DISTRICT HEALTH BOARD A
DR A
DISTRICT HEALTH BOARD B
DR B
DISTRICT HEALTH BOARD C

A Report by the

Health and Disability Commissioner

(Case 99/07220)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

District Health Board A /Dr A/ District Health Board B / Dr B /District Health Board C

Opinion – Case 99/07220

Summary of facts and conclusions

This case involves the tragic suicide of a 37-year-old man, Mr C, at a Mental Health Hospital in City B on 26 May 1999.

Mr C was a former Police Officer who lived in Town C. This report is concerned with the care he received from 1 July 1998, when Mr C first came to the attention of mental health services, until the date of his death.

Over that period Mr C came under the care of District Health Board A in City A, District Health Board B in City B, and District Health Board C in Town C. On 1 July 1998 Mr C was admitted to a Public Hospital in City A. On 13 July he was discharged and was transferred into the care of the Town C community mental health team, under the umbrella of District Health Board C. Mr C remained in Town C until 5 August, when he briefly returned to City A, ended up in Police custody, and again came to the attention of District Health Board A's mental health services. On 11 August, Mr C again returned to Town C, where he remained until 2 December. At that date, following an acute episode, he was admitted to a Mental Health Hospital in City B under the provisions of the Criminal Justice Act. He remained at the Mental Health Hospital until 12 March 1999, at which time he returned to Town C on trial leave from the Hospital. This leave was revoked on 31 March and Mr C returned to the Mental Health Hospital as a compulsory patient where he remained until his death on 26 May 1999.

Mr C's family complained about the services Mr C received from all three regional providers, as well as specifically Dr A from District Health Board A and Dr B from District Health Board B.

A summary of my opinion in respect of the complaint is as follows:

District Health Board B – no further action
I have decided to take no further action in respect of District Health Board B because, in my view, issues surrounding the care it provided to Mr C have been adequately addressed through the independent inquiry and the inquest. I acknowledge that Mr C's family does not accept that these investigations canvassed all the relevant issues. However, District Health Board B has responded proactively to those inquiries in order to improve its services at the Mental Health

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Hospital, and in the circumstances I do not feel that there is anything further I can add to the process.

District Health Board A – No breach
In my opinion District Health Board A did not breach the Code of Health and Disability Services Consumers' Rights. I consider that District Health Board A appropriately managed the transfer of Mr C from City A to Town C.

Dr A – No breach
In my opinion Dr A provided services with reasonable skill and care and did not breach the Code. While I accept that he may have said the words alleged by Ms C, and that she may have thought he was indicating a reluctance to treat Mr C, I am satisfied that Dr A did make considered decisions in respect of Mr C's care, and was acting appropriately.

Dr B – No breach
Nor did Dr B breach the Code in my opinion. While Dr B was aware that community mental health services in District Health Board C were not highly resourced, it was her view that Mr C's condition was such that a transfer back home was appropriate. Dr B went to reasonable lengths to ensure that Mr C would receive the appropriate follow-up once on trial leave in Town C. In my view she acted with reasonable skill and care.

District Health Board C – Breach
District Health Board C did breach the Code in my opinion. Mr C's family complained that District Health Board C did not provide services with reasonable skill and care, and I obtained independent expert advice from Dr Murray Patton on this issue. Dr Patton made a number of criticisms of the way in which District Health Board C provided services, and concluded that there were gaps in the service which could not be explained by the fact that Mr C lived in Town C, a reasonably remote location in terms of access to services. District Health Board C responded in detail to my provisional report and accordingly I sought further expert advice from Dr Patton. Having taken this further information into account, my opinion remains that District Health Board C breached the Code.

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Parties involved

Dr A	Consultant psychiatrist, District Health Board A/ Provider
City A	City in the region of District Health Board A
Dr B	Consultant psychiatrist for Forensic Services, District Health Board B/ Provider
City B	City in the region of District Health Board B
Mr C	Consumer
Ms C	Partner of Mr C
City C	City in the region of District Health Board C
Town C	Town in the region of District Health Board C
Mr D	Mr C's brother
Dr E	Consultant Psychiatrist, District Health Board A
Mr F	Senior Nurse, District Health Board A
Dr G	Psychiatrist, District Health Board C
Mr H	Forensic Mental Health Nurse, District Health Board C
Dr I	Psychiatrist, District Health Board C
Dr J	Psychiatrist, District Health Board B

Complaint

The Commissioner received a complaint regarding the services provided to Mr C by District Health Board A, Dr A (a psychiatrist at District Health Board A), District Health Board B, Dr B (a consultant psychiatrist for Forensic Services at District Health Board B) and District Health Board C. The complaint is that:

District Health Board A
District Health Board A Limited did not provide mental health services of an appropriate standard when treating Mr C. In particular:

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- *In early July 1998 Mr C was discharged from the secure psychiatric unit at a Public Hospital in City A following a compulsory two week stay under the Mental Health Act and was required to return to City C unescorted despite being advised that an escort nurse would be made available for the journey. In addition, District Health Board A did not formally refer Mr C to the mental health team in Town C.*

- *Services that were to be arranged upon transfer from District Health Board A did not occur until Ms C contacted District Health Board C and Town C's mental health teams.*

Dr A
When Mr C was under arrest and contained in Police cells in City A on 7 August 1998, Dr A advised Ms C that Mr C was taking his medication and "was not [District Health Board A's] concern".

District Health Board B
District Health Board B did not provide mental health services of an appropriate standard when treating Mr C. In particular:

- *On 5 December 1998 upon Mr C's admission into the Mental Health Hospital Ms C tried to make contact with his doctor on numerous occasions but did not receive a response until January 1999 when a doctor contacted her.*

- *Most of the contact with District Health Board B was initiated by Mr C's family and the few meetings that did take place occurred after repeated requests from the family.*

- *Mr C's family was not consulted about, or involved in, his treatment and discharge plan and was not kept informed during his treatment.*

- *Mr C did not receive regular testing of his liver function during his final stay at the Mental Health Hospital as requested by Ms C and his mother.*

- *In May 1999 and on the night of his death there were indicators that Mr C would commit suicide but these were not recognised or acted upon. In particular:*

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- *On 3 May 1999 Mr C brought a rope into the ward*
- *The documented decline in his mental state, particularly on 25 May 1999*
- *The increased frequency of safety assurances sought by staff*
- *Expressing suicidality on 25 May 1999*
- *Declining to go out with his brother*
- *Not wanting home leave*
- *Refusing telephone contact with Ms C*

- *On 26 May 1999 District Health Board B did not listen to Ms C when she expressed concern at her partner's behaviour and did not place him on fifteen-minute observations, as requested.*

Dr B
On 9 April 1999 Dr B advised Ms C that there was inadequate follow-up care for Mr C in District Health Board C and that District Health Board C was in a "fragile state", but he had been, or was going to be, released from hospital into community mental health care.

District Health Board C
District Health Board C did not provide mental health services of an appropriate standard when treating Mr C. In particular:

- *Services that were to be arranged upon his transfer from District Health Board A did not occur until Ms C contacted the District Health Board C and Town C mental health teams.*

- *A doctor did not examine Mr C until one month after he returned from District Health Board A and Mr C received only three visits from a nurse between 13 July and 5 August 1998.*

- *On approximately 1 October 1998 Ms C asked for further psychotherapy sessions and was not advised of a further appointment until 23 December 1998, with the appointment not being until 20 January 1999.*

- *Upon his release from the Mental Health Hospital on 12 March 1999 a psychiatrist did not examine Mr C until 30 March 1999, and this only occurred as the result of repeated requests from Ms C.*

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- *Mr C's family was not consulted about, or involved in, his treatment and discharge plan and were not kept informed during his treatment.*
- *Despite Ms C continuing to advise the Town C mental health team that she was concerned about her partner's condition services were not increased and advice was given that they considered, Mr C to be well.*

Investigation process

The complaint was received on 22 June 1999 and an investigation was commenced on 29 June 1999. Information was obtained from Mr C's brother, Ms C, Dr A, Dr B, District Health Board A, District Health Board B, and District Health Board C.

Expert advice was obtained from Dr Murray Patton, an independent psychiatrist advisor, in relation to the adequacy of services provided by District Health Board C to Mr C. During the course of preparing his report, Dr Patton also had discussions with and obtained further material from District Health Board C.

An independent investigation into Mr C's suicide was commissioned by District Health Board B and performed by two staff from District Health Board A, Dr E, consultant psychiatrist, and Mr F, senior nurse. The Commissioner reviewed the findings from this investigation ("the Inquiry"), and a letter from the Inquiry team dated 8 October 1999 clarifying one of their recommendations. The Commissioner also reviewed the report of the Coroner on Mr C's death, and Mr C's medical notes from District Health Board B, District Health Board A and District Health Board C.

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Information gathered during investigation

Background
Mr C was a 37-year-old former Police Officer who lived in Town C with his partner, Ms C, and their young son, and had regular contact with his family in City B and City C. He was described by his family as a "*widely respected*" and "*well-rounded*" person prior to becoming ill.

Admission to District Health Board A: 1 – 13 July 1998
Mr C first came to the attention of mental health services on 1 July 1998 when he was admitted to the mental health unit at a Public Hospital for compulsory assessment under the Mental Health (Compulsory Assessment and Treatment) Act 1992. On 5 July 1998 Mr C was transferred to a psychiatric ward in another Public Hospital in City A. The District Health Board A discharge summary documented that, at the time of admission, Mr C was seriously mentally unwell with a psychotic illness. According to the discharge summary, his symptoms included paranoid and grandiose delusions focused on a recent high profile murder trial, and possible hallucinations. His diagnosis at this time was thought to be either a schizophrenic illness or bipolar affective disorder. Dr A, a psychiatrist, treated Mr C with sodium valproate, a mood stabiliser, and two anti-psychotic medications.

Mr C's brother stated that on 6 July 1998 the provisional plan was for Mr C to be transferred to the Mental Health Hospital's Secure Unit, City B, with an escort nurse. Dr A advised that by the time of discharge Mr C "*was settled*", so plans were made for discharge with follow-up by the community mental health team in Town C.

Discharge and transfer of care
District Health Board A advised that "*all normal steps were taken in the transfer of care by* [District Health Board A] *mental health service staff. Staff contacted the Town C mental health team with Mr C's details by telephone, fax and letter.*"

The District Health Board A clinical notes of 13 July 1998 include an unsigned entry in what appears to be Dr A's handwriting. This entry states "... *change of responsible clinician to* [Dr G]. [Town C] *has a mental health section and I have spoken to* [Mr H, community mental health nurse]." Dr A confirmed that he spoke to Mr H in Town C to arrange follow-up. A fax from District Health Board A on

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13 July 1998 documented that Dr G, a psychiatrist in City C, agreed to take over from Dr A as Mr C's responsible clinician.

A preliminary discharge summary from District Health Board A, dated 8 July 1998, initially stated "*transfer to* [City B] *psychiatric services*", but this was later crossed out and changed to "*discharged to parents in* [City C]", and the discharge date of 13 July 1998 recorded. The final discharge summary, dated 22 July 1998, stated "[Mr C] *was discharged back to* [City C] *and he will stay with his parents for at least the short term. He will also be followed up by the CATT* [community assessment and treatment] *team in* [City C]. *His responsible clinician will be* [Dr G]."

The Discharge Tasks Checklist notes that both Mr C's partner and parents were notified of his final discharge.

On 13 July 1998 Mr C flew to City C via another city. He made the travel arrangements himself after discussion with District Health Board A staff. The clinical record from that day documented "[Mr C] *to be escorted to airport 1630h and seen onto plane. Arrangements made for* [Mr C's] *parents to pick up the other end … Appropriate documentation faxed to CATT* [community assessment and treatment team] [City C] *and CMHT* [community mental health team] [Town C] *… Discharged from ward 1630h to airport.*"

District Health Board C Community Care: 13 July – 7 August 1998
District Health Board C confirmed that Mr C's care was formally transferred from District Health Board A to District Health Board C on 13 July 1998.

Mr C's family advised that while Mr C was under the care of District Health Board C, they had serious concerns about "*the quality and continuity of services available to* [Mr C] *in his hometown of* [Town C]".

District Health Board C's clinical records documented that the first contact with Mr C was on 14 July 1998 when he was seen at his home by forensic mental health nurse Mr H. Ms C stated that she instigated this contact.

Mr H had phone contact with Mr C on 17 July. Mr H also telephoned Mr C on 23 October and 2 November, but he was not at home, so Mr H spoke to Ms C instead. Mr H saw Mr C in person on 24 July, 30 July and 5 August 1998. Mr C

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attended an appointment with a District Health Board C psychiatrist on 16 July 1998.

On 22 July 1998 a second District Health Board C psychiatrist assessed Mr C. The clinical notes do not document the reason for the change in psychiatrist. At this time his diagnosis was recorded as bipolar affective disorder "in remission". The psychiatrist saw him again on 5 August 1998, at which time he was "despondent" but "not mood disordered".

Contact with Mr C's family
In response to the complaint that Mr C's family was not consulted about or kept informed about Mr C's treatment, District Health Board C advised:

> "[Mr C] was an adult voluntary outpatient of a Community Mental Health Team. He was competent to consent to sharing of information and family support person involvement in his care if he had wished this to occur. He was competent and able to share his own health information with whomever he wished.
>
> [Mr C] was the client and the Community Mental Health staff have no obligation to disclose information or make any insistence that family or a support person are provided information or are involved in his care.
>
> [Mr H] who attended [Mr C] advises [Mr C] did not wish for information to be shared or include family or a support person and this is his right to confidentiality and his right to choose. His wishes with regard to family or support person involvement were respected and this was his choice ….
>
> [Ms C] was recognised as [Mr C's] support person. … A support person does not have automatic access to patient information and is not consulted with regard to a patient's care without the patient wishing for this to occur or without them giving consent for this to occur … [unless] a situation of risk to the client or others was demonstrated ….
>
> [Mr C's] family would have been involved in his care and outpatient management if he had wished for this to occur. However his privacy and the ability for him to speak to the health professionals openly, without fear of information being shared, was his right. "

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Further contact with District Health Board A: 7 August 1998
The family advised that on 5 August 1998 Mr C "disappeared again", and on 7 August 1998 was arrested in Parliament.

Ms C advised me that following Mr C's arrest she rang Dr A at the Police cells. She stated Dr A explained that Mr C would be in care until Monday when he would appear in Court. According to Ms C, Dr A said Mr C was taking his medication and was "quite well" and "not District Health Board A's concern".

District Health Board A could not locate Dr A's notes for the relevant time period. However, they were part of the records supplied by District Health Board C. Dr A's notes from this time stated:

> "This man is well known to me as I treated him in [City A] psychiatric unit in June. He has recently been depressed, but is now well, if somewhat elevated in mood and is certainly not depressed or suicidal. In his current state he should not be granted bail but rather be remanded in custody until Monday. On Monday he should be seen by the Forensic Services. … It may be in his best interest to be transferred to [another Public Hospital in City C] rather than be sent to our local psychiatric unit as he would be near his relatives."

A District Health Board A mental health services contact form dated 7 August 1998 documented that, despite Dr A's advice that Mr C be held in custody until assessed by the forensic mental health team, a lawyer arranged bail for him. The form also documented that Mr C was released from the Police cells on the condition that he return to his home, which he did, having a brief voluntary hospital admission in a town on the way.

District Health Board C Community Care: 11 August – 2 December 1998
Mr C returned to Town C on 11 August 1998 and continued to receive follow-up from Town C mental health services. The second District Health Board C psychiatrist saw Mr C on 19 August 1998. At this time Mr C's working diagnosis was bipolar affective disorder, and his anti-psychotic medication was replaced with lithium, a mood stabilising medication. On 2 September 1998, he was seen again by the second District Health Board C psychiatrist, who documented that Mr C was "objectively not overtly depressed but looks despondent". At this time a blood test showed that his lithium level was sub-therapeutic, and the dose was increased.

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Ms C stated that on approximately 1 October 1998 she told Mr H that her partner needed "*more treatment than just medication*", and asked for Mr C to receive psychotherapy. Ms C stated that District Health Board C referred Mr C for psychotherapy, but there was no appointment available until 20 January 1999. Ms C stated the appointment on 20 January was with a psychiatrist. District Health Board C advised that it does not employ a psychotherapist, but that some of its staff hold psychotherapy qualifications and utilise psychotherapy techniques within therapeutic interventions. District Health Board C stated that "[Ms C's] concerns were acknowledged and recognised as an important part of [Mr C's] assessments. They were considered alongside [Mr C's] presentation and the clinician's assessments, evaluations and plans."

On 16 October 1998 a third District Health Board C psychiatrist saw Mr C. This psychiatrist documented a further episode of depression, and prescribed an antidepressant. A multidisciplinary review of Mr C's case was carried out by District Health Board C mental health services on 2 November 1998. The plan at this time was to retain contact with Mr C on at least a weekly basis, to await psychological assessment and to support and monitor Mr C's prescribed medication. On 27 November 1998, a psychiatrist documented "continued improvement" and stated that Mr C reported "more energy", feeling "*more focused*" and "*enjoy*[ing] *relationships at work and at home*."

Mr C's mental state deteriorated again, and around 1 December 1998 he set off in his car on another impulsive journey, believing it was his mission to achieve justice in relation to the murder trial.

First admission to District Health Board B: 2 December 1998 – 12 March 1999
On 2 December 1998 Mr C was arrested and charged with a number of driving offences committed while intoxicated. Dr B, forensic psychiatrist, advised that Mr C was admitted to a ward in a Mental Health Hospital pursuant to section 121(2)(b)(ii) of the Criminal Justice Act 1985. Dr B reported that Mr C's working diagnosis was schizophrenia, in view of his history of apparent loss of function over seven or eight years, and absence of symptoms of mood disorder.

Ms C stated that upon Mr C's admission to the Mental Health Hospital she tried to make contact with his doctors on numerous occasions but did not receive a

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response until January 1999 when a psychiatric registrar contacted her. District Health Board B advised:

> "We do not have a record of [Ms C] attempting to contact his doctor on numerous occasions, but even if she did not, she should still have been contacted by his doctor early in his admission. We have acknowledged this as an omission on our part to [Ms C]."

In response to the complaint that Mr C's family was not kept informed during his treatment, District Health Board B stated that "[Dr B] and [Mr C's] primary nurse repeatedly made contact with [Ms C] and with other members of the family without this contact being solicited, and some of the meetings that took place were at the initiative of [District Health Board B] staff". District Health Board B's clinical notes documented that between December 1998 and 5 February 1999 there were 24 contacts between Ms C and the staff of the Mental Health Hospital comprising 16 visits and eight phone calls. Ms C stated that she initiated almost all of these contacts. The clinical notes did not document that any of the meetings took place at District Health Board B's instigation. District Health Board B acknowledged that on at least three occasions during this admission the clinical notes did not record any action in response to specific requests by Ms C.

Testing of liver function
Ms C stated that "[Mr C] did not receive regular testing of his liver function during his final stay at the Mental Health Hospital as requested by [Ms C] and his mother". District Health Board B laboratory results show that Mr C's liver functions were checked on 5 February, 12 February and 23 February 1999 with a steady improvement in results (bilirubin level was 70 on 5 February 1999, down to 44 on 23 February 1999). The hospital notes documented that he was also referred to the gastroenterology service for further investigation of the high bilirubin level. At post-mortem his liver and gallbladder were found to be normal.

Discharge planning
District Health Board B records documented that Ms C requested a family meeting shortly after Mr C's admission on 2 December 1998, and that in discussion with Mr C it was agreed to consider this in January 1999. Ms C advised that she first met with Dr B in early March 1999 at a meeting to discuss Mr C's trial discharge. Ms C advised that at this time it was her expectation that Mr C would be seen on a daily basis.

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Dr B stated that prior to the trial leave she advised Mr C and Ms C of the difficulties in arranging for Mr C to reliably see a doctor weekly in Town C. Dr B advised that "although [District Health Board C] cannot provide intensive follow-up in centres such as [Town C], every effort was made to ensure adequate follow-up when Mr C was discharged on 12 March 1999". In particular, Dr B advised that she had discussions about Mr C's follow-up with a psychiatrist and psychiatric district nurse in District Health Board C's region and with the Director of Forensic Psychiatry who was based in another city and provided supervision for District Health Board C's community forensic team. She did not state what arrangements were made.

Mr C was released from the Mental Health Hospital on trial leave on 12 March 1999. On 25 March 1999 Dr B wrote to the consultant forensic psychiatrist in City C to emphasise her concern that "this man in particular should continue to be well monitored".

District Health Board C Community Care: 12 – 31 March 1999
Ms C advised that a District Health Board C forensic nurse visited Mr C at home in Town C on 12 March 1999, the day of his discharge from the Mental Health Hospital.

Ms C stated that during the period between 12 and 31 March 1999 she repeatedly advised the Town C mental health team that she was very concerned about Mr C's condition. District Health Board C records documented that Ms C called the mental health team on 22 March 1999, but did not document the content of this telephone call. Ms C stated that despite her concerns, Mr C's services were not increased. Ms C advised that a forensic nurse saw Mr C approximately three times during this period, and a psychiatrist did not examine Mr C until 30 March 1999.

On 30 March 1999 Mr C was assessed by a District Health Board C psychiatrist who documented that "[s]ince he has been back at [Town C] it appears that he has been progressively spiralling down … He expressed significant negative content, felt hopeless and had little energy or motivation." The psychiatrist also noted that Mr C had once again become preoccupied with thoughts of impulsively travelling to a government building. The psychiatrist recalled Mr C from trial leave, and he was readmitted to the Mental Health Hospital on 31 March 1999 in accordance with his discharge plan.

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Second admission to District Health Board B: 31 March – 26 May 1999
Dr B stated that on return to hospital Mr C's working diagnosis was still schizophrenia, and he was treated with increased doses of antipsychotic medication. Antidepressant medication (paroxetine) was added when he developed persistent depression.

Second opinion from a Private Psychiatric Hospital
The clinical notes documented that Dr B discussed the issue of psychotherapy with Mr C on 14 April 1999, and he "accept[ed] that we need to be quite thoughtful about the issues around counselling/psychotherapy".

The clinical record documented that on 9 April 1999 Dr B had a long telephone conversation with Ms C to discuss [Ms C's] concerns about Mr C. As a result of that conversation, Dr B wrote to the Medical Director of a Private Psychiatric Hospital on 19 April 1999 seeking a second opinion on Mr C's diagnosis, and whether psychotherapy would be helpful or contraindicated.

The Private Psychiatric Hospital's psychiatrist's response of 20 May 1999 stated that he thought Mr C's diagnosis was more likely to be bipolar affective disorder than schizophrenia, and recommended some changes in his medication. The Private Psychiatric Hospital's psychiatrist advised that psychotherapy would involve "*significant risk*" for Mr C. In particular, he commented that if psychotherapy was embarked upon, there would be "some risk of unusual behaviour and a return of psychosis or of suicide". He suggested that Mr C might benefit from residential treatment at the Private Psychiatric Hospital so that he could receive psychotherapy while also undergoing "close monitoring of his state and ongoing treatment of his psychiatric symptoms".

Discussions about community services in District Health Board C
Ms C reported that during the discussion on 9 April 1999 Dr B told her that there was inadequate back-up care for Mr C in District Health Board C and that District Health Board C was in "a fragile state". Dr B advised that by this time "[Dr I] had left [District Health Board C], there had been a reduction in manpower in the community forensic team, and medical cover for forensic services in [District Health Board C] was limited and being given by different doctors". Dr B stated that she did not record the conversation on 9 April 1999, but that she may have used the words "fragile state" to describe services in District Health Board C's region.

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Transfer to rehabilitation ward
On 20 April 1999 Mr C was transferred an acute admissions ward with intensive staffing and security, to a rehabilitation ward. The hospital notes documented "[Mr C] returned to the acute admissions ward after weekend leave prior to lunch. He reports his time home went well …. There is no bed available on the acute admissions ward for [Mr C]. Transferring to rehabilitation ward this afternoon." The rehabilitation ward's nursing notes from the day of transfer documented "Appears positive and hopeful about his future. Nil suicidal ideation evident in conversation. … [Mr C] has contacted his next of kin and informed of transfer. He verbalised this afternoon that he is feeling slightly uneasy about the change of wards."

Liaison with Ms C and Mr C's family
District Health Board B informed me that Ms C was "extensively consulted and informed regarding treatment and discharge planning" and that family meetings were held to keep the family informed. District Health Board B further advised that "[Mr D], who was the most local member of the family, was encouraged to contact both [Dr B] and nursing staff with concerns if he had them". Dr B stated that between 31 March 1999 and the time of Mr C's death, she "had a number of discussions with [Ms C]", in addition to the family meetings.

The hospital notes documented that Ms C rang the ward on 13, 14, 19 and 26 April 1999 asking Dr B to contact her. From the notes it would appear that her calls were not returned until 27 April 1999 when Dr B contacted Ms C. On 7 May 1999 the notes documented that a nurse rang Ms C at Dr B's request to emphasise that even though Mr C's mood had lifted slightly, he was still at risk of harming himself. According to the notes Ms C responded that she was aware of Mr C's fluctuating mental state and safety risks and was happy to be contacted about his care.

A family meeting was held between Mr C's family and clinical staff on 25 May 1999. Dr B stated that at the family meeting, she explained to Mr C's family that there was likely to be a wait of some months before an inpatient place would be available at the Private Psychiatric Hospital. Dr B stated that she expressed the need to look at various options for providing a safe environment for Mr C during this waiting period, including exploring the possibility of being safely supported in Town C once he had recovered from his depression. Dr B informed me that she

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had "explored with [City B's] community forensic team whether [they] could try to work jointly with the region's community forensic team to provide adequate cover for [Mr C] in the event of his discharge" but that she had "no intention of discharging [Mr C] at the time of that meeting or within any short time after it". Dr B believed she had communicated to the family that she was only exploring options at that stage and discharge was not imminent.

Indicators of suicide risk
Dr B stated that "[Mr C] had described intermittent thoughts of suicide over a period of years". Mr C's hospital notes indicate that clinical staff at the Mental Health Hospital were aware that he was at risk of committing suicide. For example, on 6 May 1999 Dr B documented in the clinical notes: "continue to carefully and closely monitor mental state as improving mood may fluctuate and may give him more energy and capacity to act out suicidal ideation if it recurs".

The hospital notes documented that during this second admission to the Mental Health Hospital Mr C brought a rope back to the ward from his home after a weekend leave with the intention of using it to hang himself. However, he disclosed this action to Ms C and to hospital staff, and subsequently allowed his belongings to be checked for such items. Dr B informed the Coroner that "in the two weeks prior to his death he had talked of his wish to stay alive, in spite of his level of depression, in order to be a father to his young son of about fifteen months, and his hope that the treatment options being explored would bring relief of his symptoms".

The hospital notes show that as Mr C's depressive illness worsened, the level of observation on the ward increased substantially. Throughout this time he remained on the rehabilitation ward.

On the shift prior to his death he was specifically asked on three occasions about his safety, and he gave assurances that he was "safe" and would not do anything. The notes from this shift documented: "[Mr C] remains low in mood – very withdrawn. Difficulty with engaging in conversation."

Ms C stated that Mr C spoke to her on the telephone on the evening of 26 May 1999 and told her that he had decided not to go out with his brother that night and he "wasn't going to be coming home for the weekend". Ms C stated that she telephoned the hospital and expressed her concerns to a nurse, and asked that Mr

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C be checked every 15 minutes. When Ms C asked to speak to Mr C she was told that he was sleeping. Nursing notes recorded that he was awake but told staff to tell Ms C that he was sleeping.

The District Health Board B nursing notes documented that Ms C had expressed her concern that Mr C had not gone out with his brother, but the notes did not document that Ms C requested 15-minute observations of Mr C. District Health Board C informed the Coroner that Mr C was observed every 30 minutes as part of the routine observation round, and that earlier in the evening he had had contact with nursing staff more frequently than every 30 minutes. The afternoon shift clinical notes concluded that Mr C "remained safe this shift and close routine observations maintained". District Health Board B informed me that "nursing staff believe they did listen to [Ms C's] concerns about [Mr C's] behaviour and frequently checked with him seeking assurances that he was feeling safe on the ward".

The evening of 26 May 1999
Mr C was last seen alive at 10.45pm on 26 May 1999, when a staff nurse observed him to be in his bed. Nursing handover from afternoon to evening shift occurred at 11.00pm and, according to the Coroner's report, it was "common knowledge to patients on the ward" that staff were occupied for at least 15 minutes during this time. Mr C's room was next checked sometime between 11.15pm and 11.25pm. Mr C was not in his bed, and his body was found on the floor.

Mr C was certified dead at 12.15am on 27 May 1999. On the morning of 27 May 1999 the family was notified of Mr C's death.

The Inquiry
On 28 May 1999 District Health Board B commissioned Dr E, psychiatrist, and Mr F, nurse consultant, both of whom worked for District Health Board A, to undertake an independent inquiry into Mr C's death. The Inquiry concluded that:

> "[Mr C] had been suffering from a major depressive illness with associated high levels of suicidality. This had been noted by staff and individual efforts had been made to monitor his risk. … The events on the night of his death could not have been predicted and … it is likely that his suicide could only have been prevented if he had been having one-to-one nursing input.

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There are however components of the systems of delivery of care and structures within the mental health service which could benefit from increased focus and we would like to make recommendations accordingly.

1. The most striking aspect of our Inquiry is the unsuitability of [the Rehabiliation] Ward for patients who pose any degree of risk. We would recommend that any patient who poses risk [of suicide or assault], not be treated on this ward.

2. Our recommendation is that training be put into place to facilitate a structured process for the improved functioning of multi-disciplinary team meetings ….

3. The discipline and skill mix on the ward given its present acuity is inappropriate and insufficient. If it is to continue functioning in its present form, we recommend an increased number of registered nursing staff as a minimum.

4. Review of the admission/transfer procedure to and from the [Rehabilitation] Ward. Criteria for admission and criteria for exclusion need to be considered.

5. That staff on the [Rehabilitation] Ward be given a clearer understanding of where the Ward fits within the wider Mental Health service.

6. That there be a review of levels of observation and the process for review.

7. Risk Management Observation – review of training of assessment of suicidality for all disciplinary members of the multi-disciplinary team.

8. If the Ward is to be redesignated as a rehabilitation ward, admission criteria will need to be adjusted."

The Inquiry also found that "[a]lthough the submission from the family describes inadequate contact with the mental health services, the contact clearly was quite substantial and perhaps greater than would normally be the case".

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The Coroner's Inquest
A Coroner's Inquest was completed on 16 June 2000. The Coroner's finding was of suicide, with death being due to asphyxia from hanging. The Coroner made the following comments:

"1. It is clear in my view that the deceased should not have been a patient in the [Rehabilitation] Ward, but should have been returned to the secure Ward. That there was an error in this respect was acknowledged by [Doctor B]. … In my view the issue then comes down to the circumstances of that final transfer on 20 April 1999 and his continuance as a patient in that ward. … [T]here is I think clear evidence that he was showing suicidal tendencies and that while a patient in the secure Ward his condition in this respect continued to deteriorate, although he did shortly before his death express a wish to stay alive for the sake of his young son. It was recommended that he be admitted to [a private psychiatric hospital] but on 25 May 1999 he, his parents and partner were advised that there would be a three-month wait for that admission to take place. In the days leading up to his death [Mr C] had been openly talking about suicide and the nursing notes at this time appear to confirm his depressed state.

2. The reason why [Mr C] was retained in the rehabilitation ward and not returned to the secure ward is not quite clear. … It is clear that nearer the time of his suicide his depressive illness was deteriorating and that the level of his observation whilst on the ward increased substantially to the extent that on the shift prior to his death, he was asked three times about his personal safety. However, he did give staff assurances that he was 'safe' and would not do anything. I am conscious that it is easy to be wise after the event but perhaps his assurances were accepted too readily. Apart from that, however, it seems that the concerns of the nursing staff were either not adequately communicated to the clinicians or if they were they were not given appropriate weight. One can understand [Ms C's] concern which she expressed to me more than once at the inquest hearing – what does he have to do to show that he is at risk? …

   In conclusion I refer to two matters:

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> First even if [Mr C] had been in a more secure ward (or had been monitored even more closely), there is no guarantee that his suicide would not have taken place. He appears to have taken his own life in a deliberate and determined way.
>
> Second [District Health Board B] is to be commended for the prompt steps it took to commission an independent Inquiry and for the actions it has since taken to give effect to its recommendations."

The family's response

Ms C and Mr C's brother provided me with a copy of their comments about the Inquiry. The family expressed particular concern about the following issues:

- The report did not adequately review the circumstances of the suicide and did not adequately identify factors and issues that may have contributed to the suicide.
- The report suggested that going the "extra mile" for Mr C led staff to tell Ms C that Mr C was sleeping when he was in fact awake. If the truth had been relayed to Ms C she would have been concerned about Mr C's refusal to talk to her, and would have been more insistent that he receive closer monitoring.
- It was illogical to conclude that "although he was not receiving ten or five minute formal observations, he was being monitored at a level commensurate with this level of supervision" when there was an apparent gap of 30 to 40 minutes between checks.
- There were no clear reasons given for the finding that there was some conflict between the treatment being offered by District Health Board B and what was felt to be appropriate by the family. The family thought psychotherapy would be a helpful addition, and not a substitute for medication.
- The conclusion that "the events on the night of his death could not have been predicted" was not justified in view of the many indicators of risk.
- The report did not mention difficulties with outpatient care in the region as part of its recommendations.

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The family supported the recommendations of the report, and requested that the following recommendation be added:

> "The insight of close family/caregivers into the mental state of a patient is just as valuable as the observations of staff. Families are usually in a better position to judge what is out of character and may be more attuned to potential warning signs of patient risk. When a patient is acting out of character and family express concerns regarding this staff should listen to the family's concerns and have regard to these concerns in reviewing patient risk and act promptly on these concerns."

District Health Board B's response to the suicide and subsequent reports
District Health Board B stated that it made several changes to their mental health services based on the recommendations of the Inquiry, and the family's response to the Inquiry. In particular, District Health Board B advised:

- District Health Board B has apologised to Ms C and the family.
- A mechanism has been put in place to address the need for family involvement. Anonymised feedback from the family will be used in education sessions.
- The number of registered nurses on the rehabilitation ward has increased by filling vacancies.
- Senior medical input to the rehabilitation ward has been boosted by the appointment of a half-time consultant psychiatrist.
- The admission/transfer procedure has been reviewed.
- The process of redefining the role and function of the rehabilitation ward has commenced.
- There has been a review of levels of observation.
- A risk management co-ordinator has been identified for the ward and will be used as a resource person by the other staff in relation to the risk management system.

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- Education on assessing suicidality will be provided as part of the ongoing training programme for nursing staff.
- Mental health services will be regularly reviewed and audited to ensure compliance with the National Mental Health Standards.

District Health Board B advised:

> "We accept that there were indicators of increasing depression and intermittent suicidality from [Mr C], over the weeks preceding his death, although his mental state had fluctuated over this time. [Mr C] did not express suicidality to staff on 26 May 1999 and in fact while describing very low mood and no energy to go out with his brother or to go home as planned the following weekend, repeatedly assured staff that he was not suicidal and had no plan to commit suicide. … We acknowledge that staff placed reliance on [Mr C's] assurances to them, in the light of his previous openness about such matters, which in the event proved to be unfounded, and that while they were checking on him and talking with him frequently they did not place him on formal observations. We have acknowledged to [Mr C's] brother, [Mr C's] parents and [Ms C], that nursing practice is a matter of judgement and in this case the judgement was erroneous."

Independent advice to Commissioner

Expert advice was obtained from Dr Murray Patton, an independent psychiatrist, in relation to the level and quality of services provided to Mr C by District Health Board C. A full copy of Dr Patton's advice is appended as Appendix I.

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Response to Provisional Opinion

District Health Board C provided me with a detailed response to my provisional report on this matter. The response addressed each of the particulars of the complaint against District Health Board C. The response also addressed a number of the factors I relied on in the provisional report in finding a general breach of standards, and in particular the issues surrounding the period of trial leave, the involvement of Mr C's family, and District Health Board C's response to concerns raised by Ms C.

A copy of the response received from District Health Board C is annexed to this report as Appendix II. The following is a summary of the key points in the response:

Period of trial leave
In my provisional report I commented, based on advice from Dr Patton, that planning for contact by District Health Board C mental health staff during Mr C's period of trial leave from the Mental Health Hospital was not consistent with the level of monitoring that had been indicated was required. District Health Board C's response to this was that:

- Dr B remained the responsible clinician throughout that period and was the person ultimately responsible for ensuring that the appropriate psychiatric follow-up was arranged;
- Dr B's letter to the psychiatrist to whom care was ultimately transferred, Dr I, which stated that "close monitoring" was required, did not reach Dr I until after the decision had been made to cancel the period of trial leave;
- Contrary to what was asserted in the expert advice, District Health Board C's clinical notes do refer to Ms C's concerns and views relating to Mr C over that period;
- Staffing shortages at District Health Board C caused difficulty in being able to follow up Mr C when he was in Town C;

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- District Health Board C responded proactively and with flexibility to Mr C's needs while he was on trial leave. Contact was made more frequently than originally planned.

Family involvement
In my provisional report I commented that Mr C's family were not involved in his treatment and progress to the extent desirable, and nor was Mr C encouraged to involve his family.

In response, District Health Board C notes:

- It is the patient's right to make decisions;
- Mr C had expressed a wish for confidentiality;
- Mr C was encouraged to involve his family;
- Further family involvement was prevented by Mr C's decisions.

Response to Ms C's concerns
In my provisional report I noted that District Health Board C displayed an under-responsiveness to concerns raised about Mr C by Ms C. In response, District Health Board C noted:

- With one exception, action was taken in response to Ms C's concerns;
- Contacts by Ms C were responded to in an appropriately proactive manner.

Actions/Recommendations
In my provisional report, I made a number of recommendations in relation to the ways in which District Health Board C could improve their mental health services, in addition to those measures already implemented since Mr C's death.

District Health Board C responded, noting that a number of my recommendations had already been addressed through measures implemented since Mr C was in their care. However, I shall deal with this issue in more detail later in this report, in the ***Recommendations*** section.

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Further expert advice

In order to address the issues raised by District Health Board C in response to my provisional report, I sought further expert advice from Dr Murray Patton, psychiatrist. Dr Patton was provided with a copy of my provisional report and District Health Board C's response to that report.

A copy of Dr Patton's further advice is appended to this report as Appendix III.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

3) *Every consumer has the right to have services provided in a manner consistent with his or her needs.*

…

5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

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Commissioner's Opinion

Opinion: No further action – District Health Board B

As a result of my investigation I have decided, in accordance with my discretion under section 37(2) of the Health and Disability Commissioner Act 1994, to take no further action in respect of the complaints against District Health Board B.

The care that Mr C received at District Health Board B, and in particular the events surrounding Mr C's death, have been the subject of two reviews, the 'Inquiry' instigated by District Health Board B, and the Coroner's inquiry. While Mr C's family had some residual concerns following the inquiries, in my view District Health Board B carefully considered the concerns highlighted by the inquiries and the family, responded appropriately to the issues raised and the recommendations made, and has taken reasonable steps to improve its mental health services. Any further investigation is unlikely to shed further light on these matters. I note that the Coroner commended District Health Board B on the action it has taken to give effect to the recommendations of the Inquiry. In my view no further benefit will flow from any further action on my part in terms of promoting and protecting consumers' rights.

Opinion: No Breach – District Health Board A

In my opinion District Health Board A did not fail to observe appropriate practices and procedures in relation to the transfer of Mr C back to District Health Board C, and accordingly did not breach the Code. Nor did District Health Board A breach the Code by failing to co-operate with mental health services in District Health Board C's region to ensure continuity of care for Mr C.

District Health Board A advised that "all normal steps were taken in the transfer of care by [District Health Board A] Mental Health Service staff". This is supported by the nursing notes, which show that the appropriate discharge tasks were all performed.

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District Health Board A staff contacted mental health services at District Health Board B prior to the transfer. It was agreed that Dr G should take over as responsible clinician. Dr A at District Health Board A also spoke to Mr H, the community mental health nurse in Town C. Mr C's family was contacted and it was arranged that they would meet him at the airport when he arrived.

It appears that Mr C's transfer complied with the relevant practices and procedures in place at District Health Board A, and that these procedures ensured Mr C's effective discharge and transfer to District Health Board C.

Mr C's family was particularly concerned that while an escort had been promised, one was not provided. I note that District Health Board A records stated: "[Mr C] to be escorted to airport 1630h and seen onto plane. Arrangements made for [Mr C's] parents to pick up at other end …." Mr C clearly arrived safely in City C and there is no indication that District Health Board A acted inappropriately in relation to this matter.

Mr C's family was also concerned that services that were to be provided on transfer to District Health Board C were not provided quickly enough. In my view, this is not a matter for which District Health Board A could be held responsible, as its staff clearly took reasonable steps to transfer care.

In my opinion, District Health Board A organised Mr C's transfer to District Health Board C in a manner consistent with appropriate policies and procedures, and co-operated fully with District Health Board C's mental health services in an attempt to ensure continuity of care. The documents show that matters such as the transfer of medical care and notification of Mr C's family were carried out by District Health Board A staff, and lines of communication between District Health Board C and City A providers were open and effective.

My opinion is therefore that District Health Board A did not breach the Code.

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Opinion: No Breach – Dr A

In my opinion Dr A, when attending Mr C at City A Police Station, exercised reasonable care and skill, and did not breach the Code.

The complaint was that Dr A had said to Ms C that Mr C "was not [District Health Board A's] concern".

Dr A stated that he did not recall the specific consultation in the Police cells during which he allegedly made this comment. He did, however, recall his involvement with Mr C from Mr C's earlier admission at District Health Board A, and recalled that they had related well.

Dr A's notes in my view demonstrate that he was taking a considered approach to Mr C's care. Dr A assessed that due to Mr C's mental state it was best that he be kept in custody. He also noted that as Mr C's family were in District Health Board C it might be more appropriate to transfer his care there.

I accept that Dr A may have made comments to the effect alleged, and that he may have unintentionally created the impression that he was reluctant to provide care to Mr C. However, this would not amount to a breach of the Code. I am satisfied that Dr A acted reasonably in all the circumstances.

My opinion is therefore that Dr A did not breach the Code, as he provided services with reasonable care and skill.

Opinion: No Breach – Dr B

In my opinion Dr B exercised reasonable care and skill in discharging Mr C into the care of Town C's community mental health services, and did not breach the Code. Mr C's family complained that this discharge was inappropriate given the level of follow-up services that would be available to Mr C in District Health Board C.

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Mr C returned to Town C on trial leave on 12 March 1999. Dr B stated that while on appropriate medication in the Mental Health Hospital, Mr C's mental health had improved, he had trial leaves home with his partner and child, and expressed a wish to be discharged to live with them. It was agreed at his discharge meeting that Dr B would continue to be available to Mr C in the event of a crisis, and that the trial leave, if necessary, could be revoked within the next three months.

Dr B discussed the proposed follow-up care with a psychiatrist, a psychiatric nurse, and the Director of Forensic Psychiatry. She also wrote to the Consultant Forensic Psychiatrist at the Public Hospital, noting her concern that Mr C should continue to be well monitored.

I am satisfied that Dr B appropriately discharged Mr C into the care of the community mental health services in the region and took all reasonable steps to ensure that Mr C received appropriate supervision and monitoring while he was on trial leave in Town C.

In my opinion Dr B did not breach the Code by releasing Mr C into community care.

Opinion: Breach – District Health Board C

Right 4(1)

In my opinion, District Health Board C did not provide adequate services to Mr C, and breached Right 4(1) of the Code.

Mr C's family complained that the services provided by District Health Board C were not of an appropriate standard, and detailed a number of particular concerns.

I accept that the particularised details supporting the general complaint do not individually amount to a breach of the Code. Nonetheless, it has become apparent during the course of this investigation that when the services provided to Mr C are examined overall, there are several respects in which those services were inadequate.

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I engaged Dr Murray Patton, psychiatrist, to independently review the mental health services provided by District Health Board C. Dr Patton's report comprehensively addresses the concerns raised by the family, and is attached in full as Appendix I. Dr Patton makes a number of criticisms relating to the level and quality of services provided to Mr C by District Health Board C.

Dr Patton indicated a number of specific concerns:

- Full assessment documentation was not completed until Mr C had been under the care of the service for two months. In light of Mr C's presentation, this documentation should have been completed within two weeks;
- A risk assessment was completed, but there is no evidence that it was ever reviewed. It would have been appropriate to review it when there was a period of altered mood, other change in mental state, or when there was difficulty maintaining sufficiently close contact. Furthermore, the risk assessment does not identify those factors that could increase or decrease risk over time, or the context in which risks are increased or decreased;
- Follow-up notes have inadequate detailing of thought content, especially in regard to identified areas of risk;
- Planning for contact after discharge from the Mental Health Hospital in March 1999 was not consistent with Mr C's requirements. In its response to the provisional opinion District Health Board C made a number of points on this issue, which I have discussed earlier in this opinion. A full copy of District Health Board C's response is appended to this opinion, but in summary the concerns raised were that:
  - Dr B remained as responsible clinician and was thus responsible for ensuring psychiatric follow-up;
  - Dr B's letter advising of the need for close monitoring was not received until after the decision had been made to end the period of trial leave;
  - Staffing shortages caused difficulty in following up Mr C when he was in Town C;

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- District Health Board C in fact responded proactively and with flexibility while Mr C was on trial leave.

Dr Patton in his further expert advice addresses these issues but remains of the view that the services over the period of trial leave were not appropriate. While he acknowledges that the responsibility to arrange the appropriate doctor to provide psychiatric follow-up in District Health Board C was that of the responsible clinician, there were "other components of follow-up necessary in addition to medical assessment by psychiatrists".

Dr Patton notes that by the time of the discharge planning meeting, the history that led to the concerns regarding Mr C's monitoring was clear. Dr Patton notes that Mr C's history indicated that monitoring should not only include visits by members of a clinical team (other than just psychiatrists) but also undertaking and reviewing a mental state examination and making an assessment of factors affecting the clinical risk Mr C was presenting. Dr Patton notes that there is no evidence of these examinations or risk assessments taking place.

I accept Dr Patton's advice that it is only on the basis of a clear understanding of mental state and risks that appropriate interventions could be planned. It seems that no such assessment took place in the present case despite Mr C's history being such that he clearly needed close monitoring.

Dr Patton also notes his concern that despite the fact that stress was identified at the visit on 17 March, a return visit was not planned until a fortnight later – this was concerning in light of Mr C's history of rapid deterioration. (Dr Patton also notes that there was a two-week gap in interventions planned after the visit on 23 March. It would seem, however, that Dr Patton was mistaken in relation to this last point. While the next visit following that of 17 March was planned for a fortnight later – which was of concern in the circumstances – following the visit on 23 March it was noted that the matter would be discussed at the team meeting that afternoon, at which time an appointment was scheduled for 30 March.)

However, Dr Patton concluded in relation to the period of trial leave that "the sufficiency of follow-up is not just a matter of frequency of visits, but must

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include what occurs on those visits". In my view, while the frequency of planned visits was cause for concern on only one occasion, throughout the period of leave vital assessments which were necessary in order to plan appropriate interventions, were not performed.

- Efforts to involve Mr C's family were inadequate. I accept that Mr C did not wish to involve his family. Nevertheless, there is little evidence that efforts were made to encourage such family involvement. There is reference in the progress notes from 18 August 1998 that Mr C was "encouraged to involve partner in understanding what is happening". However, this is only an isolated reference and there is no evidence that the community mental health team had any systematic approach to encouraging the involvement of family. It is unfortunate that the clinical notes do not document Mr C's wish not to involve his family. However, even accepting that this was the case, in my view the community mental health team should have encouraged family involvement as much as possible, especially when members of the family were clearly concerned about his well-being, and keen to discuss their concerns with mental health staff.

In response to my provisional report District Health Board C stated:

> "Regrettably for the family, [District Health Board C] were prevented from involving them in a more in-depth manner by [Mr C's] choices. The reality is that [Mr C], as the patient, was the primary concern of [District Health Board C]. Whilst clearly the family have an impact on [Mr C's] treatment, the level of their involvement was driven by the need for [District Health Board C] to respect [Mr C's] privacy and autonomy. In our view, it would seem unfair that [District Health Board C] is now criticised for abiding by the patient's decisions."

Dr Patton in his further expert advice addressed District Health Board C's response. Dr Patton concludes:

> "In my view, however, even following discussion with and confirmation by [Mr C] of this approach [not to involve his family] it would have been appropriate (and arguably even necessary) for the clinical team to work with [Mr C] to have him allow full involvement of his partner in discussion about his illness, treatment and progress."

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In response to District Health Board C noting that on one occasion the clinical notes did reflect encouragement of Mr C to involve his partner, Dr Patton concluded:

> " … although the suggestion that encouraging involvement of [Ms C] is in accord with the clinical team as seeing her involvement as necessary, to place the onus solely on [Mr C] and not to follow this up in any way was insufficient. …
>
> While I accept [District Health Board C's] contention that there was a need for [District Health Board C] to respect [Mr C's] privacy and autonomy, I can find no record of a systematic attempt to engage him in discussion about appropriate involvement of his partner."

I am therefore of the opinion that District Health Board C should have made further efforts to encourage Mr C to involve his family in his treatment and progress. Having further family involvement would have been a valuable resource in treating Mr C, especially if, as Dr Patton notes, if there were constraints on the clinical staff's contact with Mr C because of staffing shortages.

- There was insufficient response from the community mental health services to repeated expressions of concern from Mr C's family. On a number of occasions Mr C's partner contacted mental health services, but either no action was taken as a result, or the action that was taken was inappropriate in light of the reported apparent risk Mr C presented. The fact that Ms C was a potential source of useful information was acknowledged in the progress notes of 22 September 1998. In my view, the community mental health team should have immediately responded to concerns raised by someone who was in a good position to assess Mr C's mood and condition.

In response to my provisional report on this issue, District Health Board C concluded as follows:

> "It is accepted that more proactive action could potentially have been taken by [District Health Board C] for the contact of 12 October 1998, however we do not accept the contention that the other contacts were not

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> managed in a sufficiently proactive manner, or that [Ms C] was advised that [Mr C] was considered to be well."

Dr Patton does not agree that the instance on 12 October was the only time at which District Health Board C could have responded more proactively to information received from Ms C:

- On 21 August, despite Ms C being concerned about a note Mr C had written indicating he would "take off", no further action was taken as Ms C said she knew how to contact the clinical team if necessary. In the face of heightened concerns, it is surprising to me that no specific action was taken, and that Ms C was not advised as to the circumstances in which she should further contact the team;

- The contact on 12 October is of particular concern; Ms C advised that Mr C had earlier been suicidal, was not always complying with his medication, and he did not feel he was getting better. Despite these very serious concerns, no further contact was made until 23 October, and Ms C was advised to contact a psychiatrist. Furthermore, although Mr C was seen by a different psychiatrist on 16 October, neither psychiatrist was apparently advised of these concerns. In my view this is a serious example of failing to respond appropriately to obvious concerns;

- While Ms C did not express any concerns in her contact of 23 October, the record does not note that specific concerns were explored. In my view it is notable that Ms C was apparently not followed up in respect of the serious concerns she had voiced during the previous contact;

- On 2 November, when Ms C was spoken to, she advised that although she felt things were going well, Mr C felt differently. Despite this, there is nothing to suggest that the clinical team explored the issue further, and there is no further contact with Mr C documented until 30 November.

Based on the above matters, I remain of the view that the clinical team was insufficiently responsive to the concerns expressed by Ms C, when she was obviously in a position to provide important information in relation to Mr C's condition.

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- While some matters were identified as a significant source of stress to Mr C, no management plans were made to address these issues. Those issues did not become a focus for attention, and therefore progress against specified goals was unable to be assessed;
- There was too long a time between contacts at a time when contact should have been increasing, and the threshold for concern appeared inappropriate. An example occurred on 4 September 1998, when Mr C cancelled an appointment, saying that he felt low. Despite this, there was no further contact attempted by Mr C's key worker until 22 September when Mr H called at his house, but Mr C was not there. The next noted contact was not until 5 October, which meant there was a period of over a month in which Mr C was not seen by his key worker, despite indicating that he "felt low". Over this period the risk assessment was completed, assessing his risk to be in the "high" range. In this context I refer to Dr Patton's comment that "there appears to have been an under-appreciation of the need for a high level of responsiveness to his expressions of discomfort".

In his discussions with District Health Board C, Dr Patton was advised that the community mental health services in Town C were seen as a good example of the way in which services can be provided to a rural area. It was noted that when fully staffed, there was no need to rely on services from outside the team for the processes involved in the assessment and review of general mental health needs of individuals under the care of the team.

The response to my provisional report does note the fact that District Health Board C employed only one forensic psychiatric nurse, and that nurse was responsible for City C based patients as well as those in Town C, 45 minutes' drive from City C. This limited the amount of care that could be given. While I accept the limitations of those circumstances, the matters in respect of which I have criticised District Health Board C, in my view and that of my advisor, reflect not so much an inability to provide more comprehensive services, as a failure to recognise and respond appropriately to situations when Mr C appeared to be at risk.

In his initial advice to me Dr Patton concluded that:

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> "[t]he service to [Mr C] was not in my view sufficient. There were gaps in contact that cannot be explained by the rural nature of the service to the [Town C] area, nor in that period by the lack of after-hours availability of staff who could co-ordinate with the daytime activities of the team. These do not appear either to have been due to limited coverage by psychiatrists in that period, as although several psychiatrists were involved there is a reasonable frequency of contact. There simply seems to have been a failure to assess and respond to the risks with which he presented, and to the precariousness of his wellbeing in that face of stressful events."

I accept Dr Patton's advice and I consider that District Health Board C did not provide adequate services to Mr C. In my opinion the Town C mental health services, despite being reasonably resourced, did not sufficiently respond to Mr C's needs, did not have a comprehensive management plan, and were not sufficiently assertive or pro-active in the manner that they organised their interventions.

For these reasons I consider that District Health Board C breached Right 4(1) of the Code.

Actions

I acknowledge that since Mr C was under its care, District Health Board C has made efforts to improve the quality of services provided to mental health consumers. The Town C community mental health team in particular has developed a body of policies and procedures addressing matters such as consumer participation, family and carer participation, consumer assessment, and quality of care and treatment.

There is now a well-developed Risk Assessment Policy in place, which refers to the Ministry of Health's Guidelines for Clinical Risk Assessment and Management in Mental Health Services. Dr Patton considers that this new policy is a "*considerable improvement*" on earlier risk assessment forms and is now comprehensive. In my view this is particularly important given that in Mr C's case District Health Board C demonstrated a lack of responsiveness to the risks with

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which Mr C presented. District Health Board C also advised me that this policy requires patients' cases to be revisited where the risk they face or pose increases.

Further to this issue of proactively managing heightened concerns, District Health Board C has developed a mobile crisis team. District Health Board C advised me that the Coroner has recently recommended that this team be considered as a prototype for development in other areas.

Another area of concern in relation to Mr C's treatment is that of developing a management plan. This has subsequently been addressed in the policies and procedures adopted by District Health Board C. Dr Patton noted that in Mr C's case there was a lack of a comprehensive management plan, and a consequent failure to address significant issues identified as causing stress. However, Dr Patton noted that the new Mental Health Services Treatment Plan will provide a framework for identifying key treatment areas and associated actions and anticipated outcomes.

District Health Board C advised me, in response to my provisional report, that all mental health service teams have regular review systems in place. Their response refers to the 1997 National Mental Health Standards' requirement for a monthly review and notes that District Health Board C complies with this. Furthermore, there is currently a programme in place for the implementation of the recently released 2001 standards. Psychiatric input remains an issue due to the shortage of psychiatrists in the District Health Board C region. However, District Health Board C has arrangements with another District Health Board, and a consultant forensic psychiatrist from there provides supervision for forensic patients on a weekly basis, with the additional support of telemedicine consultations for specialist risk assessments. It is noted that this arrangement is currently being renewed in order to guarantee the continued availability of this service.

Mental health services now have new policies in relation to assessment on initial service contact. All clients are required to have a thorough assessment at their initial contact with the service.

In relation to the issue of family involvement, District Health Board C has advised that it has in place an education programme covering issues such as family involvement and patient privacy. The intent is to have all staff educated in respect

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of these issues. The position of "Family Advisor" is also being created. It is intended to be an advisory and educational position, in order to facilitate families having more input into the care of their family members.

Recommended Further Action

Although the improvements that have been made as noted above are encouraging, it is critical that the policies that have been developed are monitored and audited in order to ensure that the goals they are designed to achieve are in fact being met.

I am aware that in April 2002 Quality Health New Zealand is conducting a survey of District Health Board C's mental health services. I therefore recommend that, as part of that survey, Quality Health examine those policies and procedures discussed in this report that District Health Board C informed me have been implemented since Mr C was under its care. In particular, I recommend that Quality Health examine the following matters:

- The Mental Health Services Treatment Plan, referred to at page 40 of this report. In his initial advice Dr Patton identified the lack of a comprehensive management plan as an area of concern in Mr C's treatment;
- The Risk Assessment Policy, referred to at page 40 of this report. The lack of appropriate risk assessment was another major concern expressed by Dr Patton. Mr C's case emphasises the need for any risk assessment policy to enable ongoing risk assessment and to be responsive in situations where the risk a patient faces increases;
- The policy requiring a thorough assessment at initial contact with the mental health services, referred to at page 41 of this report. Dr Patton has identified as an important component of such assessment that it must be not only thorough, but also performed promptly following initial contact;
- The operation of the Case Review system, noted at page 41 of this report.

While I am supportive of the initiatives by District Health Board C in developing policies and procedures designed to ensure a more effective service for its mental health clients, there undoubtedly needs to be assessment of the extent to which such policies are being implemented in practice. As District Health Board C has

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been preparing for accreditation, and to avoid duplication of effort, the identified policies should be examined as part of the accreditation survey to be performed by Quality Health.

Finally, I recommend that District Health Board C review in detail the comments of Dr Patton, especially in his follow-up advice. Dr Patton has made a number of comments that will likely be very helpful to District Health Board C in its ongoing development and monitoring of mental health policies and procedures.

Other Actions

A copy of this opinion will be sent to Quality Health New Zealand.

A copy of this opinion, with personal identifying details removed, will be sent to the Director of Mental Health, the Director-General of Health, the Mental Health Commission, and the Royal Australian and New Zealand College of Psychiatrists.

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Appendix I
Expert Advice
Dr Murray Patton, Psychiatrist

You are seeking advice in regard to two specific aspects of the services provided to [Mr C]. Before addressing these however I shall review the specific complaints made by [Ms C] as they are relevant to the issue of whether the services provided to [Mr C] were of an appropriate standard.

I have formed my views following the review of the material forwarded to me by your office. You will be aware of the contents of that binder, being:

- Summary of information gathered during investigation
- Copy of medical notes from [District Health Board C]
- Copy of medical notes from [District Health Board B]
- Copy of [the] inquiry commissioned by [District Health Board B]
- Correspondence to and from [District Health Board C].

I have also had a telephone conversation (11 June) with […] the Patient Services Manager Mental Health Directorate ([District Health Board C]). I understand she has been involved in the service of [District Health Board C] from the period of interest through to the present and is able to offer a perspective of events at the time and subsequent changes in the service. I have received (16 June) some material from [District Health Board C], requested following that conversation with [the Patient Services Manager] ….

I shall forward that material to you along with the other material received from your office.

An overview and my conclusions are found [at the end of this advice].

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THE COMPLAINTS

1. ***Services that were to be arranged upon his transfer from [District Health Board A] did not occur until [Ms C] contacted [District Health Board C's] and [Town C's] Mental Health Teams.***

[Mr C] had 2 periods of inpatient care at [District Health Board A] in 1998.

Following the first of these (5 July to 13 July) discharge information was provided to [District Health Board C]. A handwritten facsimile transmission cover sheet dated 13 July notes that [Dr A] had discussed [Mr C] with [Dr G] (then acting in capacity of part-time psychiatrist at the inpatient psychiatric unit of [District Health Board C]) who would take over as Responsible Clinician and who would arrange an outpatient psychiatrist.

A CMHT progress note of 14 July records a visit made by [Mr H] to [Mr C] "and his fiancée …" (sic). The note does not record how this visit was arranged.

Following the second admission (7 August to 11 August) information was provided to [District Health Board C] by [Ms C], who is recorded as noting in a telephone conversation with [Mr H] that [Mr C] was in another town. She was to contact the [Town C] team when [Mr C] returned to [Town C]. That same day (10 August) [Mr H] was contacted by [District Health Board A], who advised of the course of events.

On 13 August [Mr H] visited [Mr C]. The notes do not record how that visit was arranged.

It is not entirely clear whether there was a single precipitant for contact being made, but it does seem likely that contact would have been established following the referral from [District Health Board A], whether or not [Ms C] had made contact.

2. ***A doctor did not examine [Mr C] until one month after he returned from [District Health Board A] and [Mr C] only received three visits from a nurse between 13 July and 5 August 1998.***

Following the first admission to [District Health Board A] [Mr C] was seen by a psychiatrist on 16 July. (This may have been 15 July as there is a slight discrepancy in

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the notes of [Mr H] and this doctor). [Mr H's] note of 15 July reports "accompanied to appointment with [doctor]". The psychiatrist note is unsigned.

[Mr C] was seen again by a psychiatrist on 22 July, and appears to have been seen again on 5 August although no notes of this seem to be present in the material I have seen. I note however an entry by [Mr H] in CMHT progress notes of 5 August "[Mr C] presented as arranged prior to appointment with [doctor]."

Contact with [Mr C] by nursing staff occurred on 14 July, 15 July (this may have been 16 July when accompanying to medical appointment), 17 July (telephone), 24 July, 30 July, 3 August (telephone) and 5 August.

[Ms C] is noted to have been present on 14 July. No other reference is made to her in that series of contacts.

Following the second admission [Mr C] was seen by a psychiatrist on 17 August and 2 September […] then again on 16 October, 13 November, 27 November and 1 December […]

There was therefore contact with a psychiatrist within a month of each admission to [the Public Hospital]. There were 4 face-to-face contacts between [a nurse] and [Mr C] after his discharge from [the Public Hospital Hospital], with a further face-to-face contact on August 5.

3. ***On approximately 10 October 1998 [Ms C] asked for further psychotherapy sessions and was not advised of a further appointment until 23 December 1998, the appointment not being until 20 January 1999.***

There is little reference in the notes to psychotherapy. CMHT progress notes report [Mr C] having appointments with [a] psychiatrist. The progress note of 1 September reports that [Mr H] and [the psychiatrist] were each aware of each other's mode of intervention, although the nature of these are not detailed. [Mr H] appeared to offer supportive contact.

There is no obvious reference to [Ms C] making any request in regard psychotherapy. In a telephone discussion on 12 October [Ms C] is noted to express concern that [Mr C] was not getting better, and was concerned about his care. She was advised to discuss this with [a certain psychiatrist].

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The next appointment with a psychiatrist appears however to have been with [someone else] (16 October). The file note of that appointment does not reflect any discussion of [Ms C's] request. It notes as a component of the treatment plan a consideration of "possible use of counselling around pdsd (sic) issues".

On 2 November in a telephone conversation [Ms C] is noted to have advised [Mr H] that she and [Mr C] were pleased with [that psychiatrist's] input.

A three-month client review report dated 2 November, notes recommendations that up to weekly contact would continue "re supportive counselling". It notes also that there is "No present requirement for psychology input. [A psychiatrist] suggested discontinuing his sessions".

It is unclear what arrangements were made in regard appointments, and by 23 December [Mr C] had been readmitted to hospital.

4. ***Upon his release from [the Mental Health] Hospital on 12 March 1999, a psychiatrist did not examine [Mr C] until 30 March 1999, and this only occurred as the result of repeated requests from [Ms C].***

At the discharge planning meeting on 12 March it was decided that [Dr B] would explore the possibility of [Dr J] seeing [Mr C] in [Town C].

An entry in the clinical notes on 17 March (signature not legible) records that [Dr B] had contacted Dr J, and that follow-up by him in [Town C] would not be a good option. It was agreed instead that [Dr I] of [District Health Board C] would be involved, with possible counselling via [Town C] CMHT.

[Dr I] saw [Mr C] on 30 March. [Dr B] wrote to [Dr I] on 25 March in regard to [Dr I] taking care of [Mr C].

On 23 March a note of a team meeting records that a doctor's appointment was to be scheduled for 30 March. [Dr B] was to be contacted possibly in regard to recent contacts (22 March) by [Ms C] who had indicated some concern, although this was not specified.

No other contact from [Ms C] is documented prior to 30 March. At a team meeting that day readmission was felt to be indicated.

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It is unclear why there was a period of between 2 and 3 weeks which elapsed from the time of discharge until the first appointment with a psychiatrist, although it is possible that because it was not clear whether [Dr J] would be involved, this may have delayed the arrangement with a [District Health Board C] psychiatrist. There was though a view that [Mr C] should have a high level of monitoring after discharge and an early appointment with a psychiatrist would have been appropriate.

5. *[Mr C's] family were not consulted about or involved in his treatment and discharge plan and were not kept informed during his treatment.*

[Ms C] is referred to on several occasions in the clinical notes. The notes provide little detail of the exchanges that included [Ms C]. Some contacts were initiated by her because of her concern. [Mr C] was not in when called or visited, and she was able to give some information in his absence.

There is no reference in the [District Health Board C] notes to any view of [Mr C] in regard involvement of his partner. There is no reference to this being a subject of discussion between him and the clinical staff.

On one occasion (7 August 1998) [Ms C] rang with important information (that [Mr C] was in police cells in [City A]). The nurse declined to offer any information about contacts satisfying himself that there was no immediate danger. Over the next few days [Ms C] initiated further contacts. On 13 August when a nurse visited [Mr C], there is no reference to any discussion of her involvement.

On 18 August [Mr C] was encouraged to involve his partner in understanding "what is happening". There is no reference to further discussion of this nor any offer of assistance should he require it.

On 22 September [Ms C] is noted to potentially be a useful source of information in regard [Mr C's] progress. There is no further reference to discussion of her role in his care.

On 12 October in a telephone conversation initiated by [District Health Board C] [Ms C] noted concern at [Mr C] having suicidal ideas. She was advised to talk to [a psychiatrist]. There is then a gap in the progress notes until 23 October, although a medical appointment is noted on 16 October. …

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A discharge-planning meeting took place on 12 March 1999 at [the Mental Health] Hospital. There is no reference in notes of that meeting to [Ms C] or other family members.

On 22 March [Ms C] rang the [District Health Board C] team concerned [Mr C] was thinking of leaving. Notes of a visit the following day make no reference to those concerns or to [Ms C]. There is no further reference in the [District Health Board C] records to [Ms C] in the period to admission at the end of March.

There does appear to have been less involvement of family than would ordinarily be desirable.

6. ***Despite [Ms C] continuing to advise the [Town C] Mental Health Team that she was concerned about her husband's condition, services were not increased and advice was given that they considered [Mr C] to be well.***

The notes contain a number of references to [Ms C] initiating contact with concerns. There is little evidence of any information that was supplied to her.

On 7 August 1998 and over the next few days [Ms C] made contact in regard [Mr C] being in custody in [City A]. These events were followed by a visit on [Mr C's] return to [Town C].

On 21 August in a telephone conversation [Ms C] expressed some concerns. There appears to have been no specific action taken.

On 12 October in a telephone conversation initiated by [District Health Board C] [Ms C] expressed some concerns. She was advised to discuss them with the psychiatrist. [Mr C] subsequently (16 October) saw a different psychiatrist. There is no record that her concerns were conveyed to either of these doctors by the staff member.

[Mr C] was seen again by [that psychiatrist] on October 30, and on November 13 and 27. These were planned appointments.

Mental Health Progress Notes of 30 November record a call-out initiated by contact by [Ms C]. An On-Call Urgent Assessment Form records an assessment on 1 December in follow-up events after that call.

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An On-Call Urgent Assessment form dated 30 December 1998 records a contact initiated by [Ms C], who was concerned that [Mr C] might harm himself. Police were notified, as [Mr C] was unable to be located. This form however also appears to be dated (at end) as 30 November 1998, and appears to relate to the same incident as the entry in the progress notes of 30 November. By 30 December [Mr C] was an inpatient and there is no entry in the inpatient notes at end December in relation to such an event.

On 22 March 1999, [Ms C] rang concerned. This appears to have resulted in a visit the following day with further discussions then occurring within the clinical team and with [Dr B]. There appears to have been a moderately high level of concern, but [Mr C] was not seen again until 30 March.

There does appear to have been little response from the team to the repeated expressions of concern from [Ms C].

ADVICE REQUESTED BY HEALTH AND DISABILITY COMMISSIONER

(i) Were the services of an acceptable standard?

An assessment of [Mr C] was completed by [Mr H], community mental health nurse. This assessment appears to have been completed over a number of appointments and contacts between mid July and mid September 1998, and is available in typed form in a document dated 14 September 1998.

This assessment is of a reasonable standard although appears to have been completed over a period of time rather longer than might be ordinarily regarded as acceptable, especially in view of the nature of the concerns with which [Mr C] presented. Another reasonably comprehensive assessment note was completed by [a psychiatrist] on his first assessment in mid October.

A "CMHT assessment of risk" form is present in the file. This is dated 2 September 1998. The form is complete. There is no evidence available to me of this form having been revised at any stage. It is not clear whether other documents evident in the file made available to me were available to [Mr H] in completing or revising this form. In particular, notes apparently made in the course of therapy with [a psychiatrist] illustrate ideas of hanging and note marked thoughts of suicide and worthlessness.

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The risk assessment document does not identify factors that may increase or reduce risk over time, or the context in which risks are increased or decreased. Such contextual factors are now regarded as important in assessing and managing risk, as identified in the Guidelines for Clinical Risk Assessment and Management in Mental Health Services published by the Ministry of Health in 1998.

A form labelled "CMHT crisis management" is found in the file. This is undated and has only a brief entry. No other comprehensive management plan summary is evident. Clinical progress notes do however identify attention to a number of aspects of treatment covering a number of domains of need, including investigations, pharmacological and other approaches to symptom management, and psychotherapeutic assistance. The assessment note of 16 October notes some financial and relationship stresses, but these are not clearly identified anywhere as a focus for attention with review of progress against goals addressing these stresses.

The progress notes generally reflect attention to subjective and objective matters in relation to present state, and usually note a plan for next actions. There is generally little comment about an assessment or formulation of his current state. The notes make reference to involvement by a staff member of another service, but the clinical record reveals little evidence of specific goals of that other work, or progress with it. The 3 monthly combined review however appears to be a good summary of progress and plans with good opportunity for the various parties involved coordinating their approach to care.

The notes appear to suggest that at times plans were not evident to all staff involved in care at critical periods. The nurse apparently covering for the usual key-worker on 12 October appears to have suggested [Ms C] discuss her concerns with a psychiatrist different to the one who would see [Mr C] a few days later.

There appear to be some gaps in contact at times that concern might have been thought to be heightened, and increased contact required. On 4 September 1998, [Mr C] cancelled an appointment with [Mr H], noting that he felt low. He was asked to make contact himself if he needed support. He was due to see [a psychiatrist] that day. No notes are available to me of that appointment.

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The next community mental health team progress note is dated 22 September. [Mr C] was not in. Telephone contact was to be attempted in the next day or two. The next note is dated 5 October.

It should be noted that during this period the risk assessment document was completed assessing overall risk to himself as well within the "high" range, and [Mr C] had most recently expressed concerns of low mood.

A further gap in contact with his key worker is evident between 8 October and 30 November. On 8 October he noted a tendency to dwell on self-pity. He was not available when contacted on 12 October, but [Ms C] noted concerns. She was advised to discuss these with the psychiatrist. [Mr C] saw a different psychiatrist on 16 October who noted suicidal thoughts (not detailed). Contact was attempted on 23 October, when [Ms C] said he would ask [Mr C] to call.

[Mr C] saw a psychiatrist again on 30 October. He noted himself to be feeling discouraged that he was feeling no better.

On 2 November [Ms C] advised [Mr H] (who had phoned to contact [Mr C]) that [Mr C] was working. She advised that although she still felt things were better, [Mr C] felt differently. She would try to get [Mr C] to contact the nurse. There is no record of him doing so, or of the nurse attempting to make contact again with [Mr C].

[Mr C] saw [a psychiatrist] again on 13 November (at which time he was feeling better but still depressed at times) and again on 27 November.

The next entry reflects a crisis call-out on 30 November.

Another gap in assertiveness of follow-up occurred in March 1999. At discharge from [a Mental Health] Hospital on 12 March it was felt that close monitoring was necessary. [Mr C] was not seen though until March 17 at which time the notes reflect that he had had a stressful weekend and he was having difficulty settling back into home. There is no detailed assessment of his mental state. Despite the identified difficulties, and without a basis (in the form of a detailed examination of mental state) for accurately determining an appropriate intervention, a visit was not planned for a further 2 weeks. A visit took place on 23 March, apparently precipitated by concerns from [Ms C], and discussion took place the next day with the team, then with [Dr B] the following day.

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Despite the increased concern, the only response appears to have been to schedule an appointment for March 30.

In summary it appears that although a moderately comprehensive assessment was undertaken, this was not completed for some time despite [Mr C] presenting in circumstances suggesting a moderate degree of concern was appropriate. The initial assessments by psychiatrists on 16 and 22 July are brief and generally inadequate in the absence of more detailed assessments by other staff.

Care planning is not well documented. Adequate attention is paid to attempting to address symptoms of mental illness, but other factors identified as stresses are not substantially addressed.

Despite increasing difficulty in monitoring [Mr C] directly, there is no evidence of increased efforts to make contact at times when increased concern and assertive approaches were appropriate.

Despite relationship issues being identified as a stress and despite [Ms C's] apparent interest in [Mr C's] welfare (and her apparent ability to comment upon his progress) there was no systematic involvement of her as a resource in the ongoing care of [Mr C]. Even in the absence of permission from [Mr C] (whether expressly refused or simply not sought) it would have been appropriate to encourage such participation.

The description of the role of keyworker outlined in the 1994 Policy and Procedure Manual supplied by [District Health Board C] notes "The keyworker, with consumer permission, consults with family/whanau, significant others and peers from the time of assessment, through treatment, and rehabilitation/maintenance". There is no evidence of this occurring in a systematic manner, or of discussion with [Mr C] regarding the need for this, or his views on such participation.

(ii) Was the level of service provided sufficient?

As noted above, there are some gaps evident in the series of contacts with [Mr C].

Responses to [Ms C's] expressions of concern were generally not adequate. Increase in assertiveness of contact with [Mr C], exploration of possible arrangements for review by after-hours staff at times that [Mr C] was difficult to see during the day, and detailed exploration of his mental state would have been appropriate.

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A moderately high level of contact was established in the first 2 months of [Mr C's] contact with [District Health Board C]. By mid-September 1998 the assessment document was completed and risks assessment documented.

However, despite this (presumably) greater understanding of his presentation and the expressions of concern from [Ms C], frequency of direct contact with [Mr C] appears to have dropped off. There was a long period without contact, much longer than appears appropriate in light of the aspects of his presentation that warranted review by a skilled clinician. Even in the face of a much clearer understanding of concerns about his presentation by the time of his discharge from a lengthy admission to [the Mental Health] Hospital, there appears to have been an under-appreciation of the need for a high level of responsiveness to his expressions of discomfort.

In summary therefore, in my view there are inadequacies in the level of service provided to [Mr C].

Consideration must be given though to the location of [Mr C] through his contact with [District Health Board C] and to the difficulties faced in providing services to residents of more remote areas.

I am told by [the Patient Services Manager] however that services to [Town C] have been acknowledged as a good example of how services can be provided to a rural area. The community mental health team for [Town C] is, when fully staffed, self-contained with respect to multidisciplinary team function. That is, there are positions for senior medical staff and other team members such that when occupied there is no need to rely on services from outside of the team for processes involved in assessment and review of 'general mental health' needs of individuals under the care of the team. Where there is a shortage of cover of senior medical staff however, people will travel to City C for psychiatrist review.

[The Patient Services Manager] advises though that although the staffing establishment of the [Town C] team for psychiatrist staff is 1.0 FTE, there will usually be coverage to this total from 2 or 3 doctors in an effort to get a mix of gender and practice style to the team.

For more specialised assessments, such as involvement of Forensic Psychiatry, there are processes for consultation with those specialist services and occasionally the Forensic Service will take over the care of certain individuals. There appear to be good

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processes for coordination of care between the [Town C] team and the Forensic Service, although at the time of [Mr C's] involvement, clinical records of each service were separate.

[Mr C] was thought able to be cared for within the general community mental health team, and a 'fit' between his potential needs and with the skills represented in the [Town C] team resulted apparently in [Mr H] being assigned as his key worker, at least in part because of [Mr H's] prior experience in forensic psychiatric nursing.

There has however been difficulty in ensuring sufficient psychiatrist coverage in [District Health Board C]. The first doctor to see [Mr C] was working part-time for [District Health Board C], with the remainder of his time in [District Health Board B]. He largely saw outpatients in [City C], rather than being based with the [Town C] team.

One psychiatrist was working for [District Health Board C] for a period of 18 months or so, based mostly in [City C] but also covering the [Town C] team. Another was the Clinical Director of the [District Health Board C] service, in this post for a 6-month period. Currently there is a marked shortage of psychiatrist cover to [District Health Board C], including the [Town C] team.

At the time of the involvement of the [Town C] team with [Mr C], after-hours service to the area was from rostered staff from the [Town C] team. Since 1999 there has been a crisis service covering the whole [District Health Board C] region.

Leave cover for nursing staff would usually be provided, for short periods of leave at least, from within the team.

I am advised by the Patient Services that oversight of systems of care within the [Town C] team is the responsibility of the Team Leader, who would lead and coordinate processes for review and other functions of the team. During the period of [Mr C's] involvement there was a consistent presence of one person in this role.

There does appear to be at least one example of a failing in the oversight of care of [Mr C]. As noted earlier in this report, on 12 October [Ms C] was advised by the nurse covering leave absence of [Mr H] to discuss her concerns with a psychiatrist who appears no longer to have been involved in care. The appointment just a few days later was with a different psychiatrist to the one suggested. This detail seems not to have been known to that nurse. Even if care was transferred to this other psychiatrist within

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those few days, there seems to have been no system to transfer the information in regard to the call. Apart from the 3-month reviews, it is not clear from the notes that there were opportunities for more frequent multidisciplinary discussion (and therefore perhaps enhanced coordination of care and problem-solving) at times of increased concern, such as when there were difficulties establishing contact.

Documentation received from [District Health Board C] records that at the time of [Mr C's] contact a multidisciplinary review meeting was held on Wednesdays and Fridays. There is no evidence in the file that this forum was used to discuss matters such as the difficulty contacting [Mr C].

A question could be asked as to whether this Team Leader should have the support of a single Psychiatrist in overseeing the clinical standards and breadth of planning for care by members of the team. In my view, that is an important aspect of the role of a psychiatrist. Sharing the coverage of the team across 2 or more psychiatrists, each working part-time in the team reduces the ability of the psychiatrists to take this role. Clearly however, in circumstances in which psychiatrist cover is intermittent, the role of the Team Leader – and having the right clinical skills vested in that person – becomes critical.

In brief then, the rural or remote nature of the service in [Town C] in itself does not appear to be likely to affect the nature of the service that could be provided to residents of the area. The nature of the community mental health team, after-hours cover, and systems for coordination and oversight of joint work with specialist services seem reasonable. At the time in question the separateness of the clinical records of the forensic and general community teams may however have increased the risk of poor coordination and oversight of key elements of information in relation to [Mr C] (for example the work with a psychologist of the Forensic Team and the notes and illustrations of figures suggesting suicidal ideation). I am informed though that since that time there is a system of one file per person, and that Forensic Service staff enter records in the same file as general community mental health staff.

The service to [Mr C] was not in my view sufficient. There were gaps in contact that can not be explained by the rural nature of the service to the [Town C] area, nor in that period by the lack of after-hours availability of staff who could coordinate with the daytime activities of the team. These do not appear either to have been due to limited coverage by psychiatrists in that period, as although several psychiatrists were involved there is a reasonable frequency of contact. There simply seems to have been a failure to

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assess and respond to the risks with which he presented, and to the precariousness of his well being in the face of stressful events.

OVERVIEW AND CONCLUSIONS

[Mr C] presented with features of disturbed mood and with unusual behaviour, in the context of some psychosocial stresses. Timely, comprehensive assessment and development of a range of interventions to address these features and the stresses was necessary.

Full assessment documentation was not however completed until some two months after he was first engaged in the service. Follow-up notes have inadequate detailing of thought content, especially in regard the identified areas of risk.

In my view this delay in full assessment information being documented is not satisfactory. The notes of the psychiatrists involved prior to that material becoming available were also inadequate in attending to matters of concern and were insufficient to make up for the not-yet completed nursing assessment. It would have been appropriate, in light of the concerns in [Mr C's] presentation, for the full assessment documentation to be completed within two weeks of first being seen. There is no indication from [District Health Board C] of what is regarded as the standard for timeliness of assessment documentation, and it may be useful for this to be addressed within the revised document "Procedure – Consumer Assessment".

A risk assessment was completed, but there is no evidence of it being reviewed. An appropriate trigger for such review might have been when there was a period of altered mood or other change in mental state, or where there was difficulty maintaining sufficiently close contact. There is now a revised Risk Assessment Policy in place, which refers to the Ministry of Health Guidelines for Clinical Risk Assessment and Management in Mental Health Services (1998). The policy and documentation is a considerable improvement on earlier risk assessment forms and is now very comprehensive, including attention to context of risk factors and need for review at regular intervals or change in level of risk.

There was inadequate involvement of family supports, or attention to involvement of family, especially [Ms C]. Although relationship stress was noted as a problem, it was not addressed in the management. Recognition of the potential role of family or other caregivers is evident in documentation of the service dating from 1994 (keyworker role

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description) and apparently in force at the time of contact with [Mr C], but there is little evidence of attempts to encourage appropriate involvement.

This area of interaction is emphasised in the revised Mental Health Services policy and procedure documentation. The document "Procedure – Quality Care and Treatment" contains several references to this (16.7: "… Clients are encouraged to take part in planning along with persons involved with care and support."; 16.26 "Psychiatrists see consumers, with family and caregivers as often as possible."), as does the document "Procedure – Family and Carer participation" (10.1 "… Family and carers are involved … with the consumer's consent, i.e. assessment, treatment and discharge planning …"). The document "Procedure – Consumer Assessment" also notes "Where appropriate consumers and their families and carers are involved in information sharing diagnostically, treatment plans and possible outcomes".

Given however that there was reference to involvement of family in at least one policy dating from 1994 but that this does not appear to have influenced practice in this case, there must be a question as to whether the apparently increased attention to this aspect through the focus in a number of policy and procedural statements will be sufficient to modify practice. I did not request, and have not been provided with, information about training in implementation of this aspect of policy and procedure, nor whether there has been any specific attention in the service to the promulgation and adoption of the document "Involving Families – Guidance Notes" (Ministry of Health 2000).

Management plans were limited in scope, and a significant stress identified early in his presentation, in regard his relationship, was not apparently a subject of plans. Documentation of care plans is difficult to find in the record, although this aspect of documentation will be assisted by the revised Mental Health Services Treatment Plan. Although this is not structured and does not provide prompts in regard potential domains of need for attention in the plans, it does provide a framework for clear identification of key treatment areas and associated actions and anticipated outcomes.

There was too long between contacts at a time when concern should have been increasing, and there is no record of discussion in regard whether or how more assertive efforts might have been made to make contact. I am advised (letter 15 June 2001) that in 1998 and 1999 there was a mechanism for bringing to the attention of the team multidisciplinary meeting those patients for whom the keyworker felt a team review was required, but this opportunity was either not felt necessary, was overlooked, or was not documented. It appears to me though that the threshold for concern was not

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appropriate, and that there was an under-responsiveness to the relatively infrequent contact in 1998, and that the planning for contact after discharge from the Mental Health Hospital in 1999 was less than was consistent with the stated need for close monitoring.

Mechanisms for review are still a feature of current policies and procedures although only new assessments are recorded as subject to clinical review on three days each week. Other active cases are reviewed at a monthly meeting, but with opportunity for cases of concern to be discussed with the team leader at any time (Mental Health Services Procedure – Consumer Assessment).

In my view there is merit in wider input into the discussion of cases of concern, at a more frequent basis than a monthly meeting allows. Absence of the psychiatrist from these discussions of cases of concern further reduces the range of valuable contributions that can be made in circumstances where much further thought needs to be given to the approach to care. This is clearly more of a problem currently with much reduced psychiatrist coverage for [District Health Board C], although I have not sought information in regard exploration of arrangements such as teleconferencing with other centres for such input.

To conclude, as noted, there were deficiencies in care and documentation. Some measures taken by [District Health Board C] should lead to improvements in some of those areas of deficiency, notably involvement of family, treatment planning, and risk assessment. Key deficiencies not addressed are those in relation to thoroughness of assessments at initial contact and timeliness of completion of assessment documentation, and responsiveness of the service to heightened concerns.

Please let me know should you require further assistance with this matter.

Yours sincerely

M D Patton
FRANZCP

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Appendix II
Response to Provisional Opinion
District Health Board C

"I refer to the above-mentioned Provisional Opinion ("PO") dated 1 August 2001.

… As previously indicated, [District Health Board C] has a number of concerns with regards to the Provisional Opinion, besides those that we raised in our letter of 9 August 2001. To assist you in analysing our response, we have divided our response into a number of sections. We trust that our response will be given due consideration, and appreciate your forbearance in reading through this detailed response.

The complaint laid by the family against [District Health Board C] is set out as a general complaint, with particularised sub-sets to it. Whilst some of these complaints are negatived with the expert advice at the back, at no stage during the actual PO, are the individual complaints against [District Health Board C] negatived. We believe that the Commissioner needs to clearly accept or negative each complaint. Similar complaints were made regarding [District Health Board A's] services, and it is noted that the particularised complaints against [District Health Board C] are respectively negatived. [District Health Board C] would expect to receive the same treatment as to the acceptance/declination of each complaint within the final opinion, as [District Health Board A] received.

Complaint One:

Dr Patton in his Expert Advice to the Commissioner deals with the complaints made by the family against [District Health Board C]. The first complaint is that:

> 'Services that were to be arranged upon his transfer from [District Health Board A] did not occur until [Ms C] contacted [District Health Board C] and [Town C's] Mental Health Terms.'

> Dr Patton concludes his comments on his complaint by stating that:

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> '…it does seem likely that contact would have been established following the referral from [District Health Board A], whether or not [Ms C] had made contact.'

In light of this comment, we believe that this particularised complaint should be specifically negatived within the section of the PO headed **"Commissioner's Opinion"**.

Complaint Two:

This complaint is that:

> 'A doctor did not examine [Mr C] until one month after he returned from [District Health Board A] and [Mr C] only received three visits from a nurse between 13 July and 5 August 1998.'

[Mr C's] first transfer of care from [District Health Board A] to [District Health Board C] was on 13 July 1998. As per Dr Patton's comments on page 39 [of the Provisional Opinion], the [District Health Board C] notes record that [Mr C] was seen by a psychiatrist, on either the 15th or the 16th of July1998.

[Mr C's] second transfer of care from [District Health Board A] to [District Health Board C] took place on 11 August 1998. Again, as per Dr Patton's comments on page 39 [of the Provisional Opinion], the [District Health Board C] notes record that [Mr C] was seen by a psychiatrist, on 17 August 1998.

The expert advice also comments, and the [District Health Board C] files record, that [Mr C] was seen face-to-face by Nurse, [Mr H], on the 14th of July, the 15th of July, the 24th of July, the 30th of July and the 5th of August 1998. He was also contacted by telephone by [Mr H] on the 17th of July and the 3rd of August 1998.

Again, this complaint should be specifically negatived within the section of the PO headed "**Commissioner's Opinion**".

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Complaint Three

This complaint is that:

> 'On approximately 10 October 1998 [Ms C] asked for further psychotherapy sessions and was not advised of a further appointment until 23 December 1998, the appointment not being until 20 January 1999.'
>
> The [District Health Board C] file records no mention of [Ms C] requesting psychotherapy. In the usual course of events such a request would be recorded. As no record is made of such a request, [District Health Board C] can only state that it never received this request.

As noted by Dr Patton in his expert advice, the file note of [Mr C's] consultation of 16 October 1998 with a psychiatrist records that:

> 'We will consider the possible use of counselling around pdsd issues.'

The fact that the file note of 16 October 1998 does not record any discussion of [Ms C's] request is consistent both with the fact that no such request is recorded elsewhere in the file, and with our contention that no such request was made (or at least received by [District Health Board C]). This viewpoint is further confirmed by the fact that the records are unclear as to what arrangements were made with regards to a further appointment. Notwithstanding the above, it is clear that the use of counselling was being considered as at 16 October 1998.

We believe that there is insufficient material to enable this complaint to be upheld, and would again request that it be specifically negatived within the body of the PO.

Complaint Four

Of particular concern to [District Health Board C] are the contents of both the PO, and the Expert Advice of Dr Murray Patton, with regards to the period of care for [Mr C] from 12 March 1999 through to 31 March 1999.

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The particular complaint identified by [District Health Board C] as relevant to this period of time was:

> 'Upon his release from [the Mental Health Hospital] on 12 March 1999 a psychiatrist did not examine [Mr C] until 30 March 1999, and this only occurred as the result of repeated requests from [Ms C].'

In the section of the PO headed **"Information gathered during investigation',** the PO states at page 17 that:

> '[Ms C] advised that a [District Health Board C] forensic nurse visited [Mr C] at home in [Town C] on 12 March 1999, the day of his discharge from [the Mental Health Hospital].
>
> Mrs C stated that during the period between 12 and 31 March 1999 she repeatedly advised the [Town C] mental health team that she was very concerned about [Mr C's] condition. [District Health Board C] records documented that [Ms C] called the mental health team on 22 March 1999, but did not document the content of this telephone call. [Ms C] stated that despite her concerns, [Mr C's] services were not increased. [Ms C] advised that a forensic nurse saw [Mr C] approximately three times during this period, and a psychiatrist did not examine [Mr C] until 30 March 1999.'

In the Section of the PO headed **"Commissioner's Opinion",** noted as one of Dr Patton's concerns (upon which the conclusion of breach is based), is the following bullet-pointed statement (at page 33):

> 'Planning for contact after discharge from [the Mental Health Hospital] in March 1999 was not consistent with the stated need for close monitoring.'

In the Section of the PO containing the expert advice from Dr Murray Patton, Dr Patton summarises the contents of the clinical files that he has reviewed. At pages 40 to 43 he states:

> > '… [Dr B] was to be contacted possibly in regard to recent contacts (22 March) by [Ms C] who had indicated some concern, although this was not specified.

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…

It is unclear why there was a period of between 2 and 3 weeks which elapsed from the time of discharge until the first appointment with a psychiatrist, although it is possible that because it was not clear whether [Dr J] would be involved, this may have delayed the arrangement with a [District Health Board C] psychiatrist. There was though a view that [Mr C] should have a high level of monitoring after discharge and an early appointment with a psychiatrist might have been appropriate.

5. [Mr C's] family were not consulted about or …

…

A discharge meeting took place on 12 March 1999 at the Mental Health Hospital. There is no reference in notes of that meeting to [Ms C] or other family members.

On 22 March [Ms C] rang the [District Health Board C] team concerned [Mr C] was thinking of leaving. Notes of a visit the following day make no reference to those concerns or to [Mrs C]…..

…

6. Despite [Ms C] continuing to advise the [Town C] …

…

On 22 March 1999, [Ms C] rang concerned. This appears to have resulted in a visit the following day with further discussions then occurring within the clinical team and with [Dr B]. There appears to have been a moderately high level of concern, but [Mr C] was not seen again until 30 March.'

Dr Patton then states his conclusions in the section of his advice headed up **"Advice Requested by Health and Disability Commissioner"**. Under the sub-heading **"Were the services of an acceptable standard?"**, Dr Patton states at pages 45 and 46 as follows:

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> ‘Another gap in assertiveness of follow-up occurred in March 1999. At discharge from [the Mental Health Hospital] on 12 March it was felt that close monitoring was necessary. [Mr C] was not seen though until 17 March at which time the notes reflect that he had had a stressful weekend and he was having difficulty settling back into home. There is no detailed assessment of his mental state. Despite the identified difficulties, and without a basis (in the form of a detailed examination of mental state) for accurately determining an appropriate intervention, a visit was not planned for a further 2 weeks. A visit took place on 23 March, apparently precipitated by concerns from [Ms C], and discussion took place the next day with the team, then with [Dr B] the following day. Despite the increased concern, the only response appears to have been to schedule an appointment for March 30.’

Dr Patton provides further advice to the Commissioner under the heading: **“Was the level of service provided sufficient?”**. At page 47 he stages:

> ‘… Even in the face of a much clearer understanding of concerns about his presentation by the time of his discharge from a lengthy admission to [the Mental Health Hospital], there appears to have been an under-appreciation of the need for a high level of responsiveness to his expressions of discomfort.’

Dr Patton then writes, in the section headed: **“Overview and Conclusions”**, at page 52, that:

> ‘… It appears to me though … that the planning for contact after discharge from [the Mental Health Hospital] in 1999 was less than consistent with the stated need for a high level of responsiveness to his expressions of discomfort.”

Dr Patton then writes, in the section headed: **“Overview and Conclusions”**, at page 52, that:

> “… It appears to me though … that the planning for contact after discharge from the [Mental Health Hospital] in 1999 was less than consistent with the stated need for close monitoring.”

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[District Health Board C's] Concerns

In our view, a number of these issues are erroneous and in need of correction. It is important to look at this whole period of care in the context of the discharge meeting held on 12 March 1999 at [the Mental Health Hospital]. This meeting was the beginning of [District Health Board C's] involvement in this period of [Mr C's] care. [Mr C's] [District Health Board C] file commences this period with a full-page note that reads as follows:

> '12/3/99 Discharge planning meeting.
>
> Attending – [Mr C], Forensic Psychiatric Nurse, [Dr B], S/N[1] ([Mental Health Hosp. City B])
>
> – To be discharged on 3/12[2] sec 31[3] leave. Previous to meeting [Dr B] had met c[4] [Mr C's] partner [Ms C]. She remains concerned re continuity in his Rx[5] & adequate support/assessment should [Mr C] become unwell.
>
> Involvement of [Dr J] was discussed, [Private Psychiatric Hospital] Psychiatrist, due to him visiting [Town C] on a 2/52[6] basis and his being able to offer psychotherapy as an option.
>
> _Plan_
> – [Dr B] to contact [Dr J] re possibility of [Town C] Clinic.
> – [Forensic Psychiatric Nurse] to visit every 2/52 in [Town C] or more if warranted.
> – To be discussed at Inv. team meeting and other Rx options explored, ie –
> – [Dr I] instead of [Dr J].

---

[1] Medical shorthand for: Staff Nurse
[2] Medical shorthand for: 3 months
[3] Section 31 of the Mental Health (Compulsory Assessment & Treatment) Act 1992, which provides for inpatient leave
[4] Medical shorthand for: with
[5] Medical shorthand for: treatment
[6] Medical shorthand for: fortnight (or fortnightly)

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– To be discharged on 3 months leave.
– 3/12 supply of resperidone scripted. ([Forensic Psychiatric Nurse] to arrange via [District Health Board C] Pharmacy)
– [Mr C] to accompany [the Forensic Psychiatric Nurse] on his return to [City C] and be dropped off in [Town C].

(signed) Forensic Psychiatric Nurse"

[Dr B] – Responsible Clinician

At the meeting, [Dr B] was the primary Health Professional with ultimate responsibility for [Mr C's] treatment and management. [Dr B] is a Consultant psychiatrist, and was also [Mr C's] Responsible Clinician in terms of the Mental Health (Compulsory Assessment and Treatment) Act 1992 ("the Mental Health Act").

Under the Mental Health Act, it was ultimately [Dr B's] decision to grant leave to [Mr C], and to determine the conditions under which that leave was granted. Further, without a formal transfer of care, [Dr B], as Responsible Clinician, was the person who had legal responsibility for revoking [Mr C's] leave – see section 31(4) of the Mental Health Act. This is confirmed by the copies of the following forms in the [District Health Board B] Notes, both of which are signed by [Dr B]:

– Leave of Absence for Inpatient – Signed 12 March 1999; and
– Notice of Cancellation of Leave – Signed 31 March 1999.

The plan, as recorded in the [District Health Board C] notes, was for [Dr B] to first contact [Dr J] and explore the option of him attending on [Mr C]. The only person who was in a position to transfer care to another psychiatrist (absent a crisis), was [Dr B]. It is accepted that the [District Health Board B] notes indicate that follow-up was to be with [Dr I], however they also indicate that consultant follow-up with [Dr J] would be arranged if possible. In any case, as indicated above, the leave planning was ultimately [Dr B's] legal responsibility to instigate, and there was no formal communication from her to [Dr I] until [Dr B's] letter of 25 March 1999 to [Dr I].

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We are of the opinion that the delay in arranging a psychiatrist was contributed to by the possibility of [Dr J] being involved, as suggested by Dr Patton at page 41 of the PO. However, as is clearly stated above, the responsibility for that delay rests with [Dr B], not [District Health Board C].

It is further noted that the Inquiry commissioned by [District Health Board B] makes the following comment at page 10, under the heading of Outpatient Services:

> 'There was a clear difficulty for the inpatient treatment team with the perceived absence of adequate outpatient services which made discharging [Mr C] into the community problematic. This potentially could have led to his readmission in March and also prolonged hospitalisation with associated risks…. When not an inpatient he was treated as an outpatient in the [Town C] and City C area. During the period of [Mr C's] treatment, there was shortages of clinical staff in [Town C] and [City C], which had a bearing on decisions made about [Mr C's] discharge to community care."[7]

It is reasonable to infer from this that [Dr B] knew that discharging [Mr C] to [Town C] posed a risk due to the staffing shortages that [District Health Board C] were then undergoing. Whilst ultimately, the staffing issues are [District Health Board C's] responsibility to remedy, the indication that [Dr B] was aware of these issues made it a factor that she needed to consider in the overall plan to discharge [Mr C]. Again, the decision to grant leave to [Mr C] on 12 March 1999, was [Dr B's] legal responsibility, under section 31 of the Mental Health Act.

Proactive Management

Further, it was also recorded in the [District Health Board C] notes that [the Forensic Psychiatric Nurse] would make fortnightly visits for the planned three month leave, unless more frequent visits were warranted. Notwithstanding this

[7] In light of this section of the Inquiry Report, it would appear that the Report does have some bearing on [District Health Board C's] response to the Provisional Opinion

however, the visits which took place (17 March, 23 March and 30 March), were more frequent than the planned fortnightly visits. Further, the notes would suggest, in our view, that [District Health Board C] was proactive in managing [Mr C]. The file entry for 17 March notes as follows:

> '17/3/99 Visited at home. He had a stressful w/e[8] – His son has been ill over the w/e c little sleep as a result. Having difficulties settling back into home – concerns re the community's reaction towards him, thinking about work.
>
> – [Dr B] contacted and she has been in contact c Dr J and this would probably not be a good option due to the cost $100 plus an hour and he will be finishing his [Town C] Clinic later in the year.
> – Discussed [District Health Board C] and arrangement will be medical f/u[9] via [Dr I] and possible counselling via [Town C] C.M.H.T – I had previously discussed this with them.
> **Plan** – [Forensic Psychiatric Nurse] to start referral process to [Town C]
> C.M.H.T. for counselling.
> – next visit 2/52.
> (signed) [Forensic Psychiatric Nurse]'

The notes suggested that it was the [District Health Board C] Forensic Psychiatric Nurse, who contacted [Dr B], as a result of his visit to [Mr C]. Whilst one can assume that [Dr B] was shortly to contact [District Health Board C] with regards to the changed plan (ie [Dr J's] unavailability), the changed plan was actually discovered as a direct result of [District Health Board C's] proactive contact with her. Despite the fact that there had been discussion of [Dr I] following up [Mr C's] care in place of [Dr J], as will be seen later, no formal transfer of care was received until towards the end of March 1999.

Again, despite the plan at the discharge meeting (and following the 17 March visit, including after discussion with [Dr B]) being for fortnightly visits from

[8] Medical shorthand for: weekend
[9] Medical shorthand for: follow-up

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[the Forensic Psychiatric Nurse], [District Health Board C] showed that they were flexible in managing [Mr C] by responding to the call of 22 March 1999 with a visit the next day. Furthermore, despite page 17 of the PO suggesting that [District Health Board C] records do not document the content of [Ms C's] telephone call of 22 March 1999, [Mr C's] [District Health Board C] file has the following entry:

> '22/3/99 1615 hrs – Received a phone call from [Ms C] – [Mr C] talking about leaving the relationship and moving to his own home in [Town C]. He had started shearing (against [Dr B's] advice). Some of these issues discussed and in turn she would spend more time pm c [Mr C].
>
> Plan – Visit 23/3/9.
>
> (signed) [Forensic Psychiatric Nurse]'

The visit is also recorded as follows:

> '23/3/99 1300 hrs – Feels more settled, w/e not good, though was pleased to do some shearing found it stressful – especially alcohol after the day. He did not partake.
> He reported some concerning thoughts over the w/e but more settled.
> He has decided not to move rather attempt to address his situation and find solution and ? rethink things after Winter!
> Though he finds shearing hard, doing little at home he finds just as tough.
>
> – Given educational information on schizophrenia and respiridone and encouraged to work only part time if he must.
> – Plan Discuss forensic team meeting
>
> (signed) [Forensic Psychiatric Nurse]'

The next entry in the notes is regarding the Forensic team meeting, where it was recorded that [Dr B] is to be contacted, and that a Doctor's appointment is to be scheduled for 30 March. Again, this evidences a proactive decision by [District Health Board C] to contact [Dr B], who at that point in time, was still [Mr C's]

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responsible clinician. Anticipating that this call would put in step the processes necessary to transfer care to [Dr I], the team also arranged for an appointment to be arranged for the 30th of March.

[Dr B] was then contacted the following day by the [Forensic Psychiatric Nurse]. Whilst there is no clear evidence, it appears that it was this call that finally prompted [Dr B] into action. This can be inferred from the fact that [Dr B] wrote to [Dr I] formally transferring [Mr C's] care to [Dr I], the next day, 25 March 1999. The fact that care was formally transferred at this time, is evidenced by the opening sentence of the letter, which states:

> 'I am grateful to you for taking over the care of this man, who I believe continues to be at risk of acting in impulsive and dangerous ways.'

This letter then goes on to cover [Mr C's] history, condition and risk factors, before concluding that he:

> '… should continue to be well monitored.'

This is a theme which both the Commissioner and his advisor Dr Patton have picked up on. It is noted however, that despite [Dr B's] advice for [Mr C] to be "well monitored", the PO and advice change the term to:

- "close monitoring" – pages 33, 45 and 52; and
- "high level of monitoring" – page 41

Whilst it may only be an issue of semantics, there is concern that the loose changing of terminology may result in a different emphasis being placed on [Dr B's] chosen words.

In any case, the letter from [Dr B] was not received until 31 March 1999, as evidenced by the date stamp. [Dr I] also wrote on the letter that [Mr C] had been readmitted to [the Mental Health Hospital] since the receipt of the letter. Indeed, [Dr I] had already seen [Mr C] the previous day (30 March) and transferred care back to [Dr B] by 31 March 1999.

In light of the above matters, it is hard to see how the conclusion that [District Health Board C] was not proactive can stand. This is particularly so when

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considered in the light of staffing issues. [District Health Board C] Mental Health Services is a General Psychiatry service, and during this period of care, [District Health Board C] employed one forensic psychiatric nurse who had responsibilities across the service. Bearing in mind that the town of [Town C] is approximately 45 minutes drive from [City C], and that the forensic nurse was caring for [City C] based patients as well, we believe that the amount of care provided to [Mr C] by the Forensic Nurse was reasonable in the circumstance.

Family Involvement

Dr Patton states at page 42 of the PO that there is no reference in the notes of the discharge meeting to [Ms C]. The [District Health Board C] notes for the discharge meeting clearly indicate however that [Dr B] had met with [Ms C] prior to the discharge meeting. The [District Health Board C] discharge planning meeting notes also record [Ms C's] concerns, as conveyed by [Dr B] to the meeting.

Whilst the [District Health Board B] notes are not [District Health Board C's] responsibility, it is noted that even they refer to [Ms C]. They note that: "[Dr B] will be available to [Mr C] and his partner [Ms C] in crisis…".

Dr Patton also states at page 42 that the notes of the 23 March visit make no reference to the concerns raised by [Ms C] in her telephone call of 22 March to the Forensic Psychiatric Nurse. We simply do not agree. As transcribed above, [Ms C] rang on 22 March with the following concerns:

- [Mr C] leaving the relationship;
- [Mr C] moving to his own home; and
- [Mr C] starting shearing against [Dr B's] advice.

The notes of the 23 March visit by [the Forensic Psychiatric Nurse] to [Mr C] read as follows:

> "23/3/99 1300 hrs – Feels more settled, w/e not good, though was pleased to do some shearing found it stressful – esp. alcohol after the day. He did not partake.
> He reported some concerning thoughts over the w/e but more settled.

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He had decided not to move rather attempt to address his situation and find solution and ? rethink things after Winter!
Though he finds shearing hard, doing little at home he finds just as tough.

- Given educational information on schizophrenia and respiridone and encouraged to work only part time if he must.
- Plan Discuss forensic team meeting.

(signed) Forensic Psychiatric Nurse'

Quite clearly, the notes record that the issues of shearing and leaving home were discussed. Again, the finding that the notes make no reference to the concerns raised by [Ms C] the previous day, is simply and clearly wrong.

In summary, Dr Patton's advice proceeds on the basis of a number of now identified factual inaccuracies:

- [Dr B] had legal responsibility, as the Responsible Clinician under the Mental Health Act 1992, to arrange the psychiatric follow-up in [District Health Board C's] region. She put no formal steps in place to this effect until the 25th of March 1999.

- Forensic Psychiatric Nurse saw [Mr C] on the 12th, the 17th, the 23rd and the 31st of March 1999 (four times in a period of twenty days). This was despite the discharge plan suggesting fortnightly visits only by the [Forensic Psychiatric Nurse] from the 12th March 1999. Further, the [Forensic Psychiatric Nurse] was available for telephone contact by [Ms C] on 22 March 1999, and arranged for [Mr C's] case to be discussed at a Forensic Team meeting on 23 March, with follow-up contact with [Dr B] on 24 March.

- [Ms C's] concerns were recorded at the discharge planning meeting on the 12th March.

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– [Ms C's] concerns of 22 March 1999 were also followed up and discussed with [Mr C] at the 23 March 1999 home visit.

This being the case, the validity of Dr Patton's advice, as it relates to the period of 12 March 1999 to 31 March 1999, must now be questioned. Clearly, if he has proceeded to give his opinion on the basis of a false appreciation of the facts, then the opinion cannot be relied upon.

Further, as identified above, [District Health Board C] provided care during this period against a background of staffing issues. These issues were known to [Dr B], and notwithstanding the presence of such issues, it would appear for the Inquiry Report that she still knowingly discharged [Mr C] into [District Health Board C's] care. Finally, as Responsible Clinician, [Dr B] had the legal responsibility for granting leave to [Mr C] under the Mental Health Act, not [District Health Board C]. We suggest that against this background, [District Health Board C] provided reasonable care to, and maintained reasonable contact with, [Mr C], in the circumstances.

Complaint Five:

This complaint is that:

> '[Mr C's] family were not consulted about or involved in his treatment and discharge plan and were not kept informed during his treatment.'

The [District Health Board C] notes do refer to [Ms C] in a number of places, commencing with the first nursing note of 14 July 1998. It is clearly noted that [Mr C] was seen with [Ms C], and that they were keen to get matters sorted so that they could settle.

It is desirable to note that patients receiving treatment under the Mental Health Act have the right to make decisions, as does any person, except where such decisions relate to psychiatric treatment during the assessment period of the committal process, or during the first month of a compulsory treatment order.

Dr Patton's advice states at page 41 that:

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There is no reference in the [District Health Board C] notes to any view of [Mr C] in regard involvement of his partner. There is no reference to this being a subject of discussion between him and the clinical staff'.

[District Health Board C] refutes this comment. On the file note entry for 7 August 1998, [Mr H] records as follows:

> "… I declined to offer any information which [Mr C] has shared with me in our sessions after satisfying myself that he was in no immediate danger as a result of my maintaining his confidentiality. …"

Whilst not clearly and forthrightly expressed within the notes, this file note indicates that [Mr H] had undertaken to maintain confidentiality with [Mr C]. Indeed, [Mr H] uses the test of "immediate danger", which is consistent with the test set out in Rule 11(2)(d)(ii) of the Health Information Privacy Code 1994, to determine whether or not disclosure of information is justified. It was clear that disclosing the information to [Ms C] was not necessary to prevent immediate danger to [Mr C]. Indeed, had [Mr H] disclosed information to [Ms C], he could well have been in breach of the Health Information Privacy Code, and Rights 1(2), 3, and 4(2) of the Health and Disability Code.

Indeed, the fact that [Mr C] expected confidentiality to be maintained is supported by the file note made by [Mr H] of 8 August 1998, which states:

> '… I agreed to provide [name of person] with oral and faxed information regarding [Mr C] in order to facilitate an effective mental health assessment by the team up there. I believe [Mr C] is now presenting sufficient cause for concern that it is in his best interests for me to provide the background information. I contacted on-call psychiatrist at the MHU in City C at 1548 hrs and he supported my contention that there were sufficient and justifiable reasons to undertake this course of action … .'

Notwithstanding the fact that clinical staff maintained [Mr C's] confidentiality, he was encouraged to involve his partner in understanding what was happening – 18 August 1998. On 21 August 1998 she was spoken to and her concerns were noted. Further, the file note of 22 September records that:

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> '… I will attempt to make telephone contact in the next day or so. Hopefully, [Ms C] may be able to advise how things are.'

[Ms C] was also utilised as a contact point on 12 October 1998, 23 October 1998, 2 November 1998, 30 November 1998 and 22nd March 1998.

Another comment that Dr Patton makes which [District Health Board C] refutes, is Dr Patton's comment at page 42 that there is no reference to [Ms C] during the discharge meeting at the Mental Health Hospital on 12 March 1999. This matter is discussed in further detail above, under Complaint Four – Family Involvement.

It is also noted that in the vast majority of visits to or from [Mr C], it is only him in attendance. Again, this was an indication of his desire to have privacy and confidentiality, as despite being encouraged to involve [Ms C] on 18 August 1998, he continued to attend visits without her present.

We also note the comments of the Inquiry under the section "Interface with the Family". It is noted in that Report that supporting [Mr C's] wishes was a staff task that was on occasions in opposition to supporting [Ms C's] wishes. This is consistent with the view that [District Health Board C] had of matters, as detailed to the Commissioner in our letter of 21 March 2000.

Whilst [District Health Board C] can understand Dr Patton's statement that:

> 'There does appear to have been less involvement of family than would ordinarily be desirable.'

It is our view that this is consistent with the decisions made by [Mr C].

Regrettably for the family, [District Health Board C] were prevented from involving them in a more in-depth manner by [Mr C's] choices. The reality is that [Mr C], as the patient, was the primary concern of [District Health Board C]. Whilst clearly the family have an impact on [Mr C's] treatment, the level of their involvement was driven by the need for [District Health Board C] to respect [Mr C's] privacy and autonomy. In our view, it would seem unfair that [District Health Board C] is now criticised for abiding by the patient's decisions.

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Complaint Six:

This complaint records that:

Despite [Ms C] continuing to advise the [Town C] Mental Health Team that she was concerned about her husband's condition, services were not increased and advice was given that they considered [Mr C] to be well.

The points of contact from [Ms C] are as follows:

- 7 August 1998;
- 8 August 1998;
- 10 August 1998;
- 21 August 1998;
- 12 October 1998;
- 30 November 1998; and
- 22 March 1998.

7 August 1998 Contact: This was a call from [Ms C] to advise that [Mr C] was in police custody in [City A]. It was clearly recorded on [District Health Board C's] file that [Mr C] had had previous contact with [District Health Board A's] Mental Health Services (within the previous month). No concerns regarding [Mr C's] condition are recorded. Rather, the concerns appear to relate to his disposition in policy custody, and it is not apparent, at that time, that he was arrested for a crime related to his illness. Contrary to the complaint, the note does not record that he was considered to be well.

8 August 1998 Contact: This was a call from [Ms C] to advise that [Mr C] had been processed by the Courts, and was now in another town, but that there were concerns as to his condition. She was advised to ask her friends in that town to arrange for [Mr C] to be assessed. [Mr H] contacted a Duly Authorised Officer from the region's Mental Health Service, and arranged for appropriate information to be forwarded to them to enable them to assess [Mr C]. Clearly, appropriate steps were taken. Contrary to the complaint, the note does not record that he was considered to be well.

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10 August 1998 Contact: This was a call from [Ms C] to advise that [Mr C] was now a voluntary patient under that region's Mental Health Services, and that he was likely to be discharged that day. She was advised to contact [District Health Board C] when [Mr C] returned to [Town C]. This would have been to enable the [Town C] Community Mental Health Team to implement appropriate follow-up with [Mr C]. It is also noted that [City A] Mental Health Services contacted [District Health Board C] to advise them of their perspective of [Mr C's] contact with services over the preceding days. Contrary to the complaint, the note does not record that he was considered to be well.

21 August 1998 Contact: This was a visit from [Mr C], and it would appear that [Ms C] also attended. Her concerns regarding a suicide note written by [Mr C] are noted. It is noted that [Mr C] considered taking off, and the reasons as to why he considered this are recorded. It is noted that he was forward looking with constructive plans for the weekend. The entry concludes by recording that [Ms C] phoned back and was aware of how to contact the service if needed. Contrary to the complaint, the note does not record that he was considered to be well.

12 October 1998 Contact: This was a phone call to [Mr C]. He was at work and [Ms C] answered the call. The note records her concerns that [Mr C] is not getting better, and records that the couple are talking openly about his depressed mood. [Mr C] was seen by a psychiatrist four days later. Contrary to the complaint, the note does not record that he was considered to be well.

30 November 1998 Contact: The file notes that [Ms C] contacted the on-call service and advised them that [Mr C] had taken off. It is noted that [Mr H] and another nurse believed that [Mr C] may be a risk to himself and/or others, and they contacted the [Town C] Police to alert them to the situation. The file then records that on the following day [Mr H] attended a police station in another town where [Mr C] was in custody. In conjunction with a Nurse, a Duly Authorised Officer, [Mr H] assessed [Mr C], and referrals were made for [Mr C] to be detained under the Criminal Justice Act 1985. Contrary to the complaint, the note does not record that he was considered to be well.

It is accepted that more proactive action could potentially have been taken by [District Health Board C] for the contact of 12 October 1998, however we do

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not accept the contention that the other contacts were not managed in a sufficiently proactive manner, or that [Ms C] was advised that [Mr C] was considered to be well.

Actions/Recommendations:

Multi-disciplinary Reviews: All [District Health Board C's] Mental Health Service Teams now have regular review systems in place. It is noted that the 1997 National Mental Health Standards require a monthly review, and [District Health Board C's] Mental Health Services Review Systems are compliant with this. The 2001 National Mental Health Sector Standards have recently been released, and our Mental Health Services Quality Facilitator is currently facilitating the implementation of these new standards across the Mental Health Services.

Whilst we do endeavour to have Psychiatrist input to such reviews, this does create difficulties due to workforce shortages. [District Health Board C] only has two Consultant Psychiatrists, despite continued efforts to recruit further Psychiatrists. We are currently hopeful of filling some of these positions in the near future however.

Teleconferencing: [District Health Board C] currently has arrangements with another District Health Board in this regard. [A Consultant Forensic Psychiatrist at a city there], provides supervision for Forensic patients on a weekly basis, with the additional support of telemedicine consultations for specialist risk assessments. This arrangement is in the process of being renewed, thus providing a guaranteed continuation of this service.

Initial Assessments: Mental Health Services have revamped policies regarding assessments on initial service contact. All clients are now required to have a thorough assessment at their initial contact with the service.

Proactive Management of Heightened Concerns: Whilst [District Health Board C] does not accept that it failed to react in an appropriate manner to [Ms C's] concerns (with the exception of the 12 October 1998 contact), the existing Risk Assessment Policy requires patient's cases to be revisited where the risks they pose and/or face increase.

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It should be further noted that since this case took place, [District Health Board C] have put in place a crisis team known as the [District Health Board C] Mental Health Emergency Team. The following summary of the service is taken from a recent Coroner's case involving a former [District Health Board C] client. The Coroner made a recommendation to the Ministry of Health that the team concept be considered as a prototype for other areas.

> 'The Team comprises nine people, usually Duly Authorised Officers. The service is an on-call mobile service. The Team meets daily and during the rest of the day their work is carried out in response to referrals. There are two teams of two people on call at any time. The team covers the wider regional area. They work very closely with the Police. Telephone referrals come to the Team from the public, patients themselves, general practitioners, the Police, or from other mental health services. They have an 0800 number.'

Family Involvement: Whilst the Board is of the opinion that it maintained appropriate family contact in accordance with [Mr C's] wishes, we do advise that the Mental Health Services have an ongoing educational programme, which covers issues such as family involvement and patient privacy. The current education programme makes a record of sessions attended by staff, thus enabling the Board to ensure that all staff are aware of these issues.

The service is also in the process of filling a position of a Family Adviser. This will be a joint appointment between the Board and a third party private provider. The position is intended to be an advisory/education position, allowing families to have more input into care and treatment of their loved ones.

We trust that the above sufficiently outlines the Board's position. Documentation regarding the above comments on the recommendations is available on request.

We await your consideration of the above matters, and the release of the Final Opinion in due course.

Yours faithfully

Legal/Risk Adviser"

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Appendix III
Further Expert Advice
Dr Murray Patton, Psychiatrist

"Thank you for your letter of 5 October, in follow-up of my discussion with a HDC legal advisor. I received your letter along with the letter of 14 September 2001 from [District Health Board C] (Legal Risk Advisor: [Mr C] – Provisional opinion) and with a copy of the document "A Report by the Health and Disability Commissioner (Case 99/07220)".

I shall address each of the questions raised in your letter in the order in which they appear, and shall comment upon relevant components of the response from [District Health Board C].

1. Period of trial leave 12-30 March 1999

I agree with the comment by [District Health Board C] (page 5 of letter of 14 September) that it is important to look at this whole period in the context of the discharge meeting of 12 March.

The [District Health Board C] notes record the plan agreed at that meeting. Those notes do not reflect a concern later expressed in writing by [Dr B] in her letter of 25 March, that [Mr C] "… should continue to be well monitored."

The [District Health Board B] notes of 12 March of the discharge planning meeting do not record any comment in regard intensity of follow-up. Those notes reflect an intention that [Dr I] would provide follow-up, but note too that the possibility of follow-up by [Dr J] would be explored.

As I note in my earlier opinion at section 4, it is possible that there was not clarity in regard which doctor would be responsible for follow-up. In my view this should have been made clearer. The responsibility for such clarity at the time would rest with [Dr B], as Responsible Clinician.

There are none-the-less other components of follow-up necessary in addition to medical assessments by psychiatrists.

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By the time of the discharge planning meeting the history that led to [Dr B's] concerns that [Mr C] be well monitored was clear.

Although not explicitly documented in the notes of the discharge meeting (and perhaps therefore reflecting that this was not explicitly discussed), monitoring would be an appropriate safety measure in light of that history. Such monitoring in my view would include visits by other members of a clinical team. Such monitoring would involve not simply making a visit, but in the course of these visits undertaking and reviewing the mental state examination and making an assessment of the presence of factors that contribute to an increase or decrease in the clinical risk.

A visit did take place by a [District Health Board C] staff member on 17 March, five days after discharge. There is no record of a mental state examination or of any other attempt to assess risk. There is no evidence of these assessments taking place on 23 March, despite this visit having been a response to a call of concern from [Ms C] on 22 March.

[District Health Board C] note that [Dr B] had the legal responsibility to instigate discharge planning. As a Responsible Clinician that was indeed her responsibility. It would have been appropriate, in view of her apparent concern that [Mr C] should be well monitored, to promptly investigate the possibility of [Dr J] being involved and to advise [District Health Board C] of the outcome in a pro-active manner. As it happened, the possibility of [Dr J] being involved was clarified to [District Health Board C] in response to a phone call initiated by [District Health Board C] to [Dr B].

[District Health Board C], in their response to the provisional opinion, noted at page 5 and extract of the Inquiry in relation to perceived absence of adequate outpatient services which made discharging [Mr C] into the community problematic. The Inquiry adds that there were shortages in clinical staff in [[Town C]] that had a bearing on decisions made about [Mr C's] discharge into community care.

I have noted no reference in the [District Health Board C] notes or [District Health Board B] notes to indicate that [District Health Board C] expressed a concern to [Dr B] that they could not provide adequate follow-up. [Dr B] made the discharge arrangement in conjunction with [District Health Board C]. [Dr B] appears to

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have been aware of limitations in clinical coverage in [District Health Board C], but I see no reference to her being advised by [District Health Board C] that [Mr C] was unable to be followed up sufficiently closely and that discharge to [District Health Board C] might therefore need to be reconsidered.

[District Health Board C] at page 7 of the response to the Provisional Opinion notes that [the Forensic Psychiatric Nurse] planned to make fortnightly visits. As I note above these visits by another clinical team member are appropriate to supplement the appointments for medical review. The first visit took place 5 days after discharge, earlier than the "fortnightly visits" noted in the discharge plan.

[District Health Board C] note further visits on 23 March and 30 March. These were not pre-planned visits. The visit of 23 March was a reaction to the call from [Ms C] on 22 March. It was certainly appropriate to visit then, given that call on 22 March. The plan was to visit again in 2 weeks. I remain concerned though that given the stress noted in the visit of 17 March that a visit earlier than 2 weeks later should have been planned, especially in light of a history of quick deterioration in his mental state. I accept that other plans were also made, but the only intervention that appears likely to have allowed further immediate review of mental state was the plan to visit again in 2 weeks.

I repeat my concern too that sufficiency of follow-up is not just a matter of frequency of visits, but must include what occurs on those visits. Despite the stress noted on 17 March there is no documentation that a mental state examination was conducted, nor that risk assessment was repeated. Similarly there is no documentation of these on 23 March, despite the call of concern from [Ms C] the day before.

[District Health Board C] notes 'flexibility' (page 7 of response to Provisional Opinion) in their follow-up as demonstrated by attending on 23 March, rather than at 2 weeks from March 17 as planned. To do otherwise however in the face of the call of concern would have been a marked failure to respond appropriately. I do not agree that this is an example of proactive management, as the visit appears to have been entirely in response to the call of 22 March. As such though, it was a proper thing to do.

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Discussion with the team, as noted following the contact on 23 March, was also appropriate. There was however no documented basis for determining the level of intervention that should occur beyond the discussion that took place. Contact with [Dr B] was in accord with the plan agreed at the time of discharge on 12 March. Arranging an appointment on 30 March was also appropriate. I am not clear whether [District Health Board C's] assertion that now (23 March) arranging an appointment with [Dr I] was an example of proactive management is correct, as it was known on 17 March that follow-up with Dr J was not an option. The notes though are not clear on which date efforts to arrange this appointment began. The entry on March 17 notes '[Forensic Psychiatric Nurse] to start referral process to [Town C] CMHT for <u>counselling'</u> (my emphasis), although they also note that there was discussion with [Dr B] regarding medical follow-up with [Dr I]. The signature is illegible. The reference to an appointment on 30 March occurs 6 days later, on March 23.

To summarise therefore in relation to whether follow-up was appropriate the following points are made:

- I accept that it was [Dr B's] responsibility to arrange ongoing care, and that she appears to have clarified to [District Health Board C] [Dr J's] unavailability only after [District Health Board C] made contact with her 5 days after [Mr C's] discharge. She did not formally transfer care to [Dr I] until her letter of 25 March, nearly 2 weeks after discharge, by which time [District Health Board C] had already had several contacts. More urgent transfer to and prompt communication with [Dr I] would have been compatible with her concerns that [Mr C] will be monitored.
- In light of [Mr C's] history I believe that a frequency of visits greater than fortnightly was appropriate. A fortnightly visiting frequency is reflected in the discharge plan notes, along with the comment '… or more if warranted'. This presumably was endorsed by [Dr B]. I believe however that the call on 22 March suggested that more frequent contact than in a further 2 weeks (as was the outcome of the visit the following day) was warranted. I accept [District Health Board C's] assertion that staff constraints may have limited what could be offered but I have seen no reference to discussion in any of the documentation of plans that [District Health Board C] advised they would be limited in their responsiveness, and that the discharge should be reconsidered accordingly. Even at a frequency of 2-weekly, as planned, I would expect that

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a mental state examination would be completed and documented and that a risk assessment would be reviewed. Even more emphasis is placed on the need for this if alerts are raised in the form of calls of concern from caregivers. I could find no documentation of these matters in relation to the visits of March 17, 23 or 31.

It would only be on the basis of a clear understanding of mental state and risks that a proper determination could accurately be made as to whether more, or less, frequent visits were 'warranted', yet the [District Health Board C] notes of the discharge meeting of 12 March suggest that such flexibility might apply.

- [District Health Board C] (at page 9) note my earlier comments regarding lack of reference in the notes of 23 March to the concerns identified on 22 March. I accept my earlier comments may be ambiguous. My intention was to note that on 23 March there is no documentation of discussion with [Ms C] that day in relation to those concerns, or to [Mr C's] response. I accept that [District Health Board C's] comment in relation to complaint 5 that [Mr C] did not give permission to discuss matters with [Ms C], and I shall discuss this below, but in brief I note at this point that I believe [Ms C] ought to have been involved in discussion at this point in view of her concern and her potentially valuable role in monitoring [Mr C's] well-being.

I remain of the view therefore that services were not of an acceptable standard.

2. Family involvement in treatment
[District Health Board C] notes at page 10 that patients receiving treatment under the Mental Health Act have the right to make decisions.

I agree.

[District Health Board C] at page 11 refers to my advice in regard [Mr C's] view about involvement of his partner, pointing to a file entry of 7 August 1998. I agree with [District Health Board C's] comment that this file entry does not clearly and forthrightly express that [Mr H] had undertaken to maintain confidentiality with [Mr C]. Rather it simply notes that information would not be provided.

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In my view however, even following discussion with and confirmation by [Mr C] of this approach, it would have been appropriate (and arguably even necessary) for the clinical team to work with [Mr C] to have him allow full involvement of his partner in discussion about his illness, treatment and progress. [Ms C] was clearly concerned, and involved. She initiated contact on a number of occasions. She appeared aware of features indicating deterioration in health. She could have been a valuable resource to the team, especially if there were indeed constraints upon their contact because of staff shortages.

I can find no record of attempts to persuade [Mr C] to allow such discussion, nor even any record that it was thought that such effort was necessary.

[District Health Board C] draws attention (at page 11) to the exchange with [Ms C] on 7 August 1998. That record notes that she was upset and angry. I accept that the test of ‘immediate danger’ may be appropriate in relation to that particular exchange. It remains my view however that this exchange was, amongst others, a signal that discussion ought to have occurred with [Mr C] on an ongoing basis regarding sharing information with a caregiver who clearly had concerns.

[District Health Board C] notes, in the next paragraph of page 11 of their response, a record that is said to reflect the fact that [Mr C] expected confidentiality to be maintained. I am not clear how that the record of 8 August confirms that expectation. The entry relates to a conversation between health care agencies. Such transfer of information is good practice and is permitted by the Health Information Privacy Code. This entry does not make any comment about [Mr C] explicitly or otherwise consenting to or rejecting transfer of information.

[District Health Board C] points to an entry in the file recording an exchange with [Mr C] on 18 August in which he was encouraged to involve his partner in understanding what is happening. I accept that this is an indication that such involvement was viewed by this staff member as a useful part of care. I can find no other reference to continued encouragement of this, nor any record of any attempt to follow-up this suggestion and to check whether [Mr C] did so involve his partner. I accept too that [Mr C] generally attended appointments without his partner. I can find no record of discussion suggesting that he ask her to attend with him, or any other indication that this was felt to be important.

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In my view, although the suggestion that encouraging involvement of [Ms C] is in accord with the clinical team as seeing her involvement as necessary, to place the onus solely on [Mr C] and not to follow this up in any way was insufficient.

[District Health Board C] notes several occasions on which [Ms C] was used as a contact point. I accept this is so. It is however a somewhat different matter to involve someone fully in discussion about diagnosis, treatment, risk factors and management, early warning signs of relapse and of relapse prevention measures (as would be reasonable for someone very closely involved with a patient) than it is to simply involve them as a source of information. [District Health Board C] appear to have had no difficulty limiting information given to [Ms C] on account of their understanding of the Health Information Privacy Code, yet have apparently had the view that it is appropriate to gather information from her (note file entry of 22 September), despite the same Code reflecting that information would ordinarily be gathered from the individual.

[Ms C] repeatedly expressed concern (and in volunteering information it was appropriate for [District Health Board C] to record her concerns). I accept that her concern was known at the time of the discharge meeting on 12 March 1999, and that there is reference to these in that meeting. There is no reference to how she would be involved in an ongoing manner, despite these concerns.

In summary, I remain of the view that there appears to have been less involvement of the family – in particular [Ms C] – than would ordinarily be desirable. While I accept [District Health Board C's] contention that there was a need for [District Health Board C] to respect [Mr C's] privacy and autonomy, I can find no record of a systematic attempt to engage him in discussion about appropriate involvement of his partner.

3. Response of [District Health Board C] to family's concerns

[District Health Board C] notes the points of contact from [Ms C]. The original complaint includes reference to [Ms C] being given the advice by the [Town C] Mental Health team that they considered [Mr C] to be well. It is not clear whether this advice was thought to have been delivered on any particular one of this list of contact points. [District Health Board C] identifies the context of each contact and I agree that records of each do not note any advice given that they considered [Mr

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C] to be well. As I noted in my earlier advice, there is little indication of any information that was supplied to her.

There was contact with [Ms C] on August 7. That day the outcome was that the writer of the file entry decided to await further contact.

[District Health Board C] notes at page 12 that the concerns at that time 'appeared to relate to [Mr C's] disposition in policy custody, and it is not apparent, at that time, that he was arrested for a crime related to his illness.' [District Health Board C] notes too that it was clearly recorded on his file that he had had previous contact with [District Health Board A].

I agree. Amongst those records is reference to [Mr C] having '... told friends in [another town] that he was [going to travel] to speak to the Prime Minister and Police Minister' (section 8 medical certificate dated 1 July 1998). The behaviour in August for which he appears to have been arrested was consistent with that intention, which was thought by [District Health Board A] to be consistent with being mentally disordered.

In light of the contact that the service had already had with [Mr C] it may have been appropriate for the [Town C] clinician to have resolved to contact mental health services in City A to arrange review of [Mr C], rather than simply awaiting contact.

On 8 August [Ms C] again was in contact. She apparently asked for [Mr H] to contact a DAO in another region, which he did. I agree that was appropriate.

On 9 August [Ms C] again made contact, this time in relation to [Mr C's] legal status. She was advised that even if the information about his inpatient status was known, the information would not be able to be given to her. She was advised to contact [the Public Hospital], but she was reluctant.

On 10 August [Ms C] again made contact. She advised of [Mr C's] inpatient status and likely discharge and return to [Town C]. She was asked to contact the team when he returned to [Town C]. It is not clear from the note how or when the team was advised of [Mr C's] return but a visit took place on 13 August.

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Contact occurred again on 21 August. [Ms C] apparently voiced concerns about [Mr C] taking off. Later [Ms C] is noted as saying she is aware of how to contact the team if need be. There is no record of discussion of under what circumstances it might be appropriate for her to make contact, nor of indicators that might signal a need for heightened attention by her.

Further contact occurred on 12 October. [Ms C] identified concern. She was asked to phone a psychiatrist. The clinical team appears to have done nothing in response to the call and no further contact was made until 23 October when [Ms C] was contacted when a call was attempted to [Mr C]. The file note simply records she 'did not express any immediate concerns'. The record does not reflect what specific concerns were explored.

On 2 November [Ms C] was contacted, again when an attempt was made to contact [Mr C] by telephone. Things were noted to be a little better in her view, but it is noted '[Mr C] feels differently'. There is no evidence this was explored further. The clinical team took no action. No further file entry occurs until 30 November. On that date [Ms C] contacted the service noting [Mr C] had taken off.

The service responded appropriately to that call.

On one further occasion, on 22 March 1999, [Ms C] phoned the clinical team in [Town C]. In response a visit took place the following day.

In summary, I remain of the view that there was under-responsiveness to the concerns expressed by [Ms C]. [Mr C] was under the care of the service by the time that [Ms C] made contact in August 1998, it would have been proactive of [District Health Board C], in response to her call on 7 August, to have made contact with services in City A rather than await contact. I accept however that in this series of contacts on 7,8, 9 and 10 August there was no direct involvement of [District Health Board C] in providing treatment. This serious of calls was though a clear signal of [Ms C] being interested in her partner's welfare. Later in August the clinical team appears to have accepted that [Ms C] knew how to contact them if necessary, but there is no record of discussion of what might constitute an appropriate situation. I have already commented that there is no evidence of

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actively working with [Mr C] to allow open discussion with [Ms C], as would have been proactive and appropriate, and responsive to the concern of his partner.

[District Health Board C] accepts that more proactive action could "potentially" have been taken by [District Health Board C] for the contact of 12 October. In my view it is clear that much more proactive action should have been taken. As I noted in my earlier advice, there is no evidence of use of the then existing forum of multidisciplinary meetings to discuss [Ms C's] contacts and concerns. There is no evidence of repeated detailed mental status examination or risk assessment when [Mr C] was seen following the identified contacts. There was a long period with no direct contact with [Mr C] at all, even though he was still describing himself as having difficulties. There is no evidence of attempts to engage after-hours staff to see him, when the usual team had trouble in ordinary working hours.

[District Health Board C] note that there was only one forensic nurse for the region. I had not understood that [Mr H] was employed as a forensic nurse, but rather he was assigned to [Mr C] because of his prior forensic experience. Even in a capacity as the sole forensic nurse, however, I can find no record that other demands upon his time were limiting [Mr H's] ability to follow-up [Mr C], nor of efforts to engage other clinical staff in follow-up or support of his role if he was stretched too thinly across the region.

4. Action/Recommendation
[District Health Board C] notes changes in a number of aspects of service.

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Multidisciplinary reviews
All teams are now noted to have regular systems in place. I had understood however that regular reviews were in place for the [Town C] team during the period in question. I accept that [District Health Board C] now notes confidently that the Mental Health Services Review System is compliant with the National Mental Health Standards of 1997 and is facilitating the implementation of the 2001 National Mental Health Sector Standards. It may be that [District Health Board C] will be including an internal audit and reporting systems to monitor this implementation, as I know that full compliance is often difficult to achieve for a variety of reasons. Regular audit and review will facilitate identification of any causes of incomplete compliance, should such occur.

I accept that work forces shortages, especially of psychiatrists, limit specialist input to these reviews. I am pleased that [District Health Board C] is hopeful of filling psychiatrist positions, but would not be surprised to learn of continued shortages as many centres still struggle to fill psychiatrist posts. Exploring telemedicine opportunities with other centres may be helpful as an alternative, as noted in the section 'Teleconferencing'.

Initial assessment
I had understood that [District Health Board C] had previously had policies on assessment. Assessment indeed is a basic component of service delivery. Audit and reporting of compliance as part of a regular programme of clinical indicators may be useful in monitoring compliance with policy, which policy hopefully also identifies prompt completion and documentation of assessments.

Proactive management of Heightened Concern
Proactive management, in my view, is not just about having staff available to visit. I believe it is about anticipating needs on the basis of comprehensive assessments, developing understanding of risks and their context, and developing intervention strategies to respond at times of early indicators of relapse or increased concern due to patterns of contextual factors that increase risk. Frequency of visits is only part of such pro-activity.

It is significant however that there is now an Emergency Team available. As described this service sounds similar to services available in other parts of the country, and as such will add to the range of services necessary for comprehensive

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response. I would hope that the factors noted above in relation to proactive intervention will be able to be a feature of the function of this emergency service, and that it works in a manner that is concordant with treatment approaches of the other teams to which it offers additional support.

Family involvement
The development of a Family Adviser role seems an excellent initiative. Ongoing attention to proper involvement of family in services and in care and treatment is important, and the ongoing staff education programme with records of attendance is another good initiative.

Other improvements
As noted with regard to multidisciplinary reviews and initial assessments, ongoing monitoring of implementation of the policy or achievement of the standards may be useful. I have no information in regard the extent of a quality monitoring programme in [District Health Board C]. If it does not exist already, it may be useful for the service to consider what indicators are useful to monitor progress toward the standards they are seeking. One example might be the proportion of files in which risk assessments are found, or proportion of these have clearly been updated in response to significant events. Another might be the number of teleconference consultations with other centres. The range and details of such indicators could be determined by [District Health Board C] on the basis of them identifying priorities for focus in achieving compliance with the National Mental Health Standards, or other appropriate guidelines.

I note the comment by [District Health Board C] that there was only one forensic nurse for the area at the time. I am unclear whether there has been any change in the level of resourcing of community forensic staffing. It would be appropriate for [District Health Board C], no matter what level of resource is available for community forensic follow-up, to ensure that there are clear arrangements for distributing workloads according to clinical priorities, and for general community team resources and after-hours and crisis services to be available to the forensic staff to assist in providing sufficient services. If that arrangement was not in place at the time of [Mr C's] contact with the service, as is indicated by the response that there was insufficient cover by a single forensic nurse, and if it has not yet been addressed, then that must be addressed urgently.

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5. General

The response from [District Health Board C] does not cause me to change my earlier conclusions in any substantial way. I accept the comments that [Dr B] remained Responsible Clinician for [Mr C] in the period noted in March 1999 and thus ultimately was in charge of and responsible for care provided during the period for which she was [[Mr C]'s] Responsible Clinician. [District Health Board C] also had responsibilities however, including notifying [Dr B] of any limitations in their ability to provide care.

I accept too that a delay in medical follow-up was likely to be a result of uncertainty about the role of [Dr J]. I have discussed other matters however in regard sufficiency of contact in that period.

Please let me know if I can be of further assistance.

Yours faithfully

M D Patton
FRANZCP"

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