Southern District Health Board

Psychiatrist, Dr B

Registered Nurse, RN C

A Report by the

Mental Health Commissioner

(Case 14HDC01343)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of contents

Executive summary

1. Mrs A, aged in her 60s at the time of these events, had an accident and sustained injuries to her body in Month1[1]. Mrs A's mental health declined following this.

2. On 18 Month3, Mrs A self-referred to Mental Health Services (MHS) at Southern District Health Board (SDHB). Mrs A was reviewed by consultant psychiatrist Dr B, who diagnosed a major depressive episode and prescribed antidepressants and sleeping medication. Dr B was Mrs A's lead clinician, and RN C was Mrs A's key worker. Following this review, Mrs A received regular input from MHS. She was also being seen by her GP and by the relevant team for the injuries she had sustained.

3. On 18 Month5, Mrs A self-harmed and was taken to the Emergency Department. Subsequently she was admitted to an inpatient mental health service (the inpatient service). Mrs A refused regular antidepressant medication and denied suicidal intent. She was discharged on 24 Month5. Mrs A was readmitted to the inpatient service the following day after a further incident of self-harm. Mrs A denied thoughts of self-harm and was discharged on 3 Month6 with key worker follow-up.

4. Mrs A had surgery for the injuries to her body on 19 Month6 in another region (City 2). The discharge plan was to return to City 2 in two weeks' time for a further appointment.

5. Mrs A was reviewed by RN C on 25 Month6, and by RN C and Dr B on 26 Month6. The plan was for daily key worker contact following the review, but this did not occur. Mrs A was found dead at home on 29 Month6.

Findings

6. Between Mrs A's first engagement with SDHB MHS on 18 Month3 and her last engagement on 26 Month6, there were a number of inadequacies in the coordination of her care, which the Mental Health Commissioner considers are attributable to SDHB — most notably, the failures in treatment planning and the poor coordination of key worker care. For not ensuring continuity of care for Mrs A, the Mental Health Commissioner found that SDHB breached Right 4(5) of the Code of Health and Disability Services Consumers' Rights (the Code).[2]

7. There are numerous aspects of Mrs A's care from Dr B that the Mental Health Commissioner considers were inadequate. In particular, the inappropriate decision to discharge Mrs A from the inpatient service on 3 Month6; the inadequate risk assessment during the clinical review of Mrs A on 26 Month6; the lack of documentation regarding the decision not to use the Mental Health (Compulsory Assessment and Treatment) Act 1992 provisions to treat Mrs A; and poor documentation in relation to risk assessment on 26 Month6. Overall, the Mental

[1] Relevant months are referred to as Months 1-7 to protect privacy.
[2] Right 4(5) of the Code states that every consumer has the right to co-operation among providers to ensure quality and continuity of services.

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Health Commissioner considers that Dr B did not provide services of an appropriate standard to Mrs A and, accordingly, breached Right 4(1) of the Code.[3]

8. The Mental Health Commissioner made adverse comment about RN C's communication of her expectations to RN D, and her documentation.

Recommendations

9. The Mental Health Commissioner recommends that SDHB and Dr B each provide a written apology to Mrs A's husband.

10. The Mental Health Commissioner recommends that SDHB:

a) Develop clear protocols for circumstances where key worker care may be shared in relation to a mental health care consumer. This should include a clear method of documenting the care arrangement, and the role of each key worker in the circumstances.

b) Use this case as an anonymised case study for education of its key worker and psychiatrist staff, including in relation to their respective roles.

11. In the event that Dr B returns to practise medicine, the Mental Health Commissioner recommends that the Medical Council of New Zealand consider whether a review of Dr B's competence is warranted.

12. In the event that RN C returns to practise nursing, the Mental Health Commissioner recommends that RN C undertake a course on documentation.

Complaint and investigation

13. The Commissioner received a complaint from Mr A, about the services provided to his late wife, Mrs A, by Southern District Health Board.

14. An investigation was commenced on 9 July 2015. The following issues were identified for investigation:

- *The standard of care provided by Southern District Health Board to Mrs A (dec) in 2013 and 2014.*
- *The standard of care provided by Dr B to Mrs A (dec) in 2013 and 2014.*

15. On 24 February 2016, the investigation was extended to include the following issue:

- *The standard of care provided by RN C to Mrs A in 2013 and 2014.*

[3] Right 4(1) of the Code states that every consumer has the right to have services provided with reasonable care and skill.

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

17. The parties directly involved in the investigation were:

Mr A	Complainant
Southern District Health Board	Provider
Dr B	Provider/psychiatrist
RN C	Provider/registered nurse and key worker
RN D	Provider/registered nurse and key worker

Also mentioned in this report:

Dr F	Registrar
Dr G	Registrar
RN H	Registered nurse
Dr I	Registrar
Dr J	Specialist surgeon
RN K	Mental Health Liaison Nurse
Dr L	Psychiatrist
Dr M	Emergency physician
Dr N	House Officer
Dr O	Registered medical practitioner

18. Information was also reviewed from:

Dr E
Medical centre
ACC

19. Independent expert advice was obtained from psychiatrist Dr Yvonne Fullerton (**Appendix A**), registered nurse (RN) Sally McPherson (**Appendix B**), and […] surgeon Associate Professor […] (**Appendix C**).

Information gathered during investigation

Overview

20. Mrs A, aged in her 60s at the time of these events, had an accident and sustained injuries to her body in Month1. Mrs A's mental health declined following this. She self-harmed on two occasions and was placed under the care of Southern District Health Board's (SDHB's) Mental Health Services for Older Persons (MHSOP). Mrs A died on 29 Month6.

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MHSOP

21. The MHSOP is a mental health service comprising a multidisciplinary team that provides a range of services for people aged 65 years and over who have been diagnosed with a mental health disorder or severe behavioural disorder. SDHB said that "[t]he team aims to help people live their lives as independently as possible and to live their life to the fullest in the least restrictive environments possible".

22. In accordance with SDHB policy, all current consumers of the mental health and addiction service are to have a key worker and a designated psychiatrist.

Role of the psychiatrist

23. SDHB told HDC that psychiatrist Dr B was Mrs A's lead clinician. SDHB said that the staff of Older Persons Mental Health (a section of the Community Mental Health Team) had access to Dr B at any point if they were concerned about Mrs A.

Role of the key worker

24. SDHB said that "[t]he key worker role is one of case management, co-ordinating and directing the recovery planning process, including discharge planning across inpatient and community settings, in order to meet the ongoing and changing identified needs of the consumer (tangata whaiora). The key worker is generally considered the consumer's primary co-ordination point of contact with the service."

25. SDHB told HDC that RN C was assigned as Mrs A's key worker.

26. RN C told HDC that she shared the key worker role for Mrs A with RN D. RN C stated:

> "Because I was part time, another registered nurse [RN D] was tasked with working with me as a co-keyworker for [Mrs A] on those days when I was not working, with a view to her taking over the role of identified key worker for [Mrs A]."

27. In contrast, RN D said that she was not joint key worker with RN C, and was not asked by anyone at any time to be part of the delivery of clinical services to Mrs A. There is no documented record that RN D was asked to share the role with RN C.

28. SDHB told HDC that if RN C's clients had unplanned contact on her rostered days off and action was required that day, the call would be put through to the duty worker for triage, in accordance with its procedure at that time.[4] SDHB said that, if clients required planned intervention on RN C's rostered days off, its expectation was that she would approach one of her colleagues to provide this input.

Clinical history

29. Mrs A had a history of depression, schizophrenia, and alcohol dependency in the 1970s and 1980s, which her husband, Mr A, advised coincided with diagnosis of and treatment for another serious health issue. However, Mrs A was mentally well for a

[4] Duty Person procedure, issued 28 November 2012.

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long period following this, and had no contact with mental health services for 33 years. More recently, Mrs A had been diagnosed again with the same serious health issue from which she had previously suffered, and had undergone treatment for it. She was still undergoing treatment at the time she was injured on 16 Month1. By the end of 2013, the treatment appeared to have been successful.

30. Mrs A had other personal stressors around this time. Mrs A also had a family history of mental illness.

Timeline of care

Treatment for injuries

31. On 16 Month1, Mrs A had an accident and sustained injuries to her body. She attended the public hospital's Emergency Department (ED) where she was diagnosed and a referral was made to the appropriate medical team.

32. On 24 Month1, Mrs A attended her referral appointment where she received treatment.

33. Mr A told HDC that treatment was done without anaesthetic gas as the bottle was empty, and that Mrs A had suffered a significant amount of pain. In response to the "information gathered" section of provisional opinion, Mr A said that he was present with his wife when staff at the medical clinic realised that the anaesthetic gas had run out. Mrs A also reported this incident to others, including her general practitioner (GP), Dr E, and other clinical personnel. There is no record of this in the clinical notes.

34. Dr F dictated his record of the consultation. He told HDC:

> "It was not my normal practice to dictate the patient's response to a routine procedure, unless they expressed concern or an incident of note occurred. I have not commented on [Mrs A's] response on 24 [Month1], nor does the procedure stick in my memory. I cannot categorically state that she did not experience some pain during the procedure. I can only postulate that I must have perceived the procedure to have been well tolerated by … [Mrs A] …
>
> … I can categorically state that I have never performed [this procedure] without the administration of analgesia. I do not recall the incident of the empty Entonox cylinder but I may not have been party to that discovery at the time if I had moved on to another […] clinic patient."

35. SDHB told HDC that it had spoken to the nurses involved in Mrs A's care at the […] clinic. SDHB stated:

> "With no disrespect to [Mrs A's] family's account of her experience, the discussion did not prompt a specific recall of the incident as described. Both nurses would like to say to [Mrs A's] family how distressed they were to hear about [Mrs A's] experience and how this went on to impact her."

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36. On 31 Month1, Mrs A attended a further appointment at the same medical clinic. SDHB said that because of a dictaphone failure, on that occasion the dictated consultation was not recorded.

37. On 7 Month2 (three weeks after her injuries), Mrs A was reviewed by a registrar, who recorded that Mrs A was still complaining of pain resulting from her injuries but not as severe as previously. Assessments did not reveal any obvious issue with how the injuries were healing.

38. On 28 Month2 (six weeks after her injury), Mrs A was reviewed by registrar Dr G. After investigation, Dr G considered that the way the injuries were healing was acceptable.

Mental health care

39. On 2 Month3, Mrs A consulted her GP, Dr E, who recorded:

> "Complains of feeling nauseous all the time in her lower stomach but no vomiting, bowel habit normal. Urinary tract unremarkable. Says that she can't think, feels exhausted and had it and is unhappy about her hair regrowth. She is due to [visit another region]. She feels anxious and depressed. She has completed [the treatment for her diagnosed serious health issue]."

40. Dr E recorded that he and Mrs A discussed the potential diagnosis of depression and prescribed an antidepressant, paroxetine 20mg. However, to avoid starting the paroxetine until she had returned from her trip, Dr E also prescribed oxazepam[5] 10mg, to be taken morning and night as needed. Dr E did not record that Mrs A had any concerns regarding her [injuries].

41. Mrs A was reviewed by Dr E on 17 Month3. He recorded that Mrs A was "very distressed regarding pain [resulting from her injuries]". Dr E noted "swelling and tenderness", and that Mrs A was "markedly restricted in activities of daily living including driving". Dr E recorded that Mrs A had been using the oxazepam morning and night but did not want to begin on paroxetine, as it had "apparently affected her mother". Dr E referred Mrs A to a physiotherapist and prescribed Brufen,[6] paracetamol, and codeine phosphate[7] to use as required. Dr E also recorded that "ACC apparently wanted to send her to pain clinic but she had not even tried Paracetamol".

42. The following day (18 Month3), Mrs A presented to the Mental Health Services (MHS) at SDHB via telephone self-referral after her family became increasingly concerned about her deteriorating mental condition. RN H spoke with Mrs A and recorded the following details of their conversation:

> "[Mrs A] contacted … in a distressed state 'can't cope with my body'
> feel like collapsing. 'tummy churning'

[5] A benzodiazepine that is primarily used to help treat symptoms of anxiety.
[6] Brufen (ibuprofen) is indicated for the relief of acute and/or chronic pain states in which there is an inflammatory component.
[7] An opioid analgesic used for the relief of mild to moderate pain.

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anxiety ++ tearful
poor sleep …
appetite — 'don't feel like eating at all'
poor concentration 'muddling'
flat all day 'nothing left' 'got everything — but nothing'
good husband — 'don't want kids to know' …
… describes herself as having and being fearful 'for life' …
… no happiness in life — thoughts of self harm 'don't want to die'. [Family history of mental illness and self harm] …
… went to [GP] yesterday wanting to commence her on [antidepressant] therapy but she declined …
… physical health issues — [other serious health issues, received treatment]. [sustained injuries two months] ago."

43. RN H obtained Mrs A's previous mental health history. At RN H's request, Mrs A attended the ED with her husband that day, where she was reviewed by consultant psychiatrist Dr B. Dr B recorded Mrs A's past history and family background, along with a mental state examination (MSE), which included:

> "Nicely dressed, good hygiene. Denies suicidal ideation. No homicidal ideation. No hallucinations or delusions. Affective expression is broad and appropriate. Mood is low but brightened by the end of the session. Judgement is good (self referred). Insight is good … Formal memory testing was not done."

44. Dr B told HDC that as an assessment of risk, she explored any thoughts of self-injury or suicide, which Mrs A denied. Dr B diagnosed Mrs A as suffering a recurrent major depressive episode, commenced her on clonazepam[8] (0.25–0.5mg at night) and sertraline[9] (50mg morning), and arranged for the Mental Health Emergency Team (MHET) to call her the following day. They agreed that Mrs A or her husband would call if any problems arose. RN H faxed this information to Dr E and requested relevant medical information and recent clinical notes, which he provided. Mrs A was also allocated a key worker, RN C, on this date, and this is documented in the clinical records.

45. MHET arranged for one of its duly authorised officers[10] to telephone Mrs A on 19, 20 and 22 Month3. On 20 Month3 Mrs A reported to a duly authorised officer some improvement in her overall mood and anxiety; however, on 22 Month3, Mrs A described herself to RN H as "struggling". RN H wrote:

> "[O]n-going problems with anxiety. limited effect from sertraline. clonazepam assisting with sleep pattern. appetite remains poor [increasing] negative self talk.

[8] An anticonvulsant that exhibits several pharmacological properties characteristic of the benzodiazepine class of medicines. Used in these circumstances to alleviate anxiety and assist with sleep.
[9] A selective serotonin reuptake inhibitor (SSRI) used primarily to treat depression.
[10] A person who is designated and authorised by the Director of Area Mental Health Services under Section 93 of the Mental Health Act, to perform the functions and exercise the powers conferred on duly authorised officers by or under this Act. These are often social workers or registered nurses.

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withdrawing from friends/family/interests … on-going pain and restriction due to [injuries]. rates mood as 7/10 although self reports [are] not congruent with rated mood score … acknowledges fleeting thoughts of self harm but denies intent …

plan

1. refer back to MHSOP for on-going support

2. [Mrs A] has MHET 0800 number if [increased] support required."

46. Dr B reviewed Mrs A on 24 Month3, with RN C in attendance. Dr B recorded this assessment (and all subsequent assessments) in the form of a dictated clinic letter to Mrs A's GP. On this date, Dr B noted "good improvement" but that Mrs A's "anxiety is an ongoing issue since [Mrs A] is described as a 'perfectionist'…". Under "mental status examination", Dr B described Mrs A's mood as "low but not overtly depressed", and noted: "[Mrs A] is mildly anxious. There is no psychosis noted. No thoughts of suicide or homicide." The treatment plan was to increase sertraline to 50mg morning and night, clonazepam 0.5mg at night and 0.25mg 9am and 3pm, and to review her again in one week's time or as needed. One month's supply of each medication was prescribed.

47. On 30 Month3, Dr B reviewed Mrs A, with RN C in attendance. Dr B recorded: "No changes in her mental status exam. She remains without suicidal or homicidal ideation or intent." Further improvement was noted, and that Mrs A reported "sleeping 'brilliantly'", experiencing "less anxiety during the day and … feeling less depressed, even though she said she is 'not her old self'". Dr B made no changes to Mrs A's medication, and arranged a review in two to three weeks' time or as needed.

48. A week later (7 Month4), RN C visited Mrs A and recorded that Mrs A was appearing less anxious, her sleep pattern had improved greatly, and she had more energy. RN C also wrote that Mrs A reported an improvement in her depression and said that the medication prescribed had been beneficial.

49. At the next weekly visit (15 Month4), Mrs A described to RN C gastrointestinal symptoms and anxiety about associated weight loss (weight under 44kg), which started when the increase in sertraline commenced. RN C consulted Dr B, and Mrs A's sertraline dose was halved. RN C also noted that Mrs A had been more socially active but continued to feel insecure and inferior around people.

50. RN C completed a Risk Assessment Management Plan form and recorded: "[S]elf harm not a risk." However, under potential risks, she noted possible physical risk due to poor nutritional intake and weight loss. RN C also recorded a risk pattern recognition, which detailed that Mrs A had a "fear of being alone; lacks confidence in self; [is] fearful of friends knowing about her illness; [experiences] sleep [deprivation]", and that increased anxiety levels were causing this behaviour. Listed as "protective factors" were her supportive husband; supportive sisters; and continuing on with medication, especially clonazepam.

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51. On 20 Month4, Mrs A consulted Dr E. According to Dr E's clinical records, Mrs A reported that she was eating very little, and was feeling weak and nauseated. She further reported that she "can't recall where things are put and tends to be a little bit confused". Dr E recorded that Mrs A's anxiety was gone but she was taking a "fair amount of medication, some of which is probably accounting for all of her symptoms particularly the mental type symptoms".

52. Dr E prescribed Mrs A metoclopramide[11] 10mg, three times daily, and recommended that she talk to her key worker about possibly having Fortisip[12] on a regular basis. He also suggested that Mrs A buy a muti-vitamin capsule to take in the interim.

53. On 22 Month4, RN C visited Mrs A at home. RN C recorded that Mrs A was feeling lethargic, "at a loss [and unsure] where to turn", and "unable to complete household tasks" but "denied feeling suicidal [and said she] just wants to get back to her old self". Mrs A complained of feeling nauseous and, following discussion with Dr B, RN C advised her to discontinue sertraline.

Consultation for management of injuries 24 Month4

54. On 24 Month4, Mrs A was reviewed by registrar Dr I at the public hospital. Dr I's clinic letter states:

> "[Mrs A] has not been taking the Amitriptyline that she was provided with last time … She still [experiences some symptoms from her injuries]. She doesn't think it is bad enough to require analgesia … We have encouraged [Mrs A] to continue with physio [and] have advised her that it is unlikely [she will fully recover to the same level of function as she had before in relation to one aspect of her injuries]."

55. Dr I arranged for a review in three months' time, and to consider further assessment at that stage if Mrs A was still having problems.

Further mental health care 29 Month4–14 Month5

56. On 29 Month4, Dr B reviewed Mrs A with RN C in attendance. Dr B described Mrs A as stable and euthymic.[13] She noted that Mrs A was still experiencing mild anxiety, particularly about learning that she was being sent to City 2 to see a specialist about her injuries. Dr B also wrote: "She is not suicidal, nor is she homicidal … [Mrs A] has good support … She says that she has much to be grateful for and a full life ahead of her to enjoy." The documented treatment plan was for Mrs A to continue clonazepam 0.5mg at night (Mrs A had stopped using clonazepam during the day), Dr B to review her again in three months' time or as needed, and RN C to see Mrs A "more often" (the frequency was not defined).

57. At RN C's next home visit (5 Month5) she recorded that Mrs A was "making slow progress", "coping more with visitors", but was feeling concerned about her lack of energy and poor concentration.

[11] An antiemetic used to treat nausea and vomiting.
[12] A ready-to-drink oral nutritional supplement.
[13] Normal mood.

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58. On 7 Month5, Mrs A attended an appointment with a specialist surgeon Dr J in City 2 to discuss ACC-funded elective surgery for her injuries. She underwent investigations and Dr J sent an application form to ACC on 11 Month5 for approval to proceed to surgery as soon as possible.

59. On 12 Month5, RN C visited Mrs A at home, along with RN D. RN D said that she accompanied RN C on this occasion because it was the team's practice to visit clients in pairs when staff numbers allowed.[14] At this visit, RN C recorded that Mrs A was "tearful and very anxious", feeling "desperate" and "a burden" on her friends and family. RN C wrote: "[T]he major reason for this dramatic change is due to the recent visit to [City 2] to keep an [appointment] with the [specialist] consultant." She noted that surgery was to be scheduled within the next few weeks. RN C documented that Mrs A "denied self harm but [was] not able to think clearly or positively" and requested "something that would assist her to relax and remove the pent up feeling she ha[d] in her stomach".

60. RN C arranged a meeting between Mrs A, Dr B, and RN D for two days' time (14 Month5). RN D told HDC that RN C was not working on 14 Month5, and asked her to drive Dr B to this visit. RN D said that she was not asked by anyone "to be part of the delivery of clinical services to [Mrs A]". In response to the provisional opinion, RN C told HDC that she believes she would have asked RN D to accompany Dr B, rather than drive her to the appointment, as it was SDHB practice for a key worker to attend when a psychiatrist visited a patient.

61. At the meeting on 14 Month5, Mrs A complained of feeling confused. Dr B recorded that Mrs A attributed her confusion to clonazepam and had obtained a prescription for zopiclone[15] 7.5mg from another medical doctor and intended to discontinue clonazepam immediately and replace it with zopiclone each night. Dr B wrote to Dr E that Mrs A was aware that Dr B does not prescribe zopiclone, and that if she did continue with it, she would be following up with Dr E. In addition, Dr B documented:

> "Chart review was done for historical presentations. This behaviour [regarding the use of medication] has been consistent over the years. We will be discussing this with [Mrs A] on another visit …
>
> [Mrs A's] mental state exam remains very much the same. There is no thought of self injury, no thought to hurt anyone else. The only change is that she is feeling more confused today."

[14] SDHB's policy at the time: "Home visits by staff to consumers — Mental Health (the public hospital)", issued 15 October 2012, provides information aimed at ensuring that home visits are conducted in a safe and professional manner. Regarding the number of staff members recommended to attend a home visit, it states: "Consider gender safety when preparing for a home visit. It may be necessary to take another staff member with you."

[15] A short-acting hypnotic that has sedative, anxiolytic (anti-anxiety), anti-convulsant, and muscle-relaxant properties. Its pharmacological profile is similar to that of the benzodiazepines.

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62. Dr B made arrangements for RN C to contact Mrs A "in the next few days". Dr B's letter does not detail the information from RN C's visit on 12 Month5, and there is no separate record of Dr B's consideration of this information.

63. Dr B told HDC that she and Dr E were "working together", and spoke about both Mrs A's psychiatric and medical care. Dr B said that she felt that Dr E would have notified her at any time if he had had any concerns.

First incident of self-harm 18 Month5

64. Four days later, on 18 Month5, Mrs A self harmed and was admitted to hospital via ambulance. The ambulance report stated:

> "[self harmed] … [Patient] wants to be left alone to die … Conscious to voice. [Glasgow Coma Scale (GCS)[16] score] 11 … Bradycardic.[17] Hypotensive[18] … Accuracy of information from [patient] unreliable."

65. Mrs A was assessed in the Emergency Department by a doctor who recorded:

> "[…] States wants to die and that [she] doesn't want to be around anymore."

66. The ED doctor's impression was "[self harm] with intent". The recorded plan was:

> "Observe — needs admission; Fluids; [Neurological observations]; […] Husband needs support […]"

67. An RN recorded that Mrs A was found by ambulance personnel and her husband, and that she now "states she tried to kill herself […]; states she feels alone, doesn't want to be a burden to her family, very low in mood; asks for someone to talk to …". The medical review, completed at 7.20pm, also adds that Mrs A "made plans not to be found" but that "patient states now uncertain if she wants to die". Neurological observations were completed. The following plan was made:

> "1) close monitoring
>
> […]
>
> 4) [Critical Care Unit (CCU)]
>
> 5) [Mental health emergency team (MHET)] when able"

68. At 8.15am on 19 Month5, a doctor reviewed Mrs A on the consultant ward round and recorded:

> "… She feels unable to cope with this anxiety and with her life in general.
>
> She feels full of unhappiness and feels she is a burden on her family.

[16] A common scoring system used to determine a person's level of consciousness. The GCS is scored between 3 and 15, 3 being the worst and 15 the best (fully conscious and orientated).
[17] Slow heart rate.
[18] Low blood pressure.

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> […] She doesn't like the psychiatric [medications] she is on, as they 'change her'.
>
> Anxiety manifests as nausea, stomach upset and diarrhoea.
>
> No suicidal ideation at present. Feels she would be safe to move to medical ward.
>
> …
>
> Reports [increased] confusion."

69. On 20 Month5, Mrs A was seen by Mental Health Liaison Nurse RN K. RN K's documented MSE included that Mrs A's mood was "preoccupied" and "fearful", that she was "frequently seeking external solutions and personal reassurance", and that "[t]here is an element of social embarrassment present when she reviews the events of recent months". RN K's assessment was that although Mrs A assured her personal safety and denied suicidal ideation, she should be reviewed by a consultant psychiatrist from MHET because of:

> "…
>
> a) Adverse (jointly anxious, element of co-dependency) family dynamics;
>
> b) Questionable insight, particularly in relation to adherence to [and compliance with prescribed] medication regime …;
>
> c) High psycho-social stressors, familial and economic …;
>
> d) Physical health … [including] [treatment for serious health issue] … current [injuries]…"

70. RN K documented that Mrs A did not appear to be "mentally disordered" in terms of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

71. At 4.30pm that afternoon (20 Month5), an RN recorded in the progress notes: "Very frail lady — assured me she wanted to go home — was not at risk of suicide attempt."

72. At around 5pm, Mrs A was reviewed by psychiatrist Dr L, and subsequently admitted to an inpatient mental health service (the inpatient service) at SDHB. Dr L assessed her and completed SDHB's Risk Assessment and Management Plan. Factors to be considered in this risk assessment form include previous suicide attempts; major mental illness; personality factors; lack of insight; negative factors; impulsivity; active symptoms of mental illness; unresponsive to treatment; change in medication; and suicide plans (including family history).

73. Regarding past behaviour pertaining to potential risks, Dr L wrote "major depression with recent suicidal attempt; intent". He ticked "lack of insight, negative attitudes and active symptoms of major mental illness". He did not tick "impulsivity, unresponsive to treatment, or suicidal plans". Regarding current behaviour pertaining to potential risks, Dr L wrote: "Major depressive syndrome. Recent cessation of treatment. Not actively suicidal on assessment." Under the heading "Risk statement", Dr L wrote: "Significant risk of re-attempting suicide if not admitted." Mrs A was placed on 15-minute safety checks because of the incident of self harm.

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74. Dr B reviewed Mrs A the following day (21 Month5) and recorded:

> "[Mrs A] [d]enies suicide attempt — [self harmed] because she was 'lonely'. Knew husband was there and would leave a note for him to read which would be immediate. […] She denies suicidal ideation or intent. 'Embarrassed' by what she did. No psychosis noted. Does not want medication. No [d]epression noted. Routine [observations] as risk now is low."

75. Dr B did not commence any treatment at this time. She did not record any goals of admission, nor what had changed to reduce Mrs A's risk. Dr B told HDC that "Mrs A used the term 'parasuicide'[19] because she always denied suicidal intent". Dr B also stated that Mrs A was not given antidepressant medication because she refused it, not because she was not offered it.

76. The nursing notes for the rest of 21 Month5 also record that Mrs A denied that her self harm was a suicide attempt, and said that she was "embarrassed" by being in the inpatient service. Initially Mrs A's "mood was low" and she was "tearful", but later that night her mood was described as euthymic. Mrs A was granted day leave on 22 and 23 Month5. On 23 Month5 Mrs A complained of her poor sleep since admission, and requested sleeping medication. She was charted zopiclone, which was administered.

77. On 24 Month5, Mrs A was reviewed by Dr B, who recorded:

> "No [suicidal intent]. No [harm intent]. Leave [periods] have gone well. No regular medication. [Mrs A] wants to be discharged home. Mood is euthymic. No psychosis noted."

78. Dr B discharged Mrs A home with a prescription for two zopiclone 7.5mg pills (no repeat) and instructions to take half at night. Dr B told HDC that Mrs A continued to refuse regular antidepressant medication, but stated:

> "We were all in agreement with [Mrs A] that she no longer displayed symptoms of clinical depression. At the time, she stated that she didn't need the medication and was safe without it. We were also in agreement with this … an impression was made of the situation throughout hospitalisation."

79. An RN filled out the Discharge Plan. Mrs A's current risk was recorded as low, noting that she was showing remorse for the self harm, and was future focused and happy to engage with her key worker and receive support. Her future risk was assessed as low–moderate owing to her "impulsive reactions"; however, the RN noted that Mrs A was currently denying suicidal ideation, and that her mood appeared euthymic and with reactive affect.[20]

[19] An attempt at self-harm that resembles a suicide attempt but the apparent aim is not death.
[20] The term "affect" is used in a mental state examination to record observed responsiveness of a person to his or her emotional state. It is seen as an external expression of emotion. Reactive affect describes a

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Second incident of self-harm 25 Month5

80. The next morning (25 Month5), Mrs A was readmitted following a second incident of self-harm. She was taken by ambulance to the ED, where emergency physician Dr M recorded the following presentation:

> "[…]. Husband […] called ambulance. […] Discharged from the [inpatient service] only yesterday."

81. An RN cared for Mrs A in the ED. The RN recorded that Mrs A's mood was low, and she was displaying intermittent eye contact. The RN also documented:

> "[Mrs A] stated that 'it will be better when I succeed — not fair on him' (husband) that 'he would have had enough of her'. Stated that 'as nothing else has worked — next thing is [Mrs A expressed an intended method of self harm]. Has not had any counselling or on any medication. Sister presently sitting with her."

82. Mr A is concerned that he was not informed about Mrs A's statement about a method of self harm. SDHB noted that it is documented that Mr A was with his wife in the ED. SDHB stated: "[Mrs A's] suicidal ideation was discussed with [Mr A] during family meetings whilst [Mrs A] was a consumer of the [inpatient service]."

83. Dr M arranged for Dr B to review Mrs A in the ED. Dr B recorded in the clinical notes that Mrs A was "apologetic", "not depressed", and "not suicidal". Voluntary admission to the inpatient service was arranged that evening. The following day (26 Month5), Dr B reviewed Mrs A and recorded:

> "[Mrs A] states she is better. Discussed the 'demon' which has taken over her. Denies suicidal/homicidal ideation. No psychosis noted.
>
> [Plan]: Escorted leave at nurses discretion."

84. Also on 26 Month5, an RN completed a Consumer Review Form for Mrs A, on which she termed Mrs A's actions as a "parasuicidal attempt" and noted the risk to self as "moderate, impulsive".

85. Dr B made no other record of her review. She told HDC that Mrs A refused antidepressant medication but engaged in other treatments including one-to-one sessions with experienced psychiatric nurses, relaxation techniques, coping skills, and sleep hygiene. Dr B also said that Mrs A went for escorted walks on campus and participated in group activities. Dr B opined that "[t]hese behaviours are not consistent with major clinical depression".

86. The nursing notes that day record Mrs A's mood as "mostly euthymic" or "euthymic" although she expressed some anxiety at times. According to nursing records, that

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person's expected responsiveness to external events or stimuli. Conversely, restricted affect describes a mild restriction in the range or intensity of display of emotion.

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night Mrs A requested "something to sleep", and the nurse explained why this had not been charted. She noted that Mrs A appeared dismissive and irritable. On Thursday 27 Month5, Dr B recorded:

> "[Mrs A] continues to deny thoughts of self injury. No hallucinations or delusions. Discussed discharge planning. Requesting [medications] for insomnia. [Plan] promethazine 25mg at night as needed. [Discharge planning meeting] Monday [3 Month6].

87. On 27 Month5, the RN documented:

> "[Mrs A's] [m]ood appearing neutral with an anxious affect … [Mrs A] politely refused to discuss the ([…] self harm) … Verbally denies she will do such a thing again … Discussed with [Mrs A] about taking responsibility for her own safety. Wants to go on a trip with her husband but [is] unwilling to explore the circumstances around this admission."

88. Later that day, a student nurse documented that Mrs A's mood was lower today than yesterday but that she was future focused and had enjoyed an escorted trip home for two hours with her husband.

89. On 28 Month5, Mrs A was reviewed by Dr B, who recorded that Mrs A was "upbeat, future focused [and] requesting leave in anticipation of discharge Monday morning". Mrs A denied suicidal or homicidal intent or any concerns at this time. Dr B planned day leave on Saturday and overnight Sunday. There is no recorded exploration of the suicide attempt, and no risk assessment, diagnosis, or treatment plan.

90. The RN's nursing notes on 28 Month5 record that promethazine was stopped as Mrs A complained that it made her feel "woozy", and later that "[Mrs A remains] remorseful about parasuicidal attempt which she apparently has no recollection of?".

91. Following day leave on 1 Month6, an RN reported that Mrs A returned to the inpatient service appearing bright and with reactive affect, although some anxiety around co-clients was evident. The RN wrote that Mrs A's risk was moderate/low at that time. Mrs A received zopiclone to assist her sleeping that night. Mrs A spent the night of 2 Month6 at home, but she attended the inpatient service at approximately 8.30pm to request zopiclone 7.5mg, which was provided at the inpatient service.

92. On 3 Month6, Mr and Mrs A had a discharge planning meeting with Dr B, RN C, another RN, and a medical student. Clinical notes[21] from this meeting state that Mrs A denied thoughts of self-harm, that her main concern was anxiety over inability to sleep, but that Dr B advised that they discussed natural sleep remedies and education around sleep hygiene. In response to the provisional opinion, Dr B stated that Mrs A and her husband did not consider that respite care post-hospitalisation was necessary. Dr B also stated that, at this time, Mrs A did not pose a threat to herself, and could not

[21] These were recorded on a discharge planning meeting form and in progress notes made by Dr B and and the other RN at the discharge planning meeting.

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be held under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Dr B stated: "If forced against her will, [Mrs A] would not have cooperated with further mental health treatment."

93. Dr B arranged for RN C to follow up in two days' time, and for herself (Dr B) to see Mrs A in four days' time. Mr and Mrs A were reminded to call RN C or the MET if any problems arose. On 4 Month6, RN C completed a Consumer Review Form, which reiterated the information from the meeting.

94. On 5 Month6, Mrs A was visited at home by RN C and RN D. RN C recorded that Mr A was pleased with his wife's progress, that Mrs A appeared more relaxed, and that she had slept well. According to his clinical records, Dr E also had a discussion with Mrs A that day. He recorded that he and Mrs A discussed Mrs A's suicidal feelings, and noted: "[Mrs A] refuses MET/private committal at present. Wants to try [increase] sleep." Dr E prescribed Mrs A temazepam[22] and oxazepam to reduce her anxiety and aid sleeping (to be dispensed on a weekly basis), and arranged to see her the following day.

95. On 6 Month6, Mrs A consulted Dr E, who recorded:

> "…The main concern now is about sleeping and sleeping tablets and about the ongoing nausea which she saw me first [about] at the beginning of [Month3] last year. She describes the word nausea but has not vomited and the discomfort seems to be all over the abdomen. Significant indigestion does not seem to be a particular problem. She has had some diarrhoea but this is now stable. She is off food and losing weight and feels the worst in the morning. She takes no medication other than the Oxazepam and Temazepam which I prescribed the other day. Examination revealed nil of note in the abdomen which was quite soft with some increased bowel sounds.
>
> [Her injuries] are still [causing discomfort] but she is not taking any medication for it although she has postponed her surgery as a consequence of her current mental unrest …"

96. On 11 Month6, RN C recorded that she attempted to visit Mrs A that day but no one was home. However, RN C completed a Consumer Review Form, which is dated 11 Month6. Under "Current Recommendations/Outcomes", RN C wrote: "Future focussed. Denies feeling suicidal. Looking forward to spending more time with husband." She also recorded the plan for ongoing follow-up by MHSOP on a weekly basis, and that Mr A had been advised to supervise the administration of the oxazepam and temazepam that had been prescribed by Mrs A's GP.

97. The following day (12 Month6), RN C telephoned the household without success, and left a message on the answerphone. RN C recorded in the notes, "[F]ollow up on [17 Month6]"; however, there is no record of this taking place.

[22] A benzodiazepine that is primarily used as a sedative.

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98. SDHB told HDC that the treating team were aware that Mrs A was expected to be in City 2 for surgery sometime in Month6, so were not concerned that they had been unable to contact Mr or Mrs A.

Surgery 19 Month6

99. On 19 Month6, Mrs A had surgery for her injuries in City 2 performed by specialist surgeon Dr J.

100. The operation note states that postoperatively Mrs A was to stay in hospital overnight then be discharged, then return to City 2 in 13 days' time for a further appointment.

Mental health care 24–26 Month6

101. On 24 Month6, RN C telephoned Mr A, who informed her that Mrs A had had surgery. RN C documented that Mr A was feeling worn out after caring for Mrs A since her surgery, and that Mrs A's food intake was limited and weight loss was evident. RN C also recorded that Mrs A had been expressing "feelings of despair and hopelessness … constantly" to Mr A and Mrs A's sister, and that "[Mr A] would like Dr B to see [Mrs A] — he feels an antidepressant is now required". RN C agreed to visit the next day.

102. RN C visited Mrs A at 10am on 25 Month6. RN C recorded that Mrs A did not appear well, with evident weight loss, dark circles around her eyes, lacking in energy, and a loss of interest in herself and others. RN C arranged a review by Dr B for the next day.

103. Dr B reviewed Mrs A on 26 Month6, with RN C in attendance. SDHB said that Mrs A was offered admission to the inpatient service but she declined because she did not like to be there. There is no record in the clinical notes that this offer was made. In her letter to Dr E of the same date, Dr B wrote:

> "[Mrs A] has decided that she would like to start another antidepressant. She also complains that she is unable to sleep without Zopiclone. She is aware that we do not prescribe sleep medications [such] as Zopiclone; however [Mrs A] states she is willing to continue her sleeping medication through your office.
>
> [Mrs A] remains without suicidal ideation. No homicidal thoughts. There is no psychosis noted, no evidence of a formal thought disorder."

104. Dr B prescribed Mrs A escitalopram[23] 10mg daily, and recorded that RN C was to keep in daily contact with Mrs A. It is not clear whether this request was communicated directly to RN C.

105. RN C worked three days each week at that time, and was not rostered to work again until 31 Month6. There is no written handover to RN D or anyone else to carry out the daily contact in her absence. In response to my provisional opinion, RN C stated:

[23] A three-month prescription with a request that it be dispensed weekly.

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> "A multi-disciplinary meeting was held [once a week] when I would hand over to the team any follow up work that was required in my absence. I had attended [Dr B's] review of [Mrs A] on the morning of 26 [Month6] and would have discussed that review at the [afternoon meeting]."

106. SDHB told HDC that during discussions about the treatment plan for Mrs A, both Mr and Mrs A acknowledged that they had a "great deal of support in place; two supportive adult children, Mrs A's sister and a neighbour". SDHB stated that Mr A voiced that he was happy to continue caring for Mrs A at home, and all agreed that this was the best option. SDHB stated that Mrs A had an appointment in City 2 the following week, so it was planned for Mrs A to be seen again once she returned, but she would still have key worker visits.

107. On 26 Month6, Mr A also left a voice message regarding an ACC-related matter. RN D returned his call on 27 Month6. She documented in the notes that Mr A had requested a letter for ACC to support the need for a companion to accompany Mrs A to attend her post-surgery appointment. RN D's record of this call does not reference Mrs A's well-being, and no further contact with Mrs A is documented. RN D said that she returned Mr A's call because she had some knowledge of Mrs A and she knew that RN C would not be back at work until 31 Month6.

108. Early on 29 Month6, Mrs A was found dead.

109. On 9 Month7, Dr B telephoned Mr A. Her written record of this call included the following account:

> "[Mr A] explained that the week before [Mrs A's death] he and [Mrs A] were on holiday. She was 'brilliant', happy, laughing and doing quite well. Then on the way home [Mrs A] [expressed suicidal intent and made an attempt at self harm]. … [Mr A] further explained that this impulsive behaviour is what prompted him to request the urgent meeting with myself, which was arranged for the [26 Month6]."

110. In response to the provisional opinion, Dr B explained that this information about Mrs A's impulsive behaviour was not conveyed during the appointment of 26 Month6.

Further information

Risk assessments

111. RN C stated:

> "It is SDHB policy and always my practice to complete a risk assessment during each visit. Should there be any changes to the client's mental state this would be documented. Where there was no change in mental state I did not document the details of the risk assessment."

112. RN C told HDC that, on several occasions, Mrs A said to her: "I just want to feel physically well again." RN C said she considered that Mrs A's inability to make progress was due to the trauma associated with the surgery she had had, along with

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the fear that further surgery was required to allow her to return to normal physical activities.

113. Dr B told HDC that "[r]isk assessments regarding thoughts or intent of self-injury or harm were done on a continuous basis". Dr B said that Mrs A's behaviour was impulsive, and there is always a risk to be considered with impulsive, unpredictable behaviours.

114. Dr B said that Mrs A's symptoms of loss of sleep, loss of appetite and low energy were secondary to physical illness and not to psychiatric unwellness. Dr B further said that Mrs A noted poor concentration secondary to medication, not to depression, and that Mrs A refused antidepressant medication on numerous occasions or did not take it when it was prescribed. Dr B stated: "There was no way I or any of the treatment team could force her to undergo such treatment. [Mrs A] did not lack the capacity to make such decisions."

115. In her report to the Coroner, Dr B stated that Mrs A had a great deal of support in place, including her husband, sisters, and a neighbour.

Communication and support for family

116. Mr A is concerned that, overall, his family were not supported adequately by SHDB in light of Mrs A's illness and suicide attempts. In the complaint, it was stated: "[I]s it appropriate to assume that families can cope with loved ones with significant mental health issues?"

117. SDHB told HDC that the family declined an offer to be referred to an organisation that provides support, education, information, and advocacy to families/whānau affected by mental illness or drug and alcohol issues. However, the offer was not documented in the clinical notes.

118. SDHB said that "[r]espite care is available for those who have had this identified through a needs assessment", but that Mrs A declined a needs assessment when it was offered by RN C, as she preferred to rely on her family for support. As a result, Mrs A was not entitled to planned respite care. In addition, SDHB said:

> "Crisis respite care is available to consumers suffering from mental illness as a short term intervention during episodes of crisis, in order to maintain consumer independence in the community and to prevent admission to hospital. This was available for [Mrs A] should there have been an episode of crisis. This was discussed with [Mr and Mrs A] as well as the option of private pay respite (most likely in a rest home setting) which [Mrs A] declined, again citing she preferred her family to support her."

Subsequent events

119. A reportable event brief was completed on 11 Month7, which reported the outcome of a "Sudden Death Review". It stated that Mrs A was last seen by the community mental health service on 26 Month6, and "[a]t this contact there were no clinical concerns". The review found:

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> "Risk documentation and reviews had all been completed at the appropriate times. There had been regular contacts with the client and family which were well documented."

120. As a result of the review, staff were reminded to document any contacts (including telephone contacts) with clients on the file, and that these contacts should include the current general mental state of the client.

121. SDHB conducted a special audit to review the treatment of Mrs A's physical injuries. The auditing team considered that the care provided was appropriate, as was the standard of documentation, except for the appointment where a dictaphone failure meant that no dictated clinic letter was recorded.

122. SDHB reviewed its practice in managing patient pain during procedures of the kind that Mrs A had experienced on 24 Month1 at the medical clinic she attended and identified the following improvement initiatives:

— Development of a pain scale tool to assess a consumer's pain relief requirements. This is supported by a specific protocol on the use of Entonox, including a checklist in preparation for using Entonox and clear guidelines on what to do if this mode of pain relief is not effective. SDHB plans to share the resource with other DHBs nationally.

— Development of a pamphlet for consumers outlining what to expect in their appointment (including wait times, process, pain management after appointment). It also includes guidance on when a consumer should seek further immediate treatment and how this can be accessed.

— Development of "a process for [consumers] or their support people to identify to the relevant nurse any other relevant medical issues that they believe would be important for the health professional to understand how to individualise the [consumer's] care or the need to undertake a fuller health assessment".

123. SDHB told HDC that, since the time of this incident, it has reviewed the risk assessment guidelines and the risk assessment management tools across the Otago and Southland district. SDHB also reviewed its other relevant mental health service policies, including "Role of the Key Worker", "Home visits by staff to consumers", "Clinical Reviews", and "Unexpected death of mental health consumer".

124. SDHB has reminded its staff of the importance of ensuring that there is enough family support, and to offer further support as necessary. In addition, it has employed a social worker whose responsibility is to liaise with consumers' families and offer supports as appropriate.

125. Dr B and RN C have since ceased practising.

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SDHB policies

SDHB policy "Role of the Key Worker" — Mental Health (the public hospital)

126. SDHB's "Role of the Key Worker" policy[24] describes the responsibilities of the key worker role. It states:

> "The key worker is the most suitable team member to provide a lead role in the coordinated care of the consumer …
>
> **Assessment**
> The key worker ensures:
>
> - A comprehensive assessment is completed.
> - The ongoing assessment of risk and safety.
> - All consumers have had a risk assessment completed that is reviewed regularly (at least three-monthly) by the key worker and copies are provided to relevant support teams.
>
> **Treatment**
> Key worker expectations:
>
> - Co-ordinates the development of a multidisciplinary treatment plan and ensures that treatment is planned in a manner that is least restrictive …
> - All care/treatment plans are to have review dates and are updated appropriately …
> - If a second clinician is working with the consumer, the key worker and clinician should establish strong communication links between themselves in order to provide a coordinated integrated service to the consumer. They should clearly identify responsibilities and roles to provide the best possible outcomes for the consumer.
> - Encourages and supports the consumer to be enrolled with a GP and access him or her for their physical health needs.
> - Interacts collaboratively in partnership with the consumer (and others as they wish) to develop a wellness recovery action plan (WRAP®) and/or a strengths model assessment and goal planning. All consumers must have a relapse prevention plan.
> - In the clinical support role, the key worker provides clinical assessments and interventions consistent with their professional role. This would include monitoring of the consumer's mood and mental state.
> - Ensures consumers and their families have correct, appropriate, and clear information about their responsibilities and opportunities …
> - Manages the interface with other agencies related to the recovery of the consumer with a knowledge of (and links with) community services, agencies and/or resources, and accurately conveys or provides copies of understandable information to the consumer (tangata whaiora) and family (whanau).

[24] Issued 15 October 2012.

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- Identifies any barriers preventing service delivery: addresses these where possible, and if not possible, brings them to the attention of the appropriate person, usually the clinical co-ordinator/team manager ...

Clinical Review
The key worker:

- Ensures timely review of outcomes against treatment goals, (with attention to discharge planning) within the clinical team review meeting in conjunction with consumer and family or carer …

Documentation
… Audit of clinical notes shows that the key worker is clearly identified and all documentation standards are met."

SDHB policy: "Clinical Reviews" — Mental Health (the public hospital)

127. SDHB's "Clinical Reviews" policy[25] describes the process and responsibilities when completing clinical reviews of mental health and addiction service users. The policy states:

"**Review**
The review process must include:

- A review of consumer's risk management plan and a review of any incidents that have occurred since the last review.
- A review of the outcomes of treatment and support (provided within the community).
- Examples of support by the consumers Outcomes/HoNOS rating scale.

…

Staff Responsibilities

Medical Staff
All medical staff are expected to take an active role in clinical reviews.

Key Workers
Key workers:

- Lead and co-ordinate clinical reviews ensuring that reviews occur in a timely manner and involve all interested parties, including the consumer.
- Complete all required documentation and recording.
- Ensure consumers are aware that clinical reviews take place, in what way, how often, and what is involved. This could be done when the client initially enters the service and should happen before each case review.

Team Managers/Clinical Co-ordinators
Team managers/clinical coordinators are responsible for

[25] Issued 15 October 2012.

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- Ensuring clinical reviews occur within policy requirements, are multidisciplinary in nature and involve consumers and, where possible, families and carers. The team manager/clinical coordinator also chairs the review meeting.
- Monitoring clinical reviews; the occurrence and quality of these. Any variances are reported on a monthly basis to the GM, Mental Health.
- Ensuring that clinicians are following up on information and action plans developed during clinical review meetings."

SDHB "Clinical Risk Assessment Policy" — Mental Health (the public hospital)

128. SDHB's "Clinical Risk Assessment Policy"[26] states:

> "… All individuals presenting to, or under the care of a mental health service, should be assessed for risk. The detail and specificity of such assessment will vary according to circumstance and past behaviours, but every individual should at least be screened for risk."

Responses to provisional opinion

129. Responses to the provisional opinion were received from SDHB, Dr B, and RN C. A response to the "information gathered" section of the provisional opinion was received from Mr A. Where appropriate, the responses have been included in the "information gathered" section above.

130. In response to the provisional opinion, SDHB stated: "Southern DHB sincerely regrets this incident and will make a formal apology to [Mrs A's] family. We acknowledge and apologise for the distress [the family has] experienced."

131. SDHB also stated:

> "The Mental Health Addiction and Intellectual Disability Directorate has reflected carefully on this case prior to receiving your provisional opinion. Significant work has occurred to review and improve our systems. This includes updating a number of policies with a focus on treatment plans, clinical risk assessment policies, [and] transition (discharge) planning … your findings and recommendations will guide further development and improvement."

132. In response to the provisional opinion, Dr B made the following points:

- Mrs A was not agreeable to a multitude of treatment modalities offered to her.

- Mrs A was clinically depressed, and this diagnosis remained consistent throughout her care. Dr B said that if the diagnosis had changed, it would have been recorded and discussed. Dr B noted that Mrs A's presentation was not always consistent with this diagnosis, but this did not alter the diagnosis.

[26] Issued 21 September 2012.

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- Mrs A willingly participated with staff, patients, and in activities while at the inpatient service. She had acceptable hygiene and self-care, and denied suicidal ideation, intent, or plan. She did not meet the criteria for compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

- Dr B noted that Mrs A improved following her discharge from the inpatient service on 3 Month6. Dr B considers that the discharge from the inpatient service was appropriate.

- Some of the clinical appointments with Mrs A exceeded an hour in duration. It is not possible to record the entire content of these appointments. Dr B uses the SOAP[27] documentation format in her clinical notes for the GP.

- Mrs A had many risk factors, which the treating team were constantly aware of. The initial goal was to restore and maintain stability for Mrs A; however, maintaining stability was particularly challenging because of Mrs A's pain, ongoing surgical intervention, and gastrointestinal disturbances. Mrs A's formulation considered physical illness with its many complications and challenges, genetic predisposition, psychodynamics, cognitive thoughts, feelings, social settings, employment issues, loss of independence, as well as family dynamics, stressors, and her personality.

- Dr B submitted that in the review of 26 Month6, sufficient weight was given to Mrs A's past suicide attempts, noting that during the mental status examination she explored suicidal ideation, homicidal ideation, and delusions.

133. Regarding Mrs A's mental state, Dr B stated:

> "At the times I assessed [Mrs A] her presentation clearly indicated that she was capable of making informed decisions and did not lack capacity. She was clear and coherent. There was no indication of cognitive decline or dysfunction. She was insightful and understood the consequences of her actions. [Mrs A] was not psychotic. She was appropriately reactive and her affective expression was congruous to her mood. [Mrs A] denied thoughts of self-harm or harm to others … At the time, [Mrs A] did not manifest an abnormal state of mind that was [to] such a degree that it seriously diminished her capacity to care for herself to the best of her ability, or at that time, pose a serious threat to her safety. The treatment team were in agreement that [Mrs A] did not meet the criteria for compulsory treatment … [Mrs A] was always a high risk. Enforcing the Mental Health Act would not have modified the risk at all. [Mrs A] was impulsive, unpredictable, and was not consistent with her presentation …"

134. In response to the provisional opinion, regarding the key worker arrangements, RN C stated:

[27] Subjective, objective, assessment, and plan.

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> "There was a history of [RN D] standing in for me on previous occasions and I believe that, she had had that role for long enough for there to be little significance in her not being formally appointed in writing on each case …
>
> [Mrs A] did not present a safety risk and lived in an urban environment and therefore did not require two nurses to visit her. I undertook a number of other visits to [Mrs A] on my own and do not accept there was a practice where second keyworkers were taken to all home visits … [RN D] accompanied me on 12 [Month5] and 5 [Month6] (as documented) so that I could introduce her to [Mr and Mrs A] and she had some knowledge of the case. I discussed [Mrs A's] case with [RN D] at other times to the point where I was satisfied that she was equipped to provide care for [Mrs A] on my days off and, in the longer term […] Other than at the weekly meetings with all staff present, there was no opportunity for anyone else to gain experience of [Mrs A's] case … further, [RN D] would have been present at the [regular afternoon] multi disciplinary team meetings."

135. RN C also stated that her communication of her expectations verbally, rather than in writing, was "reflective of the practice in the MHSOP at the time and reflective of many nursing settings where handovers of care are provided in verbal (rather than written) handovers." RN C also noted that at the time of her care of Mrs A, there were other "pairings" of staff who would fill in during each other's absence, and those arrangements were not documented. RN C stated that she understands that these arrangements are now documented.

136. Regarding her documentation, RN C stated that she accepts that her documentation could have been fuller in respect of documenting routine enquiries/assessments and all advice/discussions she had with Mrs A. For example, RN C recalls that she gave advice regarding alternative ways of managing anxiety, such as relaxation techniques, but accepts that she has not documented this and should have.

137. RN C stated that it is very difficult for mental health practitioners to document every point of discussion they have with clients, given the length of appointments. RN C noted that she documented every interaction she had with Mrs A, and also documented all concerns and changes in presentation, and specific actions taken to address increased risk.

Other relevant standards

138. The Nursing Council of New Zealand Code of Conduct for Nurses (June 2012) (NCNZ Code of Conduct) provides:

> "Principle 4 Maintain health consumer trust by providing safe and competent care …
>
> Standard 4.8. Keep clear and accurate records."

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139. The Royal Australian & New Zealand College of Psychiatrists' Code of Ethics (July 2010) outlines principles that psychiatrists are to follow. Principle 3.12 states:

> "Psychiatrists shall maintain legible, accurate, comprehensive, and up to date records for the purposes of optimal treatment, potential access by patients, communication with colleagues, and medico-legal and statutory requirements."

Opinion: Southern District Health Board — breach

140. Southern District Health Board had a duty to ensure that services were provided to Mrs A in a manner that complied with the Code. Mrs A received care for both the injuries she sustained to her body in Month1 and her mental health from SDHB. I acknowledge that Mrs A's physical injuries were a contributing factor to her mental health issues.

Care provided in relation to physical injuries

141. Overall, taking into account independent expert advice, I am satisfied that the care provided to Mrs A for her physical injuries was appropriate in the circumstances.

Mental health care

Coordination of care with other health service

142. Mrs A first engaged with SDHB's MHS on 18 Month3 after her family became increasingly concerned about her deteriorating mental condition after she sustained injuries to her body in Month1 of that year. Over the four months that followed, Mrs A received both inpatient and community mental health care. Mrs A's care was primarily provided by her lead clinician, Dr B, and her key worker, RN C. However, Mrs A's multiple engagements with SDHB services meant that she was also reviewed by other SDHB psychiatric and key worker staff on occasion.

143. Psychiatrist Dr Yvonne Fullerton provided independent expert advice regarding Mrs A's psychiatric care. Dr Fullerton noted that, in her experience, it is not unusual for the medical team that was treating her physical injuries to provide treatment to consumers independently of other services, and she considered that the coordination of care between the mental health service and that team in Mrs A's case was "similar to what would realistically occur elsewhere". Based on this advice, and the independent expert advice referred to above, I do not have any concerns regarding the coordination between the mental health team and the medical team treating her injuries in respect of Mrs A's care.

Coordination of mental health care

144. However, Dr Fullerton had concerns regarding the mental health care provided to Mrs A. She considers that:

- Too much reliance was placed on Mrs A's self reports.

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- Apart from Dr L's diagnostic formulation and risk assessment on 20 Month5 following Mrs A's self harm, there was no other clinical assessment of Mrs A's situation and the factors leading to her suicide attempt. There was no attempt to explain what had changed so soon after her admission(s) to render her euthymic and no longer at risk.
- The decision to grant Mrs A so much leave off the ward did not enable sufficient time for assessment, particularly as it was decided that she did not warrant treatment.
- There were no clear goals of admission to inform when discharge could be appropriate.
- Clinical staff caring for Mrs A did not appreciate the significance of Mrs A's two suicide attempts, and therefore did not assess her risk adequately.

145. Further, my independent expert advisor RN Sally McPherson, a registered nurse with mental health nursing experience, stated:

> "While risk factors were identified by various health professionals at assessment points there is a lack of obvious use of this information to guide treatment plans. There is no obvious guidance to [Mr & Mrs A] on how to manage this phase in their lives and the changes in their relationship from mutually being intradependent to [Mrs A] becoming more dependent and the change in roles this has on the couple and their family."

146. RN McPherson stated that accepted practice is that treatment planning is a multidisciplinary shared work that includes the client and those wanted by them to be involved. RN McPherson noted "a paucity of ongoing treatment plans … that does not meet the above standard". She noted that this does not demonstrate a collaboration between team members and Mrs A and her husband. RN McPherson considers that her peers would expect to see documentation reflecting input from the key worker, the treatment team, and Mr and Mrs A.

147. Based on the comments of my expert advisors, I consider that overall the treatment planning for Mrs A was lacking. In my view, there is not clear evidence to show that Mrs A's particular risks were considered adequately in order to form treatment plans to guide all staff and support persons involved in Mrs A's care.

Key worker arrangements

148. Following the review of 26 Month6, Dr B arranged for RN C to keep in daily contact with Mrs A. At that time, RN C was the sole documented key worker for Mrs A, and she worked from three days each week.

149. RN C told HDC that she shared the key worker role for Mrs A with RN D, and that RN D was a "co-keyworker" for Mrs A on those days when RN C was not working. While Mr A had a telephone conversation with RN D regarding ACC matters on 27 Month6, there was no key worker contact with Mrs A on 27 or 28 Month6.

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150. RN D said that she was not a joint key worker with RN C, and was not asked by anyone at any time to be part of the delivery of clinical services to Mrs A. There is no documented record that RN D was asked to share the role with RN C.

151. SDHB said that, if clients required planned intervention on RN C's rostered days off, its expectation was that RN C would approach one of her colleagues to provide this input.

152. RN McPherson advised:

> "Clarity of role is an important component of care. Failure to be explicit and ensure that all parties are aware of their roles and subsequent responsibilities and duties can cause treatment plans to not be enacted which may have serious consequences … As more staff age and plan for retirement by reducing working hours this will become a more common occurrence and needs explicit direction rather than relying on less formal practices of colleagues covering days off."

153. I accept RN McPherson's advice. In my view, the coordination of Mrs A's key worker care in this situation was inadequate, given that RNs D and C have very different views of their roles in these circumstances. I consider that it was SDHB's responsibility to have clear processes in place to ensure that Mrs A received appropriate continuity of care.

Conclusion

154. Providing seamless care requires effective communication between providers. While Mrs A was receiving mental health care from SDHB, she was involved with a number of different psychiatric and key worker staff. Between Mrs A's first engagement with SDHB MHS on 18 Month3 and her last engagement on 26 Month6, there were a number of inadequacies in the coordination of her care, which I consider are attributable to SHDB — most notably, the failures in treatment planning and the poor coordination of key worker care. For not ensuring continuity of care for Mrs A, I consider that SDHB breached Right 4(5) of the Code.

Opinion: Dr B — breach

Introduction

155. Dr B was Mrs A's psychiatrist and lead clinician from the time of Mrs A's presentation to the Mental Health Service on 18 Month3. Mrs A had the right to receive services of an appropriate standard from Dr B.

156. Psychiatrist Dr Yvonne Fullerton provided expert advice regarding the care Dr B provided to Mrs A. She made the following initial comments regarding Mrs A's risk:

> "Purely on demographic risk factors [Mrs A] should have been formulated as a high suicide risk. She was [aged in her 60s]; had pain and discomfort; loss of role

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and loss of independence. There were prominent feelings of guilt; intermittent despair; a history of depression complicated by anxiety; impulsivity; suicidal ideation; significant suicide attempts; limited engagement; minimization of risk and a family history of [mental illness and self harm]."

157. Dr Fullerton also stated:

"All acts of self harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise because the number of people in this age range who go on to complete suicide is much higher than in younger adults."

158. It is clear that Mrs A had numerous risk factors that needed to be considered carefully by those caring for her. Dr B stated that Mrs A had many risk factors which the treating team were constantly aware of.

Discharge 3 Month6

159. Mrs A was admitted to the inpatient service on 25 Month5 following her second incident of self-harm. In the ED, Mrs A made a statement to the nurse about the next method of self-harm she would use, and this was documented in the clinical notes. Mrs A had day leave on 1 Month6 and overnight leave on 2 Month6. After review by Dr B and RN C, Mrs A was discharged home on 3 Month6. Dr B arranged for RN C to follow up in two days' time, and for herself (Dr B) to see Mrs A in four days' time.

160. Dr B noted that Mrs A improved following her discharge from the inpatient service and considers that the discharge from the inpatient service was appropriate. Mrs A's improvement following her discharge is not a factor that I have considered when deciding whether the decision to discharge was appropriate, as it is not information that was known at the time.

161. Regarding the decision to discharge Mrs A, Dr Fullerton advised:

"I do not believe the circumstances of her suicide attempts and therefore her ongoing risk were adequately explored. The decision to discharge from hospital on 03 [Month6] without treatment and without a satisfactory formulation about why risk no longer existed is in my opinion inappropriate and again represents a significant departure from the standard of care expected by myself and by our peers.

There were no formal detailed care plans for Mrs A but following discharge on [03 Month6] the plan was for Keyworker visit within 48 hours and Psychiatrist review within four days.

In my opinion and experience this is an acceptable plan for follow-up if the goals of admission have been achieved. Goals for inpatient care typically are directed at managing risk; assessing and treating illness and providing respite to allow time for external stressors to be addressed. I do not believe any of these conditions were met when Mrs A was discharged on [03] Month6 and in my view the decision to

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> discharge was ill considered. Again in my opinion this is a significant departure from a reasonable standard of care."

162. I accept Dr Fullerton's advice on this point. While the plan for key worker visit post-discharge would have been appropriate if the goals of admission had been met, there was no clear assessment or treatment, and no adequate assessment of ongoing risk for Mrs A. In light of these factors, and despite Mrs A's improvement in the days following discharge, I consider that the decision to discharge Mrs A was inappropriate.

Final review 26 Month6

163. Dr B reviewed Mrs A on Wednesday 26 Month6, with RN C in attendance. SDHB said that Mrs A was offered admission to the inpatient service, but she declined because she did not like to be in there. There is no record in the clinical notes that this offer was made.

164. In her clinic letter to Dr E, Dr B recorded that Mrs A decided that she would like to start another antidepressant, and that she was unable to sleep without zopiclone. Dr B noted: "[Mrs A] remains without suicidal ideation. No homicidal thoughts. There is no psychosis noted, no evidence of a formal thought disorder." Dr B prescribed an antidepressant, and arranged for daily follow-up by RN C.

165. Regarding this review, Dr Fullerton advised:

> "In my view [Mrs A's] last assessment by [Dr B] should have contained a clear assessment of risk given her presentation, further deterioration, two past suicide attempts and the family history of [mental illness and self harm] (an independent risk factor). The lack of risk assessment on this occasion is in my opinion a significant departure from the accepted standard of care and would be viewed as such by our peers.
>
> In my opinion [Dr B] did not give sufficient weight to the seriousness of Mrs A's two suicide attempts.
>
> Risk assessment is not a statement of factors at cross-section. It is simply inadequate to call 'No thoughts self harm, no suicidal ideation, no psychosis', 'she stated she acted impulsively'; a risk assessment. Findings on cross-sectional review contribute to the risk assessment but they are only one dimension. There is no exploration of the frequently voiced suicidal ideation nor what preceded it. In my view appropriate consideration was not given to the two suicide attempts."

166. Dr B submitted that in this review, sufficient weight was given to Mrs A's past suicide attempts, noting that during the mental status examinations she explored suicidal ideation, homicidal ideation, and delusions. Despite this submission, I consider that Dr B's risk assessment of Mrs A was lacking on this occasion, and insufficient weight was given to Mrs A's two serious incidents of self-harm, particularly in light of her demographic risk factors. I accept Dr Fullerton's advice

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that the lack of assessment of risk was a significant departure from the accepted standard of care.

Documentation

Mental Health (Compulsory Assessment and Treatment) Act 1992

167. Dr B told HDC that Mrs A refused antidepressant medication on numerous occasions or did not take it when it was prescribed. Dr B stated: "There was no way I or any of the treatment team could force her to undergo such treatment. [Mrs A] did not lack the capacity to make such decisions."

168. Dr Fullerton advised:

> "From the clinical notes that is an incorrect statement. [Mrs A] met criteria for the Mental Health Act. She had an 'abnormal state of mind characterized by disorder of mood or disorder of volition … to such a degree that it posed a serious danger to her health or safety' …
>
> Certainly from the time of her suicide attempt Mrs A could have been detained and treated compulsorily under the Mental Health Act [MHA]. Please note the MHA allows for a mental disorder to be 'continuous or of an intermittent nature.'
>
> If however [Dr B] believed the MHA was not indicated this should have clearly been documented in the file along with a formulation about [Mrs A's] highly changeable presentation and a management plan to mitigate her risk. On the other hand if [Dr B] believed the MHA simply would not help [Mrs A], then it should have been documented that [Mrs A] remained at high risk of completing suicide but enforced hospitalisation and compulsory treatment were unlikely to modify that risk.'

169. Dr B told HDC:

> "[Mrs A] did not manifest an abnormal state of mind that was [to] such a degree that it seriously diminished her capacity to care for herself to the best of her ability, or at that time, pose a serious threat to her safety. The treatment team were in agreement that [Mrs A] did not meet the criteria for compulsory treatment … [Mrs A] was always a high risk. Enforcing the Mental Health Act would not have modified the risk at all. [Mrs A] was impulsive, unpredictable, and was not consistent with her presentation."

170. I accept that Dr B considered use of the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992 for Mrs A, following Mrs A's first incident of self-harm. As Dr B did not consider that the use of the MHA was indicated, I consider that she should have clearly documented the reasons for this, together with a management plan to mitigate Mrs A's risk.

Review 26 Month6

171. Regarding Dr B's documentation of the review of 26 Month6, Dr Fullerton advised:

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> "The clinical note from [Dr B's] assessment on 26 [Month6] is limited and without reference to mood, diagnosis or risk. Given the clear deterioration in [Mrs A's] mental state, the decision to commence medication, and the plan for daily contact there was some appreciation of risk, but no risk assessment is documented nor is there any rationale for the decision to continue managing [Mrs A] at home when an inpatient admission appears indicated or at least to be considered.
>
> [Dr B] asserts that the clinical record is contained within many documents but her own notes frequently did not reference important information that preceded her own assessments."

172. The Royal Australian & New Zealand College of Psychiatrists' Code of Ethics (July 2010) outlines principles that psychiatrists are to follow. Principle 3.12 states:

> "Psychiatrists shall maintain legible, accurate, comprehensive, and up to date records for the purposes of optimal treatment, potential access by patients, communication with colleagues, and medico-legal and statutory requirements."

173. However, I also note that the SDHB Clinical Reviews — Mental Health (the public hospital)[28] policy specifies that the key worker is to complete all required documentation of a clinical review. In my opinion, Dr B's documentation of her assessment was inadequate, but I acknowledge that the responsibility to document clinical reviews was also RN C's.

174. I further acknowledge Dr B's statement that some of the clinical appointments with Mrs A exceeded an hour in length, and it is not possible to record the entire content of these appointments.

Conclusion

175. There are numerous aspects of Mrs A's care from Dr B that I consider were inadequate. In particular:

- The inappropriate decision to discharge Mrs A from the inpatient service on 3 Month6;
- The inadequate risk assessment during the clinical review of Mrs A on 26 Month6; and
- The lack of documentation regarding the decision not to use the Mental Health (Compulsory Assessment and Treatment) Act 1992 provisions to treat Mrs A, and poor documentation in relation to risk assessment on 26 Month6.

176. Overall, I consider that Dr B did not provide services of an appropriate standard to Mrs A and, accordingly, breached Right 4(1) of the Code.

[28] Issued 15 October 2012.

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Opinion: RN C — adverse comment

177. RN C was Mrs A's key worker from the time of Mrs A's presentation to the Mental Health Service on 18 Month3. According to SDHB's Role of the Key Worker policy,[29] the key worker is the most suitable team member to provide a lead role in the coordinated care of the consumer.

Key worker arrangements

178. At the time of Mrs A's engagement with MHS, RN C worked three days each week. RN C and RN D had very different views on their roles in relation to Mrs A's care. RN C told HDC that she shared the key worker role for Mrs A with RN D, and that RN D was a "co-keyworker" for Mrs A on those days when RN C was not working. There is no documentation of this arrangement.

179. RN D said that she was not a joint key worker with RN C, and was not asked by anyone at any time to be part of the delivery of clinical services to Mrs A.

180. SDHB said that, if clients required planned intervention on RN C's rostered days off, its expectation was that she would approach one of her colleagues to provide this input.

181. In response to the provisional opinion, RN C explained that the communication of her expectations verbally was reflective of the practice in the MHSOP at the time. RN C told HDC that she discussed Mrs A's care with RN D to the point where she was satisfied that RN D was equipped to provide care for Mrs A on her days off. RN C also noted that weekly multidisciplinary meetings occurred, and RN D would have been present at these.

182. My independent expert advisor, RN Sally McPherson, a registered nurse with mental health nursing experience, stated: "It seems that there is no clear transfer of care, neither clear to RN D nor to the consumer. The communication expecting RN D to have the role of co-key worker is in doubt."

183. I agree with RN McPherson. RN D's view is that she was not asked at any time to be part of the delivery of clinical services to Mrs A, and there is no documentation of alternative key worker arrangements. Despite RN C's explanation that the communication of her expectations verbally was reflective of the practice in the MHSOP at the time, I conclude that RN C's communication of her expectations to RN D could have been clearer. While I am critical of RN C in this regard, ultimately I consider that the responsibility for having appropriate key worker care arrangements in place for Mrs A lay with SDHB.

Documentation

184. RN C had numerous contacts with Mrs A as her key worker, and was involved in clinical reviews with Dr B. According to the SDHB policy Clinical Reviews —

[29] Issued 15 October 2012.

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Mental Health (the public hospital),[30] key workers are to lead and coordinate clinical reviews, ensuring that reviews occur in a timely manner and involve all interested parties, including the consumer, and complete all required documentation and recording.

185. The Nursing Council of New Zealand Code of Conduct provides that registered nurses "4.8 Keep clear and accurate records".

186. RN McPherson noted that documentation supporting formal assessment of Mrs A's mood, risk, and social situation is not evident, and stated: "There is nothing to suggest that the information around personality factors of perfectionist traits and high standards being used to create a care plan that incorporates the changes for both [Mr & Mrs A] as a result of [her physical injuries]." RN McPherson advised that risks were identified at different points in treatment, but that specific management of these was not documented, eg, noting Mrs A's inability to carry out activities that reduced her anxiety but not describing how that risk could be managed. RN C accepts that her documentation could have been fuller in respect of documenting routine enquiries/assessments and all advice/discussions she had with Mrs A. For example, RN C recalls that she gave advice regarding alternative ways of managing anxiety, such as relaxation techniques, but accepts that she has not documented this and should have.

187. Regarding RN C's documentation, RN McPherson advised:

> "Routine recording of [RN C's] interactions is sparse and thus leaves room for conjecture as to the content of the contacts. The outcomes of the contact can be surmised eg. when a joint visit is made by [Dr B] and [RN C], but is otherwise lacking fullness and is intermittent. This is a moderate failing … Peers would expect more evidence of interactions and decisions being made."

188. RN McPherson noted that in the past it was common practice to use minimal documentation, but it is "not acceptable practice currently to assume that a risk assessment has occurred if it is not recorded". She advised that this is a serious lack of care if the enquiries did not take place, and moderately serious if they did occur and were not documented, as it provides no information to others involved in Mrs A's care. RN C stated that it is very difficult for mental health practitioners to document every point of discussion they have with clients, given the length of appointments. RN C noted that she documented every interaction she had with Mrs A, and also documented all concerns and changes in presentation, and specific actions taken to address increased risk.

189. RN C explained that it is SDHB policy, and was always her practice, to complete a risk assessment during each visit. She said that should there be any changes to the client's mental state this would be documented. However, on occasion, where there was no change in Mrs A's mental state, she did not document the details of the risk assessment. RN McPherson noted that while this removes some responsibility from RN C for the reduced documentation, it is still not acceptable, especially in complex cases.

[30] Issued 15 October 2012.

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190. RN McPherson also noted that there was a paucity of ongoing treatment plans documented by RN C, which does not demonstrate collaboration between team members, Mrs A, and her husband. RN McPherson stated that "accepted practice is that treatment [planning] be a multi-disciplinary shared work that includes the client and those wanted by them to be involved". In RN McPherson's opinion, the paucity of treatment plans documented did not meet this standard. As Mrs A's key worker, RN C was the most suitable team member to provide a lead role in the coordinated care of Mrs A. I am concerned that treatment plans were not clearly documented and made available to all involved in Mrs A's care.

191. RN McPherson acknowledged that her nursing peers would find that their documentation could be improved if scrutinised. I acknowledge this, and also acknowledge the difficultly for mental health practitioners to document every point of discussion given the length of their appointments. However, in my view, it was RN C's responsibility as the key worker to ensure clear documentation of contacts with Mrs A, especially if, as described above, RN C expected RN D to share the key worker role with her. I consider that RN C's documentation of risk assessments and treatment plans was insufficient given her responsibility as key worker.

Recommendations

192. I recommend that SDHB and Dr B each provide a written apology to Mr A. The apology should be sent to HDC, for forwarding to Mr A, within three weeks of the date of this opinion.

193. I recommend that SDHB:

a) Develop clear protocols for circumstances where key worker care may be shared in relation to a mental health care consumer. This should include a clear method of documenting the care arrangement, and the role of each key worker in the circumstances. SDHB should report back to HDC, within three months of the date of this opinion, with a copy of the protocol.

b) Use this case as an anonymised case study for education of its key worker and psychiatrist staff, including in relation to their respective roles.

194. In the event that Dr B returns to practise medicine, I recommend that the Medical Council of New Zealand consider whether a review of Dr B's competence is warranted.

195. In the event that RN C returns to practise nursing, I recommend that RN C undertake a course on documentation.

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Follow-up actions

196. A copy of this report with details identifying the parties removed, except the experts who advised on this case and SDHB, will be sent to the Coroner, the Mental Health Foundation, and the Director of Mental Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

197. A copy of this report with details identifying the parties removed, except the experts who advised on this case and SDHB, will be sent to the Medical Council of New Zealand and the Royal Australian and New Zealand College of Psychiatrists, and they will be advised of Dr B's name in covering correspondence.

198. A copy of this report with details identifying the parties removed, except the experts who advised on this case and SDHB, will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's name in covering correspondence.

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Appendix A: Independent psychiatry advice to the Commissioner

The following expert advice was obtained from Dr Yvonne Fullerton, with some amendments made following receipt of further information:

"My name is Dr Yvonne Fullerton and I have been asked to provide advice to the Health and Disability Commissioner (HDC) on case C14HDC01343 involving [Mrs A] who died on 29th [Month6].

My instructions are to provide an opinion on the adequacy of mental health care provided to [Mrs A] by the Southern District Health Board (SDHB) between [Month3] and 29 [Month6] with particular reference to:

1. The adequacy of the risk assessments carried out during this time, including the risk assessment by psychiatrist on 26 [Month6].

2. The appropriateness of the decision to discharge from the [inpatient service] on 3 [Month6].

3. The care plans implemented — particularly that implemented on 3 [Month6] which involved weekly visits from a keyworker.

    a. Please advise what factors would normally be considered when implementing a care plan, and whether it was appropriate in the circumstances.

4. The coordination of care between Mental Health Services and [medical team that was treating her physical injuries].

5. Any other comments you wish to make regarding [Mrs A's] care.

My qualifications are that I am a New Zealand trained Medical Practitioner having graduated from the Auckland School of Medicine in 1990. I held various positions within the Auckland District Health Board (ADHB) and trained in psychiatry until I was elected to fellowship of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in 2003. I subsequently completed subspecialist requirements for Consultation Liaison (C-L) Psychiatry and have been employed as a CL Psychiatrist at Auckland Hospital since 2004.

I have been the Clinical Director of the CL Psychiatry Service since 2008. CL Psychiatry is a subspecialty at the medical interface of psychiatry and in addition to managing patients in the general hospital our service assesses around 700 patients per year who present following deliberate self harm. For the past eleven years I have been on a joint Mental Health Services for Older People (MHSOP)/ CL Psychiatry roster and provide after hours consultant cover to the MHSOP acute inpatient unit at Auckland Hospital.

My non-clinical duties include investigation of sentinel events (suicides and 'near miss' situations) for the DHB.

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For the purposes of this report I have read the clinical file and documents associated with the investigation, provided by the SDHB and the HDC. I have also reviewed relevant literature including:-

- The National Institute of Health and Care Excellence (NICE) guidelines for post self-harm care (with particular reference to the section for older people) — as cited in RANZCP policy.

- The NZ Guidelines Group, Assessment and Management of People at Risk of Suicide, produced by the Ministry of Health.

- The RANZCP Guideline on use of Benzodiazepines.

- The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders IV.

Summary

[Mrs A] was [aged in her 60s and a] married woman […] at the time of her presentation to Mental Health Services (MHS) in [Month3]. […] [Mrs A] underwent [treatment for a serious health issue in 2011] and required further treatment for [the same serious health issue] in 2013.

In [Month1] [Mrs A] [sustained injuries to her body]. At presentation to MHS two months later she was still reporting pain and disability, due to complications [with those injuries]. [Mrs A] reported this impacted on her ability to perform some activities of daily living (ADLs) and to drive her car.

Other stressors for [Mrs A] included her husband's [health issues] and [matters relating to work]. [Mrs A] reported she felt guilty about this […]. These antecedent stressors are documented throughout the MHS record by multiple personnel.

From the file provided [Mrs A] first presented to her GP [Dr E] on 12 [Month3]. She was accompanied by her friend who confirmed [Mrs A's] situation was 'desperate'. A diagnosis of depression was made and the antidepressant Paroxetine was prescribed along with the benzodiazepine anxiolytic (antianxiety medication) Oxazepam and analgesia for her painful [injuries].

[Mrs A] was reviewed five days later. The GP note records she was distressed by pain [resulting from her injuries]. Swelling and tenderness were present and [Mrs A] reported she was markedly restricted in her ADLs including driving. She had not taken the prescribed antidepressant nor codeine analgesia because of concern about side effects.

The next day [Mrs A] first presented to SDHB MHS via telephone self referral (18 [Month3]).

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The record from that conversation documents [Mrs A] reporting a full complement of symptoms consistent with a Major Depressive Episode. These included decreased sleep, appetite, concentration and hedonia (pleasure in life). She described anxiety, thoughts of self harm and feeling 'flat all day', 'no happiness' and 'can't cope with my body'. She was reviewed by [Dr B] on 18 [Month3] correctly diagnosed with a Major Depressive Episode (recurrent) and commenced on appropriate treatment for depression (Sertraline) and anxiety (Sertraline and Clonazepam). The note written by [Dr B] documents no suicidal ideation (SI) or homicidal ideation (HI) but there is no detail about the volunteered thoughts of self-harm nor is there a risk assessment.

[Mrs A's] past psychiatric history was comprehensively documented on 18 [Month3] after the inactive file was reviewed.

[Summary of past psychiatric history.]

Of note there was no history of any self harm nor any further contact with MHS in the intervening 33 years.

The [family history of mental illness and self harm] was noted in the presenting history and is referenced on several occasions in the SDHB MHS record.

MHS phoned [Mrs A] daily in the days following her presentation and she was reviewed by [Dr B] on 24 [Month3]. Improvement was noted but anxiety remained prominent and mood was described as 'low'. 'Fleeting thoughts of self harm' were documented but intent was denied. The dose of Sertraline was increased along with the dose of the benzodiazepine (antianxiety) medication Clonazepam. A further review on 30 [Month3] recorded further improvement so the plan was for review in two to three weeks or as required. Intent to harm self or others was enquired about and denied.

A week later [Mrs A] was visited at home by her keyworker [RN C]. She described discomfort and functional impairment from her [injuries] but had found the prescribed medication 'most beneficial' and reported improvement to her mental state. At the next weekly keyworker review (15 [Month4]) [Mrs A] described gastrointestinal symptoms and associated weight loss which she reported coincided with the increased dose of Sertraline. [Dr B] was consulted and suggested halving the dose of the antidepressant. The Risk Assessment Form completed by the keyworker that day concluded self harm was 'not a risk' although possible risk from weight loss and poor appetite was documented. The GP had been consulted and prescribed loperamide and metoclopramide for nausea and loose stools.

Weekly home visits occurred on 22nd and 29th [Month4] and 5th and 12th [Month5]. The antidepressant was discontinued by [Dr B] per telephone on 22nd [Month4] and [Mrs A] was reviewed by [Dr B] on 29th [Month4]. She was assessed as 'stable' on low dose Clonazepam alone. The plan was for psychiatrist review in three months or sooner as required. No impression of [Mrs A's] situation

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was recorded nor was a diagnostic formulation or risk assessment documented, although home visits by the keyworker continued.

The next two home visits record [Mrs A] still reporting decreased sleep, energy, concentration, and inability to carry out chores. She's described as 'still anxious'; 'tearful'; and 'feeling a burden'. The keyworker documents 'slow progress' and notes [Mrs A] had requested medication to help her relax and 'remove pent up feelings in her stomach'. She records [Mrs A] 'denied self harm but unable to thinking clearly/positively'.

[Mrs A] was reviewed again by [Dr B] on 14th [Month5]. As [Mrs A] complained of side effects related to Clonazepam this was discontinued. [Dr B] suggested [Mrs A] access the sleeping pill Zopiclone from her GP as she did not prescribe these. Mental state examination was recorded as 'the same. No thoughts of self harm. Feeling more confused today'. A review of [Mrs A's] old file led [Dr B] to document 'this behaviour has been consistent'. It's not clear what was meant by this but the plan was to discuss further with [Mrs A] at the next review. Arrangements for follow up were made but again there was no documented formulation or clinical impression about [Mrs A's] presentation, nor was a working diagnosis recorded.

Five days later [Mrs A] was brought to hospital by ambulance following an [incident of self harm]. The ambulance note and Medical Discharge Summary record [Mrs A] […] wrote a note and was expressing intent to die when found. […].

An informal admission to the [inpatient service] was arranged for [Mrs A] when she was medically cleared two days later. A comprehensive admission and risk assessment was completed by [Dr L] on 20 [Month5]. A full complement of DSMIV symptoms of major depression were disclosed along with significant stressors; 'prominent feelings of guilt and being a burden' and a 'departure from previous level of functioning'. Reality testing, insight and judgement were deemed 'uncertain' and the diagnostic formulation was of 'Major Depressive Disorder — Severe, Recurrent; with risk of further attempt in the community'. [Dr L] advised use of the Mental Health Act (MHA) if needed. He also noted [Mrs A] was rather averse to taking medication and that the onset of reported side effects was uncertain.

[Mrs A] was admitted to the [inpatient service] on 20 [Month5] and discharged four days later. The admitting nurse noted she was reluctant to be on the ward and recorded the (known) stressors disclosed by [Mrs A]. She was placed on 15 minute safety checks with Consultant review planned for the next day. When [Dr B] saw [Mrs A] on 21 [Month5] she recorded 'no depression noted, doesn't want medication. Routine observations as risk now is low'. There was no diagnostic formulation nor any impression of [Mrs A's] situation. No treatment was commenced. No goals of admission were recorded, nor what had changed to reduce [Mrs A's] risk so rapidly.

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Nursing notes from that index admission reveal [Mrs A] consistently reported poor sleep and was noted to be awake by around 0500. Other features documented are 'guilt' 'embarrassment' 'shame' 'mood low' 'tearful at times' 'anxiety' 'poor appetite' 'pain [arising from her injuries]' 'reports feeling down'. The clinical record also documents that [Mrs A] appeared to interact appropriately with others on the ward, her affect is described as 'reactive' and SI, HI are denied. She requested and was granted significant amounts of time off the ward with day leave on the 22nd and 23rd [Month5].

[Mrs A] was reviewed by [Dr B] on 24th [Month5]. The note from that assessment documents the absence of SI, HI and psychosis. Mood is described as euthymic (normal mood). Leave at home had 'gone well' so [Mrs A] was discharged at her request. The record from her time on the ward indicates staff were supportive of [Mrs A] and reassuring but there was no working diagnosis and no specific treatment provided.

Within 24 hours [Mrs A] was returned to the hospital by ambulance and readmitted to the [inpatient service]. The ambulance note is that [Mrs A had self harmed] in her husband's absence and that she had planned this. […]

When [Mrs A] was assessed by [Dr B] in the Emergency Department, she was described as 'apologetic' 'not depressed' 'not suicidal'. […] [Mrs A's] mood was described as 'euthymic' and a voluntary admission to the [inpatient service] was arranged. No goals of admission were documented although the plan was for 'evaluation of nausea', 'observation', '[…]' and 'no leave'.

The MHS admitting nurse and the House Officer called to assess [Mrs A's] nausea described her mood as 'low' and 'flat' respectively. [Mrs A] was reviewed the next day by [Dr B] who allowed [Mrs A] to have escorted leave off the ward and recorded [Mrs A] as talking about the 'demon' that had taken her over. Mood was recorded as euthymic and affect reactive. There is no recorded exploration of the suicide attempt. No impression or diagnostic formulation is documented. No treatment was commenced.

As with the first admission to the inpatient service [Mrs A] was reluctant to be there and was granted considerable leave off the ward. On 28th [Month5] [Mrs A] was reviewed by [Dr B]. The note from that assessment describes [Mrs A] as 'upbeat' 'future focused' and 'requesting leave'. [Mrs A] denies SI, HI but there is no recorded exploration of the suicide attempt; no risk assessment, and no diagnosis. [Dr B] prescribes the antihistamine promethazine 25mg nocte to assist sleep. The plan is for leave (both day leave and overnight leave) over the weekend and if these go well, a review with a view to discharge on Monday.

Between 28th [Month5] and [Mrs A's] discharge on 3 [Month6] she was off the ward for significant periods of time. Although she denied SI/HI and reported her mood to be 'fine' she repeatedly complained of poor sleep and this was borne out by the nursing record. [Mrs A] described unpleasant side effects of promethazine so this was discontinued after one night. Instead the on-call doctor was contacted

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on two occasions overnight and authorized use of zopiclone with apparent good effect.

On the evening of 2nd [Month6] [Mrs A] returned to the ward to obtain zopiclone for her overnight leave. The nurse records she was slightly anxious and 'fixated' on receiving zopiclone for sleep. Elsewhere in the record from that admission she was described as 'anxious', concerned about her low body weight and stress related to her husband's [work]. She told one staff member she had no recollection of what was described as a 'parasuicide attempt'.

Staff assisted throughout the admission with reassurance; relaxation techniques and advice about sleep hygiene. There are references to [Mrs A] appearing appropriate in interaction and being reactive in her mood. Anxiety is also noted at times and weight loss is recorded along with a need to encourage [Mrs A] to drink.

[Mrs A] and her husband met with [Dr B] after overnight leave on 3rd [Month6]. The brief clinical note recorded [Mr A] looking forward to his wife returning home, her denial of thoughts of self harm and advice to try natural remedies such as melatonin for sleep.

A nurse recorded [Dr B] advised [Mrs A] […]. [Mrs A] was also reminded that others could not take 24 hour responsibility for her safety and that if that were required, Residential Care would be the only option. The note does not identify who reminded [Mrs A] of this, but the note records [Dr B] requested the GP to be advised of [Mrs A's] […]. It was also noted that [Mrs A] worried about not being able to sleep and that this was a 'trigger' for her. There was no explanation about what this meant.

The discharge letter typed 3 [Month6] and signed by [Dr N] for [Dr B] assigns [Mrs A] a diagnosis of Mixed Anxiety/Depressive Disorder, although she had not received treatment for this. There is a planned home visit by the keyworker within 48 hours and a psychiatrist review at day 4 post-discharge. Almost immediately following discharge [Mrs A] sought both anxiolytic and sleeping medication from her GP. When seen on 05 [Month6] by the keyworker she appeared more relaxed and said she'd slept well. Her husband was pleased with her progress […]. No mental state findings from that review were documented.

No-one was home on two further attempts to review [Mrs A] on the 11th and 12 [Month6]. Messages were left on the answerphone but there was no further contact until a phone conversation with Mr A on 24 [Month6]. He reported [Mrs A] had been in [City 2] for […] surgery in the interim but had deteriorated in mental state.

[Mr A] said his wife was not eating and had lost more weight. It's recorded he was 'worn out' looking after [Mrs A] who was constantly voicing despair and hopelessness to her husband and family. [Mr A] requested a Psychiatrist review and reinstatement of antidepressant medication. [Mrs A's] reluctance to accept medication in the past was documented.

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A home visit to [Mrs A] the next day by the keyworker [RN C] recorded loss of interest, lack of energy, weight loss, poor sleep, 'feeling she's a burden', and complaints of pain. Family were in attendance whilst [Mrs A] remained in bed. The keyworker arranged an urgent psychiatrist review the next day.

[Dr B's] final note (26 [Month6]) records a discussion with [Mrs A] about antidepressant medication. She was reminded that her GP would continue to prescribe her sleeping medication. The absence of SI, HI, psychosis and formal thought disorder was documented. There was no mental state examination recorded. There is no impression of [Mrs A's] presentation, no diagnosis and no risk assessment. There is a plan for daily contact and further review. After hours emergency contact details are provided. The SDHB response to the complaint by [the family] states a discussion about inpatient care occurred but that was not documented. The rationale for managing [Mrs A] at home when she was so unwell, had attempted suicide twice and was being cared for by her [aged] 'worn out' husband, is not recorded.

[Mrs A] is deceased the next day.

Coordination of care between MHS and [medical team]

It had been two months since the [accident that resulted in injuries to her body] at the time [Mrs A] presented to MHS. The notes from each [clinic review of the medical team providing care for those injuries] were sent to [Mrs A's] GP and were available to this reviewer.

There is no reference to [Mrs A's] mental state in any of [that] correspondence.

[…] when first assessed by MHS […] [Mrs A] was prescribed Amitriptyline (an antidepressant used in low doses for neuropathic pain) […]. At the final [clinic review of her injuries] on 24th [Month4] [Mrs A] reported 'slight improvement' with physiotherapy. She had not taken the Amitriptyline. When seen by MHS five days later [Mrs A] disclosed her plan for an [review of her injuries] in [City 2]. She underwent further surgery in [City 2] during [Month6].

Consideration of [Mrs A's] [difficulties arising from her injuries] were evident in the initial assessment by MHS in [Month3]. An ACC request for [Mrs A] to be referred to the Chronic Pain Services was noted along with her GP's decision to defer referral as [Mrs A] had not been utilizing prescribed pain relief.

Thereafter there are multiple references to the pain and disability [Mrs A] experienced as a result of her [injuries]. It is listed as a significant stressor for her with references to '[…]'; 'medical misadventure'; 'anaesthetic failure'; and 'trauma'. It is included in [Dr L's] formulation following [Mrs A's] first suicide attempt.

The House Officer admitting [Mrs A] to the [inpatient service] on 21 [Month5] contacted the GP for an update on [Mrs A's] [care relating to her physical

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injuries]. The plan at that time was for an […] if pain persisted or [clinic review] in May. A surgical remedy was discounted although [Mrs A] had discussed her plan for surgery in [City 2] during a home visit by her keyworker some nine days before.

Of note there is no reference to [Mrs A's] [injuries and] pain when she was readmitted to the [inpatient service] on 25th [Month5] or throughout that admission. She participated in ward activities on 27th [Month5] […] with no reports of discomfort and no observation of disability. There is no documentation by mental health staff about why [Mrs A] was seeking [care for her injuries] in [City 2] but she had not revealed this plan to the SDHB [service that treated injuries of the kind she had sustained]. There is no record of [Mrs A] discussing her plans for [care for her injuries] in [City 2] in any detail with mental health clinicians.

Opinion

[Mrs A] posed some treatment challenges for clinicians.

She had difficulty taking prescribed medications as demonstrated by her inability or unwillingness to take prescribed Amitriptyline, Paroxetine, Codeine, Promethazine and Sertraline. The indications are also that [Mrs A] was a proud agreeable woman who at times concealed her distress from clinicians and did not always disclose her intent. For example she told the registrar that things were improving with physiotherapy at the [24 Month4] review whilst at the same time seeking [care from another medical service] in [City 2].

Even more compelling evidence is contained within the notes from her brief admissions to the [inpatient service]. At the same time [Mrs A] was presenting well in formal interview situations, she was recorded to be low in mood, tearful at times and distressed. She admitted to poor sleep but also was not eating well and had to be encouraged to drink during the last admission where significant weight loss was documented in the chart.

[Mrs A] made two potentially fatal suicide attempts but in the aftermath of these downplayed their significance and consistently denied suicidal intent. She was noted to engage appropriately with others; discussed plans for the future and her affect was said to be reactive meaning she expressed warmth and animation in her interactions with others. I note however that within a day of her reassuring clinicians she was ready for discharge (04 [Month6]), […] when released from hospital on the first occasion, made a second serious suicide attempt — also within 24 hours of discharge.

In my opinion [Mrs A] was clinically depressed at the time of her first suicide attempt (18 [Month5]) and remained so until her […] death. The Diagnostic and Statistical Manual of Mental Disorder (DSMIV) lists nine diagnostic criteria for a diagnosis of major depression. Although only five of these criteria are required for a diagnosis following a two week period, it is most useful to consider these in the

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following grouping. The three physical or biological symptoms — referred to as the neurovegetative symptoms — are perturbations to sleep, appetite and energy. It's clear [Mrs A] experienced all of these.

In addition to the physical symptoms of clinical depression the three criteria typically associated with the condition are low mood, loss of enjoyment (hedonia) and suicidality. These remained constant themes for [Mrs A] despite her denial in formal interviews. The three depressive symptoms associated with thinking or cognition are poor concentration, thoughts of guilt and worthlessness and psychomotor agitation or retardation. From the clinical record [Mrs A] expressed concern about the first two on many occasions and the references to her anxiety are throughout her file.

Given the suicidality associated with [Mrs A's] depression by all standards of care this warranted aggressive treatment with antidepressant medication and psychological therapy if available.

With respect to the two suicide attempts I refer to Section 1:10 of the RANZCP endorsed NICE Guidelines for Management of Self Harm. This section is entitled Special Issues for Older People (Older than 65). Some relevant excerpts from that document are:

> When older people self harm treatments will be much the same as for younger adults but the risk of further self-harm and suicide are substantially higher and must be taken into account.
>
> Assessment should pay particular attention to the potential presence of depression, cognitive impairment and physical ill health and should include a full assessment of their social and home situation.
>
> All acts of self harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise because the number of people in this age range who go on to complete suicide is much higher than in younger adults.
>
> Given the high risks among older adults who have self harmed, consideration should be given to admission for mental health risk and needs assessment, and time given to monitor changes in mental state and level of risk.

The concerns I have about the mental health care offered to [Mrs A] post her suicide attempts are:

Too much reliance was placed on her self report when it was clear she did not want to be in the [inpatient service] and made a concerted effort to present well in order to get out.

Apart from [Dr L's] diagnostic formulation and risk assessment following [Mrs A's] [self harm] on 20 [Month5] there was no other clinical assessment of [Mrs A's] situation and the factors leading to her suicide attempt. There was no attempt

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to explain what had changed so soon after her admission(s) to render her euthymic and no longer at risk.

The decision to grant [Mrs A] so much leave off the ward did not in my view enable sufficient time for assessment, particularly as it was decided she did not warrant treatment. I speculate there were concerns that [Mrs A] would not remain on the ward nor accept treatment. In my view that may have necessitated use of the Mental Health Act which would have been entirely appropriate in the circumstances.

There were no clear goals of admission to inform when discharge could be appropriate.

Clinical staff caring for [Mrs A] (particularly [Dr B] and [RN C]) did not appreciate the significance of her two suicide attempts and therefore did not adequately assess risk.

Throughout the file there are references to parasuicide; deliberate self harm […]. The Discharge Plan form dated 3 [Month6] records [Mrs A] was admitted following '[…]'. [The second incident of self harm so soon after the first is not captured]

Both the formal typed discharge letter by [Dr N] and [Dr B's] own assessment note record that [Mrs A] was […]. Furthermore on 4 [Month6] and 11 [Month6] keyworker [RN C] completed 'Consumer Review Forms' in which she describes […].

I speculate that as the actual details of [Mrs A's] suicide attempts were not captured in the mental health file, neither was the significance of her comment about [her next planned method of self harm] (in the Emergency Department) appreciated. Instead it appears that [Mrs A] was regarded as a woman using 'self harm' as a means of coping with distress despite the fact that over 30 years had elapsed since her previous episode of depression which had never been associated with any suicidal behaviour. Furthermore in the intervening years [Mrs A] had been a high functioning, independent, and capable woman.

In the MOH Guidelines The Assessment and Management of People at Risk of Suicide, the section on the elderly includes the following points:

… elderly who attempted suicide usually have a strong intent to die and are more likely to make attempts that are fatal.

Any elderly person who is expressing suicidal ideation or has presented following a suicide attempt should be treated very seriously.

Risk factors particularly highlighted for the Elderly include:

- Depression
- Pain/Illness

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- Loss of health
- Loss of mobility
- Loss of role/job
- Loss of home (going into Rest Home)

The recommendation from the Guidelines are:

- Any elderly person … who has presented following a suicide attempt should be treated very seriously.
- Clinicians should treat symptoms of depression in an older person, assertively.

With respect to the areas I'm asked to comment on:

1. Risk assessments carried out for [Mrs A] during her period of MH care by SDHB may have been adequate until the first suicide attempt but thereafter (with the exception of [Dr L's] assessment) are poor or lacking. The clinical note from [Dr B's] assessment on 26 [Month6] is limited and without reference to mood, diagnosis or risk. Given the clear deterioration in [Mrs A's] mental state, the decision to commence medication, and the plan for daily contact there was some appreciation of risk, but no risk assessment is documented nor is there any rationale for the decision to continue managing [Mrs A] at home when an inpatient admission appears indicated or at least to be considered. If considered as the DHB response indicates, it should have been documented and the reasons for not pursuing, clearly outlined.

   In my view [Mrs A's] last assessment by [Dr B] should have contained a clear assessment of risk given her presentation, further deterioration, two past suicide attempts and the family history of [mental illness and self harm] (an independent risk factor). The lack of risk assessment on this occasion is in my opinion a significant departure from the accepted standard of care and would be viewed as such by our peers.

2. I've noted during [Mrs A's] admissions to the [inpatient service] that she spent considerable time off the ward. Per the MOH guidelines I do not believe she was adequately assessed. There was misinformation about her suicide attempts and a willingness to accept her self reports without reference to the available record and in the face of [Mrs A] being a reluctant inpatient.

   I do not believe the circumstances of her suicide attempts and therefore her ongoing risk were adequately explored. The decision to discharge from hospital on 03 [Month6] without treatment and without a satisfactory formulation about why risk no longer existed is in my opinion inappropriate and again represents a significant departure from the standard of care expected by myself and by our peers.

3. There were no formal detailed care plans for [Mrs A] but following discharge on 04 [Month6] the plan was for Keyworker visit within 48 hours and Psychiatrist review within four days.

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(a) In my opinion and experience this is an acceptable plan for follow-up if the goals of admission have been achieved. Goals for inpatient care typically are directed at managing risk; assessing and treating illness and providing respite to allow time for external stressors to be addressed. I do not believe any of these conditions were met when [Mrs A] was discharged on 04 [Month6] and in my view the decision to discharge was ill considered. Again in my opinion this is a significant departure from a reasonable standard of care.

4. In my experience it is not unusual for [the medical team that was providing care for her physical injuries] to provide treatment to patients independently of other service involvement unless the other service refers directly to [that team] or has primary responsibility for the patient. I've noted [Mrs A] was two months post the [accident that resulted in her injuries] when she presented to MHS and at that time she was still receiving treatment and review by [the medical team providing care for those injuries].

   MHS did appropriately consult the GP about [Mrs A's] situation and commented that a plan was in place for [ongoing care for her injuries]. At that time there were no new [concerns regarding her injuries] and the issue of chronic pain was being addressed. MHS staff do appear to have appreciated the difficulties [Mrs A] experienced as a result of her [injuries] and on the 24 [Month5] admission the House Officer reviewed the [correspondence from the medical team providing care for her injuries] and documented the updated plan.

   It's possible that MHS were reassured that [Mrs A's] [situation regarding her injuries] was under control when she disclosed her plan to travel to City 2 for specialist review and later surgery. A longer period of care in the [inpatient service] may have resulted in more coordination between MHS and [the medical team providing care for her injuries] but that is speculative.

   In my experience the coordination between MHS and [the medical team providing care for her injuries] was similar to what would realistically occur elsewhere.

5. (i) There exists in [Mrs A's] past psychiatric history a diagnosis of schizophrenia. For completeness I do not believe she ever suffered from this condition.

   (ii) On 20 [Month5] Liaison Nurse and Duly Authorised Officer (DAO) [RN K] wrote a comprehensive note following a thorough review and assessment of [Mrs A].

   He however concluded she did 'not appear to be mentally disordered in terms of the Mental Health Act 1992' which was incorrect, as [Dr L's contemporaneous assessment concluded she did meet criteria for the Mental Health Act.

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(iii) [The family has] raised concern about [Mr A] caring at home for his wife when he had his own health issues and her need was high.

The file indicates there was support via other family members and friends however [Mr A] was the primary caregiver and had indicated to the keyworker on 25 [Month6] that he was 'worn out'. Furthermore he had on two separate occasions found his wife after suicide attempts and no doubt felt traumatised by this. In response to her situation the formerly high functioning independent [Mrs A] became very dependent in her depressed state.

Notwithstanding [Mr and Mrs A's] own expressed desire to have her discharged home as soon as possible, I believe more consideration should have been given to a longer period of inpatient care. In this regard my opinion is that readmission to hospital was indicated at the last presentation.

(iv) It's clear from the file both [Dr B] and the key worker [RN C] were very involved with [Mrs A's] care and were responsive when [Mr and Mrs A] sought review. In my opinion they, along with other SDHB clinicians, provided an adequate amount of input to [Mr and Mrs A] but I believe the content of some of those assessments was inadequate.

[Dr L's] assessment on 20 [Month5] was of a high standard."

Dr Fullerton provided the following further advice:

"I have now read the additional information submitted by the SDHB and the comments of [Dr B], [RN K] and [RN C].

With respect to the response by [Dr B], I refer to The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Formulation Guidelines for Candidates (of the Consultancy Examinations).

'The Committee for Examinations believes the ability to formulate a case is one of the important skills of a Consultant Psychiatrist'.

The RANZCP explanation of Formulation includes:-

'Formulation … a comprehensive overview of the case encompassing phenomenology, aetiology, management and prognosis …

The formulation is a set of explanatory hypotheses or speculations that link the findings on history and mental state with the putative diagnosis and as such should precede the diagnostic statement'.

[Dr B] by way of response to my report has provided both elaboration of [Mrs A's] presentations and explanations for her clinical management. I do not believe however these change the facts of the case and with the exception of my errors (which I'll correct) my findings are unchanged. Notably from 14 [Month5] there is

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a lack of diagnostic formulation and risk assessment, to inform management and consequently care fell below the standard expected.

On page 7 of her response [Dr B] states '[Mrs A's] diagnosis was consistent throughout treatment'. I have read the file many times and I still do not know what diagnosis [Dr B] is referring to. On 18 [Month3][Dr B] correctly diagnosed [Mrs A] with a major depressive episode, recurrent, and treated this appropriately with an antidepressant and an anxiolytic.

Antidepressant treatment was discontinued on 22 [Month4]. On 14 [Month5] [Dr B] documented that [Mrs A's] mental state was 'the same' but also recorded she was 'feeling more confused today' and that 'behaviour has been consistent'. [Dr B] does not offer a formulation to account for these phenomena, nor is the diagnosis reviewed or — if the same — affirmed.

[Dr B] asserts on several occasions that [Mrs A's] behaviour is not consistent with major depression. She states '[Mrs A] had a propensity toward impulsivity which by definition is difficult to predict. The impulsive behaviours were inconsistent with her presentation; they were unpredictable'. Nowhere in the clinical file does [Dr B] formulate WHY this previously high functioning independent woman with no history of impulsivity should start behaving in such a way. The only note about her premorbid personality was that she was 'perfectionistic'. Such traits are not those usually associated with unpredictability.

In her response to my report [Dr B] states 'with unpredictable, impulsive behaviour, there is a constant risk.'

These are not statements that appear in the clinical file. If as she states [Dr B] had identified this risk, where was the plan to manage it? [Dr B] asserts on page 4 of her response that [Mrs A's] behaviour is not consistent with major depression. What then was her explanation for why [Mrs A] 'impulsively' tried to take her own life when she had no past history of self harm? I noted also that House Officer [Dr N] documented a diagnosis of 'Mixed Anxiety/Depressive Disorder' in [Mrs A's] discharge summary from the [inpatient service] dated 03 [Month6]. [Dr L] also assigned [Mrs A] a diagnosis of Major Depression Syndrome on 20 [Month5], however after 22 [Month4] [Mrs A] was not prescribed any medication for depression by [Dr B] and her anxiolytic medication was mostly prescribed by the GP, at [Dr B's] behest.

Throughout [Dr B's] response I see the same reliance on [Mrs A's] self report that was evident throughout the file. This is particularly the case with the two significant suicide attempts. For example:

'[Mrs A] told us'

'[Mrs A] said it was a parasuicide attempt'

'She constantly denied depression, wanting to harm herself or to commit suicide'

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'[Mrs A] denied factors leading to a suicide attempt because she constantly denied being suicidal'.

I have referenced the NICE Guidelines on the Assessment of patients who present following self-harm with particular reference to the section for older people.

In my opinion [Dr B] did not give sufficient weight to the seriousness of [Mrs A's] two suicide attempts and still does not appear to acknowledge their significance.

[Dr B] asserts that the clinical record is contained within many documents but her own notes frequently did not reference important information that preceded her own assessments.

The ambulance report from the first suicide attempt […] reads

[…] **'Patient wants to be left alone to die.'**

'Conscious to voice. […]

[…] **History of information from patient unreliable.'**

Note also this was rated **'**[…]**'** in the discharge summary from Critical Care where [Mrs A] spent two days recovering from her suicide attempt.

The ambulance report from the second suicide attempt.

[…]. **Patient admits planned to attempt suicide prior to husband leaving this am.**

Note also the Emergency Department record from that presentation includes:
[…]

This clear suicide attempt is explained by [Dr B] as '[Mrs A] knew […] would not kill her.' '[Mrs A] said it was a parasuicide.'

In his assessment of [Mrs A] following this event, [Dr L] completed the Risk Assessment Form. He wrote:

Major Depression with recent suicide attempt.
Intent.
Major Depression Syndrome.
Recent cessation of treatment.
Not actively suicidal at assessment.
Significant risk of re-attempt if not admitted.

[Dr B] asserts she completed risk assessments each time she reviewed [Mrs A].

With respect to risk assessment I refer to SDHB's own Risk Assessment and Management Plan Proforma document (as completed by [Dr L] on 20 [Month5]).

Factors to be considered in the risk assessment (per the form) include:

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Previous suicide attempts; major mental illness; personality factors; lack of insight; negative factors — and in the clinical presentation: impulsivity, active symptoms of mental illness; unresponsive to treatment; change in medication; suicide plans (including family history).

Risk assessment is not a statement of factors at cross-section. It is simply inadequate to call 'No thoughts self harm, no suicidal ideation, no psychosis' 'she stated she acted impulsively' a risk assessment. Findings on cross-sectional review contribute to the risk assessment but they are only one dimension. There is no exploration of the frequently voiced suicidal ideation nor what preceded it. In my view appropriate consideration was not given to the two suicide attempts. Similarly [Mrs A's] unwillingness to accept recommended or even prescribed medications at times also increased her risk, but this was not captured as a factor.

[Dr B] has stated that 'there is no way I or any of the team could force her ([Mrs A]) to undergo treatment.'

From the clinical notes that is an incorrect statement. [Mrs A] met criteria for the Mental Health Act. She had an

'abnormal state of mind characterized by disorder of mood or disorder of volition … to such a degree that it posed a serious danger to her health or safety.' (MHA, 1992)

Certainly from the time of her suicide attempt [Mrs A] could have been detained and treated compulsorily under the Mental Health Act. Please note the MHA allows for a mental disorder to be 'continuous or of an intermittent nature'.

If however [Dr B] believed the MHA was not indicated this should have clearly been documented in the file along with a formulation about [Mrs A's] highly changeable presentation and a management plan to mitigate her risk. On the other hand if [Dr B] believed the MHA simply would not help [Mrs A], then it should have been documented that [Mrs A] remained at high risk of completing suicide but enforced hospitalisation and compulsory treatment were unlikely to modify that risk.

Purely on demographic risk factors [Mrs A] should have been formulated as a high suicide risk. She was [aged in her 60s]; had pain and discomfort; loss of […] and loss of independence. There were prominent feelings of guilt; intermittent despair; a history of depression complicated by anxiety; impulsivity; suicidal ideation; significant suicide attempts; limited engagement; minimization of risk and a family history of suicide.

I have noted the involved clinicians were responsive to [Mr and Mrs A] and provided frequent reviews. I have noted also at times [Mrs A] presented in a positive frame of mind, motivated and with a reactive affect but I have also cited many examples from the file where staff have recorded clear features of depression. It is also not uncommon in older patients for depression to manifest

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with a marked focus on somatic (bodily function) complaints. Nowhere in [Dr B's] notes do I see it considered that this may have been a factor. Even if it clearly were not, it should have appeared on a differential diagnosis. ([Dr N] queried the possibility that [Mrs A's] nausea and weight loss were related to depression in her admission note dated 25 [Month5]).

I have amended my original report to remove the quotation marks around 'anxiety remained prominent' as that is a typo and the précis was mine.

I have not attributed the quote 'fleeting thoughts of self harm' to [Dr B]. The introduction to that paragraph references several contacts by MHS. The quote is recorded by [RN H] on 22 [Month3] following a phone call to [Mrs A]. Both [RN H] and [Dr B] make note of [Mrs A's] anxiety. She is also quoted by [RN H] to be 'struggling' two days before [Dr B] recorded 'Good improvement is noted'.

[…]

With respect to [RN K's] response. The HDC asked me to make any other comments I felt pertinent to [Mrs A's] care.

I consulted both the Ministry of Health Guidelines for the Role and Function of Duly Authorised Officers (DAO) and the Mental Health (Compulsory Assessment & Treatment) Act 1992.

In addition to their other statutory duties DAOs are charged with providing advice to members of the public and non-psychiatric clinicians, about the appropriateness of the Mental Health Act. They must therefore be familiar with both limbs of the committal process although the decision to detain a patient under the Mental Health Act is the prerogative of the Psychiatrist as [RN K] states.

On 20 [Month5] [RN K] assessed [Mrs A] after she was cleared by the medical team following what is described in the discharge summary from the Critical Care ward as 'an intentional […]'.

In completing his assessment note [RN K] wrote 'does not appear to be Mentally Disordered in terms of the MHA 1992'. The contemporaneous assessment by [Dr L] clearly states [Mrs A] did meet MHA criteria.

To paraphrase the MHA:

'Mental Disorder — an abnormal state of mind characterised by a disorder of … mood'

and
(the second criterion for compulsory treatment)

'Poses a serious danger to the health or safety of that person'

[Dr L's] note from that contemporaneous assessment:

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'Major Depressive Disorder — Severe. Recurrent. Risk of further attempt in community. Admit voluntarily to [inpatient service] (accepts but finds demeaning) 111/ MHA to be invoked if required.'

[Mrs A] had a mental disorder (disorder of mood) and posed a danger to her own health and safety. There is an expectation however, that the 'least restrictive means' are used to engage patients in treatment. Many patients meet criteria for the MHA but are successfully treated voluntarily without the need for compulsion. This was [Dr L's] plan although it's clear he endorsed the use of the Mental Health Act if required.

I stand by my assertion that [RN K] was incorrect in stating that [Mrs A] did 'not appear to be mentally disordered in terms of the Mental Health Act' (which ipso facto would mean she did not meet criteria for the Mental Health Act) but I have amended the report to include his direct quote.

I have noted [RN K's] assessment was comprehensive and he acted entirely appropriately by ensuring [Mrs A] was seen by a Psychiatrist. However, I have included this finding for completeness because there are other instances where [Mrs A] clearly met criteria for the Mental Health Act but SDHB clinicians mistakenly believed she did not, and may therefore have missed an opportunity to treat her.

I have amended my original report to correct those errors I have acknowledged. I have not altered my findings."

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Appendix B: Independent nursing advice to the Commissioner

The following expert advice was obtained from Sally McPherson, a registered nurse with experience in mental health:

"Introduction to my advice.

Reviewing care in the community [in cases like this], is problematic because of the inability of the auditor to evaluate all factors involved as the only documentation is that of health professionals, and all other information is offered in a variety of ways that make it difficult to evaluate consistently. A reason why Root Cause Analysis is no longer used in community settings.

I note that a contributing cause to [Mrs A's] [deterioration in mental health] was her [injuries] and [the care she received for them]. While I am not asked to comment specifically on this, I would like to offer the following comment. It is my experience that [injuries of the kind Mrs A had] in the older person are perceived as minor events medically and that the significance to the sufferer is not always recognized. The loss of confidence […], the sense of vulnerability, the sense of ageing and dependence and loss can be ignored. There is little research that identifies this as a particular issue for post menopausal women, but I wonder about stigma for older women, particularly influencing treatment options and reviews. The medical minimization may then influence the Psychiatric team in to seeing this traumatic life changing event as a less important factor on ego, role change, loss etc and a subsequent non recognition as content for therapy and a need for adaptive responses that are positive.

Generally I note that there seems to be little documented that supports an interdisciplinary approach to [Mrs A] and family, either in hospital or on discharge. Given the complexity of [Mrs A's] depression and anxiety post the trauma of [the injuries] and treatment, I question this apparent lack. I note only one discharge meeting and that Nursing and Psychiatry seem to be the only disciplines involved in her care and decision making.

I have been asked to comment on the standard of care provided by two Registered Nurses working in the community. However there seems to be little in the way of discharge treatment plans that would inform their care or advice for [Mrs A] and her family about managing the inter connected issues of post trauma, current pain, loss of function, […], change in husband's health, reluctant use of medication, use of other therapies (relaxation documented as a positive while in hospital) and education about depression and anxiety management.

1: [RN C's] management of [Mrs A's] mental illness, taking appropriate steps to respond including consulting with a Psychiatrist.

The level of follow-up reflects the decisions made at discharge, and were escalated to the Psychiatrist appropriately. The identification of nausea and appetite loss were managed by the GP but may have needed to be also identified as related to

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depression and strategies put in place to mange this eg dietician involvement/education around depression/anxiety management symptoms.

There is a lack of information related to contact between [Mrs A] and the RN between 12 [Month6] and 24 [Month6]. An assumption could be that this is due to [Mrs A] being in [City 2] for surgery, rather than being unvisited [at home] but does indicate a lack of communication between [Mr and Mrs A] and the RN.

[Dr B] states that follow up will be daily from the 26 [Month6] but this does not seem to have occurred.

2: Frequency and quality of risk assessments during this time.

These were not made routinely or in a succinct format (compare with that provided by [RN K] 20 [Month5]). Not documenting does not support that the assessment took place. I am left with a trust issue that [RN C] states she documented problems only but not how she reached this conclusion. In the context of self harm, asking a depressed/anxious person on their self harm risk is not always reliable and needs to be accompanied by a review of depressive/anxiety symptoms and ability of the person to manage these behaviours. The identification of protective factors (in this case husband, family, neighbour) need to be substantiated rather than accepted as offered.

The cliche is 'that if it is not written, it did not happen'. It may have happened but I do not see it.

3: Communication by [RN C] and [Mrs A] & family, and [Dr B].

[RN C's] communication with [Mrs A] and her family does not seem mutual as [Mr & Mrs A] went to [City 2] without informing [RN C]. [Mr & Mrs A] did not share the previous mental health treatment implying a lack of openness in the therapeutic relationship. The summary of home visits does not provide me with convincing evidence of the content or an assessment of the nature of the relationship. However the concluding summary of the risk assessments is an adequate one.

Communication between [RN C] and [Dr B].

[RN C's] information appears to have been received by [Dr B] and used to make decisions indicating the content was valuable. I wonder if the barriers to progress identified in the summary were shared with [Dr B]. There is a narrow focus on medication treatment but little that indicates a psychodynamic or family therapy approach.

The lack in documentation makes it difficult to comment further. For example there is no documentation reflecting the joint visits of [RN C] and [RN D] or how they would co-case manage.

Standard of care provided by [RN D].

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This is unable to be assessed as there is no documentation supporting the contacts.

Standard of care/accepted practice.

Documentation supporting formal mood, risk, social situation is not in evidence. There is nothing to suggest that the information around personality factors of perfectionist traits and high standards being used to create a care plan that incorporates the changes for both [Mr & Mrs A] as a result of [her injuries]. This is however not specific to the community RNs but follows on from the inpatient care as well. I would have expected a more cohesive plan of care to be discussed with [Mr & Mrs A] as a result of her hospitalisations for treatment of her mood and anxiety that offered a pathway to address the changes in their lives at this time in their lives. The psycho social dynamics and multiple impacts on their lives of [employment, health issues in them both], the reappearance of depression/anxiety after a long period of wellness, and the impact of unexpected illness and reduced health outcomes that creates appropriate fear and anxiety does not seem to be recognized. This is compounded by a lack of co ordination between health professionals of different specialities and the impact of difficulties with ACC and what services were assumed to be provided but were perceived as lacking.

The apparent lack of depth to the psychiatric care with what appears to be a more medical focus with a lack of a psycho-social input especially with the impact of major illness in this age group is not accepted practice. While I am unsure if the outcome would be different for [Mr & Mrs A], the process of their care seems lacking in coordination and central leadership. While risk factors were identified by various health professionals at assessment points there is a lack of obvious use of this information to guide treatment plans. There is no obvious guidance to [Mr & Mrs A] on how to manage this phase in their lives and the changes in their relationship from mutually being intradependent to [Mrs A] becoming more dependent and the change in roles this has on the couple and their family.

The psychosocial needs of an older couple and the influence of the multiple impacts of lifestyle change led by health changes in them both does not seem to be understood or appreciated. There is a need for multi disciplinary involvement when dealing with late onset mental and physical illness in the context of social changes. Risk identification needs to be supported by management strategies and education and support of those involved. This is identified by the DHB response about offering supports.

As we evolve in the management of people with depression and anxiety and suicidality I wonder if our enquiry into their self view of self harm could be over relied on in an attempt to promote self care and self responsibility at the exclusion of judging whether this is able to be supported by their inner ability and therefore is less to be relied on than we do currently.

ADDENDUM to report

This has a focus on [RN C].

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1. RISK ASSESSMENT.

A) Risk assessments occur many times in the treatment continuum. Usually at initial assessment, within 24 hours of hospitalization, at shift end, prior to discharge, on first follow-up visit, at each contact and prior to discharge.

Most of these are carried out by nurses (who may not be the primary or key worker), some by an IDT, some by a psychiatrist, and all should be documented.

It WAS common practice to use minimal documentation and for nurses to rely on verbal handovers. It is not acceptable practice currently to assume that a risk assessment has occurred if it is not recorded.

Some services use a template for risk assessments to prompt and record that they are done. Risk assessments are more than the responsibility of one staff member and involve other team members eg at peer case reviews of outpatients.

The risk enquiries are not documented that [RN C] states occurred.

B) This is a serious lack of care if the enquiries did not take place, moderately serious if they did occur and were not documented as it provides no information to others involved in [Mrs A's] care.

C) My peers would probably be concerned that their own documentation would be found wanting if reviewed, as at times personal typing is in a reduced form due to time or skill lack. Audits often only measure that it occurred not that it is of quality. In community teams peer review depends on the quality of the group, the busyness of the team and the comfort of the nurse bringing the issue for review. This can mean that any nurse in this setting may not be supported in best practice.

The initial risk assessment by a key worker should show collaboration with the treatment team, the client and significant others. It should document both current and historic risks. It should document past and current triggers, their past and current management strategies.

On going risk assessment should show continued collaboration and incorporate new information. In this instance the self harm attempts following the initial presentation to reflect the dynamism of [Mrs A's] self care ability.

RISK MANAGEMENT

A) Accepted practice has risk management documented and closely following identified risks.

B) Risks were identified at different points in treatment. However, specific management of these was not documented, eg, noting [Mrs A's] inability to carry out activities that reduced her anxiety but not describing how that risk could be managed. I note that relaxation training was included in her care and wonder if it is part of the care culture that this is done so routinely that it does not get written down.

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Noting risk is not enough if harm minimization strategies are not put in place or at least attempted to place these following discussion with client and family.

This is a serious departure from accepted practice.

C) Peers would expect that management guidelines would follow the risk, and include any management strategies that had previously worked to be included. It is less common to expect that failed strategies be included.

TREATMENT PLANNING

A) Accepted practice is that treatment [planning] be a multi-disciplinary shared work that includes the client and those wanted by them to be involved.

B) There was a paucity of ongoing treatment plans documented by [RN C] that does not meet the above standard and is serious.

It also does not demonstrate a collaboration between team members and [Mrs A] and her husband.

C) Peers would expect to see documentation reflecting input from the Key worker, the treatment team and [Mr and Mrs A].

They would expect that a copy of the treatment plan would be available to other staff, and [Mr and Mrs A].

DOCUMENTATION

A) Documentation should show connection between the client's behaviour and mental status and reflect the nurse's responses.

B) Routine recording of [RN C's] interactions is sparse and thus leaves room for conjecture as to the content of the contacts. The outcomes of the contact can be surmised eg when a joint visit is made by [Dr B] and [RN C], but is otherwise lacking fullness and is intermittent. This is a moderate failing.

C) Peers would expect more evidence of interactions and decisions being made. They would also comment that sometimes they do the work but don't write it down. Because it is a habitual occurrence, it remains poor practice.

COORDINATION/COMMUNICATION WITH FAMILY

A) All effort should be made to involve family as agreed to with the primary client. Where this is not allowed, consideration should be given to referral of the family to another health worker to address their needs separately.

B) There does not seem to be an open relationship as [Mr and Mrs A] did not share past history or the trip to [City 2] with [RN C]. This may represent barriers in [Mr and Mrs A], the structure of interviews, or the unavailability of any parties to connect. This is a moderate failing.

C) Peers would expect a collaborative approach and would expect family meetings to occur especially after the self harm attempts. This could identify changing risks and protections.

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Opinion on the standard of care of [RN C]

[RN C] refers appropriately for expert involvement and her opinion was heard. However there seems to be a reduced response to the potential seriousness of the self harm attempts and strategising for these in a treatment plan. There is reduced collaboration with family. Documentation is poor.

The letter by [Dr B] states that daily contact is to occur after the 26th. If this was communicated directly at the time of the review, it did not occur by [RN C]. If it was only communicated to [RN C] in letter, it is not indicated when that order was received. (That assessment was not carried out by [RN C], but I note it did not record as a risk [Mrs A's] fluctuating mood or [Mr A's] concern.)

There is little documentation to support that education of [Mr and Mrs A] occurred around [Mrs A's] mood, anxiety and self harm and the couple's options for dealing with this.

Re the statement about 'no change' not requiring documentation. This removes some of the responsibility from [RN C] for the reduced documentation but is still not acceptable especially in complex cases."

The following further advice was received from RN McPherson:

a) Opinion of care provided by [RN C's] account that she shared the key worker role with [RN D].

The role of key worker and co-key worker are not clearly shown to have been explained to [RN D] and I note that [RN C] states in the MHS Home visit notes that [RN D] had accompanied [RN C] on the 5th [Month5] 'I visited several times with [RN D] to introduce her to the patient prior to leaving her to visit alone'. This is not confirmed in [RN C's response] when she states that [RN D] co-visited on the 12th [Month5] not saying they visited together on the 5th [Month5].

[RN C] seems to have assumed that [RN D] was in a co-key worker role. Documentation following [Mrs A's] hospitalization was addressed solely to [RN C] as the key worker.

If [RN C] believed [RN D] was co-key worker, she would have had a reasonable expectation that daily follow-up would occur, if not by [RN C] herself but on her days off by [RN D] as was planned. This daily follow-up did not occur.

I am unable to confirm that the responsibility for this daily follow-up was communicated to [RN D]. If it was not then the plan was not actioned because of [RN C's] failure to confirm transfer of care. This may or may not have altered [Mrs A's] actions.

If it was transferred to [RN D] then she failed to follow-up or did not document it if she did.

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Transfer of care between wards is commonly documented to ensure continuity of care. In community teams this is usually done verbally or by some form of documented internal request. This is not evident in the notes.

This exposes a gap in service provision that requires a consumer to contact the team concerned rather than a team member contacting the consumer when it is not clear who has the role to follow up.

b) Opinion of care provided by [RN C] when [RN D] states she was not asked to be a co-key worker to [RN C]

It would appear that [RN D] did not share the view of [RN C] that she was in a co-key worker role but merely acting in a visit by visit role of support to [RN C]. There is no documentation to support that [RN D] was asked to be more than this and her visits to [Mr and Mrs A] was as a support to others ([RN C], [Dr B]).

It seems that there is no clear transfer of care, neither clear to [RN D] nor to the consumer. The communication expecting [RN D] to have the role of co-key worker is in doubt.

If [RN C] believed that [RN D] was in a co-key worker role, [RN C] could have reasonably expected that [RN D] would offer the daily follow-up as planned on the 26 [Month6].

If [RN D] was found to have been in a shared role with [RN C], it would be expected that she would be aware of the plan of care and carried it out, asking a colleague to do the care if she was unable to. If she failed to be aware of the plan of care, it would be needful to ask how planned care decided upon with a family and a Doctor and an RN was communicated to a third person. If the care plan was ignored it is a serious failure to care.

Clarity of role is an important component of care. Failure to be explicit and ensure that all parties are aware of their roles and subsequent responsibilities and duties can cause treatment plans to not be enacted which may have serious consequences. Departure from carrying out planned care is not acceptable unless there is a reasoned judgement made and documented or a crisis happens to change the plan.

In this […] case, it is not certain that the failure of the plan of care to be carried out […].

However the lack of documented sharing of responsibility leads me to suggest that protocols for shared care be made explicit to all concerned and documented, ensuring that consumers and families have the names and contact details of staff who are involved in their care.

Organizations have a role to ensure that when there is case management in teams where this may be carried out by part time workers, that use of a duty or triage system only covers reaction to in coming contact from consumers but does not guide staff for planned interventions when designated staff are off duty. As more staff age and plan for retirement by reducing working hours this will become a more common occurrence and needs explicit direction rather than relying on less formal practices of colleagues covering days off."

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Appendix C: Independent advice to the Commissioner

The following advice was obtained from […] surgeon Associate Professor […]:

[…]

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