

Psychiatrist, Dr C
Southern District Health Board

A Report by the
Mental Health Commissioner

(Case 13HDC00859)



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. At 4.02am on 24 Month1¹ 2012, Mr A self-presented at the Emergency Department (ED) in the public hospital concerned that he was having delusional thoughts due to the use of LSD² and/or ecstasy.³ On 1 Month2 Mr A also attended a medical centre (Medical Centre 1) wanting his ears checked to ensure there were no transmitters in his ears, and was later admitted to a mental health inpatient service. At that time Mr A reported that he could hear voices, which were telling him to kill himself. Mr A remained an inpatient until 3 Month3. When Mr A was discharged he was taking 10mg olanzapine (an antipsychotic medication) twice daily.
2. From Month3, Mr A was under the care of a mental health service of Southern District Health Board (the mental health service). Psychiatrist Dr C was Mr A's treating psychiatrist, and Psychiatric District Nurse (PDN) PDN E was his case manager. PDN D, was responsible for following up with Mr A when PDN E was on leave or unavailable.
3. Between Month3 and Month11, Mr A's care was discussed regularly at multidisciplinary team meetings, and he was seen regularly by the mental health service. During this period Mr A's olanzapine prescription was decreased progressively, partly because he had reported sedation and apathy as side effects of the drug. He had some improvement in his symptoms but continued to report auditory hallucinations intermittently.
4. Mr A's parents, Mr and Mrs B, made contact with the mental health service on a number of occasions expressing concern about their son's well-being, including his lack of motivation, personal hygiene, sleep patterns, and use of alcohol and drugs.
5. On 6 Month11, Dr C reviewed Mr A and noted that there was no evidence of the recurrence of psychotic phenomena. On 7 Month11, when on holiday with his father, Mr A self-presented at another DHB (DHB2). Mr A reported anxiety, auditory hallucinations including voices, poor sleep, and the belief that he had a microchip in his ear that had been planted by his parents. Mr A denied any thoughts of harming himself or others, and said that the voices were not telling him to do so.
6. The clinical record from this presentation records: "[Mr A] [a]cknowledges voices more noticeable since gradual reduction in olanzapine, however may not have informed treating team as feeling 'pressure' from them, family and friends to be well." Mr A was assessed, prescribed additional olanzapine (20mg twice daily), and advised to attend the mental health service as soon as possible. A copy of the records made at DHB2 was faxed to the mental health service. On 21 Month12, following Mr A's return from holiday, Dr C noted that Mr A had "gradually come off olanzapine" and that he had "no ongoing voices".

¹ Relevant months are referred to as Months 1-14 to protect privacy.

² Lysergic acid diethylamide, a psychedelic drug.

³ Also known as MDMA (3,4-methylenedioxyamphetamine), a psychoactive drug.

7. By Month14, there were significant signs that Mr A's mental condition may have been deteriorating. Furthermore, Mr A did not attend a number of scheduled appointments, and his parents made a number of telephone calls to the mental health service expressing concern for his well-being.
8. On 18 Month14, Mr and Mrs B telephoned the mental health service a number of times during the day. Dr C and PDN E visited Mr A at his mother's home. Dr C recorded that Mr A had consumed a large amount of alcohol over the weekend and could not recall what had happened but believed he had been beaten up. Dr C noted that there were no signs of psychosis and no evidence of any further drug use.
9. Dr C noted Mr A's recent weight loss but attributed it to the stopping of olanzapine. Dr C also commented in the notes that Mr A was experiencing poor sleep, but attributed this to alcohol fuelled disruption and day/night reversal.
10. On 19 Month14, Mr and Mrs B each separately rang the mental health service requesting a second opinion on Mr A's condition. Mrs B stated to PDN E that Mr A had told her that his injuries from the weekend were self-inflicted, and that she believed he was mentally disordered and needed hospital treatment. PDN E rang Mr A and asked him to attend an appointment with Dr C. Mr A denied any psychotic symptoms or wanting to harm himself. On 20 Month14, Mr A did not attend the scheduled appointment with Dr C.
11. On the morning of 21 Month14, Mrs B telephoned an emergency mental health service a number of times, expressing concern about Mr A and stating that she did not know Mr A's current whereabouts. Mr and Mrs B asked for Mr A to be hospitalised. Mrs B was advised to contact the Police if she was concerned about Mr A's safety, and the process for compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) was discussed. Mrs B completed an application form, pursuant to section 8 of the MHA.
12. That same day, Mr and Mrs B wrote a letter to the mental health service and said that the previous week, Mr A had tried to burn his bed, and he had found paint and poured it on the street. The letter also said that Mr A had told his parents that he had been "beaten up", but they discovered that his injuries were self-inflicted.
13. On the morning of 22 Month14, Mrs B presented at the mental health service distressed and insistent on being seen because Mr A had been missing since the previous day. Sadly, it transpired that Mr A had died.

Findings

Southern DHB

14. Mr A's relapse plan was developed without input from Mr A and his parents. The lack of a relapse plan that had been discussed with Mr A and his family (with his consent) amounted to suboptimal care by the DHB.
15. Mr A was not made sufficiently aware of the alternative treatments available following his presentation to another hospital. There were sufficient indications that

Mr A's behaviour was escalating, but the mental health service staff did not recognise the signals in that regard. Mr A's self-presentation at the mental health service, the family's escalating concerns and reports about Mr A's behaviour, should have led to consideration that he was relapsing.

16. Southern DHB failed to provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1)⁴ of the Code of Health and Disability Services Consumers' Rights (the Code).

Dr C

17. Mr A should have been made sufficiently aware of the alternative treatments available, following his presentation to DHB2 in Month11. Accordingly, Dr C failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Complaint and investigation

18. The Commissioner received a complaint from Mr and Mrs B about the services provided to their late son, Mr A, by Southern District Health Board. The following issues were identified for investigation:

- *Whether Southern District Health Board provided Mr A with services of an appropriate standard.*
- *Whether Dr C provided Mr A with services of an appropriate standard.*

19. The parties directly involved in the investigation were:

Mrs B	Complainant/consumer's mother
Mr B	Complainant/consumer's father
Dr C	Psychiatrist/provider
PDN D	Psychiatric district nurse/provider
PDN E	Psychiatric district nurse/provider
Southern District Health Board	District health board/provider

Also mentioned in this report:

Dr G	Psychiatrist
Dr F	Clinical psychologist
Ms H	Occupational therapist
Ms I	Social worker
Dr J	Psychiatrist
Dr K	Psychiatrist

⁴ Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

Ms L
Dr M
Dr N

Registered Nurse
Psychiatrist
Psychiatrist

20. Information was also reviewed from:

DHB2
Medical Centre 1
Medical Centre 2

21. This report is the opinion of Kevin Allan, Mental Health Commissioner, and is made in accordance with the power delegated to him by the Commissioner.
22. Independent expert advice was obtained from psychiatrist Dr Verity Humberstone (**Appendix A**).
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Information gathered during investigation

Introduction

23. Mr A was a well child. Mr A sustained a concussion during his teens. In 2010 Mr A had some contact with Southern District Health Board's (SDHB's) Community Alcohol & Drug Services (CADS)⁵ owing to concerns about cannabis use. In 2012 Mr A became a patient of the mental health service at SDHB where Dr C was his treating psychiatrist. Subsequently, sadly, Mr A died.
24. This report considers the standard of care provided to Mr A by SDHB's mental health services, including his treating psychiatrist, Dr C, in the year before Mr A's death.

Presentation to Emergency Psychiatric Service, Month1

25. In 2012, Mr A lived in a shared rental property with others. At 4.02am on 24 Month1, Mr A self-presented at the Emergency Department (ED) in the public hospital concerned that he was having delusional thoughts due to the use of LSD⁶ and/or ecstasy.⁷ At 4.15am he was assessed by the emergency mental health service at SDHB and reported wanting to have his ears checked because he was hearing voices. The emergency mental health service concluded that Mr A was under the influence of drugs/alcohol and that staff would telephone him at midday to assess whether he required further treatment or if he should self-present to his general practitioner (GP). The clinical notes record that the emergency mental health service tried to call Mr A

⁵ The Community Alcohol and Drug Service is a community-based service with a multidisciplinary team that provides assessment and outpatient treatment, including counselling and groups, for adults with moderate-to-severe substance use disorders.

⁶ Lysergic acid diethylamide, a psychedelic drug.

⁷ Also known as MDMA (3,4-methylenedioxyamphetamine), a psychoactive drug.

three times throughout the day but could not get hold of him, and instead sent him a letter, copied to Medical Centre 1, advising him to come back to the hospital if he required urgent help, or to contact his GP.

26. At 1.41am on 26 Month1, Mr A's father, Mr B, called the emergency mental health service expressing concern about Mr A, who had reported to his father on several occasions that he was hearing voices and had a microphone planted in his ear. At 10.20am Mr A attended the emergency mental health service with his father and his mother, Mrs B, for an assessment. The clinical notes record that Mr A reported that he had been hearing voices for the past two years, believed he had a microphone in his ear, and could not distinguish between real memories and ones planted in his head by the voices. The documented plan was for Mr A to be reviewed by psychiatrist Dr G the following day.
27. On 27 Month1, Dr G assessed Mr A and then wrote to the psychiatrist at Medical Centre 1 advising that he had reviewed Mr A for the first time that day. Dr G recorded that Mr A had a longstanding history of polysubstance abuse, claimed that he had had auditory hallucinations since childhood, and believed his parents had implanted a microchip in his ear when he was a child. Dr G noted that Mr A had agreed to go to CADS, and planned to review Mr A again on 5 Month2.

Inpatient admission, Month2

28. On 1 Month2, Mr A attended Medical Centre 1 wanting his ears checked to ensure there were no transmitters in his ears. Later that day he was assessed by Dr G at the emergency mental health service and subsequently admitted to a mental health inpatient service. At that time Mr A reported that he could hear voices (via the transmitter in his ear), which were telling him to kill himself. The clinical notes record that Mr A's family history included schizophrenia.
29. Mr A remained an inpatient until 3 Month3, with some periods of leave. At the start of his admission Mr A was prescribed olanzapine (an antipsychotic medicine) at 10mg twice daily plus 10mg as required up to 20mg daily; clonazepam (a benzodiazepine⁸ with sedative effects) at 1mg as required up to four times daily; and zopiclone (a sleeping pill) at 7.5mg once daily. Mr A's symptoms, particularly his auditory hallucinations, appeared to improve, and his prescribed olanzapine was reduced to 10mg once daily, partly because of concerns that the olanzapine was causing excessive sedation. However, the auditory hallucinations then increased. Olanzapine was reinstated at 10mg twice daily, and Mr A reported feeling better.
30. The clinical notes record that, during Mr A's admission, Dr G told Mr A that he suspected Mr A's diagnosis was toxin related, but that Mr A thought his symptoms were present even when he was toxin free. The clinical notes also record that on 3 Month2, at a meeting with Mr A's father, Dr G "emphasised that it is very unlikely that diagnosis is schizophrenia (although possible) but follow up with [the mental health service] as recommended to intensely monitor the situation to ensure that a diagnosis is made correctly". Dr G's preliminary diagnosis was psychosis secondary

⁸ A psychoactive medicine.

to substance abuse. During his admission, Mr A's mental state was assessed frequently by nursing and medical staff. He was provided with information about his treatment, and family meetings took place. In response to the provisional opinion, Mr and Mrs B stated that they understood that Mr A was on suicide watch during the admission, but his family was not told that he was suicidal.

31. In this respect, SDHB told HDC:

“At no point was he managed at increased risk of suicide or placed on ‘suicide watch’ — that being a term that would not be used in a contemporary mental health record. Despite his auditory hallucinations encouraging him to consider suicide, he gave consistent and congruent assurances he was safe to himself and was visible and participating on the ward.”

32. Mr A was referred to the mental health service and reviewed by psychiatric district nurse PDN E.
33. On 3 Month³, a discharge meeting was held with Mr A, his parents, PDN E and Dr G. The documented discharge plan was for Mr A to have follow-up from PDN E and psychiatrist Dr C at the mental health service, ongoing support from CADS, and for the emergency mental health service contact details to be provided for out-of-hours/emergency situations. In addition, Mr A was to continue to take 10mg olanzapine twice daily.

Follow-up treatment with the mental health service, Month³–Month¹¹

34. From Month³, Mr A was under the care of the mental health service. Dr C was Mr A's treating psychiatrist, and PDN E was his case manager. PDN D, a psychiatric district nurse at the time of these events, was responsible for following up with Mr A when PDN E was on leave or unavailable. During this time, Mr A's care was discussed regularly at multidisciplinary team meetings where usually Dr C and PDNs E and D were present, as well as clinical psychologist Dr F, occupational therapist Ms H, and social worker Ms I (occasionally there were also other individuals present).
35. A clinical assessment conducted by PDN E in Month³⁹ records that Mr A was moving between his shared house, his mother's house, and his father's house.
36. As an overview, the clinical notes record that between Month³ and Month¹¹:
- Mr A's olanzapine prescription was decreased progressively, partly because he had reported sedation and apathy as side effects of the drug;
 - Mr A experienced some improvement in his symptoms but continued to report auditory hallucinations intermittently;
 - Mr A's parents made contact with the mental health service on a number of occasions expressing concern about their son's well-being, including concerns regarding his lack of motivation, personal hygiene, sleep patterns, and use of alcohol and drugs;

⁹ The exact date is not recorded on the assessment.

- There were occasions when Mr A was happy for his parents to be involved in his care, and other occasions when he expressed irritation with his parents' involvement; and
- PDN E and D met with Mr A regularly, although Mr A did not attend a number of scheduled appointments (generally these were followed up by PDN E via a text message or telephone call to Mr A).

37. These issues are outlined in further detail below.¹⁰
38. On 12 Month3, Dr C and PDN E assessed Mr A. Dr C recorded in the clinical notes that the agreed plan was to reduce Mr A's olanzapine from 10mg twice daily to 15mg once at night. Dr C recorded that Mr A had been hearing voices for two years or longer, but that recently his auditory hallucinations had improved. Dr C assessed Mr A as low risk and noted that he was not suicidal.
39. On 23 Month3, Mr B telephoned the emergency mental health service concerned that Mr A's mental state had deteriorated over the last few days. The emergency mental health service advised the mental health service of the contact and, the next day, PDN E tried to call Mr A and visit his home address. Mr A later called PDN E and they arranged a meeting for 26 Month3. Following the meeting on 26 Month3, PDN E recorded:

“[Mr A] says things have been going ok. Still experiencing ‘voices’ — worsening in the evening. [Mr A] isn't sure whether the medication is working; also finding it too sedating. He says he is taking the olanzapine regularly. Wonders if he could have a change. Denies using cannabis. Says he has been drinking alcohol moderately.”

40. The next day (27 Month3), Dr C and PDN E met with Mr A. Dr C recorded:

“[Mr A] acknowledged that he had had a relapse with more voices but felt things had now improved ... We did discuss changing the drug [olanzapine] or the dose, because he has some side effects, feeling sedated, feeling mentally slow, struggling to relate to people but with encouragement, he was quick to agree to persist with the 15mg at present.”

41. Dr C also noted: “[Mr A] spoke again about having had the voices all his life, these seem to influence his thoughts but these experiences are not as overwhelming as they have been and [he] impresses as recovering quite nicely and as being quite insightful.”
42. Dr C recorded that he had met separately with Mr and Mrs B that day, and that Mr A's parents disagreed with each other as to whether Mr A was violent. Dr C further noted: “Hopefully with further improvement their anxieties will lessen but there is a danger that any fluctuation in his mental state will be met with great frustration on the part of his mother with resulting escalating conflict.”

¹⁰ The summary is based primarily on what is recorded in the clinical notes. Mr and Mrs B expressed a number of concerns to HDC about the accuracy of the clinical records, and these concerns are dealt with in a separate section below.

43. Dr C told HDC that on 16 Month⁴ Mrs B spoke to him and said that she wanted Mr A to stop taking olanzapine. Dr C recommended that it continue, and told Mrs B that the risk of relapse should be considered when deciding whether to stop the medication. Dr C recorded: “[Mrs B] accepted my explanation that even if the cannabis was the sole precipitant of his psychosis, abstinence from cannabis wasn’t itself a guarantee that he would now remain well.” Mr A continued to take olanzapine. On 7 Month⁵, following a further assessment of Mr A (where Mrs B was also present), Dr C recorded:

“[Mr A] reports occasional recurrences of his auditory hallucinations have now resolved and his mood is alright ... his mother feels he is substantially back to normal ... there really isn’t any evidence of psychotic phenomena and he doesn’t appear at significant risk at present. In view of his sedation, the olanzapine dose is now cut to 12.5mg.”

44. On the same day, Mr A was seen by an intern psychologist who recorded:

“[Mr A] reported he is hearing voices much less ... He claimed he has ‘gotten over it’ although did not make this claim in a particularly convincing manner.”

45. A Clinical Psychology Assessment Report for the period 15 Month⁴ to 7 Month⁵ (written on 26 Month⁵ and signed by the intern psychologist and clinical psychologist Dr F) states: “[Mr A] reported that he hears voices for approximately 2–3 hours each day ... [Mr A] reported that he has been coping with voices by spending most of each day in bed.” The report notes that Mr A reported no current thoughts, plans or intentions to harm himself.

46. Mr A spent approximately two months working in another region before returning home in Month⁶. In response to the provisional opinion, Mr and Mrs B stated that, during that time, Mr A came back to attend his appointments. On 10 Month⁶, PDN E recorded in the clinical notes that Mrs B had expressed concern about Mr A’s alcohol and drug use since his return, and wanted him to see a psychologist or CADS counsellor. PDN E recorded that he saw Mr A without his parents, and noted: “We discussed his [drug and alcohol] use in context of his recent psychotic episode and how his current use could make him more vulnerable ... Discussed seeing a psychologist again which [Mr A] is ok with ... Doesn’t feel he needs to go to CADS.”

47. On 12 Month⁶, Dr C and PDN D saw Mr A with his father present, and both Dr C and PDN D recorded that Mr B raised concerns about Mr A’s well-being. Dr C recorded:

“The psychotic content that was previously present doesn’t seem to be in evidence at present ... [Mr B’s] immediate concern is that [Mr A] will refuse to go back to [his job] and will instead enact some unrealistic plan for remaining in [his place of origin]. Overall I don’t think there are grounds for us to intervene over [Mr A’s] objections. Possibly he is in the early stages of relapse and we should attempt to have some contact with [Mr A] next week but I think it is more likely that he is mildly depressed and we are witnessing some ongoing family frustrations being played out.”

48. At this consultation Dr C noted that Mr A was not tearful or suicidal, but was concerned that his parents were attempting to control him. Dr C recorded: “Although a little irritable, I didn’t think [Mr A] was evasive and his expressed frustrations about how dull the [job] was and about his parents’ attempts to control his life, appeared reasonable.” Dr C prescribed Mr A 20mg citalopram (an antidepressant) for depression and recorded that Mr A gave “quite good assurance of ongoing adherence with olanzapine 12.5mg and has taken the trouble of asking for a further script”. The next day, 13 Month6, Dr C recorded in the notes:

“[Mr A’s] father [Mr B] came into my office unannounced this afternoon and stood squarely facing me in a somewhat menacing manner ... he seemed annoyed ... I wasn’t quite sure how best to proceed so I rang [Mr A’s] mother, [Mrs B] ... She also felt in agreement with [Mr B] and felt the system was letting [Mr A] down. She angrily complains [Mr A] wasn’t getting the support needed. Pressed for details, her main concern is [Mr A’s] current drug use and him not getting effective counselling. She also feels he is currently psychotic and is highly manipulative and pulled the wool over our eyes recently. I pressed her for what she might be referring to that made her think he was psychotic, and she had no specific details but felt that his behaviour when he smokes cannabis is quite different, with him becoming angry and complaining, whereas usually he is very friendly and gentle ... Overall there is no clear evidence that [Mr A] is currently psychotic, however he is certainly vulnerable and especially so at present with his, once again, using cannabis. I think close follow up is necessary and we should take such opportunities as arise to improve engagement with his parents.”

49. On 15 Month6, Mr and Mrs B wrote separate letters to Dr C expressing concern about Mr A. Mr B wrote:

“I would like to register directly to you my disappointment at your lack of clinical examination and history taking of my son [on 12 Month6] ... In my 5 minute discussion with you I indicated that I believed [Mr A] was once again showing early signs of psychosis. You dismissed this out of hand ... Since [7 Month6] [Mr A] has sat in the lounge at [his house], never leaving, not eating and not caring about his personal hygiene. When I have had interaction with him he has seemed disorientated alternatively laughing and smiling at something no-one else can see. He is angry with us. These are the same symptoms displayed by him prior to his admission to [the mental health inpatient service] early [Month2] ...”

50. Mrs B’s letter stated:

“You see him for 15 mins once a month and he is able to manipulate you to believe that he suffers from depression as then he gets even more drugs to fuel his habit ... This is not depression, this is early onset psychosis brought on by abusing drugs and unhealthy living ... I would like my son to be put into a drug and alcohol recovery programme immediately preferably as an in-patient.”

51. On 16 Month6, PDN D recorded in the clinical notes that she had visited Mr A at his mother’s home. PDN D recorded that Mr A was cheerful and warm, did not appear to

be paranoid, and “was not reporting any symptoms”. PDN D noted that she spent some time talking to Mr A about his alcohol intake and the damage that could cause him. She recorded that Mr A said that he was not taking citalopram but was taking olanzapine, and that he agreed for her to visit him the following day. She assessed that there was “nil risk if he is staying with his mother”.

52. PDN D recorded in the clinical notes that, on the same day, Mrs B visited her at the mental health service office. PDN D recorded:

“[Mrs B] was quite angry and upset at the way we, [Dr C] and I, had dismissed their concerns re their son becoming unwell. She said she was not at all happy that [Mr A] had been prescribed antidepressants because [Mr A] is not depressed. She said she would bin the packet ... She said as far as she and her husband are concerned [Mr A] requires ongoing psychological work with a clinical psychologist.”

53. The documented plan was for PDN D to visit Mr A the following day (17 Month6), which she did, and recorded: “[Mr A] said he was very tired and sleeping a lot ... I left him to sleep.” On 18 Month6 PDN D visited Mr A and recorded that he was much less tired and quite talkative and pleasant. In response to the provisional opinion, Mr and Mrs B stated that on 17 and 18 Month6 Mrs B made telephone calls to the service, during which she asked for Mr A to be admitted for assessment.

54. Dr C completed a Psychiatric Assessment dated 18 Month6, which referred to having seen Mr A the previous week (12 Month6). Dr C recorded that Mr A had a history of longstanding auditory hallucinations and a recent psychotic episode, the proximate precipitants of which appeared to be greatly increased cannabis and other drug use. Dr C recorded that Mr A had significant improvement with treatment and drug abstinence but that recently he had been presenting with nonspecific features of low mood. Dr C noted that Mr A’s mood appeared dysphoric and frustrated but not suicidal, and stated that there was no unequivocal evidence of relapse when Mr A was seen the previous week, but that with his vulnerability and return to cannabis use, he was acutely at risk of deterioration. The documented plan was as follows:

“1. Close follow up with a possible admission to hospital if he becomes more apparently psychotic.

2. Encourage continued olanzapine use.

3. Avoid cannabis.

4. Further opinion, which in any case his parents may arrange.

5. Despite [Mr A’s] misgivings, I think the clinical situation necessitates frank and free communication between ourselves and his parents.

6. Further CADS and clinical psychological input.

7. Parents invited to a meeting next week to hopefully resolve recent tension.

8. Need to balance support for [Mr A’s] autonomy and develop of rapport with him, with need to maintain useful relationship with his parents.”

55. On 19 Month6, PDN D again visited Mr A, who said that he felt bullied and controlled by his parents. PDN D noted that Mr A had no signs of psychosis, had not heard voices for a few months, and his risk remained low.

56. On 24 Month6, Dr C met with Mr A's parents and PDN D to follow up on Mr and Mrs B's concerns. Dr C recorded:

“[Mr A's parents] have noticed a weird grin on him on and off. It's not clear at this stage if this is a response to hallucinations. Although greatly intoxicated recently after being at his [own house] for a few days, he appears not to have relapsed into psychosis. ... His presentation [which is] apathetic, with poor self care, showering only when asked and being irritable appears to be a manifestation of intoxication, rather than psychosis, as it resolved rapidly when he is drug free.”

57. On 27 Month6, Mr A was assessed by psychiatrist Dr J at a private mental health service at the request of Mr A's parents, who had arranged the appointment. In a letter to Dr C and PDN D, Dr J noted:

“... [C]ertainly on mental state examination there was no evidence of psychotic phenomena. What was evident, was a major depressive episode where [Mr A] described feeling down in his mood for the last several months associated with low energy and motivation.

... I offered that I would be available to facilitate meetings between [Mr A] and his parents in order to enable improved communication, understanding and empathy. [Mr A] was clear he did not want this at this stage and I have let him know the door to this will be kept open.

I am aware this is not a formal second opinion, given the time limitations and needing to see [Mr A] on his own and then [Mr A] with his parents.”

58. Later the same day, Dr C saw Mr A and recorded:

“[Mr A] feels the voices that he felt he has had for years, have gone completely, and there is no real current evidence of any psychotic phenomena. ... He is tending to oversleep in the mornings and we have cut the dose of olanzapine to 10mg. He will also start on the citalopram previously prescribed, as he feels his mood still rather low.”

59. On 30 Month6, Dr F saw Mr A and recorded that he said his parents tended to assume he was using drugs when he was “under-par”, and would turn up at his house unannounced, which was stressful for him. Dr F noted: “[Mr A] said this service has been helpful in keeping his parents ‘off my back’.” She noted that Mr A had disclosed no plans or intentions to harm himself or others.

60. During Months7-9 Mr A was seen on a number of occasions by Dr C and PDN E, but on some occasions Mr A did not attend scheduled appointments or respond to telephone calls/text messages from PDN E. Dr C and PDN E consistently recorded in

the notes that there was no evidence of ongoing psychotic phenomena, but that Mr A was using cannabis and alcohol regularly, which they discussed with him and discouraged.

61. Between Month7 and Month9, either Mr B or Mrs B telephoned the mental health service on six occasions in total, and spoke to either PDN D or PDN E expressing concerns that Mr A was not taking his medication and not attending appointments.
62. On 10 Month7, Dr C recorded that he had seen Mr A with PDN E. Dr C noted that Mr A was taking olanzapine but not citalopram. Dr C further noted that Mr A was calm and friendly with no signs of thought disorder or mood disturbance, and that he was compliant with taking the prescribed olanzapine 10mg.
63. In an email to PDN D on 27 Month7, Mrs B wrote:

“[Mr A] is having terrible problems at the moment ... I’m not sure what [PDN E’s] role is. It is bad enough to have to worry about [Mr A] and I don’t want to have to worry about the service looking after [Mr A] as well. We know our boy and he is not right at the moment and [Dr C] just does not believe us. I think [Mr A] relates well to [Dr C] and yourself [Dr D], so whatever works well with [Mr A] is fine with us but please help us help him.”
64. In response to the provisional opinion, Mr and Mrs B noted that there was no follow-up after this email.
65. Mr A missed three consecutive appointments on 7, 13 and 17 Month8. On 20 Month8, Dr C assessed Mr A and recorded:

“There is really no evidence of psychotic phenomena. He claims adherence with olanzapine 10mg and in view of his lack of motivation and sedation, and absence of ongoing psychotic features, we have agreed to cut the dose to 7.5mg.”
66. Dr C noted: “Little immediate risk.” He further noted that Mr A was “comfortable” with the team talking freely with his parents at a meeting the following week but that Mr A did not want to attend himself.
67. On 27 Month8, Mr and Mrs B together attended a meeting with Dr C and PDN E and, on 25 Month9, Mrs B met with Dr C and Mr A.
68. On 13 Month10, PDN E met with Mr A and recorded that he was doing well and compliant with olanzapine but “would like to stop this as says he’s been on it for 10 months”. PDN E noted that the risk was much reduced.
69. On 22 Month10, Dr C and PDN E met with Mr A and Mrs B following a call the previous day from Mrs B, who said that Mr A was sedated on olanzapine and that she wanted it withdrawn. Dr C recorded in the notes that Mr A was doing well, he was not psychotic, and was insightful. Dr C noted:

“Early account of longstanding voices may not have reflected a long prodrome.¹¹ Mother convinced he was wholly well until recent episode. Agreed cut and stop olanzapine. [Early warning signs] discussed.”

70. Dr C told HDC that on 22 Month10 he discussed with Mr A and Mrs B the risk of relapse of psychosis when stopping olanzapine. In response to the provisional opinion, Mrs B denied that at that meeting she said that Mr A had been “wholly well until [the] recent episode”.

71. On 28 Month10, Mrs B wrote to Mr A’s previous treating psychiatrist, Dr G, stating:

“We have initiated the tapering of olanzapine as it has long served its purpose and because the excessive daytime sleeping caused [Mr A] to be unproductive. However I have concerns regarding tapering his olanzapine and lack of treatment plan ... No information was given to us in case [Mr A] developed problems when withdrawing from olanzapine ... I feel that I was not listened to when I expressed concerns about olanzapine withdrawal.”

72. In the letter, Mrs B requested copies of Mr A’s blood test results. Mr and Mrs B told HDC that Dr C failed to get blood tests performed at appropriate times. In this respect, Dr C told HDC: “[I]t is common for patients to delay or forget getting their blood test. As our goal is to identify trends over months the precise timing of the blood test doesn’t matter.”

73. Dr G forwarded the letter to Dr C (as Mr A’s treating psychiatrist), who replied to Mrs B in a letter dated 30 Month10:

“I do doubt that he will experience any particular problems withdrawing from the olanzapine however, as I had indicated, there is a risk of psychotic experiences returning ... should he or yourselves have any concern ... please feel free to contact [the mental health service].”

74. Dr C told HDC:

“At the time when it was agreed to stop [Mr A’s] olanzapine (22 [Month10]) I understood that [Mr A’s] psychotic episode had not been preceded by a prodrome. This, and his good recovery without lingering symptoms of psychosis, made me feel it was reasonable for him to come off the olanzapine.”

75. Dr C stated:

“My notes about discussions with [Mr and Mrs B] about continuation of the olanzapine are less full than they might have been. Nonetheless I have recorded discussions with them that they appeared to understand, regarding the risks and benefits of stopping the olanzapine.”

¹¹ A specific set of symptoms that may precede the onset of a mental illness.

76. On 5 Month11, Mrs B wrote a letter of complaint to SDHB's Patient Affairs, noting her concerns about Mr A stopping olanzapine and stating that she had not received a response to her concerns from Dr C.¹² She stated:

“... I feel we have not been listened to as parents and effective communication has been very slack. Regular blood tests have not taken place the last blood test has been at my request.

... Continuity of service [from the mental health service] is irregular and not very satisfactory. ... [Mr A] has been unable to advocate for himself as he has been unwell. I have reported about 2 months ago that my son was experiencing sleeping problems and needed some help. He has been given no support in this area and he is struggling. ...

I would like an independent review of [Mr A's] treatment plan and medication. [Mr A] is experiencing some withdrawal symptoms which aren't pleasant to him despite the fact we were told that there will be none. I am experiencing a lack of trust in the service.”

77. On 6 Month11 Dr C reviewed Mr A in the presence of Mr B. Dr C recorded that Mr A and Mr B were about to go away on holiday together and that there was no evidence of the recurrence of psychotic phenomena. Dr C recorded that Mr A's main concern was poor sleep since he had stopped taking olanzapine. Dr C noted:

“We discussed sleep hygiene and the importance of being patient. I have given him a supply of 8 temazepam [a sleeping pill] 10mg tablets to take [as required] ... I mentioned [Mrs B's] recent letter and they appeared to want to distance themselves from her concerns and her ongoing expressions of dissatisfaction with [Mr A's] care.”

78. In response to the provisional opinion, Mr B stated that he was not distancing himself from Mrs B's concerns, but felt that “the consultation with [Mr A] present was not the appropriate forum for discussion of the letter”. Mr and Mrs B stated that Mr B delayed going on holiday for five days in order to see Dr C because of their concerns about Mr A's symptoms having returned even though he was clear of drugs and alcohol. Furthermore, Mr and Mrs B told HDC that PDN E said that he would help Mr A to complete the “Relapse Prevention Plan and Early Warning Signs” form before Mr A went on holiday, but did not do so. There is no record of the plan having been discussed.

Treatment at DHB2, Month11

79. On 7 Month11, while Mr A and his father were travelling on holiday, Mr B telephoned PDN E expressing concern about Mr A's well-being. PDN E spoke to Mr A, who reported feeling anxious and experiencing déjà vu and sleep disruption. PDN E documented that Mr A had no suicidal or harmful thoughts. PDN E recorded that the plan was for Mr A to look at sleep hygiene strategies and take 2.5mg olanzapine

¹² At this stage, Mrs B does not appear to have received Dr C's letter dated 30 Month10.

for anxiety if necessary, as well as temazepam to try to establish a sleep pattern, and for PDN E to follow up with a telephone call on 10 Month11 and to discuss the plan with Dr C and the mental health service.

80. Also on 7 Month11, Dr C wrote to Mr A's GP stating that in recent months Mr A had "done well" and had reduced and then "completely abandoned" his use of cannabis. Dr C wrote:

"The dose of Olanzapine that he's on has slowly decreased and very much with the encouragement of his mother will be coming off this completely in the next few weeks. Looking back his episode of psychosis had quite an abrupt onset without the months of gradual deterioration that often signifies a more enduring psychosis and is very likely that the major determinant of his psychotic episode was his high use of cannabis. As such there's every room for optimism that he may remain well indefinitely ..."

81. At about 7.45pm on 7 Month11, Mr A self-presented at DHB2 (accompanied by his father). According to the clinical records, Mr A reported feeling anxious being around people in streets and in shops, experiencing auditory hallucinations including voices that made derogatory comments about him, poor sleep, and the belief that he had a microchip in his ear that had been planted by his parents. The Emergency Department record has "suicidal ideation" circled and "yes" to having thoughts that life was not worth living and thoughts of self-harm. It is also noted that Mr A had "passive thoughts of not being around but denied any intent or plan of suicide", and said that the voices were not telling him to do so. Mr A said that the voices had in the past told him to self-harm, but he was able to "distract & reality orientate at these times". Mr A told the staff that his dose of olanzapine had been reduced gradually and, at that time, he was on 5mg at night. He said that two weeks previously when his dose had been reduced from 10mg he had started experiencing hallucinations. He denied any recent history of abusing synthetic cannabis.
82. Mr A said that he had been refused a brain scan at his last admission, and that he believed people might be colluding against him. Mr A did not want his father to be informed of his symptoms.
83. The clinical record from this presentation notes: "[Mr A] [a]cknowledges voices more noticeable since gradual reduction in olanzapine, however may not have informed treating team as feeling 'pressure' from them, family and friends to be well."
84. The DHB2 clinicians offered to admit Mr A, but he refused. Mr A was assessed, prescribed additional olanzapine (20mg twice daily) as well as clonazepam¹³ and zopiclone for three days, and advised to attend the mental health service at SDHB as soon as possible. A copy of the records made at DHB2 was faxed to the mental health service and recorded as received on 10 Month11.

¹³ Used to prevent and treat seizures and panic disorder, and for the movement disorder akathisia.

85. On 10, 12, 14 and 20 Month11, the mental health service was in contact with Mr A and his father. According to the clinical records, Mr A and his father reported that Mr A was feeling better and that they would continue travelling, and were aware that they could contact the mental health service if any issues arose. PDN E recorded that, on 14 Month11, Mr A text messaged him to advise that he was taking 10mg olanzapine daily. There is a record in the progress notes on 20 Month11 recorded by PDN E stating that Mr B had described Mr A finding it difficult to stay at a public venue when there were a large number of children present, so they had left. In response to the first provisional opinion, Mr and Mrs B stated that this incident “where [Mr A] once again had trouble” suggested that his symptoms had not disappeared.

Response to Patient Affairs complaint, Month11

86. On 17 Month11, SDHB, replied to Mrs B’s complaint letter of 5 Month11. The letter stated that PDN D had investigated the complaint and noted:

“The team looking after [Mr A] had been aware of your concerns about his care for some time and, on behalf of the team, [Dr C] apologises that they had not been more successful in addressing them.”

87. The letter stated that Dr C considered that the mental health service had been “very responsive” to Mr A and his parents. In response to Mrs B’s concern about withdrawal symptoms, the letter stated: “[Dr C] and [PDN E] reported that they tried to reassure you that it was very unlikely [Mr A] would have any difficulty with withdrawal.” In response to Mrs B’s concern about Mr A’s sleep, the letter stated: “[Dr C] did not feel it needed specific intervention, but advised general measures, such as regular exercise. He is sorry if this gave the impression of nothing being done.”
88. Finally, the letter thanked Mrs B for raising her concerns and enclosed a copy of the SDHB Appeal procedure in the event she was not happy with the response. In response to the provisional opinion, Mr and Mrs B stated that Mrs B had requested a second opinion (regarding Mr A’s treatment), but that that was not arranged by Dr C or SDHB. In this respect, Dr C told HDC that “the request for a second opinion was not made of [him]” at this time.

Subsequent treatment, Month12–Month14

89. Between Month12 and Month14, Mr A did not attend a number of scheduled appointments, and his parents made several telephone calls to the mental health service expressing concern for his well-being. There are a number of calls recorded between Mr B or Mrs B and PDN E, PDN D or Dr C.
90. Following Mr A’s return to from holiday in Month12, he did not attend two scheduled appointments with Dr C. On 14 Month12 Mr B telephoned PDN E and expressed concern that Mr A was smoking cannabis and not attending his course. Mr A next attended an appointment with Dr C on 21 Month12 with his mother. Dr C recorded that Mr A was oppositional and irritated by his mother but not psychotic, and had no suicidal ideation. In response to the first provisional opinion, Mrs B stated that Dr C

never asked Mr A about suicidal ideation at the meeting. She stated that Mr A's behaviour "was out of character, as he was usually a 'peacemaker' and not aggressive".

91. Regarding Mr A's treatment at DHB2, Dr C recorded:

"[Mr A] has gradually come off olanzapine. [Mrs B] cutting tabs down to 1 and 1/4mg. He claims his crisis [while on holiday] quickly and wholly resolved, and that he has no ongoing voices. Refused to discuss further — but claims it was all due to a holiday he didn't want."

92. Dr C spoke to Mr B on 24 Month12 and recorded: "[Mr B] doubts that [Mr A] is covering up psychosis."

93. Dr C told HDC:

"[W]hen I saw [Mr A] in [Month12], after the [episode while on holiday] he was no longer on Olanzapine. I didn't re-prescribe it as he and his mother were reluctant. I didn't specifically document this as it was the same situation as on our previous meeting."

94. Mr and Mrs B told HDC: "The option of going back on medication was not discussed and that is why it is not on file. [Dr C] did not discuss treatment with [Mr A] or family in 2013." Mrs B told HDC:

"[Mr A] had an appointment [in Month12] with [Dr C] which could have avoided decompensation by prescribing medication for [Mr A]. It was not discussed, a proper examination was not done, and a proper history taking was not done."

95. Dr C told HDC that, as this appointment was not productive, he "thought the best thing would be to reschedule".

96. Dr C made another appointment for 25 Month12 to see Mr A without his mother being present. On 24 Month12 Mr B called PDN D expressing concerns about Mr A's cannabis use. In response to the provisional opinion, Mr B stated that he felt that Mr A received "good benefit" from the increased doses of medication provided by DHB2, and the psychosis was not resolving itself unaided. Mr B said: "Once that medication ran out, [Mr A] had no option but to self-medicate."

97. That day, Dr C recorded: "Episode [while on holiday] resolved [very] quickly — 1–2 days." Mr A did not attend the 25 Month12 appointment.

98. On 28 Month12 Mr B called PDN E again expressing concerns about Mr A's use of cannabis. It is recorded that Mr B stated that he was concerned that Mr A was using cannabis to cover up underlying psychotic symptoms. According to Mr B, he rang again with the same concerns on 9 Month13 and 11 Month13.

99. During this time, Mr A had some contact with PDN E. On 12 Month13 PDN E saw Mr A at his mother's house and recorded that his mood was stable and he had no psychotic, suicidal or harmful thoughts. PDN E noted:

“[Mr A] says that he has been now off the Olanzapine for 2–3 weeks and is feeling just fine without it. He has no concerns about other people looking at him or talking about him and no concerns whilst in groups of people.”

100. Dr C saw Mr A on 27 Month13, following several calls from Mr B expressing concerns about his son. Mr A attended alone and, according to the clinical notes, he felt anxious around large groups, had a reversed day/night cycle, and was missing course commitments owing to anxiety. However, he reported feeling well, was not suicidal, and did not exhibit any psychotic phenomena. Dr C recorded that he had given Mr A a “sick certificate on the basis that the functional recovery from psychosis is not yet complete”. Dr C documented:

“Ok appetite. Has lost weight, off olanzapine.

...

Discussed his parents' ongoing concern. He has indicated clearly he does not want either involved in his care ... Overall, his account is at odds with his parents' concerns and that he is depressed or drug addicted. His account today is very believable and that of his parents has often appeared based on their anxieties rather than observation.”

101. Mr A was scheduled for another appointment on 6 Month14, which he did not attend.
102. At 4.35am on 12 Month14, Mr A self-presented at the emergency mental health service requesting sleep medication. Mr A reported a recent history of poor sleep and heightened anxiety, and said that he had “thoughts in [his] head” when he tried to sleep, but denied he was unsafe. When the emergency mental health service refused to dispense sleeping medication, Mr A asked to leave and said he would contact the mental health service or his GP. The duty nurse's summary stated that Mr A might have early warning signs and would benefit from contact with his regular mental health service team. In response to the provisional opinion, Mr and Mrs B stated that no formal suicide risk assessment was completed despite staff querying the early warning signs and Mr A having thoughts in his head when he tried to sleep.
103. Later in the day on 12 Month14, PDN E tried to call Mr A but received no reply, and exchanged some text messages with him confirming an appointment for the following day.
104. At 8.45am on 13 Month14, Mr B telephoned PDN D and reported that Mr A had called him at 1am saying that he (Mr A) had spent several hours drawing a picture that he could not remember drawing. In response to the provisional opinion, Mr B told HDC that he had offered to take Mr A to the emergency mental health service but Mr A had become more upset. They drove around for about two hours and sat in the car talking. Mr B said that Mr A did not seem to understand where the picture had come

from or what it meant, “but found it extremely upsetting and kept asking his dad to explain it to him”. Eventually Mr A calmed down and Mr B took him home. Mr B said he told the mental health service that Mr A did not appear to be under the influence of drugs at that time.

105. Mr A did not attend his scheduled appointment with the mental health service later that day, and the records show that Mrs B telephoned the mental health service twice expressing concern. It is noted in the clinical record that Mrs B told PDN D that she did not want Mr A to have medication for psychosis because it impaired his functioning, and that she would rather the service addressed his illicit substance use. In response to the provisional opinion, Mrs B said she called six times that day and provided detailed descriptions of Mr A’s symptoms and issues (he had not eaten or washed, was agitated and angry, had lost “huge” amounts of weight, and would not attend the emergency mental health service or the mental health service). She said that once she had ascertained that Mr A had not attended his appointment, she repeatedly tried to make another appointment that day. She said that PDN D told her that Dr C would call Mr A directly to make an appointment that day.
106. Dr C rang Mr A, who said that he had forgotten about the appointment, and they arranged to meet on 18 Month14. Dr C noted that Mr A said that he had no complaints and it “was all good”.
107. Regarding the picture Mr A had drawn, Dr C told HDC:

“[Mr A] [...] He indicated to me he had been very frustrated with a picture he had created because he did not ‘see’ the illusion he was supposed to ... It did not appear to be in any way psychotic. [...]”
108. There is no record in the clinical notes that Dr C viewed the picture or discussed it with Mr A.
109. On 14 Month14, Mrs B called PDN E and expressed concern for Mr A’s safety. PDN E attempted to see Mr A by visiting his house and calling his cell phone but, according to the clinical records, Mr A said that he did not wish to be seen.
110. On 15 Month14, following a multidisciplinary meeting, the records of which note “‘suicidal ? impulsive”, Dr C called Mr A and arranged an appointment to see him that day, but Mr A did not attend. PDN E then visited Mr A and recorded that Mr A was “not suicidal at present”, but that he had pulled out of his course and was feeling “particularly anxious at times” and that Mr A was “escorted home to mother’s house”. Mrs B said that PDN E dropped Mr A at her home, where he was left unsupported, as no one was home.
111. PDN E later had a conversation with Mr B in which Mr B expressed his concerns about Mr A. PDN E recorded that he told Mr B that, if he was concerned about Mr A’s safety, he (Mr B) could use section 8 of the Mental Health (Compulsory

Assessment and Treatment) Act 1992 (MHA).¹⁴ In response to the first provisional opinion, Mr B said that he told PDN E about the picture incident, and PDN E said that the picture was “drug talk”. The notes state that Mr B was concerned that Mr A might have “clinical depression”, and that Mr B was concerned about Mr A’s alcohol consumption. Mr B said that the concerns he discussed are not recorded in the clinical notes. According to Mr B, PDN E did not tell him that he had dropped Mr A at his mother’s house. In response to the provisional opinion, Mrs B said that she spoke to PDN E twice on 15 Month14 expressing concern that Mr A was psychotic and asking for a second opinion about Mr A.

112. On 17 Month14, Mr A arrived at his parents’ house at 6am with injuries, and could not remember what had happened to him. He was taken to the emergency doctor.
113. On 18 Month14 Mr and Mrs B telephoned the mental health service a number of times during the day. Mr B told PDN D that Mr A had consumed vodka and drugs on Saturday night and told the patrol that he had been beaten up. Mrs B said that she spoke to PDN D, was tearful and expressed that she was concerned that Mr A could harm himself or someone else, and asked for a second opinion about Mr A. According to Mrs B, PDN D passed on Mrs B’s concerns to Dr C. This conversation is not documented, but Dr C confirms that the team was advised by Mr A’s parents that Mr A had been beaten up.
114. Dr C and PDN E visited Mr A at his mother’s home after he did not attend a scheduled appointment that day (18 Month14). Dr C recorded that Mr A had consumed a large amount of alcohol over the weekend and could not recall what had happened, but believed he had been beaten up. Mr A also told Dr C and PDN E that recently he had left a class for his course where he had been squashed together with an older woman, and he described irritation at not having textbooks for the course. Dr C recorded: “Although he can’t identify any other instance and we weren’t able to identify a very characteristic account of anxious avoidance. I suspect that his issues with his parents and his elder siblings being very successful and his own lack of confidence is likely to contribute to his being easily put off.” Dr C also recorded:

“In his presentation, he is no more than, understandably, dishevelled. He is alert, makes good eye contact, speaks candidly without any odd mannerism or evidence of thought disorder. We saw none of the subtle signs of psychosis. His mood is warm, animated and humorous, he is not suicidal.”

115. Dr C noted Mr A’s recent weight loss but attributed it to the stopping of olanzapine. Dr C also commented in the notes that Mr A was experiencing poor sleep, but attributed this to alcohol fuelled disruption and day/night reversal,¹⁵ and noted: “There is no evidence that he is psychotic.” Dr C recorded:

¹⁴ Section 8(1) states: “Anyone who believes that a person may be suffering from a mental disorder may at any time fill out an application form asking the Director of Area Mental Health Services for an assessment of the person.”

¹⁵ Sleeping during the day and being awake at night.

“[O]ther than his excess alcohol, we didn’t see evidence of any further drug use and this is consistent with his previous accounts. Overall, we don’t get the impression of psychosis or of a narrowly defined mood disorder or of anxious avoidance although this may need further exploration.”

116. On 19 Month14, Mr and Mrs B each separately rang the mental health service requesting a second opinion on Mr A’s condition. PDN E told Mrs B that this could happen if necessary and if Mr A agreed to it. Mrs B stated to PDN E that Mr A had told her that his injuries from the weekend were self-inflicted, and that on the weekend he had also poured paint on the road. She stated that she believed Mr A was mentally disordered and needed hospital treatment for his drug and alcohol addiction. PDN E rang Mr A and asked him to attend an appointment with Dr C. PDN E recorded that Mr A denied any psychotic symptoms or wanting to harm himself.
117. On 20 Month14, Mr A did not attend a scheduled appointment with Dr C, who noted in the clinical records the mixed messages Mr A was giving about the mental health service liaising with his parents. In response to the first provisional opinion, Mr and Mrs B said that they were not aware of this appointment and, had they known about it, they could have supported Mr A to attend.
118. Dr C noted that one or both parents wanted a second opinion, and that the ideal option would be CADS, “as engagement there offers most therapeutic potential”.
119. On the morning of 21 Month14 Mrs B telephoned the emergency mental health service expressing concern about Mr A. Later that day she called again expressing concern and stating that she did not know Mr A’s current whereabouts. Later, Mr and Mrs B called the emergency mental health service again and asked for Mr A to be hospitalised. Mrs B was advised to contact the Police if she was concerned about his safety, and the MHA process was discussed. She called again an hour later and received similar advice.
120. At 1.30am Mr and Mrs B attended the Emergency Department, and Mrs B completed an application form pursuant to section 8 of the MHA. Mrs B listed her reasons for believing Mr A needed to be hospitalised as follows:

“Self harm — cigarette burns, physical injuries like bruises, cuts
 Suicidal tendencies
 Set bed + clothes alight
 Got hold of buckets of paint at [his house] and poured it all over the street, he didn’t realise that he had done it and passed out (was intoxicated at the time)
 Irrational ideas like he had AIDS, autism, ADD, no X-rays done on brain for device planted by us [his parents] in his [head].”

121. That same day, 21 Month14, Mr and Mrs B wrote a letter to the mental health service in which Mrs B stated that the previous week, Mr A had tried to burn his bed, and he had found paint and poured it on the street. The letter also said that Mr A had told his parents that he had been “beaten up”, but they discovered that his injuries were self-inflicted. In response to the provisional opinion, Mrs B said she also emailed Dr C

that night stating that he had not obtained a second opinion despite repeated requests, and that she had filed a section 8 application because it was the only way to get Mr A assessed. She said that she was seeking an urgent second opinion and for Mr A to be hospitalised (both that day) and for his parents to be involved in his treatment plan.

122. On the morning of 22 Month14, the emergency mental health service contacted Mrs B at 10.15am, and then at 10.45am. She presented at the mental health service distressed and insistent on being seen because Mr A had been missing since the previous day.
123. On 22 Month14, in reference to Mrs B's email, Dr C noted in the clinical record: "Hard to judge if their escalating concern is a sign of worsening M.S. (mental state) or not." Dr C stated that at that time he had not seen the notes from the previous day.
124. A community mental health nurse saw Mrs B and recorded that during the meeting Mrs B received a telephone call from Mr B. Sadly, it transpired that Mr A had died.
125. In response to the provisional opinion, Mrs B said that at 2pm on 22 Month14, shortly after the telephone call from Mr B, Dr C telephoned her and said that he had arranged for a second opinion for Mr A, but that it would take a few days to action.¹⁶

Further information

Clinical records

126. Mr and Mrs B told HDC that "[Mr A's] medical file contains many inaccuracies, omissions and fabrications". They said that, in the 10 days immediately before Mr A's death, they made numerous telephone calls that are not recorded. They considered that records of the contact they made with the mental health service during that period were either not recorded, or were removed from the file retrospectively.
127. Furthermore, Mr and Mrs B told HDC that some of the records erroneously state that calls were made from staff to them, whereas in fact Mr and/or Mrs B made the call. They also told HDC that they made a number of calls to PDN E and PDN D that are not recorded, as is discussed further below.
128. Dr C stated that with advancing experience with a patient it is usual that the case notes become briefer and provide more summary comments. He said that all the telephone conversations he had with Mr and Mrs B are documented. Dr C stated: "I have not fabricated or altered any notes as the complaint suggests and I don't believe my colleagues did." In response to the provisional opinion, Dr C said: "[A]ll my communications with [Mr and Mrs B] were recorded in the case notes. All the phone conversations I had with [Mr and Mrs B] in 2013 were calls made by me ... I did not tamper with the clinical record."
129. SDHB told HDC that there is a high likelihood that not every interaction with Mr A was noted in the clinical record. It noted that on occasion PDN E may have received

¹⁶ Dr C was not aware of Mr A's death at this time.

up to seven telephone calls per day with regard to Mr A, many of which were while he was away from his desk, and so not all are documented.¹⁷

130. SDHB stated that it “can certainly find no issue with regards to falsification of medical records”, although it could well be that there are gaps in the clinical record.

Planning documents

131. Mr A’s clinical records include four “Treatment Plan/Review” documents, dated 18 Month5, 21 Month8, 14 Month11 and 20 Month14. The Treatment Plan/Review documents state that Dr C, PDN D and PDN E were present at each review, along with a clinical psychologist, an occupational therapist, a social worker, and a psychiatric district nurse (and, on 14 Month11 and 20 Month14, a psychiatric registrar). The documents include spaces for the consumer and the person completing the relevant document to sign. All the Treatment Plan/Review documents are signed by PDN E; however, none are signed by Mr A.
132. There is one relapse plan¹⁸ in the records dated 21 Month8, which includes detailed early warning signs and identifies a number of triggers. The plan contains information on whom to contact in a crisis situation. The only reference to antipsychotic medication is a discussion of using extra olanzapine if necessary.
133. PDN E stated that he did not attach Early Warning Sign and Relapse Plans to Mr A’s treatment plans on 18 Month5, 14 Month11, and 20 Month14 because Mr A was “ambivalent” about completing them and did not provide the necessary input to enable PDN E to complete them. In response to the first provisional opinion, Mr and Mrs B said that Mr A was not ambivalent; rather, he was “simply not engaged”. SDHB stated that its staff were “assertively engaging” with Mr A and trying to complete a relapse plan but Mr A was unwilling to do so and he “would not provide consent for the team to work with [Mr and Mrs B]”. However, there is no record of Mr A refusing to complete plans or refusing to allow consent for his parents to be involved in plans.

Subsequent events

134. Mr and Mrs B made a complaint to Patient Affairs regarding the care their son received, and also complained to HDC.
135. Mr and Mrs B complained that the mental health service did not respond to their escalating concerns about Mr A’s well-being or their repeated requests for a second clinical opinion.

¹⁷ In response to the provisional opinion, Mr and Mrs B provided HDC with a table of calls made, and asserted that 16 calls in total were not recorded in the clinical notes. They stated that there was only one day on which seven calls were made. Mr and Mrs B said that they always asked if it was “an appropriate time to speak to PDN E”, and that they were never given an indication that they were interrupting him during the course of other clinical duties. By their account, between 26 Month13 and 19 Month14 there were 37 calls.

¹⁸ A plan to identify early warning signs of a relapse and actions to take should they occur.

136. Following Mr A's death, SDHB completed a Serious Adverse Event¹⁹ report (the SAE report) into the care provided to Mr A, led by psychiatrist [Dr K] and the charge nurse manager of the emergency mental health service, Ms L. In response to the provisional opinion, Mr and Mrs B said they told [Dr K] and the Medical Director of the Mental Health, Addictions and Intellectual Disability Service at SDHB that they "believed that in terms of natural justice [Dr K] was not the appropriate person to conduct the inquiry because of his close association with [Dr C]".
137. The SAE report concluded that, in the reviewers' opinion, appropriate clinical care was provided to Mr A. The SAE report recommended that all clinical interactions (including telephone conversations with family members) are documented, and that an SDHB staff member should be identified as a contact person for bereaved families.
138. SDHB sent Mr and Mrs B a letter responding to their Patient Affairs complaint. SDHB's response was extensive and included:

"It is very clear that you both had grave concerns for [Mr A's] health. These concerns are documented in the clinical record and include follow up by the clinical team with [Mr A] as a direct result of family contact. ... [There was] a discrepancy between what was reported by you and what was assessed by the [mental health service] team members, and reported by [Mr A]. The [mental health service] team feel they did listen to your concerns but felt the concerns often lacked detail. ...

The [mental health service] team found it was a difficult balance trying to engage with [Mr A] and supporting yourselves. The team felt you were in frequent disagreement with each other, with [Mr A] and members of the [mental health service] team. ... The [mental health service] team believe they acknowledged [your] concerns and responded in a timely manner but often found that [Mr A's] clinical presentation did not match the concerns identified by you both."

139. SDHB noted that, as a result of Mr and Mrs B's complaint:

"[T]here have been a number of areas for improvement identified both within [the mental health service] and the wider [mental health service]. These include a review of the metabolic monitoring data sheet as part of a District-wide physical health monitoring project; implementation of a policy regarding Second Opinions; and reinforcing the need to maintain comprehensive records of contacts with family members."

140. Mr and Mrs B appealed both the SAE report and SDHB's response to their Patient Affairs complaint. SDHB responded in a report dated 30 April 2014 (the appeal report).
141. The appeal report noted that SDHB did not have a formal second opinion policy at the time of these events, and that it had since developed a Second Opinion policy.

¹⁹ Severity Assessment Code 2 (SAC2).

142. The appeal report concluded that, while there were “less than optimal matters of documentation and other events during [Mr A’s] clinical pathway”, there were no major departures from the standard of care expected of SDHB’s mental health services.
143. The appeal report noted that there were some deficiencies in the SAE process followed after Mr A’s death, and that the bereavement support SDHB provides for families who have lost someone in these circumstances needs to be reviewed.

Dr M’s report

144. In response to the independent expert advice obtained by HDC (discussed below), SDHB commissioned an independent review of Mr A’s care from psychiatrist Dr M, and his report is summarised below. In response to the first provisional opinion, Mr and Mrs B said that they were never invited to be part of this process, whereas Dr C was allowed to give his version of events.

Assessments

145. Dr M considered that, when Mr A initially engaged with the emergency mental health service and the mental health service, comprehensive assessments were made by Dr G, Dr C and PDN E. Dr M noted that later the mental health service’s assessments identify but do not describe in detail key symptoms, but he considered that documentation is “likely ... informed by each clinician’s earlier detailed knowledge of the nature of [Mr A’s] psychotic symptoms”. Dr M considered that there is little evidence of formulation of risk documented in Mr A’s notes (which would have been best practice) but, overall, the risk assessment processes reach “a minimum test for appropriate standard”.

Antipsychotic treatment

146. In Dr M’s view, a longer period of antipsychotic treatment was indicated in Mr A’s case because, when he ceased taking olanzapine entirely in Month12, he had been taking olanzapine for less than a year,²⁰ and, in addition, he had had a recent relapse of his symptoms (in Month11). Dr M also noted that the presence of a probable two-year prodrome meant that an enduring psychotic disorder was likely, and that Mr A’s symptoms were unlikely to be solely the result of substance abuse. Dr M considered that, if side effects from olanzapine were barriers to its ongoing use, an antipsychotic with different side effects could have been considered.
147. Dr M noted that the clinical records show that there were differing views at different times between Mr A and his parents about the use of olanzapine. Dr M said that the views of a patient and his or her family are a very important factor in deciding treatment options and maintaining an effective therapeutic relationship.
148. Dr M stated that he considers that the clinical records do not show clear evidence that advice was given to Mr A and his parents to continue antipsychotics for longer, or that the option of trialling another antipsychotic was discussed, except on 27 Month3. Dr

²⁰ Dr M noted that standard practice is to continue antipsychotics for at least one year post-remission from a first episode, and that relevant guidelines recommend one to two years.

M considered that this advice was important and, if not given, was one element of care by SDHB and Dr C that fell below an appropriate standard.

Engagement with parents

149. Dr M considered that, based on the clinical notes, the mental health service appropriately considered how the dynamics between Mr A and his parents were relevant to Mr A's treatment, and that the engagement by the mental health service with Mr A's parents was of an appropriate standard.

Use of the MHA

150. Dr M noted that, in the weeks prior to Mr A's death, his parents expressed significant concerns about his unusual behaviour, follow-up with Mr A became more difficult, and Mr A had decided to stop taking olanzapine. Dr M considered that this combination of circumstances raised the question of whether or not a period of compulsory assessment under the MHA was indicated. Dr M stated that, with the benefit of hindsight, "one could argue that a period of compulsory inpatient assessment might have allowed closer observation for evidence of psychosis if Mr A was disguising such symptoms, as he indicated he ha[d] done previously during his assessment with the DHB2 services". Overall, however, Dr M considered that this was speculative and, accordingly, the decisions made about the use of the MHA were of an appropriate standard.

Dr C

151. Dr C told HDC: "I must say ... how sorry I am about [Mr A's] death, and for his family's loss and how sorry I am for the horrible time his parents have had."
152. Regarding the presence of a prodrome, Dr C told HDC:

"This is relevant because a long prodrome should generally guide us to more prolonged use of an antipsychotic drug. The lack of a prodrome will influence clinicians towards a shorter duration of treatment with antipsychotic medication.

However assessment of prodrome in the presence of drug use and acute psychosis (the case [for Mr A] in early 2012) is not easy. As time went on our impression of a significant prodrome changed and I was influenced in my assessment of the prodrome by [Mrs B's] view on 22 [Month10] that [Mr A] had been entirely well until his psychotic episode [in Month1] implying: no prodrome."

153. Regarding Mr A's presentation at DHB2, Dr C told HDC:

"It was not clear to me that this was a relapse, for several reasons. First, [Mr A] had a history of brief disturbances associated with drug use. Second, even if [Mr A] was not using drugs ... we had a lot of experience at the time of young people having brief psychotic-like disturbance of mental state when they suddenly stop using synthetic cannabinoids. Third, the onset did appear to be very rapid. ... Fourth, that episode resolved rapidly over a similar time frame to several earlier disturbances of [Mr A's] behaviour which had not appeared to be psychotic relapses but had been related to drug use. Fifth, [Mr A's] continued wellness even

when he stopped taking olanzapine also suggested the episode had been other than a relapse of an ongoing illness. So, I was not sure.”

Responses to provisional opinion

154. Extensive responses were made by all parties. These have been considered carefully and amendments made to the opinion where relevant. In addition, the following submissions were made:

Mr and Mrs B

155. Mr and Mrs B submitted that there were systemic failures at Southern DHB in that: nurses assessed and discharged Mr A when he presented at the emergency mental health service without reviewing his history or having sign-off by a doctor; emergency mental health service staff discharged Mr A at night without support; and clinicians were not adequately trained in suicide prevention and suicide assessments.
156. Mr and Mrs B also noted that there were long periods when Mr A was more stable and they had little contact with the service.

Dr C

157. Dr C’s extensive submission included the following points:
- He did consider the picture Mr A drew but did not ask to see it or refer to it in the clinical records because “it appeared not to indicate [Mr A] was psychotic” and Mr A “calmly and clearly [offered] a reasonable and non-psychotic explanation for it”. Dr C said that only in hindsight can this be seen as an opportunity missed.
 - On the three times he saw Mr A in 2013, “his presentation didn’t suggest any kind of deteriorating trajectory at all”.
 - He was aware of evidence that there was a prodrome, but in his discussion with Mrs B in Month10 she was sure that Mr A had been well prior to his admission to the mental health inpatient service.
 - Mr A and his mother continued to indicate that they did not want Mr A to have antipsychotic drugs and, in any event, there was no evidence of psychosis. Mr A was assessed and, as he was found not to be psychotic, an antipsychotic medication was not restarted.
 - The team repeatedly saw and noted the evidence that Mr A was psychotic as well as the evidence that he was not psychotic: “Relapse was not the only explanation [for Mr A’s behaviour] and the other information we had pointed distinctly away from relapse.”
 - Mr A was “perfectly aware that other drugs were less sedating, but also that they might have other side effects” (from Month3 and other times when medication was “touched on”). However, Dr C stated that “in the face of continued reluctance for [Mr A] to have antipsychotic medication from [Mr A] and his mother, we were going to need [a] particularly compelling case to restart medication”.

- Dr C told HDC:

“[Mrs B] continued to voice her opposition to him having drug treatment as recorded on 13th [Month14]. I knew, as did my colleagues, that we were going to have to have particularly persuasive reasons to get [Mr A] to restart an antipsychotic drug of any kind. In view of our difficult relationship with the family I did not want to nag.”
- Dr C stated that he considered a number of factors in relation to Mr A’s presentation during Months12-14 that indicated that Mr A was not psychotic, and that these were recorded at different times in the clinical notes. These included that Mr A presented with: no formal thought disorder; no concerns about people looking at him or talking about him; he was candid and had a warm manner; was alert; animated; humorous; had good eye contact; was not anhedonic; he was hopeful; he had no odd mannerisms; and he was not evasive.
- Mr A’s irritability or failing to attend appointments were not particular signs of deterioration.
- Mr A’s parents’ accounts and concerns were inconsistent and hard to clarify, and often they differed from each other. The parents were concerned about Mr A’s drug and alcohol use. PDN E and another senior nurse spoke to Mr A’s parents multiple times and heard no particular evidence that he was psychotic. There were difficulties with engaging with the parents, and “[the] concerns raised by [Mr A’s] parents in Month14 were not about delusions, or hallucinations, or him being a risk to himself”.
- The case files do not show that Mr A’s parents contacted Dr C “at all with concerns, escalating or otherwise, in [Months12-14] ... We knew [Mr A] was at risk of becoming psychotic, and the assessments I and my colleagues made reflect this.”
- The team placed “more emphasis than might be ideal on [Mr A’s] own account”.
- His notes from each time he saw Mr A in [Months12-14] contain explicit reference to exploring the possibility that Mr A might be psychotic, and at no time do the notes rule out the possibility that Mr A had a more enduring psychosis.
- The evidence was not of escalation or progression, “but of isolated events and concerns separated by good evidence that [Mr A] was not psychotic” and that, on the three times he saw Mr A in [Months12-14], Mr A’s “presentation didn’t suggest any kind of deteriorating trajectory at all”.
- With regard to Mr A’s unusual behaviour, he gave a reasonable and not farfetched account of events.
- Despite his using reasonable care and skill, either Mr A’s relapse was not identified or he was not relapsing.

- In Month13 and Month14, Mr and Mrs B did not make calls to him or leave messages with his colleagues for him to contact them.
 - Mr A was repeatedly intoxicated in the last weeks of his life and, when seen afterwards, he was sometimes hung over but without evidence of psychosis. There were issues of concern on 18 Month14 which “in light of [Mr A’s] non psychotic presentation at other times looked simply to be isolated events, not escalating or progressive deterioration at all”.
 - The service obtained further information after 18 Month14 (ie, that Mr A’s injuries might have been self-inflicted, that he poured paint on the road, and that he might have tried to burn his bed). There was a request for a second opinion at that time, which was the first such request since before Month11.
158. Dr C provided an opinion from Dr N, a Psychiatrist at SDHB. Dr N opined that the first provisional opinion did not take into account the difficulties the team had in trying to keep Mr A under treatment, the “balancing act” between respecting Mr A’s autonomy and keeping his parents informed, and the puzzling and changing nature of his symptoms.

Southern DHB

159. SDHB stated:

- The mental health service worked closely with Mr A from Month3 until Month14. “There was a complex family dynamic and the team strived to reconcile [Mr A’s] clinical presentation, his wishes, and the concerns of his parents [Mr and Mrs B]. For much of the time the team worked with [Mr A] and his parents, this balance was achieved.”
- Recovery plans are valuable, but they require the engagement of the consumer and their consent to work with the family, which in this case was not provided. SDHB submitted: “[T]hat [Mr A] was not recorded to have refused completion of the relapse plan dated 21 [Month8] is not germane to his ongoing treatment.”
- The events noted by the DHB2 team in Month11 “may have been a possible relapse of psychotic symptoms”; however, Mr A recovered quickly within two days.
- Mr A did not talk to any member of the mental health service about experiencing psychotic symptoms after Month11 “despite being asked continually”.
- PDN E attended assessments with Mr A and Dr C and others with Mr A’s parents “where medication was discussed at length”. Mr A was aware of non-sedating options but he was at times reluctant to use them, and his parents were reluctant for him to have them.
- Not attending appointments is not exclusively a sign of deterioration in young people. All possible steps were taken to facilitate Mr A’s attendance.

- The difficulties reported “could all be attributed to a young man struggling with his direction and place in life”.
- Mr A’s mother said that on the day before his death she took him shopping and for a meal. SDHB believes that this indicates that he was not experiencing psychotic symptoms at that time.
- Joint decision-making was “less than optimal” in this case; however, this was “not due to a lack of commitment by [the mental health service], but rather an unfortunate consequence of the difficulties in reconciling [Mr A’s] clinical presentation, his wishes, and the concerns of his parents”.

160. SDHB accepts the proposed recommendations. SDHB mental health service initiated actions to improve service delivery.

Dr M

161. A further report was provided from Dr M.
162. Dr M stated that he had interviewed Dr C previously, and his (Dr M’s) views had remained consistent between his reviews of the paper files and interviewing Dr C.
163. Dr M considered that in the period 20 Month11 until 22 Month14:

- With regard to psycho education and advice about the advantages of continuing an antipsychotic: “There is insufficient information in the clinical record and in my interview with [Dr C] to give me confidence that these matters were appropriately discussed. I therefore remain of the view that this aspect of care fell below an appropriate standard.”

Dr M noted that the indications for such a conversation were greater after Month11 than prior to that. Dr M stated that “this was the only aspect of care that [he] considered fell below an appropriate standard”, and that it was a failure to a “moderate degree”.

- However, Dr M said that this does not mean there was a failure to initiate treatment, as that would have required Mr A’s agreement or the use of compulsion under the MHA.
- The absence of an agreed and signed relapse plan is not evidence of the absence of attempts at shared planning.
- Efforts to engage Mr A did not lack assertion, and the attempts to follow up when Mr A failed to attend appointments, or at other times of particular concern, were appropriate.

Opinion: Preliminary matters

164. For the avoidance of doubt, my role does not extend to determining the cause of Mr A's death. My role is to assess the quality of care provided to him in light of the information that was known at the time that care was provided. Accordingly, my opinion should not be interpreted as having any implication as to the cause of Mr A's death.
165. This report is focussed on the care provided to Mr A, and does not cover a number of other issues raised by Mr and Mrs B, which include, but are not confined to, their interactions with SDHB following Mr A's death.
166. At the outset, I note that this matter has been considered by a number of advisors including [Dr K], Dr M, Dr N and Dr Humberstone. I note that [Dr K] and Dr N both have professional relationships with Dr C and SDHB. Consequently, although I have considered all opinions carefully, I have been guided more by the opinions of Dr M and Dr Humberstone.
167. This investigation has been complex, and I have taken a considerable period of time to carefully review and consider the substantial quantity of material provided.

Opinion: Southern District Health Board — Breach

Treatment under the mental health service, Month3–Month11

168. On 3 Month3, Mr A was discharged from the mental health inpatient service. The discharge plan was for Mr A to have follow-up from PDN E and Dr C at the mental health service, ongoing support from CADS, and for the emergency mental health service's contact details to be provided for out-of-hours/emergency situations. In addition, Mr A was to continue to take 10mg olanzapine twice daily.
169. Mr A's care was discussed regularly at multidisciplinary team meetings, where usually Dr C and PDNs E and D were present, as well as clinical psychologist Dr F, occupational therapist Ms H, and social worker Ms I.
170. During this period, Mr A was seen on a number of occasions by PDN E, PDN D and/or Dr C. On a number of occasions, Mr A did not attend scheduled appointments (generally these were followed up by PDN E via a text message or telephone call to Mr A).
171. However, there were also several instances when Mr and Mrs B contacted the mental health service or Dr C to express concern about Mr A's mental state and/or suspected drug/alcohol use. In the period prior to Month11, Mr A's parents made contact with the mental health service expressing concern about their son's well-being, including his lack of motivation, personal hygiene, sleep patterns, and use of alcohol and drugs. At times, Mr A was happy for his parents to be involved in his care, but on other

occasions it is noted in the clinical records that he expressed irritation with his parents' involvement.

172. PDN E completed one relapse prevention plan, dated 21 Month8; however, the relapse plan had no input from Mr A and his parents.
173. PDN E stated that he did not attach Early Warning Sign and Relapse Plans to Mr A's treatment plans because Mr A was ambivalent about completing them and did not provide the necessary input to enable them to be completed.
174. In response to the provisional opinion, SDHB submitted that the team were "assertively engaging with [Mr A] but that [Mr A] was unwilling to work with the service to develop a plan and did not provide consent to do this with his parents". However, I note that, in this respect, there is no refusal by Mr A recorded in the clinical records.
175. The 21 Month8 relapse and recovery plan included detailed early warning signs and identified a number of triggers. It contained information on whom to contact in a crisis situation. However, the only reference to antipsychotic medication was a discussion on using extra olanzapine if necessary.
176. My expert advisor, psychiatrist Dr Verity Humberstone, advised:

"The main advantage in developing relapse recovery plans is to use these as a psycho-educational tool to inform both the consumer and family members about the illness, about early warning signs and how to actively intervene to prevent relapse. Although it is important that a plan is available for staff to check early warning signs off, the main purpose of a relapse prevention plan is for the benefit of the consumer and family. Therefore developing these plans several months after discharge from hospital and in the absence of the consumer or family is not a useful clinical approach."

177. Dr Humberstone further advised that developing recovery plans with family members can be an effective way for clinical services to ascertain the subtle signs of relapses that may have been noticed by the family, which the services may be unaware of. Similarly, consumers themselves may describe subtle changes at an early stage, which would inform services, should more assertive intervention be required. SDHB agreed that recovery plans are valuable but said that they require the engagement of the consumer and the consumer's consent to work with the family, which, in this case, was not provided. Mr A's parents stated that Mr A was not ambivalent but he was not engaged in the process, and that in Month11 PDN E did not follow up and help Mr A to complete the plan as agreed.

178. Dr Humberstone stated:

"One of the features of [Mr A's] psychiatric records that seems apparent was that there was a miss-match in the level of concern expressed by the family compared with the staff. Having a shared relapse recovery plan and explicit discussion

around the different manifestations of psychosis and schizophrenia and the evidence based treatment for them, may have reduced some of these differences.”

179. In my view, during the period of Month3 to Month11, for the most part, Mr A and his parents received regular and assertive follow-up in the community from the mental health service and access to different multidisciplinary team members.
180. However, the 21 Month8 relapse plan was developed without input from Mr A or his parents. Furthermore, Mr A’s records do not show refusals to complete a relapse plan or to allow his parents’ involvement in the development of such a plan. In the absence of any such record, I remain of the view that the lack of a relapse plan that had been discussed with Mr A and his family (with his consent) amounted to suboptimal care.

Treatment under the mental health service, Month11–Month14

181. On 7 Month11, while travelling with his father for a holiday, Mr A attended DHB2 Emergency Department. He was seen by a psychiatric registrar and a crisis nurse, who recorded that Mr A had had several stressful periods since leaving home, and that he felt anxious being around people in streets and in shops. Mr A reported anxiety, auditory hallucinations including voices that made derogatory comments about him, poor sleep, and the belief that he had a microchip in his ear that had been planted by his parents. The form that staff completed has “suicidal ideation” circled and “yes” to having thoughts that life was not worth living and thoughts of self-harm. However, it is also noted that Mr A denied any thoughts of harming himself or others, and said that the voices were not telling him to do so. Mr A said that the voices had in the past told him to self-harm, but he was able to “distract & reality orientate at these times”.
182. Mr A told the staff that his dose of olanzapine had been reduced gradually and, at that time, he was on 5mg at night. He said that two weeks previously when his dose had been reduced from 10mg he had started experiencing hallucinations. He denied any recent history of abusing synthetic cannabis.
183. Mr A said that he had been refused a brain scan at his last admission, and he believed people might be colluding against him. Mr A did not want his father to be informed of his symptoms, and said he might not have told the SDHB treating team about his symptoms as he was feeling “pressure” from clinicians, family and friends to be well.
184. The DHB2 clinicians gave Mr A a prescription for three days’ medication and offered an admission, which Mr A refused. The records of the consultation were faxed to the clinical team at SDHB.
185. Following Mr A’s return from holiday in Month12, he did not attend two scheduled appointments with Dr C. On 14 Month12, Mr B telephoned PDN E and expressed concern that Mr A was smoking cannabis and not attending his course. Mr A next attended an appointment with Dr C on 21 Month12 accompanied by his mother. Dr C recorded that Mr A was oppositional and irritated by his mother, but not psychotic, and had no suicidal ideation.
186. Regarding Mr A’s treatment at DHB2, Dr C recorded:

“[Mr A] has gradually come off olanzapine ... He claims his crisis [while on holiday] quickly and wholly resolved, and that he has no ongoing voices. Refused to discuss further — but claims it was all due to a holiday he didn’t want.”

187. Dr C noted that he needed to see Mr A alone, and arranged to see him on 25 Month12. However, Mr A did not attend that appointment.
188. SDHB stated that the events noted by the DHB2 team in Month11 “may have been a possible relapse of psychotic symptoms”; however, Mr A recovered quickly within two days and did not talk about experiencing psychotic symptoms to any member of the mental health service after that time “despite being asked continually”. SDHB stated that during consultations medication was discussed at length and Mr A was aware of non-sedating options but was at times reluctant to use them, and his parents were reluctant for him to have them. Dr C said that he was unsure whether Mr A had suffered a relapse in Month11.
189. Dr Humberstone advised that the incident in which Mr A presented to DHB2 Emergency Department indicated that Mr A had experienced an exacerbation of psychotic symptoms following the reduction of the olanzapine. She stated that there were clear signs of relapse of the symptoms that had been present when he was admitted to hospital in Month2. The signs included Mr A’s persecutory delusions, delusions involving déjà vu experiences, auditory hallucinations, and delusions of control involving a transmitter device. There were also signs of psychosis, such as mood changes and sleep disturbance. Dr Humberstone considered it significant that Mr A had found it difficult to discuss his symptoms with his family and the mental health service team because he felt under pressure to be well. Furthermore, Mr A believed that his parents had caused the transmitter to be in his head. Dr Humberstone noted that, as Mr A became more unwell, his irritability towards his parents and his reluctance to disclose symptoms increased.
190. With regard to the information from the consultation at DHB2, Dr Humberstone advised:
- “This was very important information for the [mental health service] to have used on [Mr A’s] return to their team. This material should have been used to inform the need for ongoing antipsychotic treatment and the need of the best way therapeutically to work with [Mr A].”
191. Dr M was of the view that a longer period of antipsychotic medication was indicated, particularly after Month11. Dr M stated that, with regard to psycho education and advice about the advantages of continuing an antipsychotic, there is insufficient evidence in the clinical record to give him confidence that these matters were fully and appropriately discussed with Mr A and his family. Dr M considered that in the period post Month11 (DHB2 presentation) this was, in his opinion, a failure to meet expected standards to a moderate degree.
192. Dr Humberstone also considered that antipsychotic medication should have been reinstated, and that this should have been discussed in detail with Mr A and his

parents as an important treatment recommendation. Dr Humberstone considered that, certainly by Month14, there were “clear signs of significant concern in [Mr A’s] mental state that would be indicative of the need to assess for and start an antipsychotic medication”. Dr Humberstone noted that although Mr A had difficulties with sedation while taking olanzapine, there is a range of other non-sedating antipsychotic medication that could have been offered.

193. I agree with Dr Humberstone and Dr M that the reinstatement of antipsychotic medication should have been more fully discussed with Mr A following his presentation at DHB2. In this respect, I consider that further action should have been taken by Mr A’s treating clinicians following his return from holiday. However, I note that when seen by Dr C on 21 Month12, Mr A refused to discuss the events of Month11 in any detail, and Dr C assessed him as having no psychotic symptoms at that time. Consequently, I consider that it was not unreasonable for Dr C to make another appointment for 25 Month12 to see Mr A without his mother being present.
194. In response to the provisional opinion, Dr C stated that Mr A was assessed and, as he was found not to be psychotic, an antipsychotic medication was not restarted. Dr C said that Mr A was well aware of antipsychotic options (from Month3 and other times when medication was “touched on”) and “in the face of continued reluctance for him to have antipsychotic medication from [Mr A] and his mother, we were going to need [a] particularly compelling case to restart medication”.
195. I note that the clinical records do not contain any record of Mr A having refused medication. Dr C said that the reason he did not record the conversations about alternative medication was because Mr A was “perfectly aware that other drugs may be less sedating, but also that they might have other side effects”.
196. In this respect, Mr and Mrs B told HDC: “[T]he option of going back on medication was not discussed and that is why it is not on file. [Dr C] did not discuss treatment with [Mr A] or family in [Months12-14].” Mrs B told HDC: “[Mr A] had an appointment [in Month12] with Dr C which could have avoided decompensation by prescribing medication for [Mr A]. It was not discussed, a proper examination was not done, and a proper history taking was not done.”
197. Given the above factors, I remain of the view that Mr A was not made sufficiently aware of the alternative treatments available.

Parents’ escalating concerns and Mr A’s behaviour

198. Between Month11 and Month13, there were increasing numbers of telephone calls to the mental health service from Mr A’s parents, expressing concerns about his drug abuse and lifestyle. During this time, Mr A attended appointments with his parents. Mr A then agreed to attend an appointment with Dr C on 27 Month13, without his parents, during which Mr A indicated that he did not want his parents involved in his care. According to the clinical notes, Mr A felt anxious around large groups, had reversed day/night cycle, and was missing his course owing to anxiety; however, he reported feeling well, he was not suicidal, and he did not exhibit any psychotic phenomena. By Month14 there were significant signs that Mr A’s parents’ concerns

were escalating and that Mr A's mental condition may have been deteriorating, as summarised below:

- On 6 Month14, Mr A did not attend an appointment.
- On 12 Month14, Mr A self-presented at the emergency mental health service requesting sleep medication, and reported a recent history of poor sleep and heightened anxiety, and said he had "thoughts in [his] head" when he tried to sleep, but denied he was unsafe.
- On 12 Month14, according to Mrs B she called the mental health service six times and provided detailed descriptions of Mr A's symptoms and issues (he had not eaten or washed, was agitated and angry, had lost "huge" amounts of weight, and would not attend the emergency mental health service or the mental health service).
- On 13 Month14, Mr B telephoned PDN D and reported that Mr A had called him at 1am saying that he had spent several hours drawing a picture that he could not remember drawing.
- On 13 Month14, Mr A did not attend his scheduled appointment with the mental health service, and Mrs B telephoned the service twice expressing concern. Dr C rang Mr A, who said that he had forgotten about the appointment, and they agreed to meet on 18 Month14.
- On 14 Month14, Mrs B called PDN E and expressed concern for Mr A's safety.
- On 14 Month14, PDN E attempted to see Mr A by visiting his house and calling his cell phone, but Mr A said that he did not wish to be seen.
- On 15 Month14, Dr C called Mr A and arranged an appointment for that day, but Mr A did not attend.
- On 15 Month14, PDN E saw Mr A and recorded that Mr A was "not suicidal at present" but that he had dropped out of his course and was feeling "particularly anxious at times".
- On 15 Month14, PDN E talked to Mr B regarding his concerns about Mr A, and told Mr B that, if he was concerned about Mr A's safety, he could use section 8 of the MHA.
- On 18 Month14, Mr and Mrs B telephoned the mental health service a number of times during the day.
- On 18 Month14, Dr C and PDN E visited Mr A at his home. Mr A had consumed a large amount of alcohol the previous night and could not recall what had happened but believed he had been beaten up. It was noted that there were no signs of psychosis.
- On 19 Month14, Mr and Mrs B rang the mental health service requesting a second opinion of Mr A's condition. Mrs B told PDN E that Mr A had told her that his injuries from the previous weekend were self-inflicted, and said that she believed he was mentally disordered and needed hospital treatment.

- On 20 Month14, Mr A did not attend a scheduled appointment.
 - On 21 Month14, Mrs B telephoned the emergency mental health service expressing concern about Mr A.
 - On 21 Month14, Mrs B called again expressing concern and stating that she did not know Mr A's current whereabouts.
 - On 21 Month14, Mrs B called the emergency mental health service and expressed concern and said that previously Mr A had tried to burn his bed and had poured paint over the street.
 - On 21 Month14, Mrs B completed an application form, pursuant to section 8 of the MHA.
 - On 21 Month14, Mrs B emailed Dr C expressing concern and asking for a second opinion and for Mr A to be hospitalised.
199. The mental health service faced difficulties engaging with Mr A and, although there were regular scheduled appointments with Dr C and follow-up calls to Mr A when he did not attend appointments, it is clear that this system was not effective in facilitating Mr A's attendance. I note that Dr M considered that the efforts made to follow up non-attendance were appropriate. However, Dr Humberstone advised that other methods, such as co-ordinating assistance for Mr A to attend appointments, should have been considered. She stated:
- “These strategies are often used in community mental health context to help people who are reluctant to engage or finding difficulties engaging to attend regularly. As sometimes non attendance is a sign of deteriorating mental health in people with psychotic illness it is best practice to have clear strategies to enhance the likelihood of attendance and clinical review.”
200. Dr Humberstone advised that it may have been helpful to arrange one-on-one sessions with a team member to whom Mr A was close, in order to discuss his difficulties with disclosing his symptoms explicitly and reassure him that it was not a sign of failure if psychosis emerged, but something that happens episodically during recovery and can be treated effectively. I consider that this may have been helpful but, overall, I agree with Dr M that reasonable attempts were made by the team to follow up Mr A's non-attendance at appointments.
201. Dr Humberstone considered that the symptoms and functional changes described by Mr A's parents to different members of the mental health service team during this period were very clear. They included persistent difficulties with sleeping and organising daily activities, and signs of depression. Dr Humberstone stated: “It is likely they would have been even more detailed should they and the clinical team and [Mr A] have jointly worked on a plan exploring signs of psychosis utilising the expertise of the clinicians and the personal knowledge of [Mr A] and his parents.”
202. Dr Humberstone advised that Mr A having attended the emergency mental health service during the night on 12 Month14 was a clear indication that there were

concerns regarding his mental health, and stated that his description of difficulties with sleep, anxiety, and “thoughts in [his] head”, in the context of not being on antipsychotic medication and having intermittent triggers through marijuana use, were clear warning signs for the need for antipsychotic medication. In addition, Dr Humberstone considered that Mr B’s description of Mr A ringing him at 1am and talking about a picture in an unusual and detailed manner, indicated that he was likely to have been experiencing psychosis. She stated:

“If the staff had asked [Mr A] to see his picture and discuss the meaning of this with him this could have been a strategy which elicited a clearer understanding of his internal world. From the notes it does not appear this happened.”

203. In this respect, Dr C told HDC that he did consider the picture Mr A had drawn, but did not ask to see it or refer to it in the clinical records because “it appeared not to indicate [Mr A] was psychotic”, and Mr A “calmly and clearly [offered] a reasonable and non-psychotic explanation for it”. Dr C said that only in hindsight can this be seen as an opportunity missed.
204. I acknowledge Dr C’s submissions that Mr A’s irritability and failure to attend appointments did not, on their own, indicate relapse. However, in my view, there were sufficient indications that Mr A’s behaviour was escalating, but the mental health service clinicians did not recognise the signals in that regard. Mr A’s self-presentation at the emergency mental health service on 12 Month14 and the family’s escalating concern about Mr A, and reports about his behaviour, should have led to consideration that Mr A may have been relapsing. However, it seems that the staff considered that Mr A’s behaviour was normal.
205. SDHB accepts that “joint decision making was less than optimal in this case”, which was “an unfortunate consequence of the difficulties in reconciling [Mr A’s] clinical presentation, his wishes, and the concerns of his parents”.

Conclusions

206. During the period of Month3 to Month11, for the most part, Mr A and his parents received regular follow-up from the mental health service.
207. However, the mental health service staff failed to recognise that the events noted by DHB2 in Month11; the increase in contacts by Mr and Mrs B after Month11 and their reports of Mr A’s behaviour; and his self-presentation at the emergency mental health service on 12 Month14, signalled that Mr A was becoming more unwell, and so important indications were missed.
208. I accept that efforts were made to see Mr A when he did not attend appointments and, at times when clinicians did see him, his presentation seemed at odds with his parents’ descriptions. In addition, at times Mr A indicated that he did not want his parents involved in his treatment, which was a decision he had the right to make. I accept that the mixed messages Mr A gave about his parents’ involvement in his treatment, and the differences of opinion at times between Mr and Mrs B, impaired the ability of the mental health service to develop a plan jointly with Mr A and his parents.

209. However, the 21 Month8 relapse plan was developed without input from Mr A or his parents. Mr A's records do not show refusals to complete a relapse plan or to allow his parents' involvement in the development of such a plan. SDHB submitted: "[T]hat [Mr A] was not recorded to have refused completion of the relapse plan dated 21 [Month8] is not germane to his ongoing treatment."
210. In the absence of any such record, I remain of the view that the lack of a relapse plan that had been discussed with Mr A and his family (with his consent) amounted to suboptimal care. Furthermore, I consider that Mr A was not made sufficiently aware of the alternative treatments available, following his presentation to DHB2 in Month11. For the above reasons I consider that Southern DHB failed to provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Documentation — Adverse comment

211. Mr and Mrs B have made very serious allegations that SDHB staff deliberately removed information from the clinical records.
212. SDHB stated that it "can certainly find no issue with regards to falsification of medical records", although it could well be that there are gaps in the clinical record.
213. During Month13 and Month14, Mr A's parents made several telephone calls to the mental health service expressing concern for Mr A's well-being. There are a number of calls recorded between Mr and Mrs B to PDN E, PDN D and Dr C.
214. However, Mr and Mrs B told HDC that some of the records erroneously state that calls were made from staff to them, whereas in fact Mr and/or Mrs B made the call. They also told HDC that they made a number of calls to PDN E and PDN D that are not recorded. SDHB agreed that there is a high likelihood that not every interaction with Mr A was noted in the clinical record, and said that on occasion PDN E may have received up to seven telephone calls per day with regard to Mr A, many of which were while he was away from his desk, and so not all are documented.
215. Dr C told HDC that all of the conversations he had with Mr and Mrs B are documented.
216. I have not found evidence to support the allegation that the records have been deliberately falsified. However, I accept that not all contacts the team had with Mr and Mrs B were recorded, which is regrettable. I acknowledge that this was in part a consequence of work pressure and the number of contacts received. However, in my view, the mental health service staff should have at least kept a record of the number of contacts and the general nature of the concerns raised. This was particularly important in order to enable the whole team to be aware of the full picture in relation to Mr A's condition and subsequent decline. I am critical that this did not occur.

Inpatient admission, Month2 — Other comment

217. On 1 Month2, Mr A attended Medical Centre 1 wanting his ears checked to ensure that there were no transmitters in his ears. Later that day he was assessed by Dr G at

the emergency mental health service and subsequently admitted to the mental health inpatient service under section 11 of the MHA. Mr A reported that he could hear voices, via the transmitter in his ear, which were telling him to kill himself.

218. On 3 Month², Dr G met with Mr A's father and noted in the clinical records that he "emphasised that it is very unlikely that diagnosis is schizophrenia (although possible) but follow up with [the mental health service] as recommended to intensely monitor the situation to ensure that a diagnosis is made correctly". Dr G's preliminary diagnosis was psychosis secondary to substance abuse.
219. Mr A remained an inpatient until 3 Month³, with some periods of leave. During his admission, Mr A was assessed frequently by nursing and medical staff.
220. Dr Humberstone stated that, in her view, a diagnosis of schizophrenia was more likely than a psychosis secondary to substance abuse. However, she considered that the information that was given to Mr A and his parents at that stage — that schizophrenia was unlikely — was reasonable, "as often it is only the longitudinal progress of the client's mental health that determines the ultimate diagnosis".
221. Dr Humberstone advised that an appropriate level of psychiatric care was provided to Mr A during his inpatient admission. She noted that nursing and medical staff assessed his mental state frequently, and that Mr A was provided with information about his treatment. She considered that the use of olanzapine as an antipsychotic, supplemented when required by clonazepam, was appropriate.
222. Dr Humberstone also noted that family meetings occurred during Mr A's hospitalisation, and that appropriate discharge was arranged, during which Mr A and his parents had the opportunity to meet the community staff prior to discharge.
223. I agree with Dr Humberstone's advice that the care provided to Mr A during his inpatient admission in Month² was appropriate.

Response to complaints — Other comment

224. On 22 Month¹⁰, Dr C and PDN E met with Mr A and Mrs B following a call the previous day from Mrs B, who said that Mr A was sedated on olanzapine and that she wanted it withdrawn. Dr C recorded in the notes that Mrs B was convinced that Mr A was wholly well until a recent episode. Dr C agreed to cut and stop the olanzapine, and discussed early warning signs.
225. On 28 Month¹⁰, Mrs B wrote to Mr A's previous treating psychiatrist, Dr G, stating:

"We have initiated the tapering of olanzapine as it has long served its purpose and because the excessive daytime sleeping caused [Mr A] to be unproductive. However I have concerns regarding tapering his olanzapine and lack of treatment plan ... No information was given to us in case [Mr A] developed problems when withdrawing from olanzapine ... I feel that I was not listened to when I expressed concerns about olanzapine withdrawal."

226. On 30 Month10, Dr C replied to Mrs B: “I do doubt that he will experience any particular problems withdrawing from the olanzapine however, as I had indicated, there is a risk of psychotic experiences returning ... should he or yourselves have any concern ... please feel free to contact [the mental health service].”
227. On 5 Month11, apparently before she received Dr C’s letter, Mrs B wrote a letter of complaint to SDHB’s Patient Affairs, noting her concerns about Mr A stopping olanzapine and stating that she had not received a response to her concerns from Dr C.
228. On 6 Month11, Dr C reviewed Mr A in the presence of Mr B. Dr C recorded: “I mentioned [Mrs B’s] recent letter and they appeared to want to distance themselves from her concerns and her ongoing expressions of dissatisfaction with [Mr A’s] care.”
229. On 17 Month11, SDHB wrote a reply to Mrs B’s complaint letter of 5 Month11. The letter stated that PDN D had investigated the complaint, and noted:
- “The team looking after [Mr A] had been aware of your concerns about his care for some time and, on behalf of the team, [Dr C] apologises that they had not been more successful in addressing them.”
230. The letter also noted that Dr C considered that the mental health service had been “very responsive” to Mr A and his parents. In response to Mrs B’s concern about withdrawal symptoms, the letter stated: “[Dr C] and [PDN E] reported that they tried to reassure you that it was very unlikely [Mr A] would have any difficulty with withdrawal.” In response to Mrs B’s concern about Mr A’s sleep, the letter stated: “[Dr C] did not feel it needed specific intervention, but advised general measures, such as regular exercise. He is sorry if this gave the impression of nothing being done.”
231. Mr and Mrs B complained to Patient Affairs regarding the care their son received. They complained that the mental health service did not respond to their escalating concerns about Mr A’s well-being or their repeated requests for a second clinical opinion.
232. SDHB sent Mr and Mrs B a detailed letter responding to their Patient Affairs complaint.
233. I have considered SDHB’s responses to the complaints received. Given the level of detail in both the complaints and SDHB’s responses, I consider that SDHB’s responses were appropriate and timely.
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Opinion: Dr C — Breach

234. From Month3, Dr C was Mr A's treating psychiatrist. During this time, Mr A's care was discussed regularly at multidisciplinary team meetings, and he was seen regularly by Dr C and other members of the mental health service team.
235. At the time Mr A came under Dr C's care in Month3, he was taking olanzapine 10mg twice daily. Over the next eight months, Dr C progressively decreased Mr A's olanzapine prescription. On 22 Month10, Dr C and PDN E met with Mr A and Mrs B. Dr C recorded: "Agreed to cut and stop olanzapine. [Early warning signs] discussed." Dr C did not record any further detail about the discussion.
236. On 28 Month10, Mrs B wrote to Dr G, stating:
- "We have initiated the tapering of olanzapine as it has long served its purpose and because the excessive daytime sleeping caused [Mr A] to be unproductive. However I have concerns regarding tapering his olanzapine and lack of treatment plan ... No information was given to us in case [Mr A] developed problems when withdrawing from olanzapine ... I feel that I was not listened to when I expressed concerns about olanzapine withdrawal."
237. On 30 Month10, Dr C replied to Mrs B's letter:
- "I do doubt that he will experience any particular problems withdrawing from the olanzapine however, as I had indicated, there is a risk of psychotic experiences returning ... should he or yourselves have any concern ... please feel free to contact [the mental health service]."
238. Dr C said that, in Month10, he understood that Mr A's 2012 psychotic episode had not been preceded by a prodrome, and that factor, together with Mr A's good recovery without lingering symptoms of psychosis, made Dr C feel that it was reasonable for Mr A to come off the olanzapine.
239. However, on 7 Month11, Mr A self-presented at DHB2 reporting anxiety around people in streets and shops, auditory hallucinations including voices that made derogatory comments about him, poor sleep, and the belief that he had a microchip in his ear that had been planted by his parents. Mr A stated that he had started experiencing hallucinations two weeks earlier when his olanzapine dose was reduced.
240. The DHB2 clinicians re-commenced olanzapine at 20mg daily, and relayed this information to the mental health service. By 14 Month11, Mr A was taking 10mg daily.
241. Following Mr A's return from holiday in Month12, he did not attend two scheduled appointments with Dr C. On 14 Month12, Mr B telephoned PDN E and expressed concern that Mr A was smoking cannabis and not attending his course. Mr A next attended an appointment with Dr C on 21 Month12 with his mother. Dr C recorded

that Mr A was oppositional and irritated by his mother but not psychotic, and had no suicidal ideation. Dr C recorded:

“[Mr A] has gradually come off olanzapine. [Mrs B] cutting tabs down to 1 and 1 1/4mg. He claims his crisis [while on holiday] quickly and wholly resolved, and that he has no ongoing voices. Refused to discuss further — but claims it was all due to a holiday he didn’t want.”

242. By Month12, Mr A had ceased taking olanzapine completely.
243. Dr C made another appointment for 25 Month12 to see Mr A without his mother being present. However, Mr A did not attend the appointment.
244. With regard to the information from the consultation at DHB2, my expert advisor, Dr Humberstone, stated:

“This was very important information for the [mental health service] to have used on [Mr A’s] return to their team. This material should have been used to inform the need for ongoing antipsychotic treatment and the need of the best way therapeutically to work with [Mr A].”

245. Dr Humberstone advised that the incident in which Mr A presented to DHB2 Emergency Department indicated that Mr A had experienced an exacerbation of psychotic symptoms following the reduction of the olanzapine. She stated that there were clear signs of relapse of the symptoms that had been present when he was admitted to hospital in Month2, including persecutory delusions, delusions involving déjà vu experiences, auditory hallucinations, and delusions of control involving a transmitter device. She considered that there were also signs of psychosis such as mood changes and sleep disturbance. During Month13 and Month14, Mr A did not attend a number of scheduled appointments with Dr C, and his parents made several telephone calls to the mental health service expressing concern for his well-being. Mr A had contact with PDN E, including some home visits. On 12 Month13 PDN E recorded that Mr A’s mood was stable and he had no psychotic, suicidal or harmful thoughts. In response to the first provisional opinion, Dr C stated that Mr and Mrs B did not make calls to him or leave messages with his colleagues for him to contact them. However, I note that a number of contacts with the team are noted in Mr A’s clinical records.
246. Dr C saw Mr A again on 27 Month13 (following several calls from Mr B expressing concerns about his son). Mr A attended alone and, according to the clinical notes, reported feeling well; however, he felt anxious around large groups but was not suicidal, and did not exhibit any psychotic phenomena. Dr C documented:

“Discussed his parents’ ongoing concern. He has indicated clearly he does not want either involved in his care ... Overall, his account is at odds with his parents’ concerns and that he is depressed or drug addicted. His account today is very believable and that of his parents has often appeared based on their anxieties rather than observation.”

247. Mr A was scheduled for another appointment on 6 Month14, which he did not attend. At 4.35am on 12 Month14, Mr A self-presented at the emergency mental health service requesting sleep medication. Mr A reported a recent history of poor sleep and heightened anxiety, and said he had “thoughts in [his] head” when he tried to sleep, but denied he was unsafe. When the emergency mental health service refused to dispense sleeping medication, Mr A said that he would contact the mental health service or his GP and left. The duty nurse’s summary stated that Mr A might have early warning signs and would benefit from contact with his regular mental health service team.
248. Later in the day on 12 Month14, PDN E tried to call Mr A but received no reply, and exchanged some text messages with him confirming an appointment for the following day. At 8.45am on 13 Month14, Mr B telephoned PDN D and reported that Mr A had called him at 1am saying that he had spent several hours drawing a picture that he could not remember drawing. Mr B said he told PDN D that Mr A did not appear to be under the influence of drugs. Mr A did not attend his scheduled appointment with the mental health service that day, and the records show that Mrs B telephoned the mental health service expressing concern.
249. Dr C rang Mr A, who said that he had forgotten about the appointment, and they arranged to meet on 18 Month14. Dr C noted that Mr A said that he had no complaints and it “was all good”. On 14 Month14, Mrs B called PDN E and expressed concern for Mr A’s safety. Mrs B said that she spoke to PDN E twice on 15 Month14 expressing concern that Mr A was psychotic, and asked for a second opinion. There is no record of those calls in the clinical notes.
250. PDN E attempted to see Mr A by visiting his house and calling his cell phone but, according to the clinical records, Mr A said that he did not wish to be seen.
251. On 15 Month14, following a multidisciplinary meeting, the records of which note “? suicidal ? impulsive”, Dr C called Mr A and arranged an appointment for that day. PDN E then saw Mr A and recorded that he was “not suicidal at present”, but that he had pulled out of his course and was feeling “particularly anxious at times” before then escorting Mr A to his mother’s house. PDN E also had a separate conversation with Mr B regarding his concerns about Mr A, and recorded that he told Mr B that, if he was concerned about Mr A’s safety, he (Mr B) could use section 8 of the MHA.
252. On 18 Month14, Mr and Mrs B telephoned the mental health service a number of times. That day, Dr C and PDN E visited Mr A at his mother’s home after he did not attend a scheduled appointment. Dr C recorded:

“Although he can’t identify any other instance and we weren’t able to identify a very characteristic account of anxious avoidance. I suspect that his issues with his parents and his elder siblings being very successful and his own lack of confidence is likely to contribute to his being easily put off ... In his presentation, he is no more than, understandably, dishevelled. He is alert, makes good eye contact, speaks candidly without any odd mannerism or evidence of thought disorder. We

saw none of the subtle signs of psychosis. His mood is warm, animated and humorous, he is not suicidal.”

253. Dr C noted Mr A’s recent weight loss but attributed it to the stopping of olanzapine. Dr C also commented in the notes that Mr A was experiencing poor sleep, but attributed this to alcohol fuelled disruption and day/night reversal, and noted: “There is no evidence that he is psychotic.” Dr C recorded: “[O]ther than his excess alcohol, we didn’t see evidence of any further drug use and this is consistent with his previous accounts. Overall, we don’t get the impression of psychosis or of a narrowly defined mood disorder or of anxious avoidance although this may need further exploration.”
254. Dr Humberstone considered that, certainly by Month14, there were “clear signs of significant concern in [Mr A’s] mental state that would be indicative of the need to assess for and start an antipsychotic medication”. Although Mr A had difficulties with sedation while taking olanzapine, Dr Humberstone noted that there is a range of other non-sedating antipsychotic medication that could have been offered.
255. In response to the first provisional opinion, Dr C stated that Mr A was assessed and, as he was found not to be psychotic, an antipsychotic medication was not restarted. Dr C said that Mr A was well aware of antipsychotic options (from Month3 and other times when medication was “touched on”) and “in the face of continued reluctance for him to have antipsychotic medication from [Mr A] and his mother, we were going to need [a] particularly compelling case to restart medication”.
256. I note that the clinical records do not contain any record of Mr A having refused medication. Dr C said that the reason he did not record the conversations about medication was because Mr A was “perfectly aware that other drugs may be less sedating, but also that they might have other side effects”.
257. Dr M is of the view that a longer period of antipsychotic medication was indicated, particularly after Month11. Dr M stated that with regard to psycho education and advice about the advantages of continuing an antipsychotic: “There is insufficient information in the clinical record and in my interview with [Dr C] to give me confidence that these matters were appropriately discussed.” Dr M considered that in the period post Month11 (DHB2 presentation) this becomes a failure to meet expected standards of a moderate degree.
258. Dr Humberstone also considered that antipsychotic medication should have been reinstated, and stated that this should have been discussed in detail with Mr A and his parents as an important treatment recommendation. I agree with Dr Humberstone and Dr M that the reinstatement of antipsychotic medication should have been discussed more fully with Mr A following his presentation at DHB2.
259. In this respect, Mr and Mrs B told HDC: “[The] option of going back on medication was not discussed and that is why it is not on file. [Dr C] did not discuss treatment with [Mr A] or family in 2013.” Mrs B was present for the 21 Month12 appointment and stated that no discussions surrounding antipsychotic medication took place at that time.

260. The clinical records record that the option of trialling another antipsychotic was discussed only on 27 Month3. However, Dr C said:

“My notes about discussions with [Mr and Mrs B] about continuation of the olanzapine are less full than they might have been. Nonetheless I have recorded discussions with them that they appeared to understand, regarding the risks and benefits of stopping the olanzapine.”

261. Dr C told HDC:

“[Mrs B] continued to voice her opposition to him having drug treatment as recorded on 13th [Month14]. I knew, as did my colleagues, that we were going to have to have particularly persuasive reasons to get [Mr A] to restart an antipsychotic drug of any kind. In view of our difficult relationship with the family I did not want to nag.”

262. Dr Humberstone advised that the overall care provided to Mr A should have been “significantly more focussed on the role of antipsychotic medication preventing relapse”, and I agree. I note that Dr M also considered that a longer period of antipsychotic treatment was indicated in Mr A’s case because, at the time he ceased taking olanzapine entirely in Month12, he had been taking it for less than a year, and had had a recent relapse of his symptoms (in Month11). Dr M also noted that the presence of a probable two-year prodrome meant that an enduring psychotic disorder was likely, and that Mr A’s symptoms were unlikely to be solely the result of substance abuse.

263. The clinical records show that there were differing views at different times between Mr A and his parents about the use of olanzapine, and I accept that, as a competent adult, Mr A had the right to decide not to continue taking olanzapine. However, I consider that, given his problems with taking olanzapine, Mr A should have been made more aware of the alternative treatments available.

264. Dr Humberstone considered that Mr A’s diagnosis was schizophrenia with co-existing marijuana and alcohol abuse, rather than a drug-induced psychosis. Dr C and Dr M disagreed with the use of the term “schizophrenia”. In response to the first provisional opinion, Dr C stated that it was not clear that Mr A had a psychotic illness, and Mr A assured them that he was not suicidal. In my view, the issue is the treatment approach taken rather than the label for the illness.

265. I note Dr Humberstone’s advice that “in the context of a young man who has a clear psychotic illness, which is not fully resolved, the actions that occurred prior to his death would be indicative signs of psychotic relapse”. In response to the first provisional opinion, Dr C stated that his notes from the three times he saw Mr A in 2013 contain explicit reference to exploring the possibility that Mr A might be psychotic, and at no time do the notes rule out the possibility that Mr A had a more enduring psychosis. Dr C said that Mr A gave reasonable and not farfetched accounts of the events relating to his unusual behaviour. Dr C further stated that prior to 18 Month14 the evidence was not of escalation or progression, “but of isolated events

and concerns separated by good evidence that [Mr A] was not psychotic” and that, on the three times he saw Mr A in 2013, Mr A’s “presentation didn’t suggest any kind of deteriorating trajectory at all”.

266. Dr C stated that the team repeatedly saw and noted the evidence that Mr A was psychotic, as well as the evidence that he was not psychotic. Dr C stated that “signs of relapse were ambiguous and better explained by, for example, [Mr A’s] alcohol use”. Dr C said that Mr A may not have shown clear signs of relapse until after his last contact with Mr A. Dr C stated: “Relapse was not the only explanation [for Mr A’s behaviour] and the other information we had pointed distinctly away from relapse.”

Conclusion

267. I am not able to make a finding as to whether Mr A was having a recurrence of psychosis in 2013. However, I accept the advice from Dr M and Dr Humberstone that the use of antipsychotics was indicated in order to prevent a relapse during this time.
268. Mr A had been experiencing problems with taking olanzapine, such as a perceived sedative effect. I remain of the view that Mr A was not made sufficiently aware of alternative treatments available following his presentation to DHB2 in Month 11.
269. Accordingly, I find that Dr C failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Recommendations

270. I recommend that Dr C provide a written apology to the family for his breach of the Code. The apology should be sent to HDC within one month of the date of this report, for forwarding.
271. I recommend that Dr C undertake further education and training on recognition of deteriorating consumers, and provide evidence to HDC within three months of the date of the this report, confirming his attendance or enrolment.
272. I recommend that Southern District Health Board provide a written apology to the family for its breach of the Code. The apology should be sent to HDC within one month of the date of this report, for forwarding.
273. I recommend that, within three months of the date of this report, Southern District Health Board:
- a) Review the process for the development of recovery plans and their regular review, including clear processes for engagement with consumers and their families.
 - b) Provide refresher education sessions for the mental health service staff on the treatment of psychosis and substance abuse as co-existing disorders.

- c) Review the processes and practices within the mental health service for collaborative care planning with consumers and their families, and documentation of contacts.
 - d) Report on the implementation of the recommendations of the Serious Adverse Event report, including an audit of compliance with the new processes.
 - e) Arrange an independent audit of the mental health service documentation and provide the results of that audit to HDC.
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Follow-up actions

- 274. A copy of this report will be sent to the Coroner.
- 275. A copy of this report with details identifying the parties removed, except Southern DHB and the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr C's name.
- 276. A copy of this report with details identifying the parties removed, except Southern DHB and the expert who advised on this case, will be sent to the Mental Health Foundation of New Zealand and the Royal Australian and New Zealand College of Psychiatrists.
- 277. A copy of this report with details identifying the parties removed, except Southern DHB and the expert who advised on this case, will be sent to the Director of Mental Health.
- 278. A copy of this report with details identifying the parties removed, except Southern DHB and the expert who advised HDC on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent expert advice to the Commissioner

The following expert advice was obtained from psychiatrist Dr Verity Humberstone:

“Qualifications of Report Writer:

I obtained my MBCHB from Auckland Medical School in 1992.

I obtained my FRANZCP in 2000.

I hold a Post Graduate Diploma in Forensic Psychiatry.

I worked for the first 11 years as a Consultant Psychiatrist in an Intensive Community Team in Counties Manukau. For the last six years of this period of employment I was Clinical Head of Adult Mental Health Services.

Since late 2009 I have been employed as a Consultant Psychiatrist for Northland District Health Board.

My current position is Consultant Psychiatrist for Te Roopu Whitiara, Community Maori Mental Health Services and Senior Clinical Head of Mental Health Services, Northland.

Issues to be addressed:

I have been asked to provide an opinion on the care provided to [Mr A] by the [mental health service], Southern District Health Board. I have been asked to provide an opinion on whether the clinical care provided was consistent with expected standards or whether this departed from expected standards in any way.

I have been asked to comment on the following:

1. The overall care provided to [Mr A].
2. The appropriateness of the diagnosis and [Mr & Mrs B's] perception that [Mr A's] worsening mental health was not taken seriously.
3. Whether [Mr A's] pleas were responded to appropriately.
4. The appropriateness of the [mental health service's] response to [Mr & Mrs B's] escalating concerns and requests for a second opinion.
5. Communication with [Mr & Mrs B] surrounding [Mr A's] suicidal thoughts.
6. The appropriateness of the withdrawal of olanzapine.
7. The care provided by the [mental health service] following [Mr A's] psychotic relapse while [on holiday] in [Month11].

8. The alleged inaccuracies in the clinical documentation.
 9. [Dr C's] alleged failure to undertake a Risk Assessment on 18 Month14.
 10. Should the use of the 1966 Alcohol & Drug Addiction Act have been considered to support compulsory rehabilitation for [Mr A's] drug and alcohol use?
 11. Should consideration have been given to placing [Mr A] under a Compulsory Treatment Order in accordance with the 1992 Mental Health Act?
 12. The appropriateness of the Southern DHB's recommendations arising from the incident investigation.
 13. Suggested additional recommendations.
- Any additional comment you would like to make.

Material Reviewed

In preparation of this report I have reviewed the following correspondence in extensive detail:

- The complaint
- Southern DHB's response to the HDC
- Southern DHB's instant investigation report
- The DHB's response to the coroner
- Correspondence between [Mr & Mrs B] and the DHB
- [Mr A's] clinical notes — both as an outpatient and as an inpatient and including the clinical documentation from [DHB2 Mental Health Services]

In addition to this information initially provided to me I have further received correspondence addressed to the Health & Disability Commissioner, dated 11 January 2014 from [Mr & Mrs B] in response to [Dr C's] timeline for SDHB investigators.

The overall care provided to [Mr A]:

Although [Mr A] had some contact with Alcohol & Drug Services in 2010, his clinical contact with Southern DHB for the purposes of reviewing the complaint commenced in late [Month1] where [Mr A] was seen initially by the emergency psychiatric triage service and then subsequently by [...]Psychiatrist, [Dr G] before his admission to [the mental health inpatient service].

In the initial triage assessment dated 26 [Month1] he described experiencing voices for the past two years. He described the voices being from different people that he knew and that these voices were usually negative. He described feeling overwhelmed by the voices and that when he was talking to people the voices

often tell him what to say and he then found it difficult to respond. He also described believing that he had a microphone in his ear and that he could not distinguish between real memories and ones that were planted in his head by the voices.

On 1st [Month2] when reviewed by [Dr G] he had been to [Medical Centre 1] because he wanted a nurse there to look in his ear to find the transmitter which he believed had been implanted. He was convinced that his parents had implanted the transmitter and he was angry when the nurse found no evidence of a transmitter.

[Dr G] documents ‘the transmitter has a voice telling him to kill himself. He doesn’t want to kill himself but he’s ++ frightened’. On Mental State Examination [Dr G] recorded that ‘he had some neologisms that he was very angry with everyone especially his parents and the health system and that he had ‘no insight/judgement’. [Dr G] recorded positive urine toxicology for both amphetamines and marijuana and organised [an admission] under the Mental Health Act.

During his admission there are several examples of detailed assessments of his mental state.

In an early assessment on 2nd [Month2] by [a psychiatric registrar] it is recorded ‘using drugs to deal with his problems which are voices in head. Hearing voices from a young age. Thought it was his family ‘messaging with him’ voices are intense now, less so after smoking marijuana. Can’t always distinguish voices from own thoughts or others talking. Voices command him to do things, sometimes illegal. Feels they go away after smoking weed and he can ‘be himself’. Voices have told him to commit suicide on several occasions but he doesn’t actually want to kill himself. Voices usually have a negative attitude and can make him depressed. Feels that the voices are encouraging him to upset others and make mistakes’. In this clinical entry it also states ‘voices have changed recently, telling him to go and get help instead of commands to kill himself’. Further in this entry the assessing doctor commented on formal thought disorder with tangentially and thought blocking and neologism in addition to delusional beliefs.

In nursing notes on 4th [Month2] there is reference to [Mr A] asking for scissors to get the device out of his head. There is also reference to him appearing disorganised, believing that he has been in the ward before and describing himself as autistic. He stated that the voices had been present from when he was a child. He also stated that he had previously been to a general practitioner believing he had an STD because of what the voices had said to him.

During his admission [Mr A] was prescribed olanzapine and clonazepam.

On 6th [Month2] it is recorded that [Dr G] ‘informed [Mr A] that he suspects his diagnosis is toxin related. [Mr A] feels that symptoms were present even when he was toxin free’.

A negative toxicology screen was obtained on 5th [Month2].

A family meeting was held on 6th [Month2] where [Mr A's] father was updated on his psychiatric progress. [Dr G] discussed the role of illicit drugs with psychosis and 'emphasised that it is very unlikely that diagnosis is schizophrenia (although possible) but follow up with [the mental health service] as recommended to intensely monitor the situation to ensure that a diagnosis is made correctly'.

It appears from the documentation that the use of olanzapine was discussed 'probably for the duration of two year follow up'. The weight gain and metabolic side effects were also noted to have been discussed. Notes indicate that [Mr A's] mother arrived somewhat after the meeting started and it is noted that [Mr A] found the meeting difficult to tolerate and his parents commented that it is not in his usual style to be confrontational.

On 6th [Month14] [Mr A's] psychotic symptoms were still prominent. It is documented in nursing notes that he stated 'I think someone is going to come into my room tonight and take it out of my head and put it under the carpet and pretend it was never there'. He continued to blame his parents for the transmitter in his head and was requesting a brain scan.

On 8th [Month2] [Mr A] was still agitated at his level of voices and required additional medication.

On 10th [Month2] [Mr A] had home leave which did not go well. His mother stated to the staff that he had asked to see his birth certificate and that he still believed something was in his ear or brain, causing the voices that he was hearing.

By 15th [Month2] [Mr A] still had active hallucinations and discussed with the nursing staff, voices coming through the walls. He also had persecutory delusions that people were talking about him.

On 16th [Month2] a nursing record states 'hearing voices ++ want him dead. Better off leaving the country. Parents feel [Mr A] has slipped back to when he was admitted'.

[Mr A] gradually showed a reduction in the severity of his auditory hallucinations and was given progressive amounts of leave from the ward.

A family meeting occurred on 27th [Month2] with [Mr A's] parents, [Dr G] and [a psychiatric registrar]. At this stage [Mr A] was still taking 20mg olanzapine and he stated at the meeting that the voices were 'less noticeable'. It is recorded that [Dr G] discussed the side effects of olanzapine and that he 'informed parents that we are not giving [Mr A] a label, there is not enough evidence to suggest/confirm if there is a serious mental illness'. He discussed the importance of follow up with the [mental health service] and avoiding illicit drugs and alcohol.

[Mr A] had a period of leave, but then returned on 31st [Month2] as there had been some increase in the level of his auditory hallucinations since his medication had been reduced prior to his leave.

[PDN E], [a] nurse from the [mental health service] engaged with [Mr A] prior to discharge and met with [Mr A's] parents prior to formal discharge from the ward.

On 3rd [Month3], [Mr A] was clear that he felt better as his olanzapine had been reinstated to 10mg twice daily.

It appears that the reduction of olanzapine that had been trialled at the beginning of his leave had not been sufficient to control his psychosis.

At the time of discharge, 24 hour service contact was discussed. Follow up with the [mental health service] team was arranged and [Dr G] is also documented as having discussed the risk of a depression after the psychotic symptoms start resolving.

There was a detailed discharge summary of hospitalisation printed on 4th [Month3] by the ward psychiatric registrar. This hospitalisation discharge summary summarised the history of presenting complaint, the mental state of [Mr A] during his admission and summarised his drug and alcohol history as a significant contributing factor. It noted in particular daily use of synthetic cannabis up to the time of his admission and intermittent LSD and ecstasy use. It also noted a [family history of schizophrenia]. The discharge summary was clear about follow up appointments for [Mr A] and gave a provisional discharge diagnosis of Organic Psychosis secondary to Substance Misuse or Psychotic Disorder NOS.

Summary of overall care provided to [Mr A] during his inpatient admission:

In my clinical opinion the level of psychiatric care provided to [Mr A] during his inpatient admission was appropriate. He received frequent assessments detailing his mental state by both nursing and medical staff. He was provided with information about his treatment and the use of olanzapine as an antipsychotic, supplemented when required by clonazepam, a benzodiazepine was appropriate.

I note that family meetings occurred during the hospitalisation and that appropriate discharge was arranged with [Mr A] and his parents having the opportunity to meet community staff prior to discharge.

I also note that information was shared appropriately about the Mental Health Act and that trial leave occurred prior to a planned discharge.

The area where my clinical opinion differs from that of the inpatient staff was in the issue of Differential Diagnosis. Whilst the possibility of a diagnosis of schizophrenia was discussed, certainly the clinical preferred diagnosis expressed by the inpatient services was that of a psychosis secondary to substance abuse.

Sometimes the distinction between these conditions can be difficult, however there were several features in [Mr A's] presentation which even at the time of his admission, makes in my opinion, schizophrenia a more likely diagnosis. [Mr A] was clear on multiple occasions, speaking to several different members of staff, that his auditory hallucinations had been persistent for some period of time. Initially this was documented as approximately two years with a worsening over the year prior to admission, although it is also documented at times, that [Mr A] was aware of hallucinations during childhood. Whilst sometimes the veracity of a timeline is difficult to establish in someone who is acutely psychotic, there was evidence that [Mr A's] hallucinations had lasted for a long period of time. It is also clear that [Mr A] may have had problems, particularly with marijuana use and intermittently amphetamines for an unspecified duration. People with schizophrenia have an increased likelihood of abusing substances, so the presence of regular marijuana and intermittent amphetamine abuse in someone with features consistent with schizophrenia, does not preclude schizophrenia as a diagnosis.

Typically drug precipitated psychoses are transient in nature. Phenomenologically they may be more likely to present with illusions rather than with persistent auditory hallucinations. Features such as incongruence of affect and formal thought disorder are more commonly associated with schizophrenia rather than a transient drug precipitated psychosis.

It appears on the mental states that I have read, during the inpatient assessment period, that [Mr A] prominently demonstrated auditory hallucinations and persecutory and bizarre delusions. There was documentation in the early stages of admission of disorder of thought form. This was not as prominent as the hallucinations or delusions. [Mr A's] clear psychotic symptoms continued throughout his admission. A negative urine screen was obtained during hospitalisation and yet [Mr A] continued to have psychotic symptoms that became gradually attenuated with olanzapine use. Again the dur[ation] of these psychotic symptoms suggests that there is likely to be an enduring psychotic illness present rather than a brief toxin related psychosis.

Despite these comments, I feel that the information given to [Mr A] and his parents was reasonable as often it is only the longitudinal progress of the client's mental health that determines the ultimate diagnosis.

I also note that [Dr G] had recommended ongoing antipsychotic prescription for two years during the time of follow up under the [mental health service]. A discussion of this length of antipsychotic treatment taking into consideration the severity of [Mr A's] symptoms, was appropriate.

I was unable to see in the inpatient record that I reviewed, any specific relapse recovery plan, however these are often delegated to the community team who become involved in the discharged client's care to develop.

Although clinicians are often reluctant to give clients and their family members' information about schizophrenia at an early stage, sometimes this can be introduced in a way that can still give a sense of hope and recovery. Unfortunately there is significant stigma associated with a diagnosis of schizophrenia, however it is clear that with appropriate treatment, schizophrenia does not need to be associated with poor outcomes and discussing this possibility with clients and family members at an early stage is important, as often this is part of an ongoing dialogue over a long period [of] time where individuals and their family learn about psychosis and its management.

Period of Treatment under the [mental health service] between [Month3] and [Month11].

This is the period of treatment where [Mr A] was under the follow up of the [mental health service] up to his crisis assessment in [DHB2].

[Dr C] assessed Mr B on 12th [Month3] in the presence of his community nurse. He described [Mr A] sleeping a lot, lacking energy and being behind with his [course]. He noted that [Mr A] described having voices for two years or longer. Although he documents that [Mr A] said he had them as a child he brackets this with the word unconvincing. The voices are described in [Dr C's] note as second and third person 'abusive, sometimes voices seem to trick him, pretending to be his thoughts in order to control him. Drove him to conclude he had a microphone in his ear. Accepts now this is unlikely'.

[Dr C] took a drug and alcohol history of marijuana, including synthetic marijuana, up to daily in a year before admission and occasional amphetamine use. He also documented alcohol consumption prior to admission of 12 beers, three times a week. However, after discharge it was written that [Mr A] was no longer taking any drugs or alcohol.

On [Dr C's] mental state examination, the pertinent aspects were that [Mr A] continued to have auditory hallucinations, although these had reduced in severity and he did have documented abnormality of thought content 'did experience T.V show as being for him alone. Still feels people in general (none specific) are 'doing stuff' behind his back, people whisper about him. He can overhear them less than before'. [Dr C] also commented that although [Mr A's] insight was improving, he ([Mr A]) still suspected that admission was unnecessary.

He assessed his risk as being low at this stage and that [Mr A] was not suicidal.

[Mr A's] treatment was 10mg olanzapine twice daily.

Over [Month3] [Mr A] was seen on a regular basis by his Psychiatric District Nurse, [PDN E].

Although some of the notes that I have been provided with are faded, it appears that on documented nursing review on the 26th [Month3], [Mr A] was still experiencing hallucinations which were worse in the evening. He was also

struggling with the sedating effect of olanzapine. He denied using marijuana although had been episodically using alcohol.

A further assessment was provided by [Dr C] on 27th [Month3]. On this assessment [Dr C] discussed the option of changing his medication because of the sedative side effect, but it was decided to persist with a lower dose of 15mg, that [Mr A] had been taking. Again he spoke to [Dr C] about having had voices all his life that influenced his thoughts. Collateral History from [Mr A's] parents was that [Mr A] had had a normal childhood and that [Dr C] felt it had been unlikely that his hallucinations had been a lifelong experience. The plan at this stage was to continue with 15mg olanzapine over the next two months with regular community team review.

On 16th [Month4], [Mr A] was again reviewed by [Dr C] and also spoke to [Mr A's] mother, who was at the meeting. [Dr C] records 'she is very pleased at his current progress. His personality is back to usual, he is laughing, communicating well with people. She sees no evidence of him being psychotic, although he does now wear earplugs at night'.

On 7th [Month5] there is a note from [Dr C] that [Mr A] was seen with his mother and psychiatric district nurse. He documents 'he reports occasional recurrences of his auditory hallucinations have now resolved and his mood is alright. He is a little quiet today and his mother feels that he is substantially back to normal'. The plan from [Dr C] was in view of the level of his sedation, the olanzapine dose was reduced to 12.5mg at night from 15mg at night.

There are records over [Month4] and [Month5] by [an] Intern Psychologist, who had sessions with [Mr A]. It appears in these sessions details of his mental state were able to be elicited in some depth.

On 17th [Month4] the Intern Psychologist Report notes 'he hears voices occasionally, generally when he is alone and immediately after interacting with people he knows. [Mr A] reported that the content of the voices generally involves people saying negative things about him and indicating that there are aspects of himself which require improvement. He said that in the past the voices arose when he thought that he was not putting enough effort into his social relationships. [Mr A] pointed out that he finds himself interpreting situations negatively even when they seem positive in nature'.

[Mr A] discussed with the intern psychologist that he was not using drugs although sometimes taking alcohol. He also confirmed a longitudinal history of psychosis 'he said that he has heard voices for as long as he can remember but in the past they had been in the background, less intense, often positive and he assumed everyone heard them'. Further in the [Month4] report it is recorded '[Mr A] said that for some time he believed there was a transmitter planted in his ear, which he thought explained the voices. He mentioned that he was having paranoid thoughts about other people and sometimes thought people were following him and listening to his thoughts. [Mr A] reported that he still had thoughts about the

transmitter being present, but he now challenges these thoughts by telling himself that they are just thoughts’.

In the report dated 7th [Month5] by the intern psychologist it appeared that [Mr A] was still having psychotic symptoms. ‘[Mr A] reported that he is hearing voices much less. He is trying to think positively and has not experienced any periods recently where his thoughts have been racing and confused ... He had a tendency to experience voices when he was in places with lots of people, particularly supermarkets and shops. He pointed out that the aisles in the supermarket are a factor that contributed to the intensity of his voices as he can hear many people but cannot see them ... [Mr A] reported that sometimes he heard voices from his head and other times from his ears. He mentioned that the voices frequently used his name, sometimes repeating it over and over and he pointed out that when the dialogue was simple like this, he could exert some control over the voices and alter content.

I note that the detailed description of [Mr A’s] symptoms by the intern psychologist is not commented on by [Dr C] in his assessment.

[Dr C] again reviewed Mr B on 22nd [Month5]. This was in the presence of his mother. At this stage [Mr A] was working [in another region] and had been able to get up in the morning for work. He had not been taking marijuana, but continued to use beer intermittently. [Dr C] stated that there was no evidence of psychosis and that his social anxiety had improved. A follow up plan for a review in a month was made and his medication was continued on olanzapine 12.5mg.

On 10th [Month6], [Mr A’s] mother expressed concern that he had been using cannabis and alcohol since returning [home].

[Mr A] was with his father on 12th [Month6]. His father expressed significant concern about [Mr A] and it is documented in nurse [PDN D’s] notes that he stated ‘[Mr A] is back to square 1, like he was before [being admitted to the mental health inpatient service]’. [Mr A] had admitted to smoking marijuana. On assessment by [Dr C], he stated that he was not tearful or suicidal and that his sleep was intact. [Dr C] states in his notes that he asked Mr B ([Mr A’s] father) for details of why he thought [Mr A] was back to square 1, but [Dr C] concluded ‘the psychotic content that was previously present doesn’t seem to be in evidence at present ... his immediate concern is that [Mr A] will refuse to go back to [work] and will instead [en]act some unrealistic plan for remaining in [his place of origin]. Overall I don’t think there are grounds for us to intervene over [Mr A’s] objections. Possibly he is in early stages of relapse and we should attempt to have some contact with [Mr A] next week, but I think it is more likely that he is mildly depressed and we are witnessing some ongoing family frustrations being played out’. [Dr C] does not document a detailed mental state looking for psychotic symptoms; however he charted 20mg citalopram as he believed there was sufficient evidence of depression.

On the 16th [Month6] as documented, Mrs B ([Mr A's] mother) rang [PDN D] and expressed her concerns about [Mr A's] well being. 'She said he was paranoid and she is very concerned for his mental health. She also said her husband ... had spoken to [Mr A's] [housemate], who divulged that [Mr A] overindulges to the extreme'. [PDN D] assessed [Mr A] on 16th [Month6] and did not elicit symptoms of psychosis and established from him that he had been taking olanzapine but not citalopram.

Over the next few days [Mr A's] parents expressed considerable concern about his wellbeing and documented their concerns as well as having phone calls and a face to face meeting with the mental health service's staff.

A letter from Mr B (father) dated 15th [Month6] to [Dr C] states 'since Saturday, 07 [Month6], [Mr A] has sat in the lounge at his [house], never leaving, not eating and not caring about his personal hygiene. When I have had interaction with him, he has seemed disorientated, alternatively laughing and smiling at someone no one else can see. He is angry with this. These are the same symptoms displayed by him prior to his admission to [the mental health inpatient service] in early [Month2].

In a letter dated 15 [Month6] to [Dr C] from [Mrs B] she states 'his symptoms during the last few days include being suspicious of us and anger, same as before. He obviously hears voices at this point, but they are pleasant voices so it isn't a problem to him yet. We can see it on his face as he suddenly starts smiling as if someone told him a joke. He is not eating and not caring for his appearance, like not brushing his teeth or washing himself. He doesn't have any bedding at his [house] and he is not changing his clothes. He is like a zombie sitting in front of the T.V. doing nothing. It is very unlike the boy we know from a week ago. This is not depression, this is early onset psychosis brought on by abusing drugs and unhealthy living'.

[Mr A's] mental state was assessed by Nurse [PDN D] on 19 [Month6], who stated that he did not have any signs of psychosis and that he told her he had not heard voices for a few months and that he was taking olanzapine 12.5mg at night.

[Mr A's] reports of not hearing voices for a few months are not consistent with the Intern Psychologist's record or with the detailed documentation of his parents.

On 24 [Month6] [Dr C] had a meeting with [Mr A's] parents and with [PDN D]. They discussed [Mr & Mrs B's] observations of 'a weird grin on him on and off' and also the changes and poor self care and showering. [Dr C] noted that he had been using marijuana and his opinion of these changes in his mental state related to his increased marijuana use and possibly missing some of his olanzapine.

[Dr C] records a clinical meeting with [Mr A] on 27 [Month6] where he states 'he feels the voices that he felt he had had for year have gone completely and there is no real current evidence of any psychotic phenomena. He appears calm, friendly and candid. He is tending to oversleep in the mornings and we have cut the dose

of olanzapine to 10mg. He will also start on the citalopram previously prescribed, as he feels his mood still rather low. He is not suicidal or irritable and it is reasonably likely that his sense of low mood is the result of sedation and frustration at his current situation’.

On 27 [Month6] [Mr A] was assessed by [Dr J], Psychiatrist at [the private mental health service], at the request of [Mr A’s] parents. It is recorded in the report ‘[Mr A] was clear from the start that he had agreed to this assessment in order to appease his parents. Aware his parent’s concerns, for around their belief he was using drugs all the time’. [Dr J] stated that [Mr A] did not exhibit any psychotic symptoms and she documents in her report that she discussed with both [Mr A] and his parents issues around a low mood, interaction of alcohol and cannabis with psychosis and developmental issues for [Mr A] as the youngest child. She also talked about communication issues with the [mental health service], but ended her report saying ‘I am aware this is not a formal second opinion. Given the time limitations of this session and needing to see both [Mr A] on his own and then [Mr A] with his parents’. I note in her report there was not detailed description of [Mr A’s] psychopathology nor was there a detailed assessment of his mental state as this had not been the focus of the interaction.

On 10 [Month7] [Mr A] was reviewed by [Dr C] in the presence of his CMHN, [PDN E]. [Dr C] records that [Mr A] looked well and that he answered in the negative to questions about psychotic phenomena. However he also records that he is isolated and unmotivated. He asked [Mr A] about his compliance with olanzapine and believed this was being taken reliably, however citalopram was not being used, but his mood appeared substantially intact. [Dr C] concluded that his recovery appeared to be going well.

In contrast, on the 13 [Month7], [Mr B] rang [PDN E]. [Mr A’s] father was so concerned about [Mr A’s] functioning and use of substances that he stated he may be ‘dead before the end of the week’. He had also checked [Mr A’s] room and stated that he had not used all his olanzapine.

On 17 [Month7] [Mr A] was reviewed by [PDN E] and admitted to using small amounts of marijuana. He stated that he was using olanzapine 10mg ‘when he remembers’. There was no detailed description of mental state. [PDN E] notes ‘no psychotic symptoms for three months. Mood stable’. Again this does not appear consistent with collateral information.

[Mr A] did not attend appointments with [Dr C] on three occasions in [Month8].

[Mr A’s] parents had made contact with the [mental health service] expressing concerns about his mental health including stating that [Mr A] had broken a window at [his house].

[Mr A] was seen by [Dr C] on 20 [Month8]. [Dr C] records him as being ‘more apathetic and slightly sedated’. He noted that in terms of his functioning he is ‘doing little with his time except relaxing’. He also noted that his sleep had been

disturbed and that his mood was 'up and down'. He stated 'there is really no evidence of psychotic phenomena. He claims adherence with olanzapine 10mg and in view of his lack of motivation and sedation and absence of ongoing psychotic features, we have agreed to cut the dose to 7.5mg'.

There was a family meeting with [Mr A's] parents, [Dr C] and CMHN, [PDN E] on 27 [Month8]. [Mr A's] father stated that he had been anxious and preoccupied on the way to his mother's house recently, but this was a one off event. Again the conclusion of the treating team was that there was no active psychosis.

On 11 [Month9] CMHN, [PDN E] received a call from [Mr A's] mother concerned that the service had not had recent contact with [Mr A]. [Mr A] did not turn up to an appointment that day with [PDN E]. However he was seen a short time afterwards where [PDN E] described him as not having psychotic thoughts or suicidal thoughts. He noted that his sleep was in a pattern where he would get up at midday or 1pm.

He was scheduled to see the Occupational Therapist but did not attend.

On 19 [Month9] he denied hearing voices to [PDN E] but stated that he could not get off to sleep, but then would sleep through until lunch time.

On 25 [Month9] he was reviewed by [Dr C] and his mother. [Dr C] records him as being 'not psychotic, euthymic, looking for work'. He also commented on the day/night reversal of sleep.

In late [Month9] he had contact with the team's occupational therapist.

On 21 Month10, [Mrs B] is documented as having called [the mental health service] stating that [Mr A] was doing very well but he was too sedated on olanzapine and she preferred it to be withdrawn. [Dr C] agreed to discuss this in the meeting on 22 [Month10].

At this time [Mrs B], [Dr C], [PDN E] and [Mr A] met to review progress. He was described as not being psychotic and being insightful. He was also clear that he was not using drugs. [Dr C] recorded that he wondered if the account of longstanding voices may not have reflected a long prodrome as his mother had stated that he was wholly well until the recent episode. They agreed to 'cut and stop olanzapine'. [Dr C] records 'EWS discussed' however there is no record of what symptoms were discussed and what would be indicative of relapse.

On 6 [Month11] [Mr A] was reviewed in the presence of his father. [Dr C] states '[Mr A] appears a little tired and bored but warms easily and reports his mood is good. [Mr B] feels he is well too. There is no evidence of the recurrence of psychotic phenomena. [Mr A's] main current concern is poor sleep. He finds he sleeps lightly and wakes frequently since the dose of olanzapine was cut'. [Dr C] gave [Mr A] a supply of eight 10mg temazepam tablets.

Of note [Mrs B] wrote to [Dr G] as a prior treating psychiatrist of [Mr A]. ‘We have initiated tapering of olanzapine as it has long served its purpose and because the excessive daytime sleeping caused him to be unproductive. However I have concerns regarding tapering his olanzapine and lack of treatment plan. I was told by [Dr C] that there will be no withdrawal symptoms when tapering slowly, however I have concerns because no Plan B was put in place and we have already noticed changes in his behaviour. No information was given to us in case [Mr A] developed problems when withdrawing from olanzapine be it due to withdrawal or otherwise ... is it possible for [Mr A] to develop any problems due to the fact that his medication is now being withdrawn’.

[Dr G] forwarded this communication to [Dr C] to reply to. [Dr C] wrote to [Mrs B] stating ‘should [Mr A] have any difficulties with his mental health over the next few weeks or if yourself or his father are concerned about him, please feel free to contact myself or the other staff at the [mental health service]... I do doubt that he will experience any particular problems withdrawing from olanzapine, however as I had indicated, there is a risk of psychotic experiences returning. Although in light of the fact his psychotic episode appeared to be the result of drug use, I think we can be cautiously optimistic that he will remain well’.

Opinion regarding the adequacy of overall care during the second time period:

In my opinion there were areas where the clinical care was appropriate for [Mr A] during this time period. [Mr B] was seen very frequently by the services. He was seen on a regular basis for a community client by both [Dr C], the nurses involved and he had access to Clinical Psychology and Occupational Therapy.

However there are areas of concern during this second period of care regarding the clinical adequacy of treatment.

One major area of concern was that there were indications that [Mr A] continued to suffer from an enduring psychotic illness and that he did not have normal psychosocial functioning. There is a tendency in the clinical notes to normalise his functioning in symptoms and to be very reliant on [Mr A’s] account of whether or not there were any symptoms rather than a more overall view of his progress including collateral information.

When seen individually and in some detail, it appeared that he continued to describe psychotic phenomenon, certainly up to the point of [Month5].

In the brief progress notes from [Dr C] and the nursing staff, it appears they regularly ask [Mr A] about whether or not he is hearing voices and that he responded in the negative. However I note in a more detailed psychiatric assessment which is typed by [Dr C] dated 18 [Month6], he noted that ‘In the main, recovered from his psychotic episode, although still experiencing longstanding auditory hallucinations’.

Indicators of poor mental health that became increasingly apparent over this period of time included fluctuations in mood, sleep disturbance, in particular difficulty getting off to sleep and deterioration in functioning.

In 2011 [Mr A] had been [doing a course]. At the time of discharge from hospital he wished to [do some part-time study]. Over his remaining time in 2012 he managed a period of work in [another region], but otherwise his functioning diminished to a level where his parents were frequently checking on his whereabouts and his basic day to day well being.

I believe there is evidence in the documentation that particularly over a period of time in [Month6]; [Mr A] very likely had an emergence of psychosis, which may have been triggered by both a lower dose of olanzapine and the use of marijuana [at his house]. The collateral information from his parents describing mood irregularities and laughing to himself and very poor self care in the context of someone who has been very actively psychotic for some time would be indicative of worsening psychosis.

Whilst it is clearly more difficult for staff to elicit psychosis in someone whose rapport varies and can be guarded, I do believe that over this period of time there was evidence that [Mr A's] psychotic illness had not fully resolved.

The second major area of concern that I would have about the clinical care that he received was whether there was adequate information shared about early warning signs and information indicative of worsening relapse and how to respond to this.

It is clear that the staff at the [mental health service] spoke to [Mr A] regularly about the effects of marijuana and other drugs on psychosis; however it is not clear from the documentation that the role of antipsychotic medication in improving functioning and preventing psychotic relapse was assertively discussed.

I understand that the [mental health service] was trying to reduce the olanzapine dose in response to the sedation and apathy experienced by [Mr A]. Whilst this could have been a side effect of olanzapine, it is equally possible that this was also part of the negative symptoms that can be seen in schizophrenia.

In the notes there is one record of a relapse prevention plan, dated 21 [Month8]. This was completed by CMHN, [PDN E], however on this plan it indicates that it was not developed with either the family or [Mr A]. The main advantage in developing relapse recovery plans is to use these as a psycho-educational tool to inform both the consumer and family members about the illness, about early warning signs and how to actively intervene to prevent relapse. Although it is important that a plan is available for staff to check early warning signs off, the main purpose of a relapse prevention plan is for the benefit of the consumer and family. Therefore developing these plans several months after discharge from hospital and in the absence of the consumer or family is not a useful clinical approach.

The plan that is available does have appropriate information in that it has detailed early warning signs and it has a number of triggers identified. It does have information on who to contact, although the only reference to antipsychotic medication is discussing using extra olanzapine if necessary and there is no reference on this plan to making sure to take regular olanzapine as prescribed as an effective strategy for preventing the recurrence of psychosis.

Developing recovery plans with family members can also be an effective way of clinical services learning about subtle signs of relapses that may be noticed by the family and the services may be unaware of. Similarly the consumer themselves, often may describe subtle changes at an early stage that would inform services of when more assertive intervention is required.

One of the features of [Mr B's] psychiatric records that seem apparent was that there was a miss-match in the level of concern expressed by the family compared with the staff. Having a shared relapse recovery plan and explicit discussion around the different manifestations of psychosis and schizophrenia and the evidence based treatment for them, may have reduced some of these differences.

From the records when [Mr A] was on a higher amount of medication and not using marijuana over the initial time after discharge there was not concern expressed by his parents about his mental state. It is recorded over [Month4] in particular that they saw signs of recovery. As medication was reduced there appeared to be more concerns and particularly when there was coexisting marijuana use.

The support of the family regarding the withdrawal of antipsychotic medication may have been influenced by the strong emphasis of the service on [Mr A's] presentation being a drug induced psychosis rather than an enduring psychotic illness. If the family had been given more detailed information on the strong possibility that [Mr A] would require ongoing antipsychotic medication to prevent relapse, they may have been less supportive of the plan to withdraw antipsychotic medication. Other options on less sedating antipsychotic medication such as risperidone, ziprasidone and aripiprazole could also have been discussed.

[Mr A] was an informal patient and as such had the legal right not to take antipsychotic medication.

There is some documentation in the notes that [Mr A] expressed a preference to come off medication. In these situations it is even more imperative that there is extensive psycho-education about the risk of relapse, which in [Mr A's] case would have been extremely high.

In summary:

Although [Mr A] and his family received regular and assertive follow up in the community, in the most part, from the [mental health service] and access to different multidisciplinary team members I believe that the overall care provided to [Mr A] should have been more focused on an enduring psychotic illness and

should have been significantly more focused on the role of antipsychotic medication preventing relapse.

I believe that this is a moderate departure from best expected standards.

Contact with [DHB2] Psychiatric Services 8 [Month11].

[Mr A] had attended Emergency Department in [DHB2], for help with his mental health. He and his father were going [for a holiday] and on the way [Mr A] asked his father to take him to the Emergency Department. He told his father he needed to obtain medication for anxiety. He was seen by a psychiatric registrar and crisis nurse in [DHB2] and they recorded that he had had several stressful periods since leaving home and that he had felt anxious being around people in streets and in shops. He told them that when he felt anxious he ‘often experiences the onset of auditory hallucinations, a number of voices that make derogatory comments about him’. He also described experiencing a sense of ‘déjà vu’ believing that he is ‘re-experiencing a situation that he has been through previously’. He told the [DHB2] staff that he had had poor sleep for several weeks, but that he was tending to sleep during the day. He told them that he had had passive thoughts of ‘not being around, but denied any intent or plan of suicide’. He told them that he occasionally experienced command hallucinations ‘voices telling him to do things like take drugs, but does not follow through and manages by distracting or occupying self’. He described to the [DHB2] staff, gradually reducing his dose of olanzapine and at the time of this assessment, was on 5mg nocte. He told them that he has started experiencing hallucinations when he cut down his dose from 10mg, two weeks previously. He denied any recent history of abusing synthetic cannabis.

It is recorded that he had anxiety that ‘he may have a microchip in his ear. Stated that he had requested a brain scan at his last admission but was refused it. Believes that people may be colluding against him. Did not want his father to be informed of his symptoms’.

I note in the documentation from [a nurse], he stated that he had difficulty confiding in his treating team and his family and his friends regarding his symptoms. ‘Acknowledges voices more noticeable since gradual reduction in olanzapine, however may not have informed treating team as feeling “pressure” from them, family and friends to be well’.

The [DHB2] services gave [Mr A] a prescription for 20mg olanzapine and clonazepam 1mg bd for three days only and Zopiclone 7.5mg nocte for three days. They record that they had offered an admission which was refused by [Mr A] and they record that they faxed information of this interaction to the clinical team [at SDHB].

A record that the fax was received from the [mental health service] is recorded on 11 [Month11].

I note that prior to [Mr A's] assessment by the [DHB2] team, [PDN E] had received a phone call from [Mr B] and had recommended additional olanzapine on hearing the concerns about a re-emergence of anxiety and déjà vu experiences with sleep disruption.

I note that [PDN E] records 'I explained that sometimes people did feel a little anxious when they came off medication. This could be their body adjusting'.

In my opinion the more likely reason for the re-emergence of symptomatology would be an increase of psychosis.

Clinical Period of Care of [Mr A] from 20th [Month11] until 22nd [Month14].

On 20th [Month11], [PDN E] and [Mr B] had telephone contact. [PDN E] records '[Mr B] says [Mr A] has mostly been good, sleeping well and eating well. [Mr A] is now taking 10mg olanzapine daily. He found the clonazepam he was given really useful for the anxiety, wanted more when this ran out'.

An appointment was scheduled with [Dr C] for 14 [Month12]. There is a record that [Mr A] did not attend.

[Mr A's] father rang on 14th [Month12] informing [PDN E] that [Mr A] had been smoking marijuana and that he was not sure if [Mr A] was attending [his course].

He did not attend a further appointment on 18th [Month12] with [Dr C] and there is a note from [Dr C] that he left a message both with [Mrs B] and then contacted [Mr A] who stated that he had forgotten the appointment.

[Mrs B] brought [Mr A] in for an assessment on 21st [Month12] with [Dr C].

[Dr C] records that [Mr A] was sneering towards his mother and at one stage abusive. He records that [Mr A] had now come off his olanzapine and there was conflicting information between [Mrs B] and [Mr A] with [Mrs B] stating that [Mr A] had disrupted sleep patterns and [Mr A] denying this. [Dr C] recorded that [Mr A] was 'v unforthcoming' he records 'he claims his crisis [while on holiday] quickly and wholly resolved and that he has had no ongoing voices. Refused to discuss further, but claims it was all due to a holiday he didn't want'. [Dr C] arranged to meet [Mr A] without his mother being present, to which [Mr A] stated that his mother even knowing the time of this appointment would lead to her taking over. [Dr C] records [Mr A] as being oppositional but not psychotic.

It is not recorded whether or not the option of going back on medication after such a recent flare up of psychotic symptoms was discussed or not.

On 24th [Month12] [Dr C] records that he spoke to [Mr B], who stated that [Mr A] was using cannabis regularly and that 'doubts he is covering up psychosis, episode in summer resolved v quickly, one to two days'.

[Mr A] did not attend an appointment on 25th [Month12] and a further appointment was scheduled for the 4th [Month13].

A record from [PDN E] documents concerns from [Mr A's] father that [Mr A] may be using marijuana to cover up 'underlying psychotic symptoms'.

I am unclear over the time that [Mr A] did not attend appointments, whether [PDN E] was actively involved in offering transport or reminding [Mr A] around these appointments. These strategies are often used in community mental health context to help people who are reluctant to engage or finding difficulties engaging to attend regularly. As sometimes non attendance is a sign of deteriorating mental health in people with psychotic illness it is best practice to have clear strategies to enhance the likelihood of attendance and clinical review.

On 9th [Month13] there is record of a further phone call from [Mr B] to [PDN E] again questioning [Mr A's] use of cannabis and whether it is covering up underlying psychotic symptoms.

[Mr A] had also pulled out of [his course].

On 12th [Month13] [PDN E] home visited [Mr A] and documented that he had been completely off olanzapine two to three weeks and that he denied concerns of other people looking at him or talking about him and that he stated that he did not believe he had a device or transmitter in his ear. He stated that [Mr A] was continuing to intermittently use cannabis and that they had discussed the vulnerabilities to a further psychotic episode.

On 15th [Month13] there was another phone call from [Mr B] to [PDN E]. At this stage he believed that [Mr A] had cut down his marijuana, but had been finding things hard without this. He also wondered whether [Mr A] had signs of depression.

On 19th [Month13] there was a further phone call from [Mr B] to [PDN D]. He stated that [Mr A] had not organised to register [for his course] or made any effort to move regarding his housing. He said that [Mr A] may be depressed and that he was unmotivated and tends to stay in bed to clear his head. He also described him being irritable and angry and he requested a review of treatment from [Dr C].

[Dr C] contacted [Mr A] on 20th [Month13] and recorded that he offered to visit [Mr A], but that [Mr A] had agreed to an appointment without his parents at the clinic.

There was a further phone call on 25th [Month13] from [Mr B] to [a] nurse at the [mental health service], stating that he was concerned that [Mr A] may be depressed as he had low mood, poor motivation and was sleeping until the late afternoon. He also expressed concerns about alcohol consumption and marijuana.

[Mr A] missed a further appointment with [Dr C] on 25th [Month13].

[Dr C] and [Mr B] had a phone conversation where [Mr B], [Mr A's] father again indicated his concerns.

On 26th [Month13], [Mrs B] spoke to [PDN D] expressing concerns because [Mr A] had been unable to get out of bed during the day and was up all night. He was falling asleep around 4:30am and this was making it difficult to attend psychiatrist's reviews. She was concerned that his presentation might be due to substance addiction. She believed that [Mr A] would only be able to manage [part time study].

[Mr A] was reviewed by [Dr C] on 27th [Month13]. He had started [his course] and stated that he 'feels anxious around large groups, eg: [classes], although managed a [class] today and feels more confident as a result. Missed some [classes] last week, part anxiety and part day/night reversal' [Dr C] recorded that he had lost weight off olanzapine and was using marijuana once a fortnight. On mental state assessment he recorded that he was warm, relaxed and animated and was not hopeless or suicidal and that there were no psychotic phenomena. [Dr C] described him having social anxiety that may benefit from specific input. He discussed with [Mr A] his parents' ongoing concerns to which [Mr A] 'indicated clearly he does not want either involved in his care'. [Dr C] comments that his account is at odds with his parents' concerns but that [Mr A] was 'very believable'. [Dr C] stated in his notes that [Mr A's] parents' concerns 'often appear based on their anxieties rather than observation'. [Dr C] gave [Mr A] a Sickness Certificate 'on the basis that his functional recovery from psychosis is not yet complete'.

[Dr C] had arranged to [see] [Mr A] on 6th [Month14], but again, it is recorded as a DNA.

On 12th [Month14] [Mr A] attended Emergency Department. He self presented and there is a record of him being seen by the psychiatric duty nurse at 04:35 hours. He stated that he did not want to talk to someone he didn't know, but would like sleeping medication. He described a history of poor sleep and increasing anxiety. It is recorded 'says he has "thoughts in my head" when he tries to sleep, but he did not want to discuss these. Says he would rather do so with [Dr C]'. The nurse explained that they would not prescribe sleeping medication, he then became irritable and asked to leave.

Under Risk Assessment it is stated 'denies he is unsafe', 'that's not the problem'.

The summary of the on duty nurse was that he may have early warning signs and would benefit from contact with his regular team.

[PDN E] phoned [Mr A] to follow up and had no reply so recorded a text dialogue where he confirmed an 11am appointment with [Dr C] on 13th [Month14]. [Mr A] did not attend this. [Dr C] rang [Mr A] who was described as being apologetic and a further appointment was arranged.

On 13th [Month14] [Mr B] rang [PDN D] saying that he had received a phone call from [Mr A] at 1am asking him to come into town and talk about a picture that [Mr A] had drawn. [Mr A's] father met him and they had a long discussion about a picture, which [Mr B] said had a lot of detail. [Mr A] told [Mr B] he could not remember drawing it but said it took several hours.

It is recorded that both parents were worried about [Mr A's] mental health and expressed concerns that they wondered if he was unwell. The intervention from the nurse was that she would discuss with [Dr C] this call.

[Mrs B] phoned [PDN D] later in the day to see whether [Mr A] had attended his review with [Dr C]. She again stated that she believed [Mr A] was unwell 'she said she knew something was up with [Mr A] yesterday when he phoned her to say he had to leave a [class for his course] " because an older woman sat next to him and creeped him out. He said he didn't want to be paired up with her'. [Mrs B] is recorded to say that she did not want [Mr A] to have medication for psychosis but that she preferred to address issues of illicit substance use.

[PDN D] stated that [PDN E] would home visit [Mr A] the following day.

It is recorded that [Mrs B] again spoke to [PDN D] with distress and stated that [Mr A] was angry and dismissive of her over a request for money for cigarettes.

On 14th [Month14] [Mrs B] is recorded as speaking to [PDN E] stating 'expressed the wish that I see [Mr A] today, as worried about his safety'. [PDN E] did not make face to face contact with [Mr A] as no one answered the door at his [house]. He then rang [Mr A's] cell phone, where [Mr A] stated he did not wish to have a visit, but confirmed an appointment with [Dr C] on the Monday. [PDN E] records that [Mr A] over the phone denied being suicidal.

On 15th [Month14] [Mr A] did not attend an appointment. This is documented in [Dr C's] record. [PDN E] then had a face to face assessment with [Mr A]. [Mr A] had self presented although this is not clear in the clinical record. He described [Mr A] as suffering after drinking a bottle of Vodka the night before but denying other substances. He vomited twice during the time that [PDN E] assessed him. [PDN E] records that he was not suicidal and 'denies psychosis, denies depression', 'says he pulled out of [his course], not a place for the likes of me', 'wouldn't elaborate on this, just said he was particularly anxious at times'.

He records that there was an appointment with [Dr C] on 18th [Month14], arranged.

[PDN E] documents communication was held with [Mr B], [Mr A's] father on 15th [Month14]. [Mr B] again expressed his concerns and [PDN E] stated that from his assessment an hour ago, '[Mr A] was extremely hung over, no psychosis that I could detect, not suicidal at present'. [PDN E] records under his plan that he had discussed with [Mr B] 'if concerned re: safety or risk, then possible Section 8, Mental Health Act'.

I note in documentation from [Mr and Mrs B] that they have evidence of further phone calls that were not recorded expressing significant concern.

On 18th [Month14], [PDN D] records at 8:15 that she had received a phone call from [Mr B] to say that [Mr A] had consumed Vodka and illicit drugs and that he had been found in the gutter by [a patrol] and had been beaten up. He had been taken to the [after hours medical service] by his mother and was at his mother's house. '[Mr B] is extremely concerned and alarmed at [Mr A's] apparent recklessness. He will discuss with [Dr C] today.'

On 18th [Month14] [Dr C] records that he and [PDN E] home visited [Mr A] after he did not attend a scheduled appointment. He told [Dr C] that he had consumed a large amount of Vodka and over a four hour period could not recall what happened but 'believes he was beaten up, given that he got a variety of cuts, bruises and some evidence that he is a little concussed'. He described the class he left, where he was squashed tightly together with an older woman and he described irritation at not having text books for the course. [Dr C] stated 'I suspect that his issues with his parents and [his elder siblings] and his own lack of confidence is likely to contribute to his being easily put off'. [Dr C] stated 'we saw none of the subtle signs of psychosis. His mood is warm, animated and humorous, he is not suicidal'. [Dr C] comments on recent weight loss but attributes this to the stopping of olanzapine. [Dr C] also commented on poor sleep but he attributed this to alcohol fuelled disruption and day/night reversal. [Dr C] concluded 'other than his excess alcohol, we didn't see evidence of any further drug use and this is consistent with his previous accounts. Overall we don't get the impression of psychosis or of a narrowly defined mood disorder or of anxious avoidance, although this may need further exploration. We didn't get the impression he was being at all evasive. He seems like a young man struggling under the weight of parental expectation, who is short on confidence and determination and who is underestimating the potential hazardous effects of his drinking pattern'. [Dr C] concluded that the team would continue to offer support.

There was further telephone contact from both of [Mr A's] parents ringing in on the 18th [Month14] for feedback on [Dr C's] assessment.

On 19th [Month14] at 9am [Mrs B] rang up to give the [mental health service] further information. [Mr A] had told her that his injuries were self inflicted and that he poured paint [on the road]. He stated that [a staff member from his course is looking for him to throw him out]. [Mrs B] stated to [PDN E] that she believed he is mentally disordered and needed treatment in hospital. [PDN E] talked about the possibility of a second opinion.

Later the afternoon of 19th [Month14] [Mr B], [Mr A's] father rang up again asking for another opinion on [Mr A's] mental health, as did [Mrs B].

On 19th [Month14] [PDN E] rang [Mr A] at his mother's house and asked him to attend an appointment with [Dr C] and to discuss a second opinion. [PDN E] records that he denied psychotic symptoms or wanting to harm himself.

On 20th [Month14] [Dr C] discusses that there was a multidisciplinary team review of [Mr A's] care and that 'ideal option would be CADS or engagement there of his most therapeutic potential'. He also records that [Mr A] did not attend an appointment on 20th [Month14].

On 21st [Month14] at 9:30, [Mrs B] rang the [emergency mental health service] with concerns about [Mr A's] welfare. She described that the prior weekend when he was intoxicated he had set his bedding alight and spilt paint on the street and had a phone call from the Police about this. She stated that she and her husband supported him being admitted. The crisis nurse discussed the Mental Health Act and advised her to contact the Police and organise an appointment with the [mental health service]. The crisis nurse also told her that if [Mr A] was intoxicated the crisis team would be unable to assess him.

Later in the evening there was a further call from [Mrs B], again expressing concern about the welfare of [Mr A]. She told staff that 'he has been talking about stuff being planted in his head'. She did not know his current whereabouts and she was given advice to call the Police.

At 1am both parents attended the Emergency Department to fill out a Section 8A, they were still unaware of [Mr A's] whereabouts.

On 22nd [Month14] records that [Dr C] had received an email from [Mrs B] and he states 'hard to judge if the escalating concern is a sign of worsening mental state or not. Discussed in team and peer review'.

On 21st [Month14] [Mr & Mrs B] had written their concerns to the [mental health service] 'We have serious concerns about our son [Mr A] who has been under your care, last week 13 [Month14] we contacted you regarding his strange behaviour which including [calling] his dad 2am, to discuss a picture that he had drawn and couldn't remember drawing. The picture upset him and wanted an explanation from his father about the picture. He was agitated and unsettled and wanting to know what was wrong with him. His father tried to get him to go to [the emergency mental health service] voluntarily, but he declined. After about two hours he calmed down sufficiently enough to be able to go back to his [house]. Last Saturday 16 [Month14] he got severely intoxicated and got hold of paint which was stored on the premises [...]. He poured it all over the street. He claimed that he had got beaten up. But it had transpired that it was [self inflicted injuries]. The injuries were so severe we took him to [an after hours medical centre], suspecting broken arm and concussion. We have requested that you visit and assess him after he repeatedly didn't turn up for his appointments with you. We were told by you that he had answered the door and showed no signs of psychosis. Your diagnosis was that he wasn't depressed or psychotic. We however, have continued to find his behaviour totally out of character and not his usual self at all. Self harm is of serious concern. It has now come to our attention, through the Police, that on Thursday evening 14 [Month14] he tried to burn his bed and all his clothes. On 16 [Month14] he poured paint all over the street. The fire department and DCC got called out to clean up the mess. We want a second opinion ASAP.

We have requested the second opinion on several occasions and because he doesn't want to go to [the emergency mental health service] himself, it is your duty to see that as he is under your care this is long overdue and [Mr A] is at great risk, as we pointed out to you repeatedly. He needs to be assessed urgently please, today we would like him hospitalised. (query, [the private mental health service]) today and would like to be involved in his treatment plan.

Yours sincerely [Mrs B] and [Mr B]'

On the Section 8A that [Mrs B] completed dated 21 [Month14] she not only outlines the self harm that [Mr A] had completed but also outlines 'irrational ideas like he has AIDS, autism, ADD, no x-rays done on brain for device planted by us in his name'.

On 22nd [Month14] [a Nurse] records that [Mrs B] had arrived at the [mental health service] at 10:25 in the morning, very distressed and insistent on being seen explaining that [Mr A] had gone missing the night before. During this time [Mrs B] received a telephone call.

Summary of Opinion on the Standard of Clinical Care received by [Mr A] during this period.

In my opinion the quality of clinical care received by [Mr A] during this period departed from expected standards. In my opinion this was a severe deviation from expected standards.

The overall deficiency in care over this period of time was a failure to appropriately identify a worsening psychotic episode and a failure to initiate appropriate treatment for this.

On [Mr A's] return from [his holiday] with his father, it was clear that he had had an exacerbation of psychotic symptoms with an attempt to reduce antipsychotic treatment.

Of particular note in the clinical material available from [DHB2], were clear signs of relapse that had been present during the time that [Mr A] had been initially admitted to hospital. These signs included persecutory delusions, delusions involving déjà vu experiences, auditory hallucinations and delusions of control involving a transmitter device. These were also present with signs of psychosis such as mood changes and sleep disturbance.

Of particular note in the record from the assessment in [DHB2] was that [Mr A] had found it difficult to discuss these symptoms both with his family and also with the [mental health service]. This was recorded as being because he felt a pressure to be well.

It is also noteworthy that the nature of [Mr A's] symptoms were that his parents had caused the transmitter in his head and that when he became more unwell his irritability towards his parents and his reluctance to disclose symptoms increased.

This was very important information for the [mental health service] to have used on [Mr A's] return to their team. This material should have been used to inform the need for ongoing antipsychotic treatment and the need [for] the best way therapeutically to work with [Mr A]. When antipsychotic medication is being gradually withdrawn from someone where there has been a prolonged period of psychotic illness, it is important that when psychosis re-emerges, antipsychotic medication is again reinstated. I am unclear from the records of the [mental health service] why this did not occur. This should have been discussed in detail with [Mr A] and his parents as an important treatment recommendation.

By the time the Early Intervention service again engaged with [Mr A] on his return from his holiday there were indications of difficulty with engagement. Although [Dr C] scheduled clinical appointments on a very regular basis, it was clear that the system for ensuring that [Mr A] was assessed by him was not effective.

With clients who are at high risk of psychotic relapse, which [Mr A] clearly was, using strategies such as nurses actively going to pick the clients up for appointments or using strategies such as enlisting parents to assist with appointments or providing home visits are often useful.

The main strategy used by the [mental health service] appeared to be ringing [Mr A] after he did not attend the scheduled appointment rather than proactively co-ordinating assistance to appear on the day.

Although [Mr A's] parents, in their interactions with the [mental health service] often attributed his symptoms to drugs and alcohol, this is because they were using the diagnostic formulation they had been given. From the notes available to me it does not appear that after the [DHB2] exacerbation of symptoms that [Mr & Mrs B] and [Mr A] were given information detailing the possibility of schizophrenia and the various ways that this could manifest.

It would have also been appropriate for the [mental health service] to have been sensitive of [Mr A's] difficulties in disclosing his experiences. One on one sessions with a team member that [Mr A] was close to discussing explicitly his difficulties regarding disclosing symptoms could have been helpful. Reassuring [Mr A] that it was not a sign of failure if psychosis emerges, but that it is something that happens episodically on the journey to recovery that can be effectively treated would have been important.

There were many opportunities for the [mental health service] to have considered [Mr A's] presentation to have been part of worsening psychosis.

In the documented notes [Mr A's] parents give very useful information that is consistent with psychotic relapse.

From [Month12] [Mr A's] parents intermittently identified that his use of marijuana may be part of dealing with a psychotic illness. Even if they had not

made this connection the staff should have seen this as a possibility. [Mr A's] parents described his difficulty with motivation. They described persistent difficulties with sleeping and difficulties with organising daily activities. Although [Mr A's] father questioned depression, I am unclear whether he had information on the symptoms of low mood, poor motivation, reduced functioning and reversed day/night cycle that can be part of poorly treated psychosis.

Of course it is not the role of family members to give the correct diagnosis; that is the role for clinical services; however I note that the symptoms and functional changes described by [Mr A's] parents were very clear. It is likely they would have been even more detailed should they and the clinical team and [Mr A] have jointly worked on a plan exploring signs of psychosis utilising the expertise of the clinicians and the personal knowledge of [Mr A] and his parents.

In my opinion the assessments from the [mental health service] tended to normalise [Mr A's] experience rather than see it as part of a larger picture of someone at risk of worsening psychosis because of withdrawal of antipsychotic medication. An example of this is in [Dr C's] notes on 27th [Month13] where he describes [Mr A] feeling anxious around large groups of people and having a reversed day/night cycle and missing [classes for his course] because of this anxiety.

In a young adult who has clearly had ongoing psychotic symptoms and had these to such an extent that they were treated acutely only two months previously, the first differential for that anxiety around other people would be paranoia. Their internal world should be explored in detail for this.

By [Month14] there were clear signs of significant concern in [Mr A's] mental state that would be indicative of the need to assess for and start an antipsychotic medication.

For [Mr A] to attend Emergency Department in the middle of the night would be a clear sign of concern regarding his mental health. Again his description of difficulties with sleep, anxiety and 'thoughts in my head' in the context of not being on antipsychotic medication and having intermittent triggers through marijuana use would be a clear warning sign for the need for antipsychotic medication.

As [Mr A's] mental state deteriorated the level of contact that [Mr & Mrs B] had with the [mental health service] increased. There is a clear correlation between these events.

Again on the 13th [Month14] [Mr B's] description of [Mr A] ringing him at 1am and talking about a picture in an unusual and detailed manner would lead to the clear conclusion that he is likely to be experiencing psychosis. I did not find a written account of an assessment of this unusual event by clinical staff. Since [Mr A's] death [Mr and Mrs B] have submitted changes in [Mr A's] [forms of expression] over the time where there were changes in his mental state. If the staff

had asked [Mr A] to see his picture and discuss the meaning of this with him this could have been a strategy which elicited a clearer understanding of his internal world. From the notes it does not appear this happened.

Although it is intermittently recorded in the notes that [Mrs B] did not support the use of psychiatric drugs, I am not clear that she or her husband had been given sufficient information about antipsychotic medication and recovery. If they had been told that what [Mr A] described to his father was likely delusional and that the treatment of choice would be antipsychotic medication they [would] have been more informed about the role of medication. These recorded statements about parental opposition to medication are not sufficient grounds for the staff to discount the use of antipsychotic medication.

By 15th [Month14] a record in the [mental health service] team's MDT report notes that [Mr A] has had unusual behaviour but does not clearly indicate that the most likely reason for this is progressive psychosis.

Further seriously concerning behaviour occurred with [Mr A] having severe intoxication and injuries that required medical attention.

The review by [Dr C] and [PDN E] appropriately occurred at home when he did not attend clinic. However, I do not believe the assessment comprehensively addressed the progressive and escalating deterioration in [Mr A's] mental health. I am unclear from this assessment if [Dr C] had explored with [Mr A] why he had rung his father in the middle of the night with odd ideas about a picture. I am also unclear from this assessment about whether [Dr C] explored with him why he attended Emergency Department in the middle of the night asking for help. I am also unclear about whether any collateral history was obtained regarding the four hour period where [Mr A] stated he could not remember what was happening to him when he ended up with cuts, bruises and concussion. It appears that his parents were later able to elicit that this was self inflicted, however it seems that the [mental health service] staff accepted at face value that [Mr A] was unable to remember being beaten up. It appears that rather than seeing [Mr & Mrs B] as having escalating concern with their son's increasingly bizarre and functionally diminished behaviour, the services looked for dynamic explanations in the family, such as parental expectations and parental issues of control.

[Mr & Mrs B's] concern had been to such a high level with fear regarding the welfare of their son that a collaborative approach to the final psychiatrist assessment on 18th [Month14] should have occurred. If [Dr C] and [PDN E] had been unable to elicit acute psychosis I believe it would have been appropriate for them to have met face to face, proactively with [Mr & Mrs B] and hear in detail a face to face description of their observations. At this stage they could have discussed jointly whether despite the difficulty in eliciting psychotic symptoms directly from [Mr A], whether there would have been grounds at this stage to have admitted for a period of stabilisation. It was clear from the records that [Mr & Mrs B] were needing to actively ring into the service to ask for support, rather than being part of a combined treatment plan.

By 21st [Month14], [Mr & Mrs B] had information that [Mr A] had tried to burn his bed and his clothes and then later the same week poured paint all over the street. These were again clearly bizarre actions that were indicative of very poor mental health.

Liaison with the police around this time may have also given important collateral information.

It is unclear why it is then recorded by [Dr C] on 22nd [Month14] ‘hard to judge if the escalating concern is a sign of worsening M.S or not’.

Although some of my summary under question 1 of the overall clinical care provided to [Mr A] addresses subsequent questions requested of me I will now work through these sequentially.

Question 2: The Appropriateness of the Diagnosis and [Mr & Mrs B’s] perception that [Mr A’s] worsening mental health was not taken seriously.

These are in fact two separate issues. I have already commented that in my opinion the diagnosis of [Mr A] was more appropriately seen as that of Schizophrenia with co-existing marijuana and alcohol abuse. I do not believe his diagnosis was consistent with a drug induced psychosis.

Regarding the second part of this question, [Mr A’s] deteriorating mental health was responded to by phone follow ups, the offer of generally clinic based assessments and a documentation of their concerns. However, the difficulty was it appears that the [mental health service] staff already had preconceived ideas around [Mr A’s] mental health needs. Their interventions appeared driven by a presumption that the issues for [Mr A] were more of an intermittent drug induced psychosis and stressors and conflict between [Mr A] and his parents. These preconceptions appeared to have coloured their assessments and management of [Mr A].

Question 3: Whether [Mr A’s] pleas were responded to appropriately.

In my opinion the appropriate course of action for [Mr A] should have been continuing antipsychotic medication on his return from [his holiday]. Although I accept that [Mr A] had difficulties with sedation on olanzapine there is a range of other non-sedating antipsychotic medication that can be offered. I also believe that it would have been appropriate to have given more detailed information to both [Mr A] and his family about the signs and symptoms of psychosis.

The need for this approach to management became increasingly apparent as [Mr A’s] behaviour became more bizarre and deteriorated, particularly over late [Month13] and [Month14].

I believe that there was an over-reliance on cross-sectional assessment of [Mr A] and an acceptance of his denying psychotic symptoms to direct questioning. This occurred without looking more fully at both collateral information and level of

functioning and taking into account that [Mr A] had already disclosed that it was very difficult for him to open up about his psychosis.

Question 5: Regarding communication with [Mr & Mrs B] surrounding [Mr A's] suicidal thoughts.

The [mental health service] have regularly documented that [Mr A] did not have suicidal thoughts. It is not the case that they elicited suicidal thought or intent and failed to respond to it, the issue was that they did not elicit suicidality or in their opinion evidence of worsening psychosis.

Question 6: The appropriateness of the withdrawal of olanzapine

In my opinion the plan to withdrawal olanzapine towards the end of 2012 was premature. This is because [Mr A] had evidence of psychosis over a period of some time possibly two years prior to admission. Another reason for not stopping antipsychotic medication would have been that although there were some signs of times of progress [...]there were also difficulties in terms of intermittent exacerbations, particularly in the presence of marijuana use and there was also evidence of difficulties with functional recovery.

I would have addressed the issue of sedation on olanzapine by offering a change of antipsychotic medication. It is common for antipsychotic medications to be changed because of issues of tolerability and there are a range of less sedating antipsychotic medications available.

Should [Mr A] and his family have actively requested a cessation of antipsychotic medication, despite having clear information on the potential risks of this, I would have provided a detailed relapse recovery plan and an advanced directive. In this agreement should have been reached with [Mr A] and his parents about what signs would be indicative that antipsychotic medication should be reinstated. I would have also given them information that should antipsychotic medication need to be reinstated it would be important to then have a long period of stability and recovery on antipsychotic medication.

Question 7: Has already been addressed under the overall comment on clinical care.

Question 8: Alleged inaccuracies in the clinical documentation.

I note from the correspondence of [Mr & Mrs B] that the family concern risk sheet did not contain escalating communication of risk. For the purposes of this report I have not attempted to clarify the family's concerns around the entry regarding metabolic monitoring as I do not feel I can address this.

I also note that [Mr & Mrs B] have been clear that some of their phone contact over the last 10 days of [Mr A's] life have not been documented in the clinical file. Although [Mr & Mrs B] are clear they have phone records about this, I have again felt that to comment on this is beyond the level of the capacity of which I am addressing this report which is to give a clinical opinion.

Question 9: [Dr C's] alleged failure to undertake a risk assessment on 18th [Month14].

I have already commented on this, however in my opinion [Dr C's] assessment of [Mr A] at this time did not comprehensively address risk. It did not factor in the escalating bizarre behaviour that had occurred for [Mr A] and it did not address the issue of [Mr A] being particularly vulnerable to escalating psychosis as he was not on antipsychotic medication. I believe that his description of [Mr A] not being psychotic overly relied on direct questioning of [Mr A] whilst there was other evidence that his behaviour was becoming progressively more bizarre. I also believe that [Dr C] and the [mental health service] team should have moved to have had a collaborative care plan with [Mr A's] parents rather than assessments of the service being cross-sectional and underestimating the severity of [Mr A's] mental health.

Question 10: Should the use of the 1966 Alcohol & Drug Addiction Act have been considered to support compulsory rehabilitation for [Mr A's] drug and alcohol use.

I disagree with this. I do not believe that the issue for [Mr A] was predominantly a substance abuse problem. As I have stated it is common for people with schizophrenia to have co-existing alcohol and marijuana abuse or abuse of other illicit drugs. The preferred approach to this is an integrated dual diagnosis approach, treating the psychotic symptoms with antipsychotic medication and offering clients specific assistance with therapy such as motivational interviewing to understand and reduce substance abuse.

[Mr A] described on his admission to the [mental health inpatient service] that he used marijuana and alcohol to deal with his distressing auditory hallucinations. It is possible that should [Mr A] have reached a state of wellbeing with his psychotic symptoms that his use of marijuana and alcohol could have reduced and become less problematic. The predominant focus for [Mr A's] clinical treatment should have been on treating his schizophrenia and then addressing triggers to ongoing psychotic relapse such as marijuana.

Question 11: Should consideration have been given to placing [Mr A] under a Compulsory Treatment Order in accordance with the 1992 Mental Health Act.

Prior to [Mr A's] deterioration in mental state, over the period of care before going on [his holiday] he would not have required the Mental Health Act. At this stage he was engaged with treatment, he was generally reliable with taking medication and he was attending regular review. However, over the period [from late Month13/Month14], there is evidence that the Mental Health Act could have been used if required to help [Mr A] receive antipsychotic treatment.

I believe this should have been considered at an earlier stage and that it is clearly unfortunate that the process for starting the Mental Health Act only occurred just prior to [Mr A's] death.

Question 12: The appropriateness of Southern DHB's recommendations arising from the Incident Investigation.

Clearly the Incident Report completed by [Dr K] and [Ms L] has a different perspective and conclusions on the care of [Mr A] than what I have drawn to in my report.

I note they have made two recommendations.

1. All clinical interactions and family concerns need to be documented. The investigation concluded that some telephone calls between [Mr A's] parents and the nurses in the [mental health service] were not recorded in the clinical record. They recommended that there were strategies to enhance recording of these conversations.

Whilst I do not disagree with this recommendation in my opinion, the more important issue was not the number of conversations that were or were not recorded, although this is of course relevant, but rather the importance of engaging and working with family members so that an oppositional approach to care is not found. It was striking in the assessment of the notes that although [Mr & Mrs B] had always been involved with [Mr A's] care, they only had escalating service contact at the times when he was clearly becoming more unwell. Over periods when he was clearly more stable, they at times expressed satisfaction with his progress. I am unclear why the escalating frequency of contact and concern expressed by [Mr & Mrs B] to the [mental health service] team about the welfare of their son, was not linked to consideration that [Mr A] may in fact be relapsing and there was something about the manner in which the team was assessing him that was not effectively detecting this.

The Second Recommendation made from the Incident Investigation was that a staff member from the Southern DHB should be identified as a contact person for bereaved families following a death of their family member.

Again this seems to be an appropriate recommendation.

Item 13: Additional Recommendations:

Additional comments that I would make have already been included in the body of this report. However

1. It is very important that Recovery Plans are developed with clients and families and are reviewed on a regular basis and used as a foundation for treatment. I am unclear if the fact that this did not occur in [Mr A's] case is a one off example or whether this is something that should be looked at more broadly in the service.
2. It appears that the identification of [Mr A] having a drug induced psychosis was an important determining factor throughout his care rather than appreciating that schizophrenia is often associated with co-existing disorders. In [Mr A's] case, the over-reliance on the treatment strategy being abstinent

from marijuana and alcohol and other drugs appears to have been at odds with generally recommended practice of the treatment of Schizophrenia and drug abuse as co-existing disorders. I am unclear if this needs to be addressed further within the service.

3. **Working with Families:** Working with families is a critical aspect of comprehensive mental health care. Although families generally do not have the clinical knowledge that is available to psychiatrists and nurses, they are the ones who are motivated to help their loved ones on their recovery in a way that can enhance service delivery significantly. When there is a difference of opinion regarding the presence of relapse between clinicians and family members it is critical that clinicians take a step back and reflect on the possibility that there may be signs and symptoms that they have neglected to elicit on direct questioning. Sharing information together and developing collaborative planning involving clinicians, family supporting the individual client is imperative at these times.

Yours sincerely

Dr Verity Humberstone
 Consultant Psychiatrist
 Te Roopu Whitiara, Community Maori Mental Health Service
 Senior Clinical Head
 Mental Health Services
 Northland District Health Board”

Further advice

Dr Humberstone provided the following further advice:

“Qualifications of Report Writer

I obtained my MBCHB from Auckland Medical School in 1992. I obtained my FRANZCP in 2000, I hold a Post Graduate Diploma in Forensic Psychiatry. I am currently employed as a Consultant Psychiatrist for Te Roopu Whitiara — Community Maori Mental Health Services and Clinic Director of Mental Health Services Northland.

Documents Reviewed

In providing further information on this case I have reviewed the following documents:

- My initial advice dated 17/12/2013
- Letters from Health and Disability Commission to Southern DHB and [Dr C] dated 22/04/2014
- Letter from SDHB to HDC dated 20/06/2014
- Letter from [Dr C] to HDC dated 20/06/2014

- Letters from [Mr and Mrs B] to HDC dated 10/08/2014 concerning [Dr C], dated 12/08/2014 concerning [Dr M] reports and dated 13/08/2014 concerning [Dr K's] letter.
- I have read the HDC guidelines for independent advisors and I am clear that I have no conflict of interest in this case.

Please clarify whether you consider the care provided to [Mr A] in [Month3] and [Month11] was a departure from expected standards and if so whether you consider if it was a mild, moderate or severe departure.

I acknowledge in my initial report that I stated *'in my opinion that the care provided to [Mr A] was a moderate departure from best expected standards'*. In re-reading the material carefully and considering the feedback received I still have concerns that the overall care provided to [Mr A] should have considered the possibility of a re-emergence or intensification of psychosis on the withdrawal of antipsychotic medication.

I have outlined in my earlier report rationale about the use of recovery plans and in particular developing collaboratively with clients and their families signs that may be indicative of psychosis and options around the treatment of this, such as re-instigating antipsychotic medication.

I note that [Dr C] had communicated with the family that they were welcome to contact services at any time; however more specific information should have been given.

The rating on departures from expected standards will always have a degree of subjectivity about this, however I believe that a key function of working with people who have psychosis, whether or not the service wishes to identify this as Schizophrenia, should include giving information about the condition, about the role of antipsychotic medication and clinical guidance on when this should be reintroduced if antipsychotic medication is being withdrawn.

As [Dr C] does record in his notes *'early warning signs discussed'* however there is no record of what symptoms were discussed and what would be indicative of relapse.

In considering how this compares to expected practice my opinion is that there has been a mild to moderate departure from expected standards.

Comments about [Dr C's] letter dated 28/06/2014, particularly regarding [Mr A's] presentation at [DHB2], whether [Mr A] had negative symptoms, appropriateness of withdrawing olanzapine and any other aspects of this response that you consider warrants comment.

[Dr C] comments *'when outpatients start to reduce their antipsychotic medicine symptoms don't usually return so abruptly, also when antipsychotic treatment is reinstated symptomatic relief is not usually so immediate as it appeared to be when [Mr A] was on holiday'*. From reviewing the record of contact with [DHB2] Psychiatric Services it does not appear that the re-emergence of psychosis was as

abrupt as implied. As I have outlined in my earlier report the [DHB2] clinical staff elicited that [Mr A] would *'often experience the onset of auditory hallucinations, a number of voices that make derogatory comments about him'*.

He had told the [DHB2] staff that he had had poor sleep for several weeks, but that he was tending to sleep during the day. He told them that he had passive thoughts of *'not being around but denied any intent or plan'*. He told them he occasionally experienced command hallucinations *'voices telling him to do things like take drugs but does not follow through and manages by distracting or occupying'*. He described that when his olanzapine was gradually reduced he started experiencing hallucinations over a two week period from when this was under 10mg in dosage. He had also denied any recent history of abusing synthetic cannabis. He also disclosed concerns that he *'may have a microchip in his ear'*.

It was also noted *'acknowledges voices more noticeable since gradual reduction in olanzapine, however may not have informed treating team as feel "pressure" from them, family and friends to be well'*. This description of an onset or intensification of psychosis with the reduction of antipsychotic medication is not atypical nor does it appear to be very abrupt.

As I have outlined in my report I am unclear from the records as to whether recommencing antipsychotic medication was discussed with [Mr A] and his parents as a treatment option. I note that [Dr C] refers to [Mr A] having withdrawn from olanzapine however I note the clear opinion of his family that rather than withdrawing it was never re-prescribed.

[Dr C] in his response to the appropriateness of withdrawing olanzapine [and] recommencing this makes the following points:

- He states that he did not believe that [Mr A's] psychosis was preceded by a prodrome.
- He believed that [Mr A] had a good recovery without lingering symptoms of psychosis.
- He stated that [Mr A] appeared well when he returned from [holiday] and that he was not sure whether olanzapine was in fact needed.
- He also stated that [Mr A] and his mother were reluctant to restart olanzapine.

As I have stated in my earlier report I do not agree with the absence of a prodrome or that the recovery was sustained.

Regarding negative symptoms I do believe that it would have been reasonable to consider negative symptoms as part of [Mr A's] presentation for the reasons that have been outlined.

In my earlier report [Dr C] responds to this by saying that [Mr A] would often appear warm and cheery and upbeat and whilst I am not disputing his observations on [Mr A's] affect I do note that at the time that he started citalopram as an antidepressant the symptoms that he was concerned about were low mood, poor

motivation, sleeping until the afternoon and part of the differential at this time could have included negative symptoms of an enduring psychosis.

I also note there are multiple areas where [Dr C] does not agree with my opinion particularly in the third period of care where he stated that there were several isolated incidences where [Mr A's] behaviour caused concern however did not indicate a relapsing trajectory.

I note that he did not see that the events leading up to [Mr A's] death were increasingly bizarre in nature and that he felt that there were reasonable explanations for the actions of concern.

I have taken this feedback into consideration however I do believe that in the context of a young man who has a clear psychotic illness, which is not fully resolved, the actions that occurred prior to his death would be indicative of signs of psychotic relapse.

Whether you consider based on all the information you have reviewed, [Dr C] gave reasonable consideration to the possibility that [Mr A's] psychotic episode in [Month1] may or may not have been preceded by a prodrome.

As I have outlined in my earlier report and as is consistent with the more recent feedback from [Dr C] he did not see the presence of a prodrome.

I have already outlined in my earlier report my opinion regarding this.

Comments on [Dr M's] report

I agree with a number of aspects of the report provided by [Dr M]. Key features of agreement include the relevance of the prodrome and the approach to antipsychotic medication.

I quote from [Dr M's] report 'in my opinion a longer period of antipsychotic treatment was indicated. He had experienced a recent relapse of his psychosis. The history of two years prodrome meant that enduring psychotic disorder was likely and that his symptoms were unlikely to be solely the result of substance abuse. If side effects from medication were barriers to on-going use of olanzapine an antipsychotic with a different side effect profile could have been reconsidered'.

This is consistent to the opinion that I have provided.

[Dr M] also states 'however the clinical notes do not show clear evidence that advice was given to [Mr A] and his parents to continue antipsychotics for longer or that the option of trialling another antipsychotic was discussed, except at the [Month3] consultation. In my view this advice was important and if not given this is one element of care by SDHB and by [Dr C] that fell below an appropriate standard'.

I agree with this opinion.

With regards to [Dr M's] comments on continuity of care I also agree with the opinion that he had continuity of care maintained by [the mental health service].

With regards to family liaison [Dr M] said that [Mr A's] parents were centrally involved as caregivers for [Mr A], especially at the time of his illness. He concludes '*in my opinion the engagement by the team and by [Dr C] with [Mr A's] parents was of an appropriate standard*'. Whilst there was significant contact between [Mr A's] treatment team and his parents I have already commented in my report that I had concerns regarding the quality of family liaison.

With regards to [Dr M's] comment on legal issues, I agree that through the majority of his period of care with Southern DHB [Mr A] was cooperative with the treatment and therefore the use of the Mental Health Act was not indicated.

I am unclear about [Dr M's] conclusions that [Mr A] had decided to stop his antipsychotic medication in late [Month12] as it appears that this was just not prescribed further at this time as it was thought that it was no longer necessary.

[Dr M] concludes that '*the one aspect of care that I conclude was less than appropriate standard was the period of time that [Mr A] received treatment with antipsychotics and in particular the recurrent absence of advice to [Mr A] and his family about this*'. This conclusion I agree with.

[Dr M's] comments on my report

[Dr M], like [Dr C] and [Dr K], talk about the use of the term Schizophrenia and how this is avoided in services adopting an early intervention model of care.

Whilst Schizophrenia is a well-accepted term for an enduring psychotic illness the label is in some ways less important than the treatment approach taken. I understand why in youth there are strong preferences to use the generic term psychosis; however it is important that if this approach is taken that where there is evidence of an enduring psychotic illness this is still treated appropriately.

I note in [Dr M's] comments on the second period of care he again states '*in my opinion [Mr A] would have benefited from a longer period on antipsychotic medication. This would have reduced the chances of relapse whilst abusing substances. The possibility that [Mr A] was experiencing an enduring psychosis (such as Schizophrenia) remained even with evidence about fluctuations in his mental state associated with substance abuse*'. '*In my opinion this aspect of care (clear advice about continuing antipsychotic medication) did not meet an adequate standard but this was a relatively minor departure at this point*'. [Dr M's] opinion concurs with my own however he rates this as a minor departure 'at this point' from expected standard of care, whereas I have rated this as a moderate departure. I am unclear what [Dr M] means by 'at this point'.

[Dr M] also notes that [Dr C] and the clinical team did review [Mr A] on a regular basis to consider the possibility of symptom relapse but they did not conclude that signs and symptoms of relapse were evident. I note that he did not share my

comments around opportunities to improve attendance at appointments. He does state *'I do agree that in hindsight [Dr C] and the team appeared to see [Mr A's] behaviour as normal for a troubled young man, rather than psychotically driven. I cannot say this view indicated a failure of appropriate care, however I believe that there was sufficient doubt about the cause of [Mr A's] psychosis (uncertainty about the presence/absence of a prodrome, the presence of symptoms over at least several months[...], the relapse of symptoms in [Month11]) to warrant keeping the possibility of an enduring psychosis such as Schizophrenia clearly in the differential diagnosis'*.

The difference in this opinion to my own is whether or not the team seeing [Mr A's] behaviour as normal for a troubled young man rather than psychotically driven indicated a failure of appropriate care.

As I have outlined in my report the continued concern expressed by [Mr A's] parents indicating that in their opinion there were serious problems with [Mr A's] health and functioning, should have led to a reconsideration of the working diagnostic formulation.

With regards to the Mental Health Act [Dr M] states *'[Dr C] stated at times after they had heard alarming sounding information he and the team would meet to assess [Mr A] thinking that they might have to use the Act. However on each occasion after assessment [Dr C] states that they were never really close to using the Act because it was not appropriate to do so'*.

My comments on this are that if clinical services repeatedly hear highly concerning information from family members and yet on assessment of the patient they do not find cross-sectional evidence to support these concerns, it would be important to then meet with the family and try and understand why there is a discrepancy on this matter. I have outlined further on this in my first report.

I also note [Dr M's] comments under risk *'however reference to thoughts of harm to himself and others are often brief and the phenomenology is not fully documented. This is relevant because [Mr A] had previously experienced command hallucinations to kill himself and paranoid delusions about his parents planting a microchip and trying to control him'*. He concludes that despite little evidence of risk formulation this meets the minimum test for an appropriate standard of risk assessment. I have already outlined in my report concerns about the risk assessment and management provided to [Mr B] in the third period of care.

[Dr K's] letter

I note that [Dr K] has a different opinion to myself about the likelihood of an enduring psychotic illness and that he shares the diagnostic formulation of [Dr C] that it was unlikely that [Mr A] had an enduring Schizophrenia.

I note [Dr K's] comments regarding the use of the Mental Health Act, I believe that for the majority of [Mr A's] period of care under Southern DHB the Mental

Health Act would not have been required as I have stated in my original report. [Mr B] was generally reliable with taking medication and attending regular review. However over the period of increasing concern with [Mr A's] behaviour from late [Month13], [Month14] it may well have been appropriate to use the Mental Health Act if [Mr A] had been assessed as having a psychotic illness and if he had been offered and refused antipsychotic medication. However I note that [Dr C] did not actually believe that antipsychotic medication was required at this stage.

I also note the comments of [Dr K] and [Dr C] regarding the use recovery plans and advanced directives. I note that their opinion on the utility of these differs from that of myself. I remain of the opinion that recovery plans and advanced directives are very important clinical tools that can be used with clients both to improve therapeutic alliance and also to improve understanding about management of psychotic illness.

Appropriateness of the relevant policies provided by SDHB — Appendix G, H and I

I have read the policies attached in G, H and I and these appear to be very comprehensive. The information related to the mental health service seems very thorough and in appropriate language. I have no other comments to make on these policies.

Conclusion

In conclusion, in my opinion the quality of clinical care by [Mr A] during the third time period from [Month12] to [Month14] is a significant deviation from expected clinical standards. I have already outlined in my first report my reasoning for this opinion. I have carefully considered the additional material provided to me. I do not agree with [Dr M] that although there were aspects of care below an appropriate standard that this was minor.

Yours sincerely

Dr Verity Humberstone

Consultant Psychiatrist

Te Roopu Whitiara — Maori Mental Health

Clinical Director

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