are better explained by individual error or system failings; for example, it seems likely it was human error that meant phone calls to [Ms A] were

forgotten and that [Dr C] was not aware of an appointment that had been made, however it may be that better systems would prevent such oversights. [RN H's] progress note on 11 [Month2] described [Dr C] as being employed on a short term contract. As such it might be that [Dr C] was unfamiliar with processes at [the DHB] that impacted on how his treatment recommendations were communicated and enacted.

From the documentation provided I'm unsure about whether there are systems in place at [the DHB] to prompt a more complete risk assessment and ensure more sophisticated consideration of risk. Risk assessment is however a core clinical skill that should be achievable without a specific clinical form to complete.

The Serious Adverse Event Review completed by [the DHB] has an analysis of the various factors that may have contributed to [Ms A's] death. They identify possible team factors that you may want to consider.

My concerns about [Dr C's] diagnostic process, his medication prescribing, his lack of clinical documentation and his insufficient risk assessment are individual failings not systems errors."

**Further advice**

"**Re: HDC Complaint 19HDC01547**

Following my report to you of July 2020 you approached both [the DHB] and [Dr C] for further comment and in light of their responses have asked that I provide further opinion on the care provided to [Ms A] between [Month1] and [Month4]. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I am not aware of any personal or professional conflicts in providing this report. I understand that my role as an expert is to provide this advice to you independently. I will ensure I keep within my area of expertise.

**Expert Advice Requested**
You ask that I review the documentation provided and advise on:

[The DHB]

1. Whether the further response and information provided by [the DHB] changes your previous advice and if so, why
2. Any other matters in this case that you consider warrant comment

[Dr C]

1. Whether the further response and information provided by [Dr C] changes your previous advice and if so, why. In particular please consider:
   a. Adequacy of documentation
   b. Adequacy of risk assessment
   c. Medication Prescribing

d. Diagnosis

2. Any other matters in this case that you consider warrant comment

**Documentation Provided**

1. [The DHB's] response dated 12 October 2020 and the MHAIDS Internal Transfer of Care procedure
2. [Dr C's] response dated 11 September 2020

**Opinion**

Having reviewed the additional information provided I remain concerned about the care provided to [Ms A]. This is primarily with regard to the care provided by [Dr C] rather than systems issues within [the DHB].

**1. Whether the further response and information provided by [the DHB] changes your previous advice and if so, why. Any other matters in this case that you consider warrant comment.**

The further information provided from [the DHB] does not substantively change my earlier opinion. The Internal Transfer of Care procedure appears to be a useful process.

**2. Whether the further response and information provided by [Dr C] changes your previous advice and if so, why.**

I remain concerned about the care provided to [Ms A] by [Dr C]. The dilemma for me in responding to the additional information he has provided is in how strongly to weigh his now recollection (some 18 months later) of details of his assessment and interactions with [Ms A] in 2018 when they were absent from his documented clinical notes at the time. I worry that he is over sure in recalling what he says he specifically discussed with [Ms A] and I note some discrepancies between his letters to the HDC in June and September of this year.

**a. Adequacy of documentation**

[Dr C] himself concedes that his 'note taking could have been more comprehensive' and that his documentation is not an adequate reflection of his assessment and liaison in his care of [Ms A]. I am sympathetic to the challenges of managing adequate documentation in the context of a busy work environment however my previous advice is unchanged.

**b. Adequacy of risk assessment**

[Dr C's] September letter to the HDC does not significantly change my earlier impression of deficits in his risk assessment. He says that he did indeed ask the necessary questions of [Ms A] but was 'falsely assured by her'. Without the necessary documentation at the time it is difficult to know the veracity of that. I am suspicious that he may be over confident of his memory, myself I would struggle to remember specific questions I asked at a consultation a year and a half ago. What [Dr C] has written in his September letter to the HDC infers an expectation [Ms A] would have disclosed relevant information to him, which adds to me wondering how much he specifically did ask. This would not

meet the expectation of a reasonable standard of care or the accepted practice for a consultant psychiatrist.

[Dr C] wrote in his September letter to the HDC that 'it does appear … that I was not made aware through my discussions with [Ms A] of certain things', including that he wasn't aware that she had made two past attempts at suicide. He says this 'was based on what she had told me on a number of occasions'. It is unclear from this statement whether he specifically asked her, though later he says that he did. It is usual practice/expected standard of care that psychiatrists explicitly ask about a history of suicidality and deliberate self harm, especially in patients presenting with depression. I remain suspicious that this wasn't specifically asked about.

Despite [Dr C's] September 2020 assertion as to his understanding of [Ms A's] employment and relationship issues, I am unsure whether indeed he did understand the nuances. They remain unclear to me, with clinical notes contradictory and [Dr C] himself describing things quite differently in his September 2020 letter to the HDC compared to his June 2020 letter to the HDC. These issues are important in that they describe the context in which a client lives and speaks to their stressors (likely to increase risk) and their support (likely to reduce risk).

In his September letter to the HDC [Dr C] continues to describe [Ms A's] relationship with her partner in … as having been 'positive'. I remain concerned that the clinical notes indicate the opposite, for example, from [Ms E's] clinical entry of 01 [Month4], 'she stated she is having some trouble with her partner which is increasing her feelings of worthlessness and is bringing back negative feelings from relationships'.

In his June letter to the HDC [Dr C] wrote that her employment was difficult, 'she experienced bullying in the workplace and she felt over worked'. In his September letter he has formulated this much more positively, arguing that her employment protected against suicide because 'she loved her work'.

The clinical notes are contradictory with regard to the role of family and [Dr C] himself says that he 'respected her feelings' in terms of reluctance to talk about her family suggesting he had failed to seek to clarify these issues.

In his June 2020 letter to the HDC [Dr C] wrote that [Ms A] had 'been exposed to several stressful events including loss of two of her close friends'. In his September letter to the HDC he wrote 'I was aware that [Ms A] had lost two friends to suicide … it did not affect her badly because they were not that close'.

The coroner's report provided by [Ms A's GP] records that '[Ms A] used cannabis daily'. Her cannabis use is also noted on the MHAIDS Intake form. I am unsure how to reconcile this with [Dr C's] ongoing assertion that 'substance use was not a significant risk factor', 'she never indicated to me that she used cannabis on a daily basis'. From this I might presume that he hadn't specifically questioned [Ms A] about substance use in his assessment however he says that he did. Usual standard of care for a psychiatrist includes assessment of substance use as it has implications in both diagnosis and

treatment. [Dr C] commented in his September letter that 'social use of cannabis is not linked to suicide'; daily use of cannabis would not typically be considered 'social use'.

Her use of cannabis is also significant in terms of understanding possible causes of vomiting. [Dr C] in his recent correspondence incorrectly stated 'cannabis does not cause nausea and vomiting'. He is correct that cannabis can have a short term role in treating nausea and vomiting (for example, the nausea and vomiting of chemotherapy), however there is a Cannabinoid Hyperemesis Syndrome, that whilst uncommon and frequently under recognised does manifest with nausea and vomiting in longer term, frequent cannabis users.

In explaining inaccuracies in his initial report to the HDC [Dr C] has explained that he did not have access to all the recorded information 'because once a suicide occurs information is taken out of the routine system'. You may want to clarify that with [the DHB] as that has not been my experience in the three DHBs I have worked in.

**c. Medication Prescribing**

[Dr C] writes in his September 2020 correspondence with the HDC about his usual prescribing of lamotrigine as being that he typically starts at 25mg every second day and then doubles the dose every fortnight. This would be more conservative than most psychiatrists prescribe (and most guidelines recommend), typically psychiatrists start lamotrigine at 25mg daily and increase to 50mg/day after a fortnight and to 100mg /day a fortnight later. [Dr C] says he increased the dose more quickly for [Ms A] due to the 'severity of her clinical condition', however even now I wonder if [Dr C] appreciates his prescribing was a quadrupling of what he says is his usual practice or twice what the guidelines stipulate. As previously I note that the [DHB] pharmacist has provided similar commentary and noted her concern.

[Dr C] writes in his September letter to the HDC that he understands the dosing of [Medication A] and escitalopram but chose to start at higher than recommended doses, though he concedes this rationale was not reflected in his notes. I fail to be reassured by this and see that he has written in his recent letter to the HDC that he chose to start escitalopram at 10mg (twice the usual starting dose, potentially four times the starting dose in someone known to be sensitive to medication adverse effects) because he understood [Ms A] to have previously experienced the least side effects with this group of medication. This is in contrast to the notes he himself documented in her clinical file on 18 [Month2], 'she also said that she could not tolerate escitalopram and venlafaxine'. I wonder if in his prescription of 10mg escitalopram in the morning for a week before increasing to 20mg each morning he mistook escitalopram for the similarly named citalopram (for which that would be usual prescribing).

[Dr C] agrees with my concern [about] a month's supply of [Medication A] […] and has resolved to be more conscious with dispensing in the future.

[Dr C] defends his prescription of diazepam (a benzodiazepine medication) saying he was not aware of her prior suicide attempts. The information that previously the use of

a benzodiazepine exacerbated her risk was available on the GP referral, with it documented there that clonazepam (an alternate benzodiazepine) resulted in 'day after felt worse with dark thoughts, suicidal ideation'. The onus was on [Dr C] to have read the GP referral.

**d. Diagnosis**

If indeed [Dr C] did explicitly elicit the signs and symptoms of PSTD and BPAD as he has described in his letter to you in September 2020 then I have no argument with his diagnoses. Given his lack of documentation at the time I have no way to validate or otherwise his assertion that he 'undertook a comprehensive assessment that clearly elucidated signs and symptoms that fitted the DSM 5 criteria for PTSD and BPAD 2'. As with his now report of his risk assessment I am surprised at his capacity to recall in detail these signs and symptoms some 18 months later. [Dr C] now writes with confidence of the diagnosis of BPAD type 2, this seems more emphatic than his description in the clinical notes of the time with him then writing 'her depression is suggestive of a bipolar 2 component' (04 [Month2]).

In [Dr C's] letter to you in September 2020 he says that when he wrote in his initial report to the HDC (June 2020) he wrote DBT (dialectical behaviour therapy) in error, 'I noted that [Ms A] was to have DBT when in fact I meant CBT … I thought one thing and wrote something else'. This is a potentially understandable error had he written it only the once, however it is not a one off error in his report to the HDC, rather it is documented throughout [Ms A's] clinical notes by him and others that the intention was for DBT. A referral for DBT skills work is noted in the clinical notes to have been made to the [PDS]. It is very unlikely that CBT for PTSD would be provided by the [PDS]. DBT skills work with the [PDS] infers consideration of a diagnosis of personality disorder or traits (or as previously discussed, my wondering about cPTSD).

**e. Any other matters in this case that you consider warrant comment**

I don't doubt that [Dr C] is as he describes, a hardworking and committed psychiatrist. I'm not sure of the relevance of the reference of a prior employer, provided in another context (maybe with regard to securing further employment in 2015) in reviewing the care he provided to [Ms A] in 2018. …

In his recent response to the HDC, [Dr C] has again emphasised (he also noted this in his earlier report) that he provided [Ms A] with his phone number. From his comment she should 'call me if she needed anything, at any time' I presume he provided her with his personal phone number. This is not usual practice in New Zealand public mental health teams. I worry that the 'extra layer of protection' that [Dr C] perceived this to provide was reliant on his belief that he and [Ms A] shared a close and disclosing therapeutic relationship (which might not have been the case given he reports she didn't disclose to him either her prior attempts at suicide or her cannabis use) and is at odds with usual recommendations about processes to contact treating teams (in [Ms A's] case her CMHT) in hours, and urgent services out of hours. For example the consistent message in my current role is that if clients need urgent support and are unable to reach their case manager they speak with the team 'duty clinician' and all after hours concerns are

directed to 'Intake' (our version of a 'crisis team'). The value in this approach is that there are clinicians specifically employed and available to assist 24/7 whereas I wonder as to [Dr C's] genuine availability overnight and in the weekend, and even if he was available, whether it is appropriate for his clients to be contacting him at these times.

**Conclusion**

I hope this additional information has been of assistance. In summary I remain concerned about the care provided to [Ms A] by [Dr C]. His documentation was poor of which I am critical. This lack of documentation then complicates my evaluation of his risk assessment and diagnostic process. In his letter to the HDC from September 2020 [Dr C] writes that he recalls precisely the signs and symptoms to fit with DSM 5 criteria for PTSD and BPAD type 2. If this is the case, I cannot fault his diagnosis though I wonder at his capacity to recall in detail some 18 months later. [Dr C] says that in terms of risk assessment he was 'falsely assured' by [Ms A], again it is not possible for me to know whether this was indeed the case, or whether he failed to ask the necessary questions to understand her risk to herself. [Dr C's] letter to the HDC from September doesn't reduce my concern about his pattern of prescribing, and I wonder if he continues to misunderstand the concerns raised with regard to his prescribing of lamotrigine and escitalopram."

**Further advice**

"In point 1, where you say this is not a significant departure, would you say it was a mild or moderate departure:

'These gaps *(in enacting treatment plans)* in [Ms A's] care were unfortunate. One could speculate that they may have contributed to [Ms A] losing faith in the treatment she was receiving but I'm not convinced they represent a significant departure from accepted practice. (page 4)'

ie: not ideal care but not reaching threshold for 'departure of care'.

Regarding:

2. In point 2, 'the adequacy of the assessments undertaken', can I clarify if the significant departure relates to [Dr C]:

'This lack of documentation with regard to risk is a significant departure from the expected standard of care and would be viewed as such by my peers. (page 5)'

If it relates to [Dr C], is this the same as the significant departure identified on page 8–9 (under point 4, risk assessment) or an additional significant departure.

As I wrote at the beginning to point 2 (adequacy of assessments undertaken) '*Without knowing more about the systems and expectations of roles at [the DHB] it is difficult to clarify with whom the responsibility for this (risk assessment) primarily sits'.*

That remains the case. I am certainly very critical of [Dr C's] lack of documented risk assessment, it may be that others within the team also had a role in risk assessment, it is difficult for me to say without knowing more about the structure and culture of the services in [the DHB] (not something that can be gleaned from the notes). In my current team risk formulation is shared between clinicians with case managers and the multi disciplinary team as a whole often taking a leading role with this, in other teams it is very much more limited to the psychiatrist.

Kind regards,

Lindsay"

**Further advice**

"**Re: HDC Complaint 19HDC01547**

I have previously provided advice to the Commissioner with regard to this case, by written correspondence on 1 August 2020 (incorrectly dated 2018 on the letter I sent, my apologies) and 6 December 2020, and with further email clarification in response to additional questions on 7 December 2020.

I remain unaware of any personal or professional conflict in this case, though I do note that … (who has provided a letter of support for [Dr C]) is a colleague of mine at …

**Expert Advice Requested**
You have asked that I review additional documents and advise on the following:

[The DHB]

1. Whether the response provided by [the DHB] to [Dr C's] comments and the statement from [Ms E] change your previous advice and if so, why.
2. Any other matters in this case you consider warrant comment.

[Dr C]

1. Whether the further response provided by [Dr C] changes your previous advice and if so why. In particular, where there are conflicting accounts please consider both scenarios and describe any departures in each scenario.
2. Any other matters in this case that you consider warrant comment.

**Additional Documentation Provided**
1. [The DHB's] response dated 18 December 2020
2. [Dr C's] response dated 18 January 2021 and 2 letters of support
3. Statement from [Ms E] dated 21 January 2021

**Opinion**

The additional information provided has not changed my opinion from my earlier correspondence in any significant way. Previously I had identified my concerns were primarily with regard to the care provided to [Ms A] by [Dr C], and that these concerns fell within the headings of documentation, risk assessment, medication prescribing and diagnosis. As such I will speak to those points in this letter, including a discussion of alternate scenarios.

**1. Whether the response provided by [the DHB] to [Dr C's] comments and the statement from [Ms E] change your previous advice and if so, why. Any other matters in this case you consider warrant comment.**

This additional correspondence doesn't change my earlier advice. I see that both [the DHB] and [Ms E] describe that [Ms A] was to receive DBT, not CBT. I discussed in my initial advice to you of August 2020 that DBT is not a recognised treatment for BPAD or PTSD (which were [Dr C's] diagnoses for [Ms A]). His subsequent correspondence to the Commissioner has been that it was a typographical error and that [Ms A] was to receive CBT. This doesn't appear to be the case. Likewise [the DHB's] letter confirms that [Dr C] was incorrect in stating that [Ms A's] clinical notes were inaccessible after she died (his explanation for the inaccuracies in his initial letter to the Commissioner).

**2. Whether the further response provided by [Dr C] changes your previous advice and if so why. In particular, where there are conflicting accounts please consider both scenarios and describe any departures in each scenario. Any other matters in this case that you consider warrant comment.**

[Dr C's] further correspondence changes little with regard to my earlier opinion.

**a. Documentation**

[Dr C] has himself conceded that his documentation was inadequate. The New Zealand Medical Council provides a description of the accepted standard of care with regard to documentation for all doctors, including psychiatrists in New Zealand.

(https://www.mcnz.org.nz/assets/standards/85fa1bd706/Good-Medical-Practice.pdf)
Their guidelines are that:

'You must keep clear and accurate patient records that report relevant clinical information, options discussed, decisions made and the reasons for them, information given to patients, the proposed management plan and any medication or other treatments provided. Make these records at the same time as the events you are recording or as soon as possible afterwards.'

[Dr C] has clearly not met this standard. I have previously described this as a mild to moderate departure. With regard to his lack of documentation about risk assessment, if it is that [Dr C] did undertake a thorough risk assessment, but then failed to document it, this aspect of documentation is an at-least moderate departure from expected standard of care.

The peers I have discussed this with (in a de-identified manner) concur with this opinion.

**b. Risk Assessment**

I have previously noted that it is difficult to know at this point whether [Dr C's] risk assessment was insufficient, or 'just' that his documentation of it was very poor. My initial impression, given the inaccuracies in [Dr C's] original report to the Commissioner was that it was more likely he hadn't undertaken a sufficient assessment.

[Dr C] has been adamant that he did indeed undertake a robust risk assessment (letter to Commissioner of 11 September 2020 and 18 January 2021) and he says he was falsely reassured by [Ms A] with regard to various risk factors. [Dr C] is correct to say that I have had additional information available to me in the form of GP notes and a GP letter to the Coroner, however issues such as her cannabis use, feelings of hopelessness and desperation, suicidal ideation (denoted by acronym SI) and history of self harm, including … were all documented on the MHAIDS Intake form which [Dr C] would have had easy access to and good care would require he had read prior to seeing her.

If it is that [Dr C] did undertake a comprehensive risk assessment, he says utilising a structured approach which included questions about past attempts at suicide, family history of mental illness, suicidal ideation, hopelessness, mental illness, substance use, personal tragedies etc, then he met the accepted standard of care. It may be that he did undertake such an assessment and was falsely reassured by [Ms A]. I have already described above that his failure to document such an assessment as being at least a moderate departure of care.

If alternately [Dr C] did not undertake a comprehensive risk assessment, in this case in a woman referred by her GP with depression and noted on triage by mental health services to be feeling hopeless and helpless, like life was not worth living and experiencing thoughts of suicide, and this being in the context of her having past attempts at suicide or self harm, this is a serious departure from the expected standard of care for a psychiatrist. Peers that I spoke with about this (de-identified, general information only) agreed this would be a serious departure from expected standard of care for a psychiatrist.

A third alternative is that [Dr C] undertook a partial risk assessment which failed to elicit the risk factors that are now evident. This would be a mild to moderate departure from the accepted standard of care depending on the extent to which he did or didn't ask the necessary questions. This doesn't explain the information that was available to him on the MHSAID Intake form that doesn't appear to have been considered.

**c. Medication Prescribing**

[Dr C's] letter to the Commissioner of January 2021 does not change my earlier advice with regard to his prescribing. At that time I described individual prescribing decisions as each only mild departures from the accepted standard of care, but in totality reached a moderate departure of care from the accepted standard.

**d. Diagnosis**

Diagnosis and formulation is fundamental to the role of the psychiatrist in that it provides an understanding of why a person is struggling and in what way and therefore informs treatment. It is a core skill of a psychiatrist. As previously described, the difficulty in providing an opinion about [Dr C's] diagnostic process with regard to [Ms A] is that he wrote inadequate clinical notes with regard to the presence of signs and symptoms in support of his diagnoses of BPAD and PTSD. He also failed to provide any evidence for why alternate diagnoses were not relevant for her.

If, as [Dr C] maintains (letter to Commissioner 11 September 2020) he undertook a 'comprehensive assessment that clearly elucidated signs and symptoms that fitted the DSM 5 criteria for PTSD and BPAD 2' he would have met the standard of care expected and there would be no departure of care, with his failure to document these findings in his clinical notes captured above in my opinion regarding his documentation.

If, [Dr C] didn't complete a comprehensive assessment with regard to signs and symptoms of disorder, this is a departure from usual practice/expected standard of care. How significant a departure this is depends on the degree to which his assessment was incomplete. Had he made no effort at confirming the presence or absence of symptoms in support of his impression this would be a severe departure; it is unlikely he would have made no effort. Some questioning about mood symptoms and trauma symptoms, but short of a comprehensive assessment would be a mild to moderate departure depending on the degree of gaps in the assessment.

**Summary**

I hope this additional advice has been of assistance. In summary, further correspondence from [the DHB] and [Dr C] hasn't substantively changed my earlier opinion. I note significant departures from accepted practice/usual standard of care in the areas of documentation and medication prescribing. Whether there were departures of care and the extent of these departures with regard to risk assessment and diagnosis depend on whether [Dr C] undertook the necessary assessments but failed to document his findings, completed partial assessments or didn't undertake the assessments at all."

## Appendix B: *Good Medical Practice*

The Medical Council of New Zealand's *Good Medical Practice* provides the following guidance on keeping records:

"Keeping records

5. You must keep clear and accurate patient records that report:

- relevant clinical information
- options discussed
- decisions made and the reasons for them
- information given to patients
- the proposed management plan
- any medication or other treatment prescribed."