Complaint

A 62-year-old man with a severe depressive disorder and a history of alcohol abuse was admitted to a public hospital after he was found collapsed at home following a deliberate overdose of medication. Following assessment by the mental health team, he was admitted to a psychiatric unit for treatment of depression. After five days he was released from the psychiatric unit on home leave, and committed suicide the following day. The man's wife was concerned that her husband was not diagnosed with depression, and that home leave was granted despite concerns expressed by both the patient and family members about the risk of self-harm. The Commissioner's investigation was primarily concerned with issues of diagnosis, the level of consultation, the patient's discharge, and his proposed follow-up care.

30 March 2006

Dear Dr B

Complaint by Mrs A
Our ref: 04/00671/WS

Thank you for your response to the provisional decision concerning Mrs A's complaint about the treatment her late husband, Mr A, received at a psychiatric unit.

As you are aware, after reviewing your response to my provisional opinion I obtained further expert advice from psychiatrist Dr Nick Judson. A copy of Dr Judson's further report is **enclosed**.

You submitted that the care you provided to Mr A was appropriate in the context of the resources available at the psychiatric unit. In addition, you stated that it is unfair to hold you accountable in circumstances where the systemic deficiencies issues that Dr Judson has identified (such as the lack of formalised information gathering/consultation) were contributing factors.

In his further report, Dr Judson has emphasised that Mr A's past records should have been accessed to assist with your diagnosis, and considers that your rationale for discounting depression was not sufficiently documented. He remains of the view that further consultation with Mr A's family was warranted and has reiterated that there should have been a family meeting before Mr A was placed on home leave.

Dr Judson has acknowledged the resource limitations you have highlighted in your response. In particular, you did not have the support of a full multi-disciplinary team. While Dr Judson considers your comments were reasonable, he does not consider your workload and resources to be factors that materially affect his view of the care you provided to Mr A.

It is clearly inappropriate to hold you accountable for matters attributable to systems deficiencies. Because of this, I have not held you accountable for your failure to access Mr A's previous medical records (which my advisor has clarified that he considers to have been a moderate departure from an appropriate standard of care) or for the sub-optimal consultation with Mr A's family during his admission. I have drawn the systemic issues to the attention of the Board and asked them to review systems where appropriate.

I acknowledge that you were operating within a difficult working environment. Nevertheless, I concur with Dr Judson that the resource limitations you were operating under are not a full answer to the concerns he has identified.

Having carefully considered Dr Judson's further report, together with all the information obtained to date, I consider that you breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) by not ensuring that Mr A's family were fully consulted about his proposed leave. The reasons for my view are set out below.

Overview
Mr A was released from the psychiatric unit on home leave and committed suicide the following day. Mrs A is concerned that her husband was not diagnosed with depression, and home leave was granted despite concerns expressed by both Mr A and family members about the risk of self-harm. My investigation was primarily concerned with the issues of your diagnosis, the level of consultation, Mr A's discharge and his proposed follow-up care.

During the investigation I obtained information from you, Mrs A and family, the District Health Board, nurses Ms D, Mr C, Mr G and Ms E.

Background
Mr A had been diagnosed with a severe depressive disorder in 1981 and continued to receive antidepressant medication. He had a known history of alcohol abuse from 1988. In 1991 Mr A was admitted to the psychiatric unit for a period of six weeks, for treatment of depression, but since then had remained generally well for more than 10 years. However, on Day 1 of the episode of care under discussion, Mr A took an overdose of medication and was admitted to a public hospital.

On Day 2 Mr A was assessed by a crisis team member Mr C, who concluded that Mr A's insight was intact and that his crisis was primarily caused by social stresses, including a recent affair. Mr A's family were not satisfied with a proposal to discharge him. Consequently, after discussion between you and Mr C, Mr A was admitted to the psychiatric unit as a voluntary patient.

Enrolled nurse Ms D was appointed as Mr A's key worker and undertook an initial assessment. Mr A appeared alert and was without any thought or memory difficulties. He was remorseful and had no further plans for suicide. Overall, he was assessed by Ms D as a medium risk.

On the morning of Day 3 you assessed Mr A and concluded that he was not suffering from a mental illness and that psychiatric follow-up was not indicated. You noted that

Mr A probably had a significant alcohol problem and had a history of extra-marital affairs. You planned to assess Mr A further the next day and to refer him to relationship and alcohol services for counselling.

On the morning of Day 4, you reviewed Mr A and noted his "relaxed, pleasant attitude" with no signs of depression. You discussed a proposal for discharge with Mr A, and he expressed no particular concern.

Mr A became anxious as the day progressed and indicated to staff that he was not happy about his planned discharge and felt "unsafe on his own". Mrs A stated that on Day 4, her husband was in crisis and did not want to leave the ward. She said she discussed the matter with Ms D but was told that the matter was non-negotiable. In contrast, these comments have been disputed by Ms D, who stated that Mrs A was upset and "vented" her feelings about Mr A's actions. Lead nurse Mr G confirmed that Ms D mentioned Mrs A's visit at handover, and advised him that Mrs A was upset at her husband's affair. Ms D advised me:

> "Due to [Mrs A's] distress earlier in the day it was felt that it was more appropriate for the staff member who would meet with his [Mr A's] family when they came to pick [Mr A] up in the morning would explore the issue of family/home support."

On the morning of Day 5, you further reviewed Mr A. You observed that Mr A was relaxed and exhibited no signs of depression or thoughts of self-harm. Following a multi-disciplinary team meeting, the decision was made to grant Mr A leave from the ward, with a discharge meeting to be held the following week.

Registered nurse Ms E was on duty when Mr F came to collect his father from the in-patient unit on the day of his planned leave. Ms E stated that she met with Mr A and his son and informed them that the decision to discharge Mr A had been changed to grant leave. She explained that his bed would remain open and that he could return to the ward at any time. No concerns about Mr A's safety were expressed at that time, and a family meeting was arranged for the following week. Ms E stated:

> "Both [Mr F] (the son) and [Mr A] appeared to understand and agree to the terms of the leave and were asked if they had any queries or concerns.
>
> [Mr A's] (son) and [Mr A] were asked to provide a contact phone number and a suitable time for the ward staff to make contact with them, however they were somewhat indecisive about this. The decision was made for either [Mr A] or his son to contact the ward daily to up-date re: progress.
>
> At this time a family meeting was arranged with [Mr A] and his son, with the intention for them to return [at a specific time and date the following week]. It was left for [Mr A] and his son to inform [Mrs A]."

Mr F provided the following statement to this Office:

> "I picked Dad up from [the psychiatric unit] about 10.30am. I was told by the nurse that he wasn't being discharged but [was] on home leave until his review on

> Tuesday. I would have been concerned if he was being discharged but accepted that he was just on leave."

(Mrs A subsequently stated that Mr F does not recall being told that Mr A was on home leave.)

Mr A spent the rest of the day with his son and returned to Mrs A later that evening. Mr A gave no signs the following morning of an impending crisis. Mrs A went to work the next morning, planning to return after a few hours. However, at approximately 10am Mrs A arrived home to discover Mr A had committed suicide.

Assessment, diagnosis and treatment

You explained that Mr A's presentation was a result of a social crisis due to gambling debts, his affair and alcohol abuse, and that his overdose did not involve particularly dangerous medication. You considered that Mr A exhibited no physical symptoms of depression or thoughts of harm. You assessed Mr A on three separate days and considered that his dysphoria and anxiety were in keeping with his social situation. You considered that psychiatric follow-up was not indicated for Mr A, because no mental illness was identified.

My advisor commented that, given the conclusions from your assessment and diagnosis, there was nothing to suggest your management plan was inappropriate. He made the following particularly relevant points:

- Mr A's admission to the psychiatric unit for a period of assessment was appropriate;
- it was reasonable to accept Mr A's expressions of regret for his actions and to consider his suicide attempt had been the result of his unresolved social stressors;
- your assessments, diagnosis and treatment plans were generally thorough and carefully documented.

However, my advisor expressed reservations that you appeared to have very quickly discounted the possibility of a diagnosis of depression. He stated:

> "There were a number of factors that raised the possibility of a depression, and this possibility had been noted by [Mr C]: In addition to the suicide attempt, there was a past history of depressive illness as well as alcohol abuse, a documented concern by [Mr A] and others that his mood had been low for at least 2 months, significant recent weight loss, and problems with sleep (though he was described as 'sleeping OK', this was only with the use of regular hypnotic drugs). [Dr B's] clinical notes do not explain why he considered these factors did not suggest the possibility of depression.
>
> …
>
> In my opinion, it would have been wise of [Dr B] to have made some further inquiries about the past history, either from records or from [Mr A's] wife. Information about the previous assessments and contacts with mental health professionals may well have raised suspicion about the possibility of an underlying depression. Having said this, [Dr B] was clearly aware of the fact that [Mr A] had had past treatment for depression, and for alcohol problems, and had

> no doubt taken this into account when assessing him as not being depressed at the time of his examination."

In his further report, Dr Judson commented that it was not possible to make a judgement as to whether your actual diagnosis was correct. He evaluated your omission to access Mr A's past records as being a moderate departure from accepted practice, and reiterated his criticism of your lack of documentation about why you discounted a diagnosis of depression.

You emphasised that you worked within a multi-disciplinary team, which included a range of health professionals, and has replaced the "former archaic pyramid which places the psychiatrist at the top of the order".

My advisor explained that you retained ultimate responsibility for Mr A's clinical care. He stated:

> "The consultant psychiatrist is the senior clinician within the multi-disciplinary team, and carried the ultimate decision about admission, discharge, and the overall direction of treatment. Each member of the team is responsible for carrying out their own role to an adequate standard of professional practice. The psychiatrist has the role of making the diagnosis, based on his own assessment and information from the others in the team, and for determining the treatment plan, which may then be delegated to others to carry out."

Conclusion

I acknowledge your view that Mr A's care should be assessed within the context of the multi-disciplinary team that treated him. However, each team member has a different role, and the major clinical decisions were primarily your responsibility. You assessed Mr A as having no symptoms of depression, although clearly a number of factors raised this possibility. In the circumstances, I consider that you should have obtained more detailed information about Mr A's history (which was readily available from his previous psychiatric unit admission, or directly from Mrs A), and to have carefully documented the reasons for excluding a diagnosis of depression. Nevertheless, there was apparently no formalised system in relation to the retrieval of information, including past records, and it appears that you did take Mr A's history of depression broadly into account when formulating your diagnosis and treatment plan. My advisor has commended your otherwise thorough assessment and appropriate management.

Accordingly, I have decided to take no further action concerning this aspect of Mrs A's complaint. However, I trust that in future you will, wherever possible, access your patient's previous clinical records.

In the circumstances, I have drawn Dr Judson's concern about the lack of a formalised system for the retrieval of past records to the attention of the Board and asked them to review their systems.

Consultation with family during admission

You confirmed that Mr A and his family were aware that his admission would be brief (for a period of 24 to 48 hours), and Mr A raised no objections during your

discussions about his discharge. You explained that you had no direct contact with Mr A's family. However, the crisis team and nursing staff had multiple contacts, and you were fully informed by them. In particular, concerns about Mr A's proposed discharge and safety were documented on Day 4 by nursing staff and then discussed at the multi-disciplinary team meeting on Day 5.

My advisor noted that discussion with Mr A's family was not well documented by nursing staff and, as such, it was difficult to make any definitive judgement about the adequacy of the consultation. Nevertheless, my advisor considered that the consultation was "not really sufficient". He stated:

> "It is not necessary, or indeed practicable, for a busy consultant psychiatrist to interview family members of every patient under their care. It is up to the psychiatrist to judge when this is necessary, either from the point of view of ensuring that the information gathered is accurate, or because there is some conflict or tension that requires the intervention of the psychiatrist rather than other disciplines.
>
> In this case, it is clear from [Mr C's] account that there were some very strongly held feelings within the family concerning [Mr A's] mental state and risk, suggesting that some specific and careful liaison with family members was required. It is also clear that [Mrs A] could have provided more information about his past and recent mental state.
>
> …
>
> There were however clear indications that [Mr A] still felt unsafe, and that family members had asked for a longer stay on the ward. There is no indication of how these concerns were perceived or dealt with within the clinical team. Given that there were concerns about safety, I would have expected the consultant psychiatrist to satisfy himself that these had been adequately discussed and dealt with, either by himself personally or by other members of the team."

My advisor commented that it "may have been wise" for you to have taken more careful steps to ascertain that the relevant information had been systematically gathered, rather than assuming that the actions of various nursing staff had met this goal.

In response to my provisional opinion, you submitted that the consultation with Mr A's family was adequate in the circumstances.

In his further report, Dr Judson commented that the psychiatrist, as the lead clinician in the clinical team, is primarily responsible for ensuring that adequate consultation occurs. He stated:

> "Overall, it is clear that the level and quality of consultation with the family was not as good as it should have been. [Dr B] must take some degree of responsibility for this, but it was perfectly reasonable on his part to assume that the other members of the clinical team were carrying out their duties appropriately, and for

him to rely on the accuracy of the information he received and understood to have been conveyed to and from the family."

Conclusion
I accept that the responsibility for gathering relevant information from Mr A's family was, of necessity, undertaken jointly by members of the multi-disciplinary team. It was your individual responsibility to make a careful assessment as to whether adequate consultation with the family had occurred to ensure your clinical decision-making process was appropriately informed. I endorse my advisor's comments, and consider that more thorough consultation with family members was warranted during the course of Mr A's admission, and should have occurred at your direction. However, because of the difficulties in knowing exactly what consultation occurred, and the shared responsibility for consultation between team members, I do not hold you individually accountable for the deficiencies my advisor has identified.

Accordingly, I have decided to take no further action concerning this aspect of Mrs A's complaint. However, I trust that you will reflect on whether your judgement that other members of the clinical team had adequately consulted with Mr A's family was correct. I have also asked the Board to review current practice, and to take steps to ensure that current staff members are aware of their responsibilities with regard to consultation.

Consultation with family concerning leave
You explained that the decision to grant Mr A home leave was made on Day 5 at the multi-disciplinary team meeting, where information from Mr A and his family was discussed. You stated:

"The initial plan on [Day 4] was to discharge [Mr A] on [Day 5], but after the concerns raised by the family and at [Mr A's] request, it was decided at the Multi-Disciplinary team meeting to place [Mr A] on leave […]."

On the day of planned leave Mr A was collected by his son, Mr F. Mr A and his son were informed by staff nurse Ms E that Mr A was able to return to the ward at any time, and a discharge meeting was scheduled for the following week. Ms E advised me that, "it was left for [Mr A] and his son to inform [Mrs A]".

My advisor considered that the decision to grant [Mr A] home leave was appropriate as there were no indications that [Mr A] was suicidal or required further hospital treatment. However, Dr Judson considered that it was your responsibility to ensure that [Mr A's] family was involved in the decision to grant leave. He stated:

"It is clear that the family, particularly his wife, had some very real concerns about his state of mind and his safety. In my view there should have been an explicit and documented meeting with his wife and other relevant family members before he was placed on leave, to discuss the level of risk and appropriate safety and monitoring plans when he was at home. This should include, for example, whether it was necessary for someone to remain in the house with him, or whether it was considered safe to leave him on his own; whether any particular steps should be taken to look after his medication.

…

It would have been wise to have planned a much closer monitoring of his safety by family members, at least until it was clear that the 'turmoil' was resolving once he was discharged from the artificial safety of the ward and back in the same stressful home environment in which he had become so distressed as to attempt suicide.

…

The *Guidelines on The Assessment and Management of People At Risk of Suicide*, issued by the Ministry of Health, 2003, contain explicit guidelines for assessment and management, including criteria for admission, and liaison with families. The assessment and management of this case was largely in accord with these guidelines, with the probable exception of the issues of liaison with family. The guidelines suggest that clinicians should:

'Consider safety issues in the home environment and ensure family are aware of the risks' and *'Involve family in discharge planning'.*

Neither of these appear to have occurred."

My advisor considered that the multi-disciplinary team meeting held on Day 5 was constituted in a manner that placed "the decision making burden firmly on the psychiatrist". Dr Judson considered that there was little difference between granting Mr A home leave and discharging him. He stated:

"… in practice, [Mr A] had been discharged, albeit with the option of returning if he felt he needed to — the involvement of family in the discharge planning process should have occurred before the 'leave' at home.

As noted above, this liaison is not necessarily the responsibility of the psychiatrist, but, <u>while it may not have changed the ultimate outcome</u>, it should have occurred, and it is ultimately the responsibility of the psychiatrist to ensure that it was done."

In response to my provisional opinion you submitted that it was reasonable to grant Mr A home leave prior to having a formal discharge meeting. You consider that there was no reason to hold a family meeting as no concern had been expressed by the family about the decision to grant home leave, and there were no indications that Mr A was suicidal.

Dr Judson's further report reiterated that there should have been a documented meeting with Mrs A and other family members, before Mr A was placed on home leave. He emphasised that the period following discharge from in-patient care is well recognised as being high risk. He stated:

"The purpose of such a meeting would be threefold:

- to check that the clinical team were aware of all relevant information
- to ensure that family members were able to communicate any issues and problems to clinicians

- to ensure that information about potential risk, observation and management was clearly communicated to, and understood by, members of the family."

My advisor also considered that it would have been wise to arrange further psychiatric assessment, to properly exclude the possibility of any unresolved depression, once the immediate stressors in Mr A's life had been resolved. However, Dr Judson was of the view that you could not have predicted Mr A's suicide.

Conclusion
Under Right 4(2) of the Code of Health and Disability Services Consumers' Rights, Mr A had the right to services that complied with legal, professional, ethical, and other relevant standards. I consider that the *Guidelines on The Assessment and Management of People At Risk of Suicide*, Ministry of Health, 2003, are a relevant standard for the purposes of Right 4(2).

You advised that, due to the concerns about Mr A's condition on Day 4, the decision was made to grant him home leave, rather than to discharge him. However, I consider that it was unwise to proceed with this course of action without specifically consulting Mr A's family about the proposed plan, and about any possible safety issues in the home environment. I do not consider that a family meeting needs to be held in all cases. However, in this instance, there was a strong undercurrent of feelings of concern for Mr A's safety, together with limited consultation with his family (in particular, with Mrs A). I agree with Dr Judson that, from the patient's perspective, the distinction between leave and discharge is relatively negligible, and note that the period immediately following in-patient care is regarded as being one of particularly high risk.

While there was some discussion between nursing staff and Mr F when Mr A was collected from the ward, meaningful consultation with the family, ideally in the form of a family meeting, should have occurred at your direction prior to making the decision to grant Mr A home leave.

Accordingly, having carefully considered the issues Mrs A has raised, the information gathered to date, and Dr Judson's advice, my view is that you breached Right 4(2) the Code of Health and Disability Services Consumers' Rights, by giving insufficient consideration to safety issues in the home environment and not involving Mr A's family in the discharge planning process.

The District Health Board — vicarious liability
Under section 72(2) of the Health and Disability Commissioner Act 1994 employers may be vicariously liable of any breach of the Code by an employee. Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing, or omitting to do, that which breached the Code.

In my view, the inadequate consultation with Mr A's family about his proposed treatment plan was a matter of individual error of judgement. Overall, I am satisfied that the Board had appropriate policies in place that required consultation and meaningful involvement of the family with significant clinical decisions. However, I have asked the Board to review current practice and aspects of their current policy.

Accordingly, my decision is that the Board is not vicariously liable for your breach of the Code.

Recommendations
I recommend that you take the following actions:

- Review your practice in light of my opinion. Please write to me informing me of what will be different in your practice following this review and what support you will use to ensure there is a change in your practice.
- Apologise to Mrs A for your breach of the Code. The apology is to be sent to this Office and will be forwarded to Mrs A.

An anonymised copy of this letter (together with Dr Judson's reports) will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Please advise my Office by **14 April 2006** that the recommendations have been met. The file will then be closed.

Yours sincerely

Ron Paterson
Health and Disability Commissioner

cc: The District Health Board
Mrs A
Medical Council of New Zealand

Enc. Copy of expert advice

Expert advice from consultant psychiatrist Dr Nick Judson:

[Mr A] (dec)
[Date of birth]
[Date of death]

You have asked me to provide independent expert advice about whether psychiatrist [Dr B] and [the District Health Board] provided an appropriate standard of care to [Mr A].

[Mr A], a 62 year old […], was admitted to [the public hospital] on [Day 1] after he was found collapsed at home due to a deliberate overdose of medication. Following assessment by the mental health team, he was admitted to the psychiatric unit, assessed by nursing staff and psychiatrist [Dr B], and was placed on leave [on Day 5]. [Mr A committed suicide the following day].

…

Information on which this report is based

I have been provided with extensive information including:

- Letter dated 10 January 2004, with enclosures including further complaint information and relevant medical records, from [Mrs A] to the Commissioner, marked 'A' (pages 01–230).
- Investigation letter to [Mrs A] dated 23 July 2004, marked 'B' (pages 231-233)
- Letters with attachments from [Dr B] to the Commissioner dated 1 September and 14 December 2004, marked 'C' (pages 224–325).
- Letters with attachments from [the District Health Board] to the Commissioner dated 19 August 2004 and 21 January 2005, marked 'D' (pages 326–602).
- Letters to the Commissioner from nurse [Ms D] dated 8 September 2004 and12 February 2005, marked 'E' (pages 603–691).
- Letters to the Commissioner from nurse [Mr C] dated 7 September 2004 and 25 January 2005 'F' (pages 692–708).
- Letters to the Commissioner from nurses [Mr G] dated 14 December 2004 and [Ms E] dated 17 December 2004, marked 'G' (pages 709–719).
- Letter to the Commissioner from [the District Health Board] dated 2 May 2005, marked 'H' (pages 720–730).

Included in this material is:
- Copies of the recent [District Health] medical records:
  Accident and emergency dept;
  Medical assessment;
  [Crisis] team assessment;
  Records [from the psychiatric unit].

- Previous records from:
  [The DHB] Mental Health 1991–2 and 1999;
  [A second public hospital];
  [A private psychiatric clinic]

- Various clinical and organisational guidelines and protocols

…

HISTORICAL INFORMATION

[Mr A] had a family history of alcohol problems (2 Brothers) [Mrs A advised that Mr A had two uncles with a history of drinking two flagons of beer a day] and suicide (Grandfather).

He had been noted to have an anxious, obsessional personality, prone to depression.
In 1970s (?date) he had an episode of depression in [a city], treated with medication.
In approx 1978, he had a depressive episode, and was off work for 3 weeks.

In July–Oct 1981, he had admissions to […] for depression, treated with antidepressants Amitriptyline and Mianserin.

In Oct 1981, he was admitted to [a private hospital] for depression, and treated with the antidepressant Dothiepin ([…]).

In March 1988, he was admitted to [the second public hospital] for alcohol abuse. [The assessing psychiatrist] noted a 10 year history of Bipolar affective disorder, treated with Lithium and Clomipramine.

In Oct–Nov 1991, he had an admission to [the public hospital] with an episode of depression, treated with Lithium, Fluoxetine, and Buspirone. He appears to have received psychiatric follow up to 1993, then was managed by his GP.

In September 1999, he had a one-off assessment by psychiatrist (name illegible) for 'anxious depression'. At that stage he was receiving treatment with Citalopram (antidepressant) and Lorazepam (minor tranquilliser).

HISTORY OF EVENTS

(Compiled from contemporaneous hospital records with additional information from later written accounts)

ADMISSION TO EMERGENCY DEPARTMENT

[Day 1] 1730 Admitted to Emergency Department
[Mr A] was found by his wife [Mrs A clarified that Mr A was found by his nephew] collapsed on the bedroom floor, semi-conscious. It was suspected that [Mr A] had taken 8 Lorazepam tablets. Notes indicate information from wife and son that he had a history of depression in 1981 and 1991, and alcohol abuse 1988. Recent family stressors were noted.

Contacts recorded on Admission Form, with contact details:
1) [Mrs A] (wife)
2) [Mr F and Mr F's wife] (son and daughter in law)

Admission form was signed by '[…]'

[Day 1] 2220 House Surgeon admission note:
Taken citalopram 6 tabs, ?other meds.
Information from wife — 'had depression for years'
Noted 'ex-drinker — heavy'
Medication: Citalopram 20mg, Amitriptyline 50mg, Imovane 7.5mg, Losec and ?Etoricoxb trial medication (arthritis)
Drowsy, but able to follow simple commands
Assessment: Overdose, suicidal, depressed.
Plan: Observation, ECG, and 'check his safety, though he said he will not do it again'

[Day 2] Ward round [a doctor]
Overdose of Diazepam noted. Low in mood. ECG normal. Observations stable.
'Psychiatry team to review'.

[Day 2] medical note (After review by [crisis] team):
'Can go home from medical point of view'
Awaiting decision from [crisis team] re psychiatric admission

REFERRAL TO PSYCHIATRIC SERVICE

[Day 2] 0810
[A nurse] Recorded on Referral/Contact Form
Phone call from [a friend] to [the ward]. Concerned regarding [Mr A], stated that he had been depressed for the past 2 months and had been to the GP. He had told [the friend on Day 1] 'that he couldn't carry on, that he wanted to end it all.' She had been unable to contact him this morning. She was ringing to see if he was on the ward. When pressed for further details she was reluctant to give these and said she would contact his sister.
Plan — Information passed to [crisis team].

[Day 2] 0850
[Mr C] [crisis team] received a phone call from the medical ward requesting a mental health consult.

[CRISIS TEAM] ASSESSMENT

[Day 2] 1100
[Mr C] visited [Mr A] on the medical ward. Notes of the initial assessment included the following (recorded as brief handwritten notes on medical file and a 3 page typed assessment):

[Mr A] stated he had taken an overdose of 20 Diazepam, 20 Imovane tablets and an unknown quantity of Citalopram. At the time, his stated intention had been to die. Precipitating factors appear to be related to

- relationship ambivalence (wife/mistress) — family not aware of this relationship.
- financial stressors: $4500 debt, from gambling on horses and had experienced poor returns from his work
- guilty feelings re: having mistress.

Noted that [Mr A's] son described the marital relationship as poor.
Noted a past history of alcohol abuse — reported that when not working he drinks a couple of jugs of beer a day, and episodes of drinking to blackout. Also noted a past history of depression with admission 10 yrs ago, and a recent change to Citalopram.
Noted that [Mr A] denied suicidal ideation or intent at interview. A range of affect, generally 'downcast'. Following the o/d he feels 'people in his life value him'.
On enquiry, reported that he sleeps well with Imovane, and that he had experienced some weight loss which he had attributed to his new medication regime for arthritis.

[Mr C] noted historical and current risk factors including

- past history (20yrs ago) of serious contemplation of suicide
- 'a degree of instability' in his current relationship
- 'he may have symptoms of major depression'
- employment problems, financial stressors, and a degree of ongoing pain.

He noted that [Mr A] was 'seeking treatment and the opportunity to make some progress, however he remains at some degree of risk due to … stressors'. He noted that speaking to 'family members' after the interview they wished to see him admitted to [the psychiatric unit].

[Mr C] noted the following suggestions given to [Mr A]:

a) Budget advice re debts
b) Counsellor re relationship issues
c) Given [crisis team] phone number in case of future crisis
d) To review medication with GP, who will refer to psychiatric services as required

He also noted that he would discuss the assessment with the psychiatrist.

[Mr C] recorded that after discussion with the On-Call Psychiatrist ([Dr B]) a short admission was offered and accepted on a voluntary basis. He also noted that [Mrs A] was informed that [Mr A] would be admitted to [the ward], and that she would visit 1700-1730 that day.

Details of information given to/ discussion with the Family were not recorded. ([Mr C] describes in his response an interview with [Mr A's son], daughter-in-law, and daughter, [Mrs A advised that she does not have a daughter] in which they expressed a very high level of concern, and in which they had indicated a much more extensive history of mental health problems than he had obtained from the patient, including a suggestion of previous suicide attempts. [Mr C] recalls that it was this disparity between his initial assessment and the information he had obtained from the family that indicated the need for admission. Although he did not detail this in written notes, he recalls specifically discussing this with [Dr B], as well as verbally handing this information on to ward staff.)

[Day 2] 'mid afternoon' [Mrs A]
[Mrs A] spoke to [Mr C] on the phone. She recalls offering to meet [Mr C], and offering information about previous history. ([Mr C] declined this offer — he recalls this was because he was now handing [Mr A's] care to the ward team and therefore it would now be their responsibility to liaise with [Mrs A].)

INPATIENT SERVICE

Admitted to [the ward] [Day 2] at 16.45
Admission check list records [a student nurse] and [Ms D] (EN) as Key Nurse.

Clinical Assessment was completed by [Ms D] and [the student nurse]:
Presenting issues noted as:

- overdose of diazepam, imovane and citalopram, related to relationship instability/ financial issues
- low mood

Social situation recorded — lives with his wife in [a town …].
Past history noted — Admission to [the psychiatric unit] 10 yrs ago for depression; treated in the past for alcohol abuse.
Current medical problem of arthritis noted, and list of current medications.
Weight loss noted over last 7 weeks (not quantified).

Mental state examination findings included:
Lacking facial expression and mood flat, but 'warms on interaction'
Fully alert and orientated, no noticeable memory problems
Insight intact and 'has drawn appropriate conclusions about his action'.

Risk Assessment completed by [Ms D] and [the student nurse]. They noted:
— Previous suicidal thoughts but never acted
— Alcohol abuse
— ? Depression
— Past admission to psych ward
— Complacency
— Active symptoms of major mental illness — o/d 1 day ago
— Impulsivity due to relationship issues
— Recent change in medication
— Patient remorseful and has no plans for suicide
— Current relationship instability

— Lack of personal support (?) — supportive wife and significant other
— Stress — financial worries and marriage

Summary of risk stated as '62 yr old male who is keen to engage with N/S but often remains expressionless. Due to recent o/d, patient is prone to impulsivity'
Level of risk was rated as: *Probability* — Remote/Unlikely; Severity — Fatal; giving an overall risk level of 'Medium'.

Management plan recorded as follows:
- Med(ication)s as charted
- Engage in strengths model
- Build rapport and know patient's whereabouts
- To be seen by [Dr B] in the morning

[Day 2] approx 1715 [Mrs A]
Visited by [Mrs A] for approx 30 minutes

[Day 2] [Ms D] and [a student nurse] — Progress notes:
Noted the following: To have no leave until seen by [Dr B], orientated to [the ward] and strengths information which he seems interested in. Wife had been in to visit, and sister phoned to speak to him. Patient has stated he has no further plans to harm self, and is remorseful of his OD yesterday. Mood remains flat but he warms when talking about [one of his hobbies]. Has eaten tea and watched TV.

[Day 2] 2200 [Ms D] —Progress notes:
Talking to family and friends on phone he told Nursing Staff that he felt 'great support from these calls'.

[Day 3] 0620 [a nurse] — Progress notes:
Noted he had slept all night.

[Day 3] approx 0915 [Mrs A]
[Mrs A] visited. They talked about some of his worries

[Day 3] 1335 [Ms E] — Progress Notes:
Noted he had spent all day quietly reading the newspaper, visited by wife and son. Went to appointment with [a rheumatologist] with wife. Noted mood low, feeling embarrassed and guilty by his actions. Noted he had let his wife know that morning of his extra-marital affair. Both appropriately upset. Anxious and agitated for periods of time during the day. Also noted that [Mr A] had requested to go to his son's, to watch [a major horse-racing even]. Encouraged to stay on the ward and watch it with son.

[Day 3] Seen by [Dr B] — time not recorded — apparently during the afternoon.
Diagnosis: Axis I Alcohol abuse (in remission).
Axis II No diagnosis recorded.
Axis III Overdose. Arthritis of hips.
Axis IV Marital conflict and financial stress.

[Dr B] noted the presenting problem, that he had taken an overdose on [Day 1], depressed, found unresponsive by relatives. Noted that he had taken some citalopram, 120mg., and ?diazepam. He noted the patient had mentioned his having had an extra-marital affair and financial stress. He also noted he had been seen as stable but the family told [the crisis team] they had concern for the patient's safety and he was offered a voluntary admission to the ward.

He noted past psychiatric history as 'Wife said patient had had depression for years'.
Medical history reported as arthritis of hips.
No note under the heading for 'family'.

Personal information — […], lived with his wife and had a son over forty. [Mr A has two sons].
Also noted that he had problems with alcohol — 'ex drinker, heavy'.

He noted his examination, that he had been seen with nursing staff. He noted that the patient had confirmed these details and understood he was a voluntary patient. He said he had now told his wife and son about the extra marital affair. He had had the affair for seven years and this was not the first one. He had suspected his wife knew about the affair as he had been careless and had been a bad liar. When he told his wife she admitted she had had her suspicions, both wife and son had been supportive.

Mental state was recorded as follows: 'Middle aged man, fully conscious, nothing to suggest a delirium. Normal vocabulary and syntax. Initially relaxed, then began to sniff and attempted to cry. He said he was depressed but had been non compliant with Cipramil. He offered no vegetative symptoms of depression and made no mention of thoughts of DSH (*deliberate self harm*). No psychotic symptoms. Average intelligence, good insight and judgement.'

[Dr B] recorded his assessment as follows: 'No mental illness. A middle aged man who has probably got a significant alcohol problem with increased LFT, increased MCV and who had multiple extra marital affairs.'

He recorded the following plan:
'1 He agrees to stay in the ward overnight and be assessed tomorrow.
2 Meds as boarded.
3 He will be referred to relationship counselling.
4 A referral to A & D services will be offered.
5 Psych follow up not indicated.'

[Day 3] approx 1715 [Mrs A]
[Mrs A] visited after work. She also noted that [Mr F and his wife] had both visited during the day.

[Day 3] 2030 [Ms D] — Progress notes
Noted he had spent time watching TV. Had requested medication for anxiety but no PRN had been charted so 'encouraged to explore other ways of decreasing anxiety' such as reading and shower. Would not engage in any activities and decided to rest on his bed. Able to concentrate on TV for up to half an hour. Had numerous phone calls from family. Declined to have tea, citing a 'crook gut'.
Also noted he had been seen by [Dr B] that afternoon.

[Day 4] 0630 [A nurse] — Progress note
Noted he had slept until 0200 but unable to sleep after that. Reassured by nurse.

[Day 4] No time recorded. [Dr B] — progress notes
Seen with nursing staff. Noted 'looks relaxed, pleasant attitude', 'Nothing to suggest a depression'. Discussed follow up plans:
a) Marital counselling
b) Personal counselling
c) A & D referral
d) GP follow up.
Also noted that patient complained of feeling a little dizzy and was not sleeping well.
[Dr B] noted he was given reassurance and noted the following plan.
'1 Discharge tomorrow. Patient was told this information.
2 No psychiatric follow-up. He would be seen by his GP.
3 Nursing staff to refer to A&D Services. Patient has accepted this referral.
4 Patient will decide on personal and marital counselling.
5 [The rheumatologist] has requested a discharge summary.'

[Day 4] approx 0915 [Mrs A]
[Mrs A] visited. [Mr A] told her he was being discharged the next day. (She later described him as being worried, 'in crisis', and feeling not ready to come home.)

[Day 4] 1400 [Ms E] — Progress Notes
Noted A&D (*alcohol and drug counselling*) referral sent.
Noted patient feeling 'not OK' this morning, and anxious and unable to concentrate. He noted that the patient had sought re-explanation of discussion with [Dr B] and noted that he was 'not happy about being discharged tomorrow', 'feels unsafe on his own' and 'may be tempted to do something'. Noted the son had visited.

[Ms E] noted she spoke to [Mr A's] son — he was concerned by his father's condition and 'wanting his father to stay another day as needing to organise family things'.

[Day 4] approx 1730 [Mrs A]
Conversation between [Mrs A] and [Ms D]. No documentation of this conversation in clinical file. (There is a clear difference between the recollections of [Mrs A] and [Ms D] as to what was said during this conversation. [Mrs A] recalls telling the nurse that [Mr A] was not safe to come home, and asking for him to stay in a few more days; also giving information about his past psychiatric history. [Mrs A] recalls that she asked for her concerns to be noted.)

[Day 4] 2045 [Ms D] — Progress Notes:
Noted – Visited by wife, 'Strengths and WRAP assessment begun by patient'. Mood low and lifted since beginning of shift. Noted he planned to return to his wife on discharge.

[Day 5] 0600 S/N ?name — Progress notes:
'Quite restless in bed' and 'Didn't indicate non-sleeping'.

[Day 5] no time recorded
[Dr B] noted that [Mr A] would be allowed to go on leave […]. Staff were to book a discharge meeting for the next week. Family to be invited to the meeting.
[Dr B] noted he had seen [Mr A] with nursing staff while he was having breakfast.
Noted that:
— He looked relaxed, nothing to suggest a depression.
— Discussed his script and discharge meeting for next week.
— Told the patient that he could invite his family/friends.
— He mentioned going home with his wife.
— 'He made no mention of thoughts of DSH' (deliberate self harm).

Assessment: 'No mental illness, Social Crisis'.
Plan: 'Patient [to go] on leave. He has a script.'

[First day of leave] approx 1030 [Mrs A]
[Mr A] was picked up from hospital by his son, [Mr F]. There was a conversation between [Mr F] and [Ms E], but no documentation of this conversation in the clinical file.

[First day of leave] 1330 [Ms E] — Progress notes:
Noted that [Mr A] was on leave until discharge/family meeting the following [week]. Also noted he had appropriate medication.

Medication
Citalopram 20 mg mane — one month supply.
Imovane 7.5 mg nocte — one month supply
Amitriptyline 50 mg nocte —close control dispense weekly.
Omeprazole 20 mg mane —one month supply

[Dr B] completed a handwritten discharge summary dated […], addressed to the GP […], with details of the presenting problems, diagnosis, investigations and results, management, discharge medications, and referrals made. Follow up arrangements are listed as 'nil'— no mention of the leave, and the planned family meeting.

SUBSEQUENT EVENTS

(The next note in the clinical file was on the following day […] at 1135 recording a phone call from 'a very distressed woman' informing staff that [Mr A] was dead.)

[First day of leave] [Mrs A]
[Mr A] spent the rest of the day with his son and returned home to [Mrs A] later that evening. He didn't want to eat dinner. Talked about problems. Went to sleep at approx 10pm. Good night's sleep.

[Second day of leave] [Mrs A]
[Mr A] was awake early, showered, breakfasted, put washing on, made wife's breakfast. [Mrs A] went into work for an hour, intended to return by 1000. [Mr A] did not give any indication for concern.

[Mr F] phoned him at approx 0900. [Mrs A] phoned him at approx 0930.

At approximately 1010 [Mrs A] arrived home to discover [Mr A] had committed suicide […].

OPINION

[DR B]

1. ***Was [Dr B's] decision to admit [Mr A] to [the psychiatric unit] as a voluntary patient appropriate?***

Given the apparently serious intent (albeit low lethality) of the suicide attempt, the unstable social situation, the uncertainty about [Mr A's] state of mind, together with the strongly expressed concerns from the family, admission to hospital for a period of assessment was clearly indicated, and appropriate.

[Mr A] was evidently willing to stay in hospital, so there was no need to consider the use of the Mental Health Act.

2. ***Was [Dr B's] view in relation to the seriousness of [Mr A's] suicide attempt appropriate?***

The view of [Dr B] in relation to the seriousness of [Mr A's] suicide attempt is not recorded. [Dr B] appears to have accepted, not unreasonably, [Mr A's] expressions of regret for his action, and had clearly formed the view that the action had been in response to the pressures of his unresolved social stressors, a situation that had now been exposed and was starting to be dealt with. This was not an unreasonable assessment.

[Dr B] noted that [Mr A] did not express any thoughts of further deliberate self harm, but it is not clear whether he specifically asked [Mr A] about any such thoughts.

3. ***Do you consider that [Dr B] took adequate steps to sufficiently inform himself of [Mr A's] relevant patient history, including any relevant information from family members?***

There was good information readily available from both past records at [the psychiatric unit] and from [Mr A's] wife. Responsibility for accessing past records appears to have rested with the administration staff (see below for comment).

In my opinion, it would have been wise of [Dr B] to have made some further inquiries about the past history, either from records or from [Mr A's] wife. Information about the previous assessments and contacts with mental health professionals may well have raised suspicion about the possibility of an underlying depression. Having said this, [Dr B] was clearly aware of the fact that [Mr A] had had past treatment for depression, and for alcohol problems, and had no doubt taken this into account when assessing him as not being depressed at the time of his examination.

4. Was [Dr B's] assessment/diagnosis and recommended treatment of [Mr A] on [Day 4 and Day 5] appropriate?

[Dr B] very carefully documented his assessments, diagnosis and treatment plans on 3 separate occasions during the period [Mr A] was in hospital. The assessments of [Mr A] himself appear to be thorough, and adequately documented, but as noted above were not as fully informed as they could have been regarding details of his past history.

[Dr B] appears to have very quickly discounted the possibility of depression. It is not entirely clear why he came to this conclusion, as he does not document any reasoning for this exclusion. (This is not to say that he was necessarily incorrect, but rather that the rationale for making such a crucial diagnostic judgement should have been documented in more detail.)

There were a number of factors that raised the possibility of a depression, and this possibility had been noted by [Mr C]: In addition to the suicide attempt, there was a past history of depressive illness as well as alcohol abuse, a documented concern by [Mr A] and others that his mood had been low for at least 2 months, significant recent weight loss, and problems with sleep (though he was described as 'sleeping OK', this was only with the use of regular hypnotic drugs). [Dr B's] clinical notes do not explain why he considered these factors did not suggest the possibility of depression.

5. Did [Dr B] develop an appropriate management plan in relation to [Mr A]?

Given the conclusions from the assessment and diagnosis, there is nothing to suggest that the management plan was inappropriate.

6. Do you consider that [Dr B] took adequate steps to ensure [Mr A's] family were involved in the decisions made in relation to his care, or to consult with them?

[Dr B] was working in the context of a team of mental health professionals, and relied on information from other members of the team, or at least from nursing staff, about their contact with [Mr A's] family. This is not unreasonable. It is not necessary, or indeed practicable, for a busy consultant psychiatrist to interview family members of every patient under their care. It is up to the psychiatrist to judge when this is necessary, either from the point of view of ensuring that the information gathered is accurate, or because there is some conflict or tension that requires the intervention of the psychiatrist rather than other disciplines.

In this case, it is clear from [Mr C's] account that there were some very strongly held feelings within the family concerning [Mr A's] mental state and risk, suggesting that

some specific and careful liaison with family members was required. It is also clear that [Mrs A] could have provided more information about his past and recent mental state. It may have been wise for [Dr B] to have taken more careful steps to ascertain that this information had been systematically gathered, and adequate steps taken to discuss the family concerns, rather then assume that the contact with various nursing staff had achieved this goal.

7. Do you consider that [Dr B] gave sufficient consideration to the documented concerns expressed by [Mr A] and his family members in relation to his proposed discharge/leave?

The concerns that were documented were much less serious than the concerns that were set out by [Mrs A] after the event, and than suggested by [Mr C's] response to your enquiries. There were however clear indications that Mr A still felt unsafe, and that family members had asked for a longer stay on the ward. There is no indication of how these concerns were perceived or dealt with within the clinical team. Given that there were concerns about safety, I would have expected the consultant psychiatrist to satisfy himself that these had been adequately discussed and dealt with, either by himself personally or by other members of the team.

8. Did [Dr B] utilise the multi-disciplinary team appropriately?

Although there are references to the multidisciplinary team in the records, there is no indication in the records of any discipline other than nursing and medical professionals being involved in this case. The information provided by […] describes the composition of the multidisciplinary team in this case, as follows:

Consultant Psychiatrist (chair)
Medical Officer
Key workers, community psychiatric services, x3
Community support workers, x2
Maori mental health worker
Clinical leader, community psychiatric team
Lead nurse, inpatient unit

Which suggests that, in practice, the only members of the MDT who would have been able to make any contribution to the decision based on their own knowledge of [Mr A] would have been the psychiatrist and the lead nurse — thus placing the decision making burden firmly on the psychiatrist. As noted by [Dr B], the psychiatrist must depend upon the assessment and observations of other members of the clinical team, and appears to have done so in this case.

9. Was the decision to grant [Mr A] home leave appropriate?

There was no indication that [Mr A] was either actively suicidal or suffering from an illness of such severity as to warrant further stay in hospital. A decision to grant [Mr A] leave at home appears to be quite appropriate.

However, there is no indication that the decision to send him back home had been adequately discussed with the family. It is clear that the family, particularly his wife,

had some very real concerns about his state of mind and his safety. In my view there should have been an explicit and documented meeting with his wife and other relevant family members before he was placed on leave, to discuss the level of risk and appropriate safety and monitoring plans when he was at home. This should include, for example, whether it was necessary for someone to remain in the house with him, or whether it was considered safe to leave him on his own; whether any particular steps should be taken to look after his medication.

There appears to have been an uncritical acceptance of [Mr A's] assurances that he no longer felt suicidal (although it was documented that he did not feel safe). It would have been wise to have planned a much closer monitoring of his safety by family members, at least until it was clear that the 'turmoil' was resolving once he was discharged from the artificial safety of the ward and back in the same stressful home environment in which he had become so distressed as to attempt suicide.
(See comments on protocols and guidelines below.)

10. Did [Dr B] develop an appropriate plan for future treatment options and follow-up care?

Given the exclusion of a diagnosis of depression, the plans for future treatment options were reasonable. As noted earlier, I have some concerns that the possibility of a depression was so readily discounted. In the light of [Mr A's] long history of depression, and the continuing stressors (all of which are known to predispose to depression) it would have been in my view wise to have planned further psychiatric assessment.

11. What level of responsibility should be attributed to [Dr B] concerning [Mr A's] care, in light of his comment that he worked in a multi-disciplinary team?

The consultant psychiatrist is the senior clinician within the multidisciplinary team, and carried the ultimate decision about admission, discharge, and the overall direction of treatment. Each member of the team is responsible for carrying out their own role to an adequate standard of professional practice. The psychiatrist has the role of making the diagnosis, based on his own assessment and information from the others in the team, and for determining the treatment plan, which may then be delegated to others to carry out.

[Dr B] was therefore responsible for:

- Decision to admit to hospital
- Decision to discharge, or to place on leave
- Diagnosis, overall treatment plan, and responsibility for prescription of medication
- Overall assessment of risk, and safety requirements
- Follow-up plans

The stated policy of [the DHB] is in accordance with this view. As set out in the *Involving Families* policy:

'Overall clinical responsibility ultimately lies with the consultant psychiatrist who will determine —

Who is admitted to the service
Establishing a diagnosis
Treatment plans and implementation
Who is the key worker
That appropriate consultation has occurred with the family/whanau
Who is discharged from the service.'

(Though I would comment that in my experience it would be unusual to expect the consultant psychiatrist to be responsible for the allocation of a key worker.)

12. What further actions, if any, should [Dr B] have taken with regards to [Mr A's] care?

As noted above, it would have been appropriate to have ensured that there was an explicit discussion with the family members about risk issues, and the level of care and observation required while on leave. I consider that it would have also been wise to have planned a further psychiatric assessment to properly exclude the possibility of any unresolved depression once the immediate stressors had been resolved.

13. Do you consider [Dr B] discharged his responsibilities in accordance with the relevant polices and procedures?

In general terms, yes.

The *Guidelines on The Assessment and Management of People At Risk of Suicide*, issued by the Ministry of Health, 2003, contain explicit guidelines for assessment and management, including criteria for admission, and liaison with families. The assessment and management of this case was largely in accord with these guidelines, with the probable exception of the issues of liaison with family. The guidelines suggest that clinicians should:

'Consider safety issues in the home environment and ensure family are aware of the risks' and *'Involve family in discharge planning'*.

Neither of these appear to have occurred. It could be argued that in view of the clinical assessment that [Mr A] was no longer considered to be suicidal, the safety issues at home were no longer considered to be an issue. Nevertheless there should have been an explicit discussion or explanation of this. It may also be argued that as [Mr A] had not yet been discharged, the family were to be involved in the discharge planning through the meeting that had been scheduled for the following week. This would be a naïve view — in practice, [Mr A] had been discharged, albeit with the option of returning if he felt he needed to —the involvement of family in the discharge planning process should have occurred before the 'leave' at home.

As noted above, this liaison is not necessarily the responsibility of the psychiatrist, but, <u>while it may not have changed the ultimate outcome</u>, it should have occurred, and it is ultimately the responsibility of the psychiatrist to ensure that it was done.

[THE] DISTRICT HEALTH BOARD

1. ***Was it appropriate for an enrolled nurse to be appointed as [Mr A's] key worker?***

An Enrolled Nurse generally works under the direct supervision of a registered nurse, and it would therefore be unusual for an Enrolled Nurse to be allocated as key worker in current psychiatric practice. In my view, it is more important to consider the specific skills and experience of the particular staff member when assigning such a role. The information supplied regarding [Ms D] suggests that she had considerable experience in mental heath nursing.

The policies of [the DHB] are however explicit in this regard. The psychiatric services job description and the Acute Inpatient Services — Service Provision Framework both state that an Enrolled Nurse cannot be a key worker. Given this policy, it was therefore not appropriate for an enrolled nurse to be appointed as [Mr A's] key worker.

2. ***Was it appropriate for [Mr C] to undertake [Mr A's] initial assessment?***

Yes. [Mr C] was the [crisis team] nurse on duty for acute referrals. It is part of the duties (both in terms of normal accepted practice and in terms of the policies of [the DHB]) for the nurse on the acute assessment team to undertake the initial assessment of a patient in a crisis situation, and to consult with the psychiatrist on duty about further intervention, as happened in this case. It is clear that [Mr C] has the requisite training and experience to undertake such assessments.

3. ***Was it appropriate for decisions to be made in relation to [Mr A's] leave at the multi-disciplinary team meeting on [Day 5]?***

Yes. The MDT meeting would be the usual place that such a decision should be made. This provides a forum where input and observation from all members of the team can be considered, though as indicated above, the final decision rests with the psychiatrist.

4. ***Was the multi-disciplinary team meeting appropriately formulated?***

The composition of the MDT has been set out above. The professional background of those described as 'key workers' is not clear.

In addition to medical and nursing staff, a multidisciplinary team in an acute mental health setting will normally include social work, occupational therapy, psychology and cultural staff, though in practice, not all disciplines are available to be employed or included in many acute services.

The MDT in this case does not appear to contain a full range of disciplines, and those that were present were largely from the community, and therefore do not appear to have been in any position to make an informed judgement about [Mr A's] care. As noted above, this effectively means that the responsibility rests more on the shoulders of the Consultant Psychiatrist than would be the case in a fully formulated team.

The inclusion of a member of the team who has specific responsibility for coordinating the liaison with the family — often a social worker – may have been helpful in the team. The problem appears to have been not that there was a lack of contact with the family, but there was no coordination of this — no systematic gathering and giving of information, or discussion of concerns and management plans.

5. ***Were [psychiatric unit] policies and procedures appropriate and were they adhered to?***

There are a number of policies that were particularly relevant in this case, including:

- Acute inpatient unit service provision framework
- Risk assessment policy
- Policy on management of suicidal clients
- 'Involving Families' policy
- Clinical record documentation standards
- [Crisis team] standards and processes.

The policies and procedures are, in general terms, appropriate, and were largely adhered to. I have commented above on some aspects in which the care may have not adhered to the policies:

Family consultation: This is an issue covered in a variety of policies.

The service provision framework states that the Key Worker should obtain information from the family, and should *'offer family members the opportunity to discuss concerns without the client present — within 48 hours of admission'*, and also requires documentation of family contact.

The policy on management of suicidal clients states that the *'carer must be advised about the level of supervision which the client requires'*.

The policy on assessment of risk states that *'Assessment of risk must include information from family members*' as well as information from past history.

The 'Involving Families' policy states that clinical staff should '*negotiate ways in which the family can participate in the recovery process' and 'ensure families are fully involved in the review process, eg acknowledge any family/whanau observations'*, and

The Clinical record documentation standards demand a *'record of the complete assessment, including the allegations of others regarding the client…'.*

As noted above, although there has been some consultation with the family, at no point is there a coordinated or explicit attempt to marshal the information and to discuss the concerns and options with family members. In addition, what consultation that did occur is not well documented — for example, [Mr C] in his response to your enquiries, details extensive discussions with family, and a remarkably high level of family concern; yet his notes are brief and low key, and do not by any means reflect the discussion he appears to have had. Similarly, the notes by [Ms D] of her

discussion with [Mrs A] on [Day 4] are very brief, and hardly document the conversation at all. Given such sparse documentation of the family contact (in contrast to other documentation, which is generally very thorough) it is difficult to draw firm conclusions about what did occur, but it does seem clear that the consultation was not really sufficient.

Access to past records

The service provision framework states that old notes should be obtained '*if appropriate'*, and responsibility for this (at the time) appears to have rested with the clerical staff. The policy does not state who judges the 'appropriateness' of obtaining the record. No-one in this case accessed past records — seemingly it was no one's responsibility to do so. It would be, in my opinion, advisable to obtain old records as a matter of course.

Any other aspects of the care provided to [Mr A] that warrant additional comment?

There was not surprisingly an emphasis on the social crisis, particularly the extramarital affair, as the main factor in [Mr A's] distress. While this was a very obvious and dramatic factor, it may be that there was too much emphasis on this, with other possible factors (such as depression) not being fully considered.

This fact that there was known to be a problem within the marital relationship may also have led staff to underplay the concerns of [Mr A's] wife, and, perhaps not deliberately, to involve her less in the planning and decision making than would have been the case had the marital relationship been unquestionably strong.

IN SUMMARY

[Mr A] presented in a Crisis in which a number of serious social and interpersonal stressors were identified. Following the overdose, there appeared to be at least some initial resolution of these issues. There was a strong indication that the immediate crisis had passed, and that further suicidal behaviour did not appear to be imminent. There was no indication for a prolonged hospital admission.

There are issues where criticism of the care can be made:

1. It is unclear why the possibility of depression was so readily discounted by [Dr B]. Despite some evidence alerting to this possibility, the emphasis was on the more obvious, immediate and dramatic social stressors. [Dr B's] clinical notes, while otherwise clear and detailed, do not explain the rationale for his exclusion of the diagnosis of depression.

2. Neither [Dr B] nor any other members of the clinical team appears to have accessed information about [Mr A's] previous mental health, which was readily available either from past records or from his wife. This information may have alerted to the possibility of more serious concerns about his mental health.

3. There appears to have been inadequate communication with family around the assessment, diagnosis, risk issues and safety management, prior to [Mr A] leaving the ward.

4. Although the general standard of the documentation in the clinical records is good, the documentation of conversations/ discussion with family members in this case is inadequate.

Finally it is important to note that even had all these matters been addressed to perfection, the ultimate outcome may well have been no different. It is clear that a number of experienced staff had all come to the same conclusion from their assessments of [Mr A] — that he regretted his suicide attempt, and no longer harboured any wish to self harm, and that the risk of further imminent suicidal behaviour appeared to be much reduced. Unfortunately, there is no reliable or objective test for suicidal intent, and very little way to prevent a determined suicide– assessment and management of a potentially at risk individual depends entirely upon a series of potentially fallible clinical observations and judgements.

Further Independent expert advice received from Dr Nick Judson, 21 February 2006

"Having read and considered the various submissions, my opinion on these issues is as follows:

1. The standard of care provided to [Mr A] by [Dr B], given the circumstances and resources available.

a) [Dr B's] diagnosis (including discounting depression);

I stated in my original opinion that it was not clear why Dr B had discounted the diagnosis of depression. Diagnosis is not an exact science. It is a complex judgement, made by weighing up a variety of information from the individual and other sources about current, recent and past events, as well as examination and observation of the individual. It is not possible to make a judgement as to whether [Dr B's] diagnostic opinion, that [Mr A] was not suffering from depression, was correct or not. The evaluation of the diagnosis at this stage is about the *process* of collecting and marshalling the information, how the various factors were considered, and how the diagnostic judgement was made. It is clear that [Dr B] utilized a variety of information that had been obtained about [Mr A], as well as observations of ward staff and his own examination. It was not unreasonable for [Dr B] to rely on the accuracy of the information that had been gathered by other members of the team. He was aware that [Mr A] had suffered from depression and alcohol problems in the past. Additional detail would have been available from old notes if they had been accessed.

With regard to the process of diagnosis, there are two aspects of [Dr B's] care that can be criticised:

(a) Though he was clearly aware that [Mr A] had suffered from depression in the past, and presumably took this into account when making his judgement, he did not access the readily available past records that would have contained

more detailed information. Given that this information was readily available, it should have been considered. In my opinion [Dr B's] practice in this regard was a ***moderate*** departure from accepted practice.

(b) He did not record the reasons for his opinion that he did not consider [Mr A] to be suffering from depression. Although the ideal standard is to record how the various factors that bear on the diagnostic decision have been weighed and why the conclusion is reached, in practice a clinician will not usually do so, unless he considers that there are particular difficulties or dilemmas that need to be recorded. In this regard therefore, my opinion is that [Dr B's] practice in this regard was no more than a ***minor*** departure from accepted practice.

[Mr A's] family raise the issue of why it was that [Dr B] continued to prescribe antidepressant drugs for [Mr A] when he did not consider him to be depressed. It is important here to be clear that [Dr B] did not make a decision to commence treatment with antidepressant drugs. He continued to prescribe the same medication that [Mr A] had been receiving from his GP prior to the admission. Given the judgement that the suicide attempt and admission had been the result of a particular situational crisis, rather than a depressive illness, the decision to continue with unchanged medication was an obvious and perfectly reasonable course of action. Antidepressant drugs are used principally for the treatment of depression, but are used also to treat dysthymia, that is, low mood that is not sufficiently serious to warrant a diagnosis of depression as well as for some anxiety disorders. They are also commonly used (with less justification) to assist with the management of symptoms in those who experience periods of low mood and distress as the result of difficulty coping with stressful circumstances. The fact, therefore that [Mr A] had been prescribed antidepressant treatment by his GP did not necessarily lead to a conclusion that he was suffering from a depressive illness. The combination of two antidepressants is however unusual, particularly for someone who is not considered to be suffering from depression. This is one of the reasons why I indicated in my original report that further psychiatric review may have been indicated, to assist and advise the GP about appropriate management.

b) The level of consultation with [Mr A's] family;

As stated in my original report, it is essential to ensure that there is good consultation with family members. As the lead clinician in the clinical team (that is, the clinician who makes the diagnostic assessment and is primarily responsible for the overall plan of management) the psychiatrist should ensure that adequate consultation occurs as part of both the process of information gathering and the subsequent management of the patient. This is not to say that the psychiatrist must necessarily be the one who personally meets with and talks with the family members. To what extent the psychiatrist needs to, or is able to, carry out this task in person is a matter of judgement based on the complexity of the case, any specific clinical issues that require clarification, the expertise and skills of other members of the clinical team, and the available resources and competing demands on the psychiatrist's time.

Overall, it is clear that the level and quality of consultation with the family was not as good as it should have been. [Dr B] must take some degree of responsibility for this,

but it was perfectly reasonable on his part to assume that the other members of the clinical team were carrying out their duties appropriately, and for him to rely on the accuracy of the information he received and understood to have been conveyed to and from the family.

In this regard I consider [Dr B's] practice to have fallen below an acceptable standard to an extent that is not more than ***minor***.

c) Granting [Mr A] home leave without a family meeting;

The transition from being an inpatient in hospital, with 24 hour professional monitoring and care, to being at home, where there is no 24 hour monitoring, and no professional care, is a very significant transition point. The period immediately following discharge from inpatient care is well recognised as being of the most 'risky' points in the management of any patient.

In practice terms, the critical step is from being in hospital as an inpatient to being 'on leave' at home. The transition from 'leave' to 'discharge' is in many ways a paper exercise that is much less of a transition point.

It was clearly appropriate to convene a family meeting, and a meeting was, of course, planned. The purpose of such a meeting would be threefold:

- to check that the clinical team was aware of all relevant information
- to ensure that family members were able to communicate any issues and problems to clinicians
- to ensure that information about potential risk, observation and management was clearly communicated to, and understood by, members of the family.

The most critical time to do this is at the point that the patient makes the transition from the ward environment to the home environment, rather than at the end of a period of 'leave'.

In my opinion, [Dr B] should have taken steps to ensure that this occurred. It was not necessarily his role to convene, or even to attend the meeting (that would have been desirable, but had to be balanced against the various other demands on his time), but before sending [Mr A] home, he needed to ensure that all necessary information had been exchanged, and that the care environment (ie home and family) was sufficiently well prepared.

In my opinion [Dr B's] practice in this regard fell short of an accepted standard to a ***moderate*** degree.

d) The operation of systems.

I do not consider that [Dr B] had any responsibility for the management of the systems of the Board.

2. Additional Comments

a) Workload and resources

[Dr B] has provided a variety of figures and documentation that demonstrates he had a very heavy workload at the time of these events, and that he was working in an environment in which he had very limited supporting resources. I accept that these comments were reasonable. From the data that he has supplied, it is evident that [Dr B] was carrying a workload that was well in excess of what would be considered the norm for a consultant psychiatrist. As noted in the original report, [Dr B] did not have the support of anything like a full multidisciplinary team — in effect the clinical team consisted of the psychiatrist and the nursing staff — and this placed an additional burden on the psychiatrist.

Nevertheless, while I accept that carrying such a workload does place unreasonable demands on the clinician, and that some allowances need to be made for this, by accepting and taking on a specific clinical role, the practitioner assumes responsibility for carrying out the role to an acceptable standard. If a practitioner is working in a situation which he is unable to carry out his duties to an acceptable standard, there are other mechanisms that should be utilised to address this.

While I have some sympathy with [Dr B] in attempting to continue to work in what were clearly difficult circumstances, I do not consider that this additional information materially affects my original opinion.

b) Documentation

[Mr A's] family have expressed concern at what they consider to be poor standards of documentation. I have commented in my original report about the absence of adequate documentation of the interactions with the family.

I reiterate that the general standard of the clinical documentation (other than this omission) is good. [Dr B's] notes are thorough, legible and well organised. Good record keeping is commonly one of the first things that suffers when a clinician is working in a situation of overload, and the fact that [Dr B] continued to maintain a good standard of record keeping, despite the considerable workload pressures that he was under, is a credit to him.

I trust that these additional comments are helpful."

30 March 2006

Chief Executive Officer
A District Health Board

Dear Mr H

Complaint by Mrs A
Our ref: 04/00671/WS

Thank you for your response to the provisional decision on the complaint by Mrs A regarding services provided to her late husband, Mr A, by the District Health Board (the Board). I note that the Board has accepted the provisional findings, and has commenced work on addressing the issues identified.

As you are aware, I received independent expert advice in relation to the matter from nurse Ms Kaye Carncross and psychiatrist Dr Nick Judson. After reviewing Dr B's response to my provisional opinion I obtained further expert advice from psychiatrist Dr Nick Judson. A copy of Dr Judson's further report is **enclosed**.

Having carefully reviewed the information gathered to date I consider that the Board breached the Code of Health and Disability Services Consumers' Rights (the Code) by allowing enrolled nurse Ms D to be appointed as Mr A's key worker. The reasons for my view are set out below, together with a summary of my decision concerning the individual actions of the staff members involved in Mr A's care.

Background
As you know, on 23 July 2004, I decided to investigate the following matters concerning the Board:

The adequacy and appropriateness of the care provided to Mr A by the District Health Board, including:

- *whether it was appropriate for Mr C to undertake Mr A's initial assessment*
- *whether it was appropriate for enrolled nurse Ms D to undertake primary responsibility for Mr A's care and his clinical assessment*
- *whether the psychiatric unit's policies and procedures in relation to the care of patients who had attempted suicide prior to admission were appropriate.*

During the investigation I obtained information from Mrs A and family, Dr B, the Board, nurses Ms D, Mr C, Mr F and Ms E.

Nurses Mr C and Ms D
After careful review of the expert advice I received, I have decided to take no further action in relation to nurses Mr C and Ms D. My nursing advisor was of the view that registered nurse Mr C provided Mr A with appropriate care and that Ms D discharged her responsibilities in accordance with her abilities. However, as an enrolled nurse, Ms D was working outside her scope of practice and this was reflected in the depth and quality of her work as Mr A's key worker.

Psychiatrist Dr B
In his reports Dr Judson has advised that Dr B's diagnosis and treatment of Mr A during his admission was generally appropriate. However, he has emphasised that Mr A's past records should have been accessed to assist with Dr B's diagnosis, and he considers that Dr B's rationale for discounting depression was not sufficiently documented. In addition, Dr Judson does not consider that the level of consultation with Mr A's family was adequate. Most significantly, Dr Judson considered that Mr A's family should have been consulted about the decision to place him on home leave. It was Dr B's responsibility to ensure this occurred.

Having carefully considered Dr Judson's reports, together with all the information obtained to date, I consider that Dr B breached Right 4(2) of the Code by not ensuring that Mr A's family were fully consulted about his proposed leave.

I have not held the Board to be vicariously liable for Dr B's breach of the Code. The reasons for my decision are set out in the **enclosed** letter to Dr B.

The Board
The role of registered nurse Mr C
Both of my advisors considered that Mr C had the requisite experience and training to undertake Mr A's initial assessment (and considered that he discharged his responsibilities appropriately).

Accordingly, my opinion is that the Board did not breach the Code by allowing Mr C to undertake Mr A's initial assessment.

The role of enrolled nurse Ms D
The psychiatric unit lead nurse Mr F appointed enrolled nurse Ms D as Mr A's key worker on Day 2. Mr F informed me that he considered Mr A did not require either intensive nursing care or an acute level of observation, and that he provided indirect supervision for Ms D during the afternoon shifts. He stated:

> "Based on the information I received and the fact that he [Mr A] had already been in hospital 2 days prior to his admission to [the ward] I concluded that [Mr A] was stable, and that he did not require intensive nursing care or an acute level of observation."

Ms D explained she was happy to accept the role of Mr A's key worker on the basis of the information provided to her by Mr F and that she had "fulfilled this function in the past on numerous occasions."

The relevant policy documentation is the "Service Provision Framework." The "Key Worker Role", issued on 16 April 2002, stated:

> "All Multi-Disciplinary Team members except the Consultant Psychiatrist, Maori Mental Health Worker, Support Workers and Enrolled Nurses can be the Primary Key Worker."

In October 2003 a meeting was held between Ms D and the clinical leader on the ward to discuss the scope of practice of enrolled nurses. The memorandum of their meeting stated:

> "We have had discussions as a team in the past around ENs [enrolled nurses] being key workers and this has been understood to be possible when supervised by an RN [registered nurse]. In the case of [this ward], the supervisor for ENs is the clinical leader or in his absence the lead nurse on any given duty.
>
> I went through the guidelines for supervision issued by the Nursing Council with [Ms D]. In particular, we looked at the scope of practice for RNs and gained clarity around the need to consult a supervisor if matters arising with a client exceeded the scope of practice. We spent some time exploring the notion that ENs should be cautious when caring for people with uncertain health outcomes. In such cases I suggested that she should decline to continue as primary key worker and that this would be seen as positive in terms of her safety to practice."

The Key Worker Role (2002) was amended in 2003 and stated:

> "All Multi-Disciplinary Team members except the Consultant Psychiatrist and Maori Health Worker, Support Workers can be the Primary Key Worker."

In July 2004 the key worker role was further reviewed and the specific exclusion of enrolled nurses from the task was re-introduced. In addition, the job description for "Key Worker" (reviewed June 2004) states:

> "All Multi-Disciplinary Team members except the Psychiatrist, **enrolled nurses**, Maori Mental Health Workers, Community support Workers can be Key Workers."

The "[crisis team]" policy (reviewed on July 2004) states that the lead nurse is required to allocate a key worker "based on caseload acuity and likelihood of predictable outcomes".

My nursing advisor was of the firm view that the nature of work to be undertaken by a key worker placed that role outside the scope of practice of an enrolled nurse. In all the circumstances, she considered it was inappropriate to appoint Ms D as Mr A's key worker. My advisor stated:

> "[Ms D] attended to her responsibilities in a limited way. As an enrolled Nurse she has limited scope of practice. It is my opinion she was working outside of that scope in terms of acute mental health nursing (see Appendix one and two). Upon reading the nursing notes and policy documents at that time I am of the opinion

> she attended to her responsibilities to the best of her ability. However as an EN she has limited education and training in this area so does not have the level of sophistication one would expect from a Registered Nurse.
> …
>
> It is my opinion that it was inappropriate to appoint an Enrolled Nurse to be [Mr A's] keyworker. There have been clear memoranda from the Ministry of Health and Nursing Council (see appendix one and two) on the employment and role expectations of an enrolled nurse. Nursing Council has been clear that Enrolled Nurses are to work in areas that are predictable and do not call for complex nursing judgement. In her role as a keyworker there was an expectation that [Ms D] would undertake complex mental health assessments (Mental Health Service Clinical Assessment). In a letter from the Director-General of Health and CEO Nursing Council (Appendix two) it is clearly stated that Enrolled Nurses are not educationally prepared to work in acute mental health settings. Care is more appropriately provided by Registered Nurses."

My nurse advisor referred to the Nursing Council of New Zealand (the Council) guidelines in relation to the scope of practice of enrolled nurses, which states:

> "Enrolled Nurse Education Framework (November 2001)
>
> Enrolled nurses work with people across the lifespan with predictable health outcomes in situations that do not call for complex nursing judgement, in health promotion, disease prevention and care of the sick."

My psychiatrist advisor described the appointment of an enrolled nurse as "unusual" and, in addition, excluded under the applicable policy.

Under Right 4(2) of the Code, Mr A had the right to services of provided that complied with legal, professional, ethical, and other relevant standards. I consider that the Council guidelines referred to above are a relevant standard for the purposes of Right 4(2).

Mr F was apparently acting in accordance with accepted practice at the psychiatric unit in appointing an enrolled nurse to the role of key worker. The use of enrolled nurses as key workers had been the subject of internal discussion/review (particularly following the presentation on 29 October 2003) and was not otherwise considered to be appropriate when caring for patients with uncertain outcomes. Ms D had apparently undertaken this role at the psychiatric unit on numerous occasions.

Until the time of Mr A's admission the service provision framework specifically excluded enrolled nurses from undertaking key worker roles. However, there was a clear discrepancy between practice and policy and the review of the key worker role policy tacitly acknowledged the practice of allowing enrolled nurses to be key workers, by not specifically excluding them.

The policy was further reviewed in July 2004 with the re-introduction of the exclusion of enrolled nurses to the key worker role. However, I note the criteria for lead nurses

to appoint key workers is stated as being "based on caseload acuity and likelihood of predictable outcomes".

My nursing advisor was of the firm view that it was not appropriate to appoint enrolled nurses as key workers under any circumstances, and I concur. Nursing care in mental health units requires the continual exercise of complex professional judgement which is a requirement beyond what reasonably can be expected of enrolled nurses. This has been reflected in the manner in which Ms D completed her role as Mr A's key worker, which would not have been of a satisfactory standard for a registered nurse.

Accordingly, my opinion is that the Board breached Right 4(2) of the Code by allowing enrolled nurse Ms D to undertake the role of Mr A's key worker.

In the circumstances, I recommend the Board review the current practice and policy concerning the appointment of key workers at the psychiatric unit to ensure that enrolled nurses are not appointed to this role in future.

Psychiatric unit policies/procedure
My advisors considered that, overall, the Board's policy and procedure documentation and position descriptions were appropriate and largely adhered to. However, they expressed concern about the consultation between staff and Mr A's family. Dr Judson was of the view that the quality and level of consultation was sub-optimal. He stated:

> "The problem appears to have been not that there was a lack of contact with the family, but there was no coordination of this — no systematic gathering and giving of information, or discussion of concerns and management plans.
>
> …
>
> As noted above, although there has been some consultation with the family, at no point is there a coordinated or explicit attempt to marshal the information and to discuss the concerns and options with family members. In addition, what consultation that did occur is not well documented …
> …
>
> Given such sparse documentation of the family contact (in contrast to other documentation, which is generally very thorough) it is difficult to draw firm conclusions about what did occur, but it does seem clear that the consultation was not really sufficient."

My nursing advisor commented:

> "There is lack of documentation in the notes around the family's concern, although concern is noted. How the concerns were addressed has not been documented. I am left with the impression that there was not sufficient consideration of the families concerns."

I acknowledge that Mr A was admitted for a short period and the relationship between family and members of the multi-disciplinary team did not have time to fully develop.

Nevertheless, there were triggers for more consultation to occur, with significant new information being provided, and offered, by family members during Mr A's admission. However, I accept that the psychiatric unit policies and procedures were generally appropriate and acknowledge that individual staff members should have been more proactive in this regard. (You will see that in my letter to Dr B I have expressed the view that more consultation was warranted and ideally, should have occurred at his direction.)

Accordingly, my opinion is that the Board did not breach the Code in this regard.

In the circumstances, I recommend that the Board review current practice and ensure staff members are fully aware of their individual responsibilities concerning consultation. I also note that the inclusion of a social worker in future multi-disciplinary teams would assist with ensuring effective consultation and communications with family members occurred.

Other comment

Access to past records

My psychiatric advisor made particular reference to the accessing of past records. (He considered that Dr B should have considered Mr A's past psychiatric unit records, which were readily accessible.) He stated:

> "The service provision framework states that old notes should be obtained *'if appropriate'*, and responsibility for this (at the time) appears to have rested with the clerical staff. The policy does not state who judges the 'appropriateness' of obtaining the record. No-one in this case accessed past records — seemingly it was no-one's responsibility to do so. It would be, in my opinion, advisable to obtain old records as a matter of course."

I draw the Board's attention to my advisor's comments. Mr A's past records — which could easily have been accessed — obtained relevant information about his significant history of depression which may have led Dr B to give more consideration to a diagnosis of underlying depression. I recommend that the Board review its system.

Scope of practice

My nursing advisor noted several aspects of the Board's procedure and policy documentation which may require clarification with regards to scope of practice issues for enrolled nurses. She stated:

> "I note that under [the District Health Board] Procedure 'Management of Suicidal Clients' (no 2, Assessment), states that a full assessment is carried out by a 'Professional Mental Health Worker'. What this includes or excludes in terms of who can take on the role is not defined and could lead to confusion.
>
> In regard to [the DHB] policy 'Clinical Risk' it states that all Registered Professional staff will be skilled in risk assessment, does this include Enrolled nurses, if it does then this policy is at odds with Nursing Council scope statements on enrolled nurses."

I recommend that the Board review procedure documentation to ensure compliance with scope of practice requirements for enrolled nurses.

Psychiatric unit resources
In response to my provisional report Dr B submitted that he was subject to significant resource constraints at the psychiatric unit, which should be viewed as mitigating factors. Dr B submitted that the there is a wide discrepancy between the facilities which were available to him at the psychiatric unit and at a second District Health Board, and also when compared to a tertiary hospital.

In his further report Dr Judson has acknowledged that Dr B was operating without the support of a fully constituted multi-disciplinary team and was burdened with a very heavy workload.

I agree with Dr Judson that Dr B was apparently working in difficult circumstances, although I have insufficient information to form a view as to the overall adequacy of staffing levels. I trust the Board will include in their review consideration of whether the psychiatric unit is adequately staffed, particularly with respect to the membership of the multi-disciplinary teams.

Additional matter
Policy in relation to contacting families and ongoing training
In our notification letter to the Board dated 23 July 2004 it was noted that the Board had agreed to include Mrs A in future training around involving families, and that a process for contacting families following a suicide would be developed. My Office requested that the Board provide Mrs A with an update on progress. Mrs A has advised my Office that she has received no communication from the Board in relation to either of these matters. In the circumstances, I would appreciate you contacting Mrs A and advising what action the Board has taken in relation to these matters.

Recommendations
As a result of my findings I have made a number of recommendations with regards to practice and procedure at the psychiatric unit. Most significantly, I consider that enrolled nurses should not be undertaking the role of key worker and that practice in relation to consultation with families should be reviewed. I have also made several other recommendations in the *Other comment* section for the Board to consider.

As noted above, I understand that the Board has commenced work on my recommendations and that enrolled nurses no longer undertake the role of Key Worker.

Please write to me when the review of psychiatric unit policy and procedure has been completed and inform me of the outcome no later than **28 April 2006**.

An anonymised copy of my letter to Dr B (together with Dr Judson's reports) will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Thank you for your assistance with my investigation.

Yours sincerely

Ron Paterson
Health and Disability Commissioner

Enc. Copy of further psychiatric advice